BMI The Alexandra Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

BMI The Alexandra Hospital in Cheadle is part of BMI Healthcare, the UK's largest provider of independent healthcare. BMI Alexandra Hospital is registered to provide the following regulated activities:

Diagnostic and screening.

Surgical procedures.

Treatment of disease, disorder or injury.

Our inspection was undertaken as part of our on-going programme of comprehensive Independent Health Care inspections. We carried out an announced inspection visit of BMI Alexandra Hospital on 5th and 6th July and an unannounced inspection on 13th July 2016.

We inspected the core services of Surgery, Medicine, Urgent and Emergency Care, Critical Care services for Children and Young People and the Outpatients and Diagnostics service.

Are services safe at this hospital:

Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.

Senior staff were aware of their responsibilities relating to duty of candour legislation and were able to give us examples of when this had been implemented. The hospital had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence.

Incidents were reported by staff through effective systems. Lessons were learnt and investigation findings and improvements made were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse.

Staff assessed and responded to patient's risks and used recognised assessments. We found these had been fully completed.

There were systems in place for reporting risk and safeguarding patients from abuse. Staff were aware of how to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team.

Staffing levels and skills mix was sufficient to meet patients' needs.

Equipment was maintained, appropriately checked, and visibly clean. Medical equipment was checked and maintained by an independent company.

Patient records were stored securely, and access was limited to those who needed to use them.

Staff had completed their mandatory and specialist training.

Resident registered medical officers [RMOs] were employed to provide medical cover when the named consultant was not available.

Are services effective at this hospital:

Patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges.

The hospital monitored patient outcomes through surveys to ensure that patients were

Summary of findings

satisfied with the service they received.

BMI corporate policies based on national institute for health and care excellence (NICE), national and royal college guidelines were available to staff on the intranet.

Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team.

Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. We saw there were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).

Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

Are services caring at this hospital:

Patients spoke positively about their care and treatment. Staff treated patients with dignity and respect and patients were kept involved in their care.

Patient feedback from the NHS Friends and Family Test and patient satisfaction surveys showed 97% of patients were positive about recommending services to friends and family.

Staff provided emotional support to patients and chaperones were used across the departments at the request of patients or for intimate examinations or procedures.

All of the patients we spoke to during our visit told us that they had been treated exceptionally well by staff.

We observed that staff were sensitive and understanding of the emotional impact of care and treatment. Staff told us that they put the needs of patients first.

Patients consultants, named nurse looking after them. This was to ensure continuity of care. Patients we spoke with said that staff always introduced themselves and made them feel that they were involved.

Are services responsive at this hospital:

There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.

There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Staff had attended equality and diversity training, the cultural needs and specific requirements of patients were taken into account when planning and delivering services. For example, patients attending the wards were asked about their religious beliefs and dietary requirements, in case these affected their treatment options or meal choices.

The services accessed translation services for those patients whose first language was not English, and information was available to patients in differing formats if required.

Are services well led at this hospital:

There were governance structures in place. The hospital's vision and values had been cascaded across the services and staff had an understanding of what these involved.

There was clearly visible leadership within the services staff were positive about the culture within the services overall and the level of support they received.

Summary of findings

All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

On the whole, staff across the departments spoke positively about the leaders and the culture within the hospital.

Our key findings were as follows:

There were systems in place for reporting risk and safeguarding patients from abuse. Staff were aware of how to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team. Staff completion of mandatory training for their roles was high.

Equipment was maintained, appropriately checked, and visibly clean. Medical equipment was checked and maintained by an independent company. We saw records to confirm that electrical equipment had been tested.

There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse.

The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient risks. Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team.

Patients received care and treatment according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. Surgery services participated in national audits.

There was sufficient capacity in the ward and theatres so patients could be seen promptly and receive the right level of care before and after surgery.

Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Staff treated patients with dignity and respect and patients were kept involved in their care. Patients and their relatives we spoke to told us they were supported by staff that were caring, compassionate and supportive to their needs.

There were governance structures in place which included a risk register. We saw that risks had been identified and actions taken to mitigate the risks in a number of areas that included infection control and patient safety.

All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Patient records were stored securely, and access was limited to those who needed to use them. This ensured that patient confidentiality was maintained at all times.

Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs.

Procedures were in place to ensure that consultants holding practicing privileges were valid to practice. We saw there were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).

Staff felt appreciated and valued, they discussed with us the different ways BMI recognised staff for their hard work. At a corporate level BMI championed the 'Above and Beyond' nominations, senior staff were asked to nominate staff in for this award.

There were some areas where the provider needs to make improvements.

Action the hospital SHOULD take to improve

The hospital should ensure that appropriate procedures are in place to ensure children using the diagnostic imaging department received appropriate images.

Summary of findings

The outpatient department should ensure that sufficient action is taken when the fridge containing medication lays outside of the acceptable temperature range.

The hospital should ensure that patient temperatures and visual infused phlebitis (VIP) scores were not being recorded in theatres in line with evidence-based practice in the prevention of surgical site infections.

The hospital should ensure the development of multidisciplinary working, for all teams across the hospital. For example teams should attend multidisciplinary meetings to discuss the care of patients with complex cases.

The hospital should consider including the 'cool off' period for cosmetic surgery in the consent policy.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	**Good**	We gave the urgent and emergency services at BMI Alexandra Hospital an overall rating of 'Requires Improvement'. This was because:- We could find no evidence to confirm that data was collated in relation to service delivery, we found no evidence to confirm that there was a clear, robust clinical audit process or audit plan in place. To routinely and continuously monitor patient outcomes. Patient outcomes were not monitored through an annual audit programme and achievements of key performance indicators were not reviewed. The service did not monitor waiting times to ensure patient outcomes were in line with the national and local standards. We were unable to confirm if clinical practice in the UCC met guideline standards. For example we could not determine if the UCC met the standards of the College of Emergency Medicine (CEM) Unscheduled Care Facilities as this had not been checked by the hospital. We found There was a lack of multidisciplinary working, the UCC staff team worked in silo but was supported by imaging and phlebotomy services within the hospital. For example the team did not attend multidisciplinary meetings to discuss the care to patients with complex cases. The unit planned their service without the input from patients, for example the facilities in the UCC were limited, and there were no facilities for patients with mental health issues or for children. Though there was a governance framework, the service lead and senior management did not have oversight of all clinical performance information. The unit performance was not measured through audits, there were no action plans to improve clinical practice. However,

Summary of findings

Staff received appraisals and had opportunities for development training. Medical staff who were employed under practising privileges underwent a process of review. All staff had received an appraisal in the previous 12 months.
Patients were cared for with compassion and dignity, staff were flexible and gave patients the time they needed to make a decision about their treatment.
Staff checked that patients understood their treatment options, and involved carers in their care when appropriate.
Those who had responded to the friends and family test said they would recommend the service.

Medical care

Good 

We gave the surgical services at BMI Alexandra Hospital an overall rating of 'Good'. This was because:-
All areas we visited were clean and infection prevention protocols were fully adhered to. Hand gels and signage to remind patients and staff how to wash their hands were displayed.
The rooms used to administer chemotherapy were kept locked and meticulously organised, arrangements were in place to ensure medicines, including cytotoxic substances, were ordered, stored, dispensed and administered safely.
Infection rates for all areas were low, the Richmond and Lancaster suite had no reported incidents of health acquired Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (C. difficile) in the six months prior to our inspection.
Patients and their carer's were well informed of their treatment plan and progress. Staff spent time discussion treatment options with patients, and responded empathetically when people needed help and support.
Staff had attended equality and diversity training, the cultural needs and specific requirements of patients were taken into account when planning and delivering services. For example, patients attending the wards were asked about their religious beliefs and dietary requirements, in case these affected their treatment options or meal choices.

Summary of findings

Mandatory training targets were met and new staff received a comprehensive induction. Staff were assessed on a competency based framework, which was regularly reviewed by senior managers. All ward staff followed the companies safeguarding policy and reporting procedures. Staff reported that they had good support from managers when dealing with safeguarding issues. In discussion with us, nursing and medical staff could name both safeguarding leads for adults and children who were level three trained.

Inpatient pathways contain relevant patient risk assessments including VTE risk and prompts to monitor the NEWS score, pain and nausea control, fluid balance and other important steps along the patient pathway.

Pain scores were documented in all of the patient notes we reviewed, staff asked patients to describe their pain on a scale of 0-10; 0 for "no pain" to 10 "being the worst possible pain". Both wards achieved 100% in the pain score audit. The Lancaster ward reported 88% compliance rate in May 2016 and 83% compliance rate and was reported on the Richmond ward in November 2015.

Provisions to support patients whilst in hospital were in place, a beautician visited the hospital to carry out any beauty treatments. A wig and scarf service to support patients with hair loss from Chemotherapy was also available and specialist cancer support services were offered to oncology patients.

Governance arrangements were robust, regular review of incidents, complaints, audit results and policy development ensured learning was shared appropriately.

However ;

? Information about patient's outcomes was not routinely collected and monitored. This meant that the hospital was unable to benchmark it's practice against national or local standards. However the ward did collect data for three CQINs. This information was provided to the local commissioning group.

We found that the quality of documentation recorded by consultants, within patient medical records not always complete. 13 sets of medical

Summary of findings

records were reviewed; we found that all clearly documented, patient information about allergies, diagnosis and specific patient needs. Notes we reviewed also held a clear patient management plan. However, the grade of medical doctor was not always present and two of the notes we reviewed did not contain signatures from medical staff after changes were made to medication.
We found no audits of patient's outcomes in any area with regards to the efficacy of the treatment they had received. This meant that departments did not collect data or monitor patient outcomes to improve their service or clinical practice.

Surgery

Good

Start h
We gave the surgical services at BMI Alexandra Hospital an overall rating of 'Good'. This was because: -
Patients received care from sufficient numbers of well-trained staff.
Systems were in place to ensure the competence and compliance of consultants operating under practising privileges.
Staff were kind, caring and compassionate and high numbers of patients would recommend the hospital to their friends and family.
Outcomes from surgery were good.
Care was mostly provided in a timely way and in line with evidence based-practice.
The hospital participated in national audits and benchmarked its service with other providers.
Leadership and culture in surgery services was positive and open.
Staff and the public were involved in developments and service improvement initiatives
Nursing staffing was regularly reviewed and calculated based on patient acuity and dependency. Staffing in theatre was in line with national guidance.
There were clear processes in place to access resident medical officers and consultants 24 hours a day. Clear systems were in place to manage the care of deteriorating patients.
Staff were encouraged to report incidents and were aware of how to report an incident. The reporting system was paper based, with a different form for clinical and non-clinical incidents. There

Summary of findings

had been 262 clinical incidents in surgery between April 2015 and March 2016. This was not high when we compared this to other independent health (IH) providers. The majority of these incidents were graded as no or low harm, indicating a good reporting culture.

There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse.

Medicines were stored safely and given to patients in a timely manner.

Care and treatment was delivered in line with national guidance and best practice. Hospital policies and pathways reflected evidence based care and treatment.

The hospital participated in a number of national audits of patient outcomes including patient reported outcome measures, DENDRITE and the AQUA orthopaedic audit. There were also plans to submit data to the SPINE TANGO database for neurosurgical patients to allow outcome measurement and national comparison.

There were systems in place to ensure the competence of consultants working with practising privileges at the hospital. Staff were supported to develop their skills through additional training. Eighty-two per cent of staff had completed the 2015/2016 appraisal and the hospital was on target to achieve 100% compliance for all eligible staff.

The medical advisory committee (MAC) provided clinical scrutiny in relation to evidence based care and treatment. If consultants wanted to introduce new treatment methods or procedures, the evidence and guidelines for these procedures was reviewed by the MAC and approved if this was appropriate. Minutes we reviewed showed that the MAC refused permission to carry out procedures where there was insufficient evidence to support the use of the procedures.

There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

There were systems in place to support vulnerable patients. Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Summary of findings

There were governance structures in place which included a risk register. The hospital's vision and values had been cascaded across the surgical services and staff had an understanding of what these involved.
There was clearly visible leadership within the services.
However,
Patient temperatures and visual infused phlebitis (VIP) scores were not being recorded in theatres in line with evidence-based practice in the prevention of surgical site infections.
Do not attempt cardiopulmonary resuscitation forms were not immediately visible within the medical record. In all patient records we reviewed, the DNACPR section was blank.
Staff assessed and responded to patient's risks and used recognised assessments but these were not always fully completed.
The hospital had not implemented recognised schemes to help meet the individual needs of patients living with dementia.
Some staff had not completed their mandatory training or had an up to date appraisal

Critical care

Requires improvement

Star
We gave the critical care services at BMI Alexandra Hospital an overall rating of 'Require Improvment'.
This was because:-
We found a patient had been prescribed potassium, and the prescription sheet was poorly documented; there was no indication of dilution, or duration and no record of the level of potassium to commence the treatment at.
Patients admitted to the unit were not were not screened on admission for delirium, as recommended by NICE guidance. During illness, hospitalization, or recovery from surgery or stroke, many people experience delirium, a rapidly developing and severe confusion accompanied by altered consciousness and an inability to focus.
Patients were not routinely screened for delirium on admission and this was not in line with Faculty of Intensive Care Medicine (FCIM) guidance.

Summary of findings

Results of safety thermometers were not shared amongst staff or patients and data gained from the safety thermometers did not appear to be used to improve service delivery.
We did not see any evidence of how the service was monitoring itself against other BMI Hospitals.
We found that the unit did not have a follow up clinic where patients could reflect upon their critical care experience. This was not in line with Guidelines for the Provision of Intensive Care Services, 2015.
However:
All patients and relatives we spoke to said that their care, treatment and condition had been explained to them throughout their stay.
The BMI patient satisfaction survey for April 2016 showed that 92.3% of patients said that they were 'definitely' involved in the decisions about care and treatment.
The hospitals Patient-led assessment of the care environment (PLACE) scores for privacy, dignity and wellbeing were 87%, which is in line with the England average.

Services for children and young people

Good

We gave the services for children and young people at BMI Alexandra Hospital an overall rating of 'Good'. This was because:-
Children and young people were cared for by sufficient numbers competent staff. Parents spoke very highly of the caring and compassionate nature of staff.
Systems to safeguard children and young people were effective. There was evidence that consultants holding practicing privileges for children had been assessed as holding the relevant skills and experience.
Systems within the outpatient booking programme ensured a registered children's nurse, trained in safeguarding children level three and European paediatric life support was always available within the hospital, regardless of the location of the child or young person.
Risks to children and young people were effectively managed. The service took pro-active steps to prepare for potential deterioration of a

Summary of findings

child through regular practice cardiac arrest calls and there were good systems in place to transfer patients to ICU and subsequently a relevant NHS hospital for ongoing care.
All staff on the children and young person's unit had received and up to date appraisal. Consultants were expected to hold practising privileges for the care of children and young people and there were systems in place to ensure competence in this area.
Parents or guardians were encouraged to stay with their child on the ward, in the anaesthetic room and on return from recovery.
Parents were provided with emotional support and reassurance from nurses whilst their child was in theatre.
Care and treatment was provided in line with evidence based practice and guidance. The individual needs of children and young people were considered and responded to. The recently established children and young people quality care sub-committee provided a forum to learn from incidents, discuss governance and risk management.
Children and young people were cared for in an environment suitable for their needs with a range of toys and facilities for parents to stay overnight. The unit had considered the needs of young people, and evaluated the provision of a room for this patient group.

Outpatients and diagnostic imaging

Good

We rated Outpatients and Diagnostic imaging as 'Good' overall because;
There were systems in place for reporting risk and safeguarding patients from abuse. Staff were aware of how to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team.
Clinical areas and waiting rooms were all visibly clean and tidy. Infection prevention and control practices were in place and monitored.
The departments used evidence based guidance to inform their practice and to approve new procedures. The diagnostic imaging and

Summary of findings

physiotherapy departments were auditing their practice to monitor the effectiveness of their work. Staff completion of mandatory training for their roles was high.

Staff in all the departments were caring and compassionate. Patients were positive about how they were treated by staff. Staff maintained patient privacy and dignity across the departments. Patients were kept well informed about the treatment they were receiving in the hospital. Staff provided emotional support to patients and chaperones were used.

Services were planned and delivered to meet the needs of patients. The departments were open outside of working hours and the service was routinely exceeding the referral to treatment targets for patients waiting to be seen as outpatients. Staff understood how they could provide a service to patients with additional needs. From observations we saw that equipment was maintained, appropriately checked, and visibly clean. Medical equipment was checked and maintained by an independent company. Additionally, equipment and electrical equipment was tested and monitored by the on-site facilities team. We saw records to confirm that electrical equipment had been tested.

There were appropriate governance processes and reporting structures in place and on the whole, staff spoke positively about the leaders and the culture within the services. While the services did not have formal strategies, they each had plans to develop the services they offered.

Patient records were stored securely, and access was limited to those who needed to use them. This ensured that patient confidentiality was maintained at all times.

Patients and their relatives we spoke to told us they were supported by staff that were caring, compassionate and supportive to their needs. Patients had a choice of appointments available to them through the 'choose and book' service. This allowed patients to be able to attend appointments at a time best suited to their needs.

The hospital had a risk register which highlighted risks associated with the daily operation of the

Summary of findings

hospital. We saw that risks had been identified and actions taken to mitigate the risks in a number of areas that included infection control and patient safety.

All staff told us that managers of the service were approachable and supportive. We observed managers to be present on the department providing advice and guidance to staff and interactions were positive and encouraging.

However,

The outpatient department were not taking sufficient action when the fridge containing medication was outside of the acceptable temperature range. The departments also did not have their own risk registers.

While the outpatient department regularly checked the resuscitation equipment, the log book did not accurately record when equipment passed its expiry date and some of the equipment in the paediatric resuscitation trolley had passed its expiry date.

Summary of findings

Contents

Good

BMI The Alexandra Hospital

Services we looked at

Urgent Care services; Medical care; Surgery; Critical care; Services for children and young people; Outpatients and diagnostic imaging;

Summary of this inspection

Background to BMI The Alexandra Hospital

BMI The Alexandra Hospital is part of BMI Healthcare, the UK's largest provider of independent healthcare and opened in October 1985. BMI The Alexandra Hospital is located in Cheadle, Cheshire. The hospital has seven theatres, two endoscopy suites, a day care unit and a 12 bedded critical care unit. The BMI Alexandra Hospital treats both NHS funded patients, and patients who wish to pay for their own treatment.

The registered manager and accountable officer for controlled drugs for BMI Alexandra Hospital is the hospitals executive director, Simon Shepard, who has been in post since 2016.

The majority of the consultants are from local NHS trusts. The main surgical procedures undertaken at the hospital include hip and knee replacements and gynaecological procedures. These are undertaken between Monday to Friday and Monday to Sunday one week a month. The outpatients and diagnostic imaging services at BMI The Alexandra hospital covered a wide range of specialties including breast clinics, Cardiology services, Cosmetic surgery, general medical admissions, Neurophysiology, Orthopaedic services and Oncology services.

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services. We carried out an announced inspection visit on 5 and 6 July 2016 and an unannounced inspection on 13 July 2016.

BMI The Alexandra Hospital has previously been inspected by the Care Quality Commission in February 2014 . Five core standards inspected and were found to be compliant.

Our inspection team

Our inspection team was led by:

Inspection Lead: Inspection Manager Care Quality Commission

The team included a CQC Inspection Manager, four CQC inspectors and a variety of specialists, these governance specialist, consultant surgeon, senior nurse manager Operating department assistant, critical care specialist and an outpatient services manager.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 5 and 6 July 2016 and an unannounced inspection on 13 July 2016.

We spoke with a range of staff in the hospital both individually and as part of a focus group, including the registered manager, nurses, consultants, administrative, ancillary and clerical staff.

During our inspection we reviewed services provided by BMI The Alexandra Hospital in the ward, operating theatre, outpatients and imaging departments.

During our inspection we spoke with patients and staff, including a consultant surgeon who was chair of the Medical Advisory Committtee[MAC]. We also spoke with family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients. We also reviewed data provided by the hospital and local commissioners of the service.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

? Is it safe

Summary of this inspection

? Is it effective

? Is it caring

? Is it responsive

Information about BMI The Alexandra Hospital

BM The Alexandra Hospital is located inin Cheadle, Cheshire. The hospital has seven theatres, two endoscopy suites, a day care unit and a 12 bedded critical care unit. The BMI Alexandra Hospital treats both NHS funded patients, and patients who wish to pay for their own treatment.

BMI The Alexandra Hospital was built in 1981 and is currently using 128 of its 172 registered beds for inpatient/day case activity. The hospital has an urgent care centre, seven theatres, an endoscopy suite, a minor procedure unit, seven bed day care unit, a complex range of diagnostic radiology services, a physiotherapy department with links to off-site hydrotherapy, six level three and six level two critical care beds. The hospital has a twelve bed critical care which means that the hospital covers a full range of complex patients from those that have multi organ involvement to those that have single organ involvement. The hospital has 108 Single rooms all of which provide an ensuite facility.Facilities also include; 34 Consulting rooms, eight daycase beds, seven theatres and three treatment rooms.

The main surgical procedures undertaken at the hospital include cataracts, hip and knee replacements and gynaecological procedures. These are undertaken between Monday to Friday and Monday to Sunday one week a month. The outpatients and diagnostic imaging services at BMI The Alexandra hospital covered a wide range of specialties including orthopaedics, Ear Nose and Throat (ENT), urology, dermatology, gynaecology, neurosurgery, ophthalmology, general surgery, and cosmetic surgery.

There were 19,905 inpatient and day case episodes of care recorded at BMI The Alexandra Hospital in the reporting period (Apr 15 to Mar 16); of these 15% (2,900 patients) were NHS funded and 85% (17,005 patients) were other funded.

The outpatient facilities consist of 34 outpatient consulting rooms, a minor procedures unit and two treatment rooms. The hospital provided outpatient physiotherapy services in a dedicated physiotherapy department which had 6 treatment rooms and a gym.Between April 2015 and March 2016, the hospital had 127,755 outpatient appointments

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24/7 by an onsite resident medical officer (RMO.) Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital. Doctors have practicing privileges and their individual activity is monitored.

Good

Urgent and emergency services

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

Information about the service

The urgent care centre (UCC) at the BMI Alexandra hospital offers care and treatment for minor injuries service to adults and to children from the age of three years. It offers self-paying patients diagnosis and treatment for minor accidents and injuries on a walk in basis and also provides travel health. Patients are referred to the UCC from their consultant or GP and triaged accordingly. Staff were trained to provide patients with advice and treatment for minor injuries or minor complications. Patients, who attend with major injuries or complicated illness, were medically reviewed and stabilized before being transferred by ambulance to the local accident and emergency (A&E) department. The Centre is open seven days per week from 10.00am to 8.00pm Monday to Friday and 10.00am to 6.00pm on a Saturday and Sunday. Start here.

Summary of findings

There were processes in place to report, investigate and monitor incidents. Incidents were reported appropriately and we were assured that staff fully understood their role and responsibilities in relation to reporting of incidents.

Nurses often staffed the unit by doing overtime and there was usage of bank and agency staffs to ensure staffing numbers were safe. However we were not assured that senior managers understood staffing requirements of the unit as they did not monitor the number of attending patients against the number of staff. There was a robust system in place to monitor and re-assess staff competencies. Staff were well informed of safeguarding processes and clearly understood how to identify and escalate concerns.

All areas we visited were visibly clean and tidy. Staff adhered to 'bare below the elbows in clinical areas' guidance. The unit was small but had facilities available to patients such as drink machine and toilet's nearby. The privacy and dignity of patients were maintained, doors of the consulting and treatment room were always closed when patients were being examined.

The service did not provide care and treatment that took account of best practice policies and evidence based guidelines. The service did not have clear standards agreed with commissioners and key performance indicators to monitor performance and standards of service delivery. Data was not collated in

Good

Urgent and emergency services

relation to service delivery, there was no clear, robust clinical audit process or audit plan in place to routinely and continuously monitor patient outcomes. Records we reviewed were clear, legible and up to date.

There was a clear system in place for the service to review medical staff practising privileges. The review process also checked to ensure doctors were operating within scope of practice. Data showed 100% of nursing staff and 100% of medical staff had received an appraisal 2015/2016.

Feedback from people who used the service was positive about the way they were treated. People were treated with dignity and respect by staff and we observed staff being considerate and compassionate towards patients. Patients who presented with complex needs, were identified as high risk, they were referred to a local NHS trust to ensure all their needs were met appropriately. Systems were in place to obtain consent from patients and consent was well documented in the patient record.

Whilst the clinical lead could clearly articulate the vision for the service there was no clearly defined and documented strategy in place. It was clear the management team were committed to improving governance processes but systems were not yet embedded and further work was still required. Learning from audits, incidents and manager meetings should have been cascaded via team meetings. However, due to service demand and the use of bank and agency staff, team meetings did not happen regularly.

Are urgent and emergency services safe?

Good

We rated safe as good

The Unit was visibly clean and there were good infection prevention and control practices to reduce the risk of infection. Patients were triaged to make sure only those that were suitable of admission to the ward were admitted.

All patients were admitted to the ward under a named consultant.

Equipment was well maintained and tested in line with manufacturer's guidance.

Medicines were stored and handled correctly. All medicines checked were in date and accounted for.

Mandatory training targets were met, staff received a comprehensive induction when they started.

Staff had an awareness of safeguarding and steps to take to prevent abuse from occurring. We were given two examples of safeguarding concerns that were escalated appropriately.

However

There were sufficient nursing and medical staff to provide safe medical care. However staff we spoke with told us that they were often unable to attend courses or mandatory training sessions, because there were too few staff to allow them to attend.

Incidents

There were established systems for reporting incidents and 'near misses' in the urgent care centre. All staff had received training and were confident with using the incident reporting system. Incidents were initially documented on a paper based form and transferred to the electronic system. This meant that staff duplicated entering the information and was time consuming. There were six incidents reported in the Urgent Care centre (UCC) from the reporting period April 2015 – March 2016.

None of the incidents reported, highlighted any concerns regarding overall patient safety.

Good

Urgent and emergency services

Staff were familiar of the process for reporting any identified risks to staff, patients or visitors. There were good examples of learning from incidents, for example changes in the way patients were triaged was implemented following an incident investigation.

The unit was small which allowed staff to informally update each other of the outcome of investigations after the formal review had taken place.

Staff in the UCC were fully aware with the duty of candour regulation (Regulation 20), they were able to describe the concept and understood the organisation's responsibility to be transparent and open as set by the Duty of Candour requirement. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

There was a visibly high standard of cleanliness throughout the urgent care centre. Staff were aware of current infection prevention and control guidelines and observed good practice. Hygiene audits demonstrated a high level of compliance the unit had suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in all rooms. Staff adhered to the 'bare below the elbow' policy when providing care and treatment Personal protective equipment (PPE), such as disposable aprons and gloves were used as appropriate. Staff were 100% compliant with hand hygiene between April to June 2016

Hand gel and sanitisers were readily available on entry to clinical areas and on entering the ward. Signage above sinks displayed the correct way for staff, patients and supporters to wash their hands. The display boards were clear and visible reminding everyone to wash their hands to reduce the risk of infection. We observed personal protection equipment such as gloves and aprons in all areas.

We reviewed the hospital infection control policy and this provided clear guidelines about preventing the spread of infection. The infection prevention and control (IPC) policy was in date and an infection prevention and control work plan for 2015/2016 was in place. The plan took into consideration the amendments made to the Adult and Social act 2008 and had identified areas of improvement. Where actions were outstanding the organization used a RAG rated system to inform senior managers if they were not meeting deadlines in a timely way.

The UCC did not have an area to isolate patients; a side room was used to isolate patients if there was a risk of cross infection.

Environment and equipment

The UCC had a dedicated entrance not far from the main reception; the waiting area was not staffed but was clean.

The space in the unit was limited; the waiting area was small with a small table for children books. There was one triage room and two consulting rooms to treat patients. However if the UCC was busy and patients required further monitoring the triage room became blocked and there was nowhere else to triage patients.

In the past six months the treatment room was occupied with two fracture neck of femur patients who required an ambulance. Waiting patients were unable to be triaged which caused delays.

The UCC was not divided into different areas depending on the acuity of patients, all patients sat together; this included children.

The resuscitation area had resuscitation equipment; all equipment was checked and monitored. The trolley was clean, regularly checked and ready for use. The resuscitation equipment had comprehensive checks and these were up to date with a check list for July in place. However there was adequate adult resuscitation and medical equipment in the UCC but not equipment was not specific to paediatric resuscitation equipment. Following our inspection we received confirmation from the provider that a Paediatric Resuscitation trolley was available near the Consulting Suite. However the Paediatric Resuscitation Trolley was situated through an adjoining door

We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that they had been inspected and were safe to use. The asset registered showed maintenance contracts for three items in the UCC were up for renewal at the end of September.

We found that there was a no call button in the triage room; this meant staff could not summon help in the event of an emergency.

Good

Urgent and emergency services

Medicines

There were systems in place to demonstrate that medicines were handled securely, and were securely stored and accounted for.

We saw that medication was stored in locked cupboards, within clinical rooms. Controlled drugs were checked daily in all the areas we visited.

Medicine fridge temperatures were consistently checked, recorded, and were within the safe temperature ranges. All medications in fridges were labelled and systematically stored. Medication that had been opened was dated so that staff were able to discard them if they exceeded the expiry date.

Drugs for use on the unit were stored in a room that had its ambient temperature monitored daily. This was to ensure that the room temperature did not go above the maximum recommended temperature of 25°C.

Records

The UCC used a combination of paper records, which were stored securely, and also completed electronic medical records that allowed patients to be tracked through the department and hospital.

A record was generated at the reception desk when the patient first registered their arrival. Information such as name, date of birth and insurance details were taken and added to the electronic record. All healthcare professionals recorded care and treatment using the same document.

We looked at eight sets of medical records; they were all clearly documented, containing information about allergies, diagnosis and a clear management plan. However, all the records we reviewed did not have evidence of a documented pain score.

A copy of the discharge letter and patient referral letter was given to the patient and a copy was sent to their general practitioners (GP) once the patient had been discharged.

Safeguarding

The systems, policies and procedures for safeguarding children and vulnerable adults were robust, well understood and supported by staff training.

All nursing staff had received child and vulnerable adult safeguarding training, this was not in line with the intercollegiate safeguarding guidelines. However not all staff had completed level 3, the senior manager was aware of this and had training booked.

All ward staff followed the trust's safeguarding policy and reporting procedures. Staff reported that they had good support from managers when dealing with safeguarding issues.

Staff were aware and had a good understanding of Female Genital Mutilation (FGM). A member of staff described the steps and actions taken when a patient presented with FGM. All the appropriate measures were taken by all staff involved.

Mandatory training

Staff had access to mandatory training but found it difficult to attend training days because there were too few staff to allow them to leave the department.

Systems were in place to identify staff, which required updated mandatory training. The service maintained a training matrix to identify training completion levels.

Data received from the hospital confirmed that 95.83% of all staff in the UCC had completed their mandatory training.

Registered medical officers (RMOs) were required to send evidence of their mandatory training to the hospital this was recorded in their files.

Assessing and responding to patient risk

Staff advised that they relied on observations and the national early warning score (NEWS) to identify patients whose condition was at risk of deteriorating. An assessment of the patients symptoms would be made by the consultant before a management plan was agreed. For example a patient presented with a fracture neck of femur, once triaged, staff agreed that the patient needed to be transferred to a NHS hospital due to comorbidities and age.

We were unable to determine if and how the centre was prioritising their patients according to risk. This was because there was no monitoring or auditing of triage or assessments in the UCC.

Good

Urgent and emergency services

The UCC worked within the admission policy set by BMI, this policy contained agreed criteria for admission to the service. All patients who were admitted to the ward from the UCC were admitted under the care of a named consultant.

Systems were in place to ensure that patients received prompt medical assessment and support should their condition require it. For example, when a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to a member of the medical team who provided a review and updated treatment plan. Once they were stabilized, they were transferred by ambulance to a local accident and emergency (A&E) department. A total of 98 patients were referred to the NHS during June 2015 – May 2016. Patients who were transferred were triaged and did not meet the criteria for admission/further care - including urgent and routine referrals.

Staff in the UCC had access to laboratories for certain diagnostics. This was particularly relevant for patients with suspected pulmonary embolism or cardiac related problems. Staff advised that any patient presenting with a chest pain were normally transferred out via ambulance to the NHS.

The UCC was supported by an insensitive during operating hours; this meant there was a resident medical officer (RMO) in the hospital that was able to provide first line emergency treatment.

In discussion with staff, concerns were raised regarding staffing levels on the UCC; staff reported that the rise in patients attending the UCC caused 30% of patients not being triaged within 15 mins as per national standards. Staff reported that there was no flexibility to cope with increased patient attendance numbers, which had the potential to impact on patient safety.

We reviewed eight patient records and saw that there were detailed information relating to care plan and management of presenting symptoms and diagnosis.

Nursing staffing

Two nurses worked in the UCC across seven days, at present the UCC was currently staffed to their established nurse staffing level. However we unable to identify if this was sufficient because the unit did not use a acuity tool or monitor the number of patients triaged.

Nursing staff who worked in the UCC had experience of working within a NHS accident and emergency setting and were trained in advanced life support (ALS). At the time of the inspection only one nurse was trained in paediatric life support (PLS), this staff member worked part time. If a child presented at the UCC when the trained nurse was not working, a paediatric nurse was requested from the childrens ward. However, if the children's ward was busy this need was not always met.

Nursing staff told us they did not have dedicated administrative staff to support the service which meant that nurses were responsible for all administrative duties. There were no plans to recruit an administrator.

Medical staffing

Urgent care services were provided by two consultants who had been granted practising privileges by the hospital. Checks were carried out by the medical advisory committee (MAC) before granting the consultants practising privileges. These checks included certification on their scope of practice and assurances that they were trained to manage patients in an urgent care setting.

The Clinical lead, attended meetings with the senior management team representing the centre.

Both doctors who worked in the UCC were employed through an agency and had at least a years' experience in accident and emergency.

The clinical lead for the UCC advised that staffing of the UCC was "adequate and safe". Guidance from the College of Emergency Medicine states that a 'Service should have a minimum of ST4 or equivalent working in the department when the service is open', both doctors met this criterion. The UCC doctors were available and onsite during operating hours, patient notes were reviewed and further investigation such as x-rays, bloods, and ECG's were ordered. The doctors in the UCC advised that they were able to access support from the other consultants who worked within the hospital if necessary.

Patients were initially triaged by a nurse from the UCC; an initial clinical assessment was carried out prior to being seen by the doctor. After being reviewed by the doctor, patients were either discharged or admitted to the hospital or transferred out by ambulance to a NHS hospital.

Major incident awareness and training

Good

Urgent and emergency services

Staff we spoke with were not aware of a major incident policy and reported that they had not been part of any formal skills and drills practice.

Chemical spillage equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (CBRN).

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Staff were not provided care and treatment that took account of best practice policies and evidence based guidelines. The service did not have clear standards agreed with commissioners and key performance indicators to monitor performance and service delivery.

Policies and procedures were not fully developed but staff sought guidance from national Institute for Health and Care Excellence (NICE).

Patient outcomes were not monitored through an annual audit programme and achievements of key performance indicators were not reviewed. The service did not monitor waiting times to ensure patient outcomes were in line with the national and local standards.

However,

Staff received appraisals and had opportunities for development training. Medical staff who were employed under practising privileges underwent a process of review. All staff had received an appraisal in the previous 12 months.

Staff understood how to seek consent from women, including children under 16 years of age.

Evidence-based care and treatment

Policies and guidelines were not developed but staff sought guidance from national Institute for Health and Care Excellence (NICE). At the time of the inspection the unit was developing chest pain pathway and were looking to develop further pathways to streamline practice.

We were unable to confirm if clinical practice in the UCC met guideline standards. For example we could not determine if the UCC met the standards of the College of Emergency Medicine (CEM) Unscheduled Care Facilities as this had not been checked by the hospital.

There was no information on patient outcomes as they were not routinely collected and monitored. The UCC did not participate in relevant local and national audits, benchmarking, accreditation, peer review, research and trials, which meant that it was not clear that the intended outcomes for people were being achieved.

Pain relief

Patients said they felt that their pain and analgesia administration had been well managed but we did not see any pain scores documented on eight of the case notes we reviewed.

Procedures were in place to ensure that patients received pain relief if it was requested. The unit held analgesia such as paracetamol, ibrupophen and codeine.

Nutrition and hydration

The hot and cold drinks machine was available to patients waiting in the UCC; staff told us that they informed patients if they were going to be waiting for longer than 15 minutes, so that they could go to the hospital canteen.

Patient outcomes

The UCC did not conduct any patient outcome audits such as ED waiting times, readmissions or returns to the service following assessment at the UCC. The unit did not meet the criteria for any of the College of Emergency medicine audits due to the low number of patient they treated.

Competent staff

All staff received a trust induction when commencing employment, which included basic life support, health and safety and fire training. Staff on the UCC had completed the BMI corporate and hospital induction programme, and developed and maintained competencies specific to their role.

Competency assessments were included as part of the induction system within the hospital. These included the use of equipment and medicine administration. This meant that staff were observed to be competent before carrying out procedures or using equipment alone.

Good

Urgent and emergency services

Nurses we spoke with were aware of the requirements of the Royal College of Nursing (RCN) revalidation scheme. The hospital had arranged workshops to support the nursing staff through this.

The Medical Advisory Committee (MAC) was responsible for ensuring any new consultant were only granted practising privileges if they were competent and safe to practice. This meant the MAC carried out checks, according to BMI's practising privileges policy, before allowing new consultants practicing privileges.

The MAC required consultants to annually evident their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their admitting privileges were renewed.

We saw professional documents of three registered medical officers; all documents were up to date and had been checked.

All staff we spoke with had undergone an annual appraisal due to some staff changes. The hospital provided evidence that 100% of staff had undergone an appraisal in the previous year. Staff told us they found the appraisal system useful to discuss their progress and career aspirations with their line manager. For example nursing staff had completed an immunisation course and had put forward a business case for advanced practitioner nursing course.

Multidisciplinary working (in relation to this core service)

There was a lack of multidisciplinary working, the UCC staff team worked in silo but was supported by imaging and phlebotomy services within the hospital. For example the team did not attend multidisciplinary meetings to discuss the care to patients with complex cases.

Doctors had access to other consultants from within the the hospital; they told us that there was always someone available if they had a query.

Seven Day Service

The UCC operated a seven service but this was not a 24 hour service. during out of hours patients were directed to the local NHS A&E.

Access to information

Senior managers attended Comm Cells meetings each morning, allowing senior managers to convey any relevant information to ward staff. .

Staff were asked to read and sign Standard Operating Procedures to confirm that they understood the information.

Discharge letters were sent to the patient's GP with details of the treatment provided once they had been discharged. Letters detailed follow up advice, arrangements and medicines provided. A copy was also given to the patient their information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

During the inspection no patients were subject to a deprivation of liberty application, but staff were able to discuss with us their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards(DoLS)

Records reviewed showed discussions with patients and verbal consent was documented.

Staff recorded confirmation that the patients was given appropriate information regarding the charges and treatment before they underwent the treatment they had been offered. Written consent was obtained prior to treatment and monetary charges were explained to them.

Are urgent and emergency services caring?

Good

Patients were cared for with compassion and dignity, staff were flexible and gave patients the time they needed to make a decision about their treatment.

Patients we spoke to felt care was person centred and the advice they received was easy to understand.

Good

Urgent and emergency services

Staff checked that patients understood their treatment options, and involved carers in their care when appropriate. Those who had responded to the friends and family test said they would recommend the service.

Patients gave positive feedback about the caring aspect of the service. They consistently said they had felt listened to, were given clear explanations by staff and had been involved in decisions about their treatment.

The service offered patients the opportunity to discuss their treatment plan, so that they were informed about the costs and process once they were admitted on to the ward.

Compassionate care

Staff delivered care in a kind and compassionate way; we observed staff speak with patients in a caring and helpful manner. One patient referred to himself as a regular attendee and said he wouldn't go anywhere else because the staff were so friendly and supportive.

? Patients were taken into the treatment room and screened in privacy. We noted that door signs were in use to indicate when a room was occupied. Doors to all rooms in the UCC were closed at all times.

The hospital received feedback from patients via the Friends and Family Test (FFT), for the period June 2015 to May 2016 the hospital had consistently high FFT scores which was above the national average. This was based on a moderate response. The overall hospital Friends and Family Test results showed that 100% of patients said they would recommend the hospital to others. Data was not broken down specifically for the UCC.

Understanding and involvement of patients and those close to them

Staff introduced themselves to patients and explained the procedure and payment process. Patients were involved in their treatment plan and were actively involved in decision making. We observed staff explain why diagnostic tests were ordered and the next steps of their care plan.

Staff spoke with patients about the treatment options available to them and discussed the cost of treatments and the overall care plan. Patients were given time to ask questions and discuss any concerns they had. For example patients who required FAST chest management were billed a fix fee, staff made sure that patients were aware of the price and that they fully understood what was included in the management plan.

Carers or family members were able to accompany the patient into the treatment room if patients felt anxious. However in the records we reviewed we did not see any documentation of information discussed with family or carers.

Emotional support

Staff recognised that patients attending the UCC were at times distressed and anxious. Staff provided emotional support to both patients who attended the hospital, and their families.

Staff reassured patients all times by explaining to their treatment plan. The hospital provided a counselling service but staff did not always offer this to patients as they did not always need the facility.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

The unit planned their service without the input from patients, for example the facilities in the UCC were limited, and there were no facilities for patients with mental health issues or for children.

Staff within the division, did not participate in a programme of local or national audit, this meant that leaders were not able to identify areas of improvement and develop the service to meet the needs of the local people.

Staff had access to an interpretation service called "language line" and had guidance materials in a range of languages. However all information leaflets and the discharge letter were in English and given to the patient even if English wasn't their first language.

However

The service was planned and delivered to meet the needs of patients accessing the Urgent Care Centre.

Good

Urgent and emergency services

Patients with complex needs or who did not meet the clinic's suitability guidelines were referred to the local NHS trust.

People were given information how to complain and raise concerns. The service responded to informal and local complaints and monitored the action taken and identified any trends.

Service planning and delivery to meet the needs of local people

The UCC at the hospital provided treatment for people living in the North West and surrounding areas. The UCC was recommended to patients by previous attendees or referred to their GP.

Attendance in the UCC had increased from 288 attendees in January 2016 to 410 attendees in April 2016. This increased the diversity of patients who might attend the hospital but this had not been considered when planning the service.

The UCC opening hours were from 10am to 8pm Monday to Friday and 10am to 6pm on Saturdays and Sundays. Staff reported that the UCC had become busier but staffing had remained the same. It also meant that the opening times could not be extended because resources were limited.

Hot and cold drinks were available for people to help themselves in the waiting area located in the UCC.

The hospital website provided Information and an extensive pricing list of all the services the UCC provided. This meant that patients were able to review pricing before they attended the UCC. For example the unit offered travel health; a price list for injections was on the web page for patients to check.

Patients were informed of all costs when they booked into the UCC. For example if a patient was going to need additional X-ray's they were informed of the additional charges before medical staff proceeded.

We were unable to confirm if the UCC met the needs of children in line with national standards as data was not collected to determine compliance. The unit did not have any child friendly information or an adequate area for children.

The UCC had a separate waiting area which did not have adequate seating for patients and their relatives.

We found gaps in service provision for local people in the planning of services. For example the facilities in the UCC were limited, there were no facilities for patients with mental health issues or and staff could not triage more than one person when the centre was busy.

Staff within the division, did not participate in a programme of local or national audit, this meant that the divisional leaders were not able to identify areas of improvement and develop the service to meet the needs of the local people.

Meeting people's individual needs

Translation facilities were available for those patients whose first language was not English. Staff had access to a bilingual book, the book contained phrases in English and in several other languages. Staff used the book in the absence of a translator.

Nursing staff assessed patients' individual needs during triaging them and communicated to them their individual care plan. For example if a patient needed to be admitted to a medical ward, an explanation for admission was given to the patient and the ward was pre alerted about the patients' medical history and if any further support was required. This was so that additional resources to support the patient could be organised.

In discussion with us, staff were clear regarding the process in place to make information available in alternate formats. For example people who were visual impaired had access to the information they needed.

Patients we spoke with agreed that they received care and attention when they arrived at the UCC. They told us their needs were met, this was observed whilst on the announced and unannounced inspection.

There was no specific area that was dedicated to children in the UCC. The UCC had a limited selection of toys and books for children waiting in the waiting area.

Access to information was poor; we did not see any comprehensive information for patients regarding the management of their individual conditions in the waiting area. Leaflets were kept with the triage nurse and offered to patients once they were assessed.

Whilst all of the patient leaflets we saw were in English, there was no information on how to access the information in another language.

Good

Urgent and emergency services

Access and flow

A total of 3705 patients were seen between June 2015 – June 2016, of them a total of 241 paediatric patients were seen. When broken down 220 of these patients were aged 3 to 15 and 21 aged 16 to 17 years old.

The unit had only started collecting data on waiting times between arrival and triage since the end of May 2016. Therefore we were unable to statistically analysis if the service was performing within best practice or had improved their practice since the previous year. Data captured for a total of 213 patients in June 2016 showed 150 (70.4%) were triaged within the first 15 minutes of arrival and 18 (86%) were triaged within the first 30 minutes of arrival.

To reduce the amount of transfers out, patients were admitted to the ward if they were medically unfit to be discharged, between June 2016 and May 2016, 94 patients were admitted from UCC to the ward.

Discharge information was communicated to GPs, a written summary of the care and treatment was sent to GPs, so that they were aware of the patients visit to the UCC.

Learning from complaints and concerns

Complaints were handled in line with hospital policy. Staff we spoke with, sign posted patients to information about making a complaint if they were unable to deal with concerns directly. Patients were advised to make a formal complaint if their concerns remained unresolved.

The complaints procedure in place set out the various stages of complaints and the time scales for responses.

We noted that Information on how to complain was displayed throughout the hospital. We spoke with patients in the waiting room, they all knew how to raise concerns, make complaints and provide comments should they wish to do so.

At the time of the inspection the UCC had one outstanding verbal compliant from April 2016, staff told us that patients would informally comment about the waiting time before being triaged but this was resolved with an explanation.

Are urgent and emergency services well-led?

Requires improvement

Staff understood and were familiar with the BMI hospital values and told us they were committed to providing a high quality service to patients using the Urgent Care Centre.

The provider had an effective governance framework for reviewing the quality and safety of care. Performance and quality data such as incidents, complaints, policy and legislative updates were discussed at national and regional meetings.

Key messages were communicated to staff through email and a team brief.

The leadership and culture on the unit was pleasant and staff we spoke to applauded team work between colleagues.

However,

Though there was a governance framework, the service lead and senior management did not have oversight of all clinical performance information. The unit performance was not measured through audits, there were no action plans to improve clinical practice.

Senior managers were not able to identify if the unit was sufficiently staffed, no information was collected to identify attendance rates against staffing ratios.

Vision and strategy for this this core service

There was a clear vision and strategy for the hospital, staff were well informed about the hospitals developments and five year programme.

Staff we spoke with were clear on the organisational vision and strategy. There was a clear focus on providing safe and effective care and treatment in the UCC.

Governance, risk management and quality measurement for this core service

At the time of the inspection a corporate team to lead on the UCC had been formed to govern and manage the UCC throughout BMI at head office.

Senior managers understood the challenges to providing good quality care and could describe the actions needed to address them. It was difficult to arrange provisions to ensure that the quality of care and treatment was in line

with best practice. However the overall hospital family and friend test showed that patients would recommend the service to and were happy with the care and treatment they received.

Senior department leads attended governance meetings and were responsible for informing staff about the information discussed. Complaints, incidents, health and safety issues and patient satisfaction was discussed at meetings and actions were set with timely dates.

The Medical Advisory Committee (MAC) met quarterly and was attended by a group of consultants who held practising privileges and represented colleagues from each speciality service across the hospital. The MAC discussed regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.

Practising privileges of new medical staff was discussed at the MAC meeting. New consultants were granted rights to work at the hospital after a number of checks were carried out. These included; GMC history, qualifications, insurance indemnity, references and checks on their scope of practice to ensure they were undertaking procedures they were competent to carry out.

All medical staff were required to produce documented evidence of their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development annually before their admitting privileges were renewed. This information was stored centrally at head office and onsite.

We found no evidence of quality measurement, for example the UCC did not participate in regular audits and therefore were unable to evident how they had improved practice and bettered patient care.

Senior managers were not able to identify if the unit was sufficiently staffed, no information was collected to identify attendance rates against staffing ratios. Staff could not attend courses because there were too few colleagues to staff the unit.

Leadership / culture of service

Staff reported that the clinical lead for the department was visible and provided good leadership. Staff in the department felt supported and were able to raise concerns with senior managers.

Staff told us that they were able to approach management with ideas to improve the care and treatment they delivered in the UCC. For example nursing staff were looking to complete advance practitioner nursing course so that they could deliver more clinical procedures.

The hospital conducted daily management meetings called "comm cells". The heads of departments both clinical and support services and senior management team meet each morning to discuss key issues. These meetings were introduced to improve communication across the hospital and report daily performance. Managers fed back information from this meeting to their own teams; staff we spoke to confirmed that key messages were feedback.

The department did not have any administrative support which meant that clinical staff were responsible for collecting data for audits, reporting incidents, updating pathways, discharge letters and follow up calls to patients.

There was an open and positive culture across within the UCC. Staff told us that the positive open culture, promoted loyalty and teamwork among the medical and nursing teams.

Nursing staff enjoyed working on the unit; self-rostering meant they were able to maintain a good work life balance.

Staff morale on the UCC was positive and morale was high. Nursing and medical staff felt supported by one another and felt listened by their clinical lead.

Public and staff engagement

The Comm Cell meetings took place first thing every morning, which gave staff the opportunity to feed any key messages about their department.

The unit did not collect comments about the service from patients and therefore did not display information about their service.

Staff received a weekly newsletter that contained updates of any local or national changes to the business.

Staff felt appreciated and valued, they discussed with us the different ways BMI recognised staff for their hard work. At a corporate level BMI championed the 'Above and Beyond' nominations, senior staff were asked to nominate staff in for this award.

Innovation, improvement and sustainability

Good

Urgent and emergency services

A new cooperate team for urgent care centres across BMI had be formed, the unit was working towards a centralised unit so that they could benchmark patient outcomes with the rest of the independent health sector.

Good

Medical care

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

Information about the service

Medical service included delivering chemotherapy and endoscopic procedures to insured, NHS funded and self-paying patients. The hospital also provided medical care and support to those of palliative care.

The Richmond Suite was predominately a chemotherapy ward mostly used by day case patients. The ward also ran outpatient clinics for chemotherapy patients, staffed by oncology nurses.

Oncology services included diagnostics, intravenous and oral chemotherapy, chemotherapy instillations, monoclonal antibody therapy, trans-arterial and chemo-embolization.

The Lancaster Suite accepted unplanned admissions through the Urgent Care Centre (UCC).Acute medical patients with or without multiple co-morbidities were admitted to the ward under a named consultant. The Suite also took day case Orthopaedic patients.

The endoscopic unit is based in theatre areas, the unit was opened for elective procedures (where required) from 08:00 until 20:00 Monday, Tuesday and Thursday. Wednesday, Friday and Saturday from 08:00 until 17.30, in some cases, Sunday and out of hour's emergency cover was provided. Types of cases treated in the Endoscopy Unit included; Gastroscopy (Including Peg insertion etc.), Colonoscopy (Including Polypectomy, Argon therapy etc.), Gastroscopy and Colonoscopy (Including Paediatrics), flexible Sigmoidoscopy, Flexible Cystoscopy, Bronchoscopy, ERCP.

However , the unit did not accept upper GI bleeds into the Hospital.

We carried out an announced inspection of The BMI Alexandra on 5 and 6 July 2016, this was followed by the unannounced visit on 13 July 2016. We spoke with six staff, including nursing and medical staff, support and administrative staff, allied health professionals and housekeeping staff across all areas. We spoke with eight patients or their relatives using the services at the time of our inspection and reviewed 13 sets of patient records across the Richmond and Lancaster ward. We observed care and treatment and looked at information the hospital provided and other information we requested.

Good

Medical care

Summary of findings

Overall we rated medical care as good for safe, effective caring, responsive and well-led.

We found:

All areas we visited were clean and infection prevention protocols were fully adhered to. Hand gels and signage to remind patients and staff how to wash their hands were displayed.

The rooms used to administer chemotherapy were kept locked and meticulously organised, arrangements were in place to ensure medicines, including cytotoxic substances, were ordered, stored, dispensed and administered safely.

There was defined process and a policy in place for handling cytotoxic substances and cleaning chemotherapy spillages. Clinical waste, including chemotherapy waste and sharp objects, were disposed of safely.

There were clearly defined systems and processes to keep patients safeguarded from abuse. Staff were confident in escalating their concerns to the named safeguarding lead and the local authority.

Infection rates for all areas were low, the Richmond and Lancaster suite had no reported incidents of health acquired Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (C. difficile) in the six months prior to our inspection.

Staff were competent in their roles; they had received the adequate training and support in their individual learning and development.

Feedback from patients and relatives was positive, we were told and we observed patients being treated with respect and dignity at all times.

Patients and their carer's were well informed of their treatment plan and progress. Staff spent time discussion treatment options with patients, and responded empathetically when people needed help and support.

Patients received care and treatment in line with current evidence based guidance, best practice and legislation.

There was good multidisciplinary working between nurses, specialist nurses, medical staff, and allied health professionals

Senior managers in the endoscopy unit were working towards achieving Joint Advisory Group (JAG) accreditation in gastrointestinal endoscopy. An action plan was in place to achieve each stage of the JAG accreditation frame work.

There was no evidence of any long waiting times, delays or cancelled appointments. The service met national waiting times for patients requiring an endoscopy to wait no longer than 18 weeks for their procedure after referral. Consultants held their own patient records and were able to access diagnostic test results without delay.

Staff had attended equality and diversity training, the cultural needs and specific requirements of patients were taken into account when planning and delivering services. For example, patients attending the wards were asked about their religious beliefs and dietary requirements, in case these affected their treatment options or meal choices.

Staff described an open culture in their departments and felt senior managers were visible and approachable.

There was a governance structure for the senior managers of the wards and endoscopy unit to report to for concerns/ issues to be discussed.

However

Information about patient's outcomes was not routinely collected and monitored. This meant that the hospital was unable to benchmark it's practice against national or local standards. However the ward did collect data for three CQINs. This information was provided to the local commissioning group.

Good

Medical care

Are medical care services safe?

Good

Incidents

Incidents were initially documented on paper based forms and then transferred to the provider's electronic system. Staff told us that they felt this system duplicated entering the information and was time consuming.

The Lancaster and Richmond Suite's reported 91 clinical incidents in the reporting period April 2015 to June 2016, of which only 45 related to the oncology (chemotherapy service). Documentation we reviewed confirmed that all incidents were rated as low or no harm and appropriate action had been taken at the time to prevent similar incidents happening again. None of the incidents reported, highlighted any concerns regarding overall patient safety.

Ward managers told us that they discussed learning points with the staff member who reported the incidents. We reviewed 10 incident reporting forms on the Richmond suite. The forms were detailed with the incident, a log of the discussion between the manager and staff member and any lessons learned.

No never events were reported in the reporting period April 2015 to June 2016, never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Records we reviewed confirmed that staff had received training and were confident with using the incident reporting system. The hospital reported no injuries diseases and dangerous occurrences [RIDDOR] ,which required reporting under RIDDOR incidents regulations 2013. These regulations requires employers to report workplace specific incidents to the Department of Health.

Duty of Candour

In discussion with us it was clear that staff on both the Lancaster and Richmond Suite's were fully aware with the duty of candour regulation (Regulation 20), they were able to describe the concept and understood the organisation's responsibility to be transparent and open as set by the Duty of Candour requirement. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff understood the principles of 'being open'.

However we found that senior staff senior staff we spoke with, were not fully aware of the specific requirements of the duty of candour.

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

The wards gathered patient information such as hospital acquired infections and reviewed these on a monthly basis through its clinical governance processes. This information was displayed on staff notice boards, within clinical areas. Safety thermometer results were recorded monthly. There had been no reported infections, including those related to intravenous catheters, pressure ulcers, falls or blood clots

Cleanliness, infection control and hygiene

We reviewed the hospital infection control policy and this provided clear guidelines about preventing the spread of infection. The infection prevention and control (IPC) policy was in date and infection prevention and control work plan for 2015/2016 was in place. The plan took into consideration the amendments made to the Adult and Social act 2008 and had identified areas of improvement. Where actions were outstanding the organization used a RAG rated system to inform senior managers if they were not meeting deadlines in a timely way.

Richmond and Lancaster Suite's had not reported any incidents of infection including Methicillin-resistant Staphylococcus aureus (MRSA), Colostrum Difficile (C Diff) or Methicillin-sensitive Staphylococcus aureus (MSSA) in 2015/16.

There was a visibly high standard of cleanliness throughout the Lancaster and Richmond wards. Staff adhered to the 'bare below the elbow' policy when providing care and treatment. Hand hygiene audit showed staff were 90% compliant in June 2016 but 100% between April to May 2016

Hand gel and sanitizers were readily available on entry to clinical areas and on entering the ward. Signage above sinks displayed the correct way for staff, patients and supporters to wash their hands.

Personal protective equipment (PPE) was worn during clinical procedures including the administration and disposal of cytotoxic medication and when dealing with a cytotoxic spillage

We observed staff use disposable gloves, aprons when they prepared medication. This was especially important when caring for patients undergoing chemotherapy treatment who were susceptible to infection because they were immune-compromised.

Staff on the Richmond Suite were aware of the hospitals cytotoxic spillage policy and demonstrated their awareness and understanding of the local policy. Staff we spoke with discussed what actions they would take if a cytotoxic drug split and where spillage kits were stored.

Clinical waste including chemotherapy waste and sharp objects were disposed of safely. For example waste was separated in different coloured boxes to signify different categories of waste. We found had suitable arrangements for the handling, storage and disposal of clinical waste, including sharps boxes in all rooms. We saw that cytotoxic waste was disposed of in purple boxes.

Endoscopy room was clean but visually cluttered. The cleaning schedule had been signed and was up to date.

Environment and equipment

The Richmond Suite had three large consulting rooms, a chemotherapy drug room and a large waiting area. The waiting room housed a television and was well stocked with magazines, it also had designated refreshment facilities. We spoke with four members of the support staff who told us that the ward always made sure amenities were available.

There were six chemotherapy treatment rooms; they all contained a reclining chair, a small television, a trolley including sharps bins for non-infectious and infectious waste. Personal protection equipment was available on entering the room and there were chairs for people supporting patients.

There were nine patient rooms with en-suite facilities on the Richmond unit, a large room located towards the end of the unit was used for patients who were for end of life. The room was spacious, allowing relatives to congregate and spend time with their loved one.

Equipment in endoscopy unit was well maintained; contacts for maintenance and repair were in place for the endoscopes, the washer disinfector and the drying cabinet. Water pH checks were systematically sampled by an external company. We reviewed maintenance records for April, May and June 2016; these were all up to date.

Resuscitation equipment for use in an emergency [Reus] was stored securely in a designated trolley; daily records were completed so that the equipment was safe and ready for use. All drawers and shelves were fully stocked with consumables and medicines that were in date. Portable Oxygen was attached to the trolley along with a bag valve mask/ ambu bag. We noted that this, unopened and clearly marked for single use only.

Electrical equipment had been portable appliance tested [PAT]; giving assurances that equipment was safe for use. The hospital held a central register that listed all the equipment across the hospital. It also detailed maintenance contract information, so that the hospital could identify when a piece of equipment needed testing.

All areas we inspected had the appropriate equipment, such as intravenous pumps and subcutaneous syringe drivers, to maintain safe and effective care.

The endoscopy unit was not Joint Advisory Group accredited (JAG), however it had separate rooms for dirty equipment and water checks were done regularly by an external company. The service was actively demonstrating improvements and changes to their practice in line with JAG accreditation standards.

Equipment in the endoscopy unit had up to date checks. Machinery was stickered with the date it next needed to be tested.

Two of the units we visited contained equipment in the corridor. Senior managers were informed of the equipment and advised that wires and prongs were trip hazard. Managers provided us with assurance that these issues would be dealt with as a matter of urgency.

Medicines

There were arrangements in place for safe managing medicines, including chemotherapy drugs. Records we reviewed confirmed that staff responsible for reconstituting cytotoxic drugs had undergone training in line with current practice.

Good

Medical care

Whilst on inspection we saw patients attending the oncology day unit for intravenous chemotherapy. Trained oncology nurses administered the chemotherapy using a peripheral cannula or using a central venous access device.

We noted that systems for obtaining, prescribing, recording, handling, storage and securely dispensing and the safe administration and dispose of medication, followed policy and hospital protocols. For example we observed two nurses checking chemotherapy drugs before it was given to a patient; this was in accordance to the policy.

Allergies were recorded on the medicines charts, so that staff were aware of patient allergies prior to administering medicines.

Staff had access to medication when the pharmacy was closed; as medication cupboards were located on each unit. Nurses with the appropriate qualifications and training were able to dispense medications.

We reviewed a sample of medication records, and found that the stock control and drug administration records h corresponded correctly.

All areas used to store medicines were secure with digi locks and access was restricted to named staff only. There were specific procedures for staff to gain emergency access to the pharmacy out of hours, with both the resident medical office (RMO) and senior nurse holding separate access keys.

Medicines that required refrigeration were stored safely and were in date. Fridges that held chemotherapy drugs were locked with a daglock. We found no gaps in daily fridge temperature checks; temperatures were recorded and were all within the required range. Both wards had displayed the process to follow if the temperature should fall out of the safe range. Staff we spoke with, were aware of the action to take should this happen.

The Richmond Suite had a clear methodical process, when administrating chemotherapy. Chemotherapy was provided and checked by trained pharmacists and pharmacy technicians with specific training in this area. Pharmacists followed and maintained their competencies by completing specialist oncology based training. No incidents relating to the management of chemotherapy drugs were reported for during January to April 2016.

Chemotherapy trained nurses gave specific advice on how to store and handle chemotherapy tablets as a take home medicine to patients.

Records

Patient records documented information of investigations; test results, treatment and the care provided by nursing and medical staff. Patients' records were paper based and were stored securely in an area only accessed by staff.

A copy of the discharge letter and patient referral letter was given to the patient and a copy was sent to their general practitioners (GP) once the patient had been discharged.

We found that the quality of documentation by consultants, within patient medical records was incomplete. We looked at thirteen sets of medical records and found that they all documented information about allergies, diagnosis and a patient management plan. However, in three of the records we looked at we found that, the grade of medical doctor was not always present and two of the notes we reviewed did not contain signatures from medical staff after changes were made to medication. For example Oxalipatin 115mg in 5% dextrose was initially prescribed in 500ml/ 5% dextrose but later changed to 250mg in 5% dextrose. This was raised with senior managers during our inspection.

The hospital provided the CQC with a list of actions they were taking to ensure consultants understood the importance of information governance, including the keeping of accurate and complete records. All consultants would be informed of their professional responsibilities in the completion of full and accurate medical record entries. A specific, consultant documentation audit wound be conducted to review and improve standards.

Documentation received from the provider following our inspection confirmed that concerns raised during the inspection were put on the next MAC meeting agenda and documentation standards were going to be included in the next consultant update newsletter.

standards were going to be included in the next consultant update newsletter.

Safeguarding

There had been no safeguarding concerns reported to CQC in the reporting period Apr 2015 to Mar 2016.

Good

Medical care

We reviewed the systems, policies and procedures for safeguarding children and vulnerable adults and found these were robust, well understood and supported by staff training.

All staff followed the trust's safeguarding policy and reporting procedures. Staff reported that they had good support from managers when dealing with safeguarding issues. In discussion with us, nursing and medical staff could name both safeguarding leads for adults and children who were level three trained.

Staff we spoke with were aware and had a good understanding of Female Genital Mutilation (FGM).

All nursing staff had received child and vulnerable adult safeguarding training; this was not in line with the intercollegiate safeguarding guidelines but within BMI protocol. However not all staff had completed level 3, the senior manager team was aware of this and were able to provide confirmation that training had been booked.

Mandatory training

The hospital ensured that staff were committed to completing their mandatory training on an annual basis.

Staff could usually attend mandatory training face to face sessions, unless there were too few remaining staff to allow them to leave the ward.

Staff had access to mandatory training at home as well as in the workplace. This meant training could be completed through e-learning at a time most convenient to the member staff.

There were systems in place that allowed senior managers to identify which staff had not completed their training and those who were due for renewal.

Data received from the hospital confirmed that corporate mandatory training levels for staff on the Lancaster ward was 90% and 95%for the Richmond Suite in June 2016. This either matched, or was above the hospital target of 90%.

The Richmond Suite's registered medical officer's [RMO's] were employed via an external agency, prior to commencing work at the hospital. As part of the recruitment process they were asked to demonstrate evidence of mandatory training, all documents were stored on the individual doctor's electronic file. Renewal/update of the mandatory training was organised by the external agency, who updated the hospital with the required information.

Assessing and responding to patient risk

Systems on both wards were in place to ensure that patients received prompt medical assessments and support should their condition deteriorate. Staff advised that they relied on observations and the national early warning score (NEWS) to identify patients whose condition was at risk of deteriorating. For example, when a patient's health was declining, nursing staff escalated their concerns immediately to a member of the medical team who provided a review and updated the treatment plan.

Patients were triaged in the Urgent Care Centre before they were admitted to the Lancaster Suite. The triage nurse was required to locate an admitting consultant and gain authorisation from the bed manager. If a bed could not be located the patient was transferred out to the NHS for admission.

All patients with known allergies were given red allergy bracelets to wear; this was so that staff providing care or treatment were alerted to their condition.

All rooms were fitted with call bells to alert medical and nursing staff when immediate assistance was required in the case of an emergency.

Nursing staff used risk assessment tools to ensure palliative and/or end of life patients were treated with care. Nursing staff gave us examples of risk assessments they had used previously, these included the water low score, the malnutrition universal screening tool (MUST), falls prevention, pressure ulcer risk and pain assessment. This was confirmed by records we reviewed.

Risks assessments were completed to support safe care, nursing staff we spoke with told us they would verbally handover a patient's risk assessment outcome so that the plan of care was continued.

Endoscopy patients were pre-assessed prior to treatment; they were either pre assessed at the hospital or by telephone. Base line observations such as temperature and blood pressure was taken at the hospital prior to any procedure and recorded on the patients file. Staff checked

that the patient understood the treatment they were having done; they discussed risks such as dangers of driving after treatment and checked discharge arrangements.

Returned health questionnaires prior to having an endoscopic procedure were checked by a registered nurse to consider if the patient's was suitable and fit to go head. If any concern about the patients' health was identified during the pre-assessment, the doctor would be alerted and a decision to proceed would be discussed.

We did not directly observe in use the five steps to safer surgery checklist in endoscopy as the list had finished on the day of inspection. The WHO audit results provided by the hospital showed that for the period of January 2016 – June 2016 staff met the hospital compliance target of 84%. However the data was not segregated into the different surgical procedures that took place and therefore we were unable to distinguish if endoscopy were compliant.

The hospital used the World Health Organisation checklist (WHO checklist) for interventional radiological procedures. We reviewed the monthly audit of the WHO checklist. Between January and May 2016 compliance with the WHO checklist was between 77% and 98.5%. Actions had been identified to improve compliance which we saw was followed up with staff at team meetings.

Consultants reviewed patients who had undergone an endoscopic procedure prior to their discharge; this was so that they could ensure patients were fit to return home

The United Kingdom Oncology Nursing Society (UKONS) triage tool was used by oncology nurses to help identify the urgency of a specific health problem. Currently two oncology nurses were undergoing training, to ensure a detailed understanding of the UKONS tool.

Named nursing staff who had completed specialist training took it in turns to be on call to provide a 24 hour telephone triage service for patients following transfer to their home, using the United Kingdom Oncology Nurses Society (UKONS) triage rapid assessment and decision tool kit. A patient we spoke with told so that the on call telephone advice line was most helpful and was used whilst aboard.

Chemotherapy patients were assessed by the oncology nurse prior to them being discharged from the ward. They were informed about the risks of chemotherapy and were advised of the management of any take home drugs if any were given.

Although ward staff had access to laboratories for diagnostic tests and this was particularly relevant for patients who came in for chemotherapy on the Richmond Suite, we found no records which confirmed that there were audits of how timely the laboratory services were when returning bloods. This was most important when patients were suspected of neutropenic sepsis whilst they were undergoing chemotherapy, such patients should receive antibiotic treatment and blood tests within an hour of arrival, which is best practice for sepsis. This is a life threatening condition whereby the chemotherapy adversely affects the body's own defence mechanism against infection and consequently affects the bone marrow and decreases white blood cell production.

Nursing staffing

There was a dedicated nursing team working in endoscopy unit, who rotated their role in the treatment room. The lead in the endoscopy unit assured us that the staffing skill mix and competencies were appropriate for the endoscopic procedure lists scheduled at the hospital. Staff on the endoscopy unit had adopted a flexible approach to rostering in response to scheduling of endoscopic procedures. This meant that the unit was always adequately staffed and the skill mix was appropriate.

Richmond Suite was staffed to provide chemotherapy treatments every day. There were two chemotherapy-trained nurse's always on duty when a patient was booked for chemotherapy; another two nurses were undergoing their oncology training.

Richmond and Lancaster Suite's had begun to use "trend care", this was a staffing acuity tool that allowed senior managers to manage workload: nurse ratio on a shift by shift basis. The tool provided a number of reports that could be used to identify and establish nursing rosters, work process and skill mix. This was so that wards had the right staff providing the right care at the right time to each patient.

Good

Medical care

We reviewed staffing rotas from May – June 2016, staffing levels met the planned required level on both wards. There were always registered nurses on duty on the ward, including nights and weekends, to enable staff to respond to emergencies.

Bank and agency staff were used across all areas we visited, ward managers and the endoscopy lead reported that they used a small number of established bank staff., data provided by the hospital showed that less than 10% of agency and bank staff were used to staff wards we visited between April 2016 to June 2016.

We observed nursing staff conduct their handover of care to staff taking over. Handover was succinct and informative. Any concerns were passed over and the new shift made aware of any patient issues or concerns.

The units displayed required staffing versus actual staffing levels at the entrance so that patients and colleagues could see. At the time of the inspection all wards we visited met their establishment.

Staff we spoke with said they sometimes felt the pressures of being understaffed. At the time of the inspection the Richmond unit had one vacancy and the Lancaster unit had 2 vacancies .

Sickness rate were high on the Lancaster Suite, from April 2015 to March 2016 the ward reported between 0.5%-10% of staff were sick. In May 2016, sickness rates had declined from 8.8% in March 2016 to 4% in May 2016.

Sickness rates on the Richmond unit were also high between April 2015 – May 2016, the ward reported a 15% sickness rate in May 2015 and 11% in December 2015. At the time of the inspection the ward reported 4.7% of staff were sick.

Medical staffing

Medical services were provided by consultants who had been granted practising privileges by the hospital. Checks were carried out by the medical advisory committee (MAC) before granting the consultants practising privileges. Documents we reviewed confirmed that these checks included certification on their scope of practice and assurances that they were trained to manage patients in an urgent care setting.

All of the patients were admitted under the care of a named consultant. Patients were reviewed by their consultant before treatment was started.

Registered medical officers (RMO's) provided daily medical services and dealt with routine and also emergency situations with the support from the named consultant.

Consultants provided patients with either telephone advice or attended in person out of hours.

All nursing staff we spoke with felt well supported by medical staff. Doctors were available for advice whilst on site and during out of hours were contactable via telephone.

Major incident awareness and training

A contingency plan was in place for staff to use in the event of interruption to essential services.

In an event where a major incident was declared and a response was needed, staff were aware of the escalation process.

Emergency bleep holders were designated each morning at the daily morning hospital meeting to ensure that there were clear lines of accountability and responsibility in managing emergencies

The hospital had a service level agreement with the nearby trust to accept patients if they had the capacity.

Not all staff we spoke with, were aware of their roles and responsibilities and reported that they had not been part of any formal practice for these procedures. Staff were able to confirm that they had access to policies and procedures relating to major incidents.

Are medical care services effective?

Good

We have rated effective as good because;

The wards used standard care pathways commissioned and developed by BMI head office to help guide patient care.

Good

Medical care

Inpatient pathways contain relevant patient risk assessments including VTE risk and prompts to monitor the NEWS score, pain and nausea control, fluid balance and other important steps along the patient pathway.

Senior managers attended Clinical Governance and Quality Committee meetings, they met bi-monthly to discuss updates to national guidelines and audits. Where appropriate policies and procedures were updated nationally to ensure policies were in line with current information.

Safety bulletins were shared with all staff at departmental meetings and were also displayed in staff areas.

We saw good examples of multi-disciplinary team (MDT) working across departments. Staff worked collaboratively as part of the multidisciplinary team to serve the interests of patients in the hospital. Patients were provided with information which helped them to understand their treatment and care before consenting to any proposed treatment.

However;

There were no audits of patient's outcomes in any area with regards to the efficacy of the treatment they had received. This meant that departments did not collect data or monitor patient outcomes to improve their service or clinical practice.

Evidence-based care and treatment

Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and Royal colleges. Policies, guidelines and protocols were available for staff to access on the trust's intranet site.

Staff used a combination of guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges as a basis to determine the treatment they provided.

Clinical pathways had been developed to guide practice in medical and chemotherapy services. These included the 'waste management policy for chemotherapy drugs' and intravenous bolus cytotoxic therapy administration. This meant that there was clear guidance for staff, based on nationally recognised guidelines, for the care and treatment of patients having chemotherapy treatment.

We found no documented evidence that here was a comprehensive programme of audit for the areas were visited. For example there was no evidence of cancer related audits in place to ensure practice was in line with national standards. In addition there were no audits of patient's outcomes in any area with regards to the efficacy of the treatment they had received.

Pain relief

Pain relief was discussed with patients at the time of the pre-assessment and staff offered patients pain advice booklets post operatively

Following endoscopic procedures, pain scores were recorded along with clinical observations. If patients had pain control issues, nursing staff escalated their concerns to medical staff, who reassessed the patient's medication prescription.

Pain scores were documented in all of the patient notes we reviewed, staff asked patients to describe their pain on a scale of 0-3; 0 for "no pain" to 3 "being the worst possible pain". Both wards achieved 100% in the pain score audit. The Lancaster Suite reported 88% compliance rate in May 2016 and 83% compliance rate and was reported on the Richmond Suite in November 2015.

Both medical and nursing staff actively sought advice from the pharmacy team if they needed support to manage a patient's pain.

The ward sent discharge letters to the patient's General Practitioner, documenting medications given to patients on discharge. This was done to ensure that the General Practitioner was kept informed of the patient's care and treatment.

Nutrition and hydration

Food and fluid intake was monitored using food charts and fluid balance charts. Whilst reviewing patient care plans we saw Malnutrition Screening Tool (MUST) in use. Staff on the Richmond ward used the tool to assess the patients BMI status and weight loss.

People were given a choice of suitable and nutritious food and drink, and we observed hot and cold drinks available throughout the day.

Staff were able to tell us how they addressed people's religious and cultural needs regarding food. We saw that, whenever possible, there was a period during meal times when activities on the wards stopped, if it was safe for them to do so.

Good

Medical care

We noted that a selection of hot and cold food was provided on the wards at meal times. Staff assisted patients who needed support with eating and drinking, and did so in a dignified and sensitive manner.

Feedback from patient survey showed the most deteriorated satisfaction scores from May 2015 to May 2016 were choice of food, temperature of food, quality of food served and correctness of food order.

Patient outcomes

At the time of our inspection we found little evidence of participation in relevant local and national audits, benchmarking, accreditation, peer review, research and trials. We did not find any information about outcomes of people's care and treatment as it was not routinely collected and monitored, which meant that we were unable to say if the intended outcomes for people were being achieved.

Competent staff

All staff received a trust induction when commencing employment, which included basic life support, health and safety and fire training. Staff were familiar with the BMI corporate and hospital induction programme, and developed and maintained competencies specific to their role.

Competency assessments were included as part of the induction system within the hospital. These included the use of equipment, cytotoxic waste and medicine administration. This meant that staff were observed to be competent before carrying out procedures or using equipment alone.

Nurses we spoke with were aware of the requirements of the Royal College of Nursing (RCN) revalidation scheme. The hospital had arranged workshops to support the nursing staff through this.

The Medical Advisory Committee (MAC) was responsible for ensuring any new consultant were only granted practising privileges if they were competent and safe to practice. This meant the MAC carried out checks, according to BMI's practising privileges policy, before allowing new consultants practicing privileges.

The MAC required consultants to annually evident their professional registration, revalidation, indemnity insurance, appraisal, mandatory training and continuous professional development before their admitting privileges were renewed.

We saw professional documents relating to two registered oncology nurses; all documents were up to date and had been checked.

All relevant staff had completed The University of Chester Chemotherapy Administration course. They held certification for cytotoxic waste, Control of Substances Hazardous to Health (COSHH) and waste management for Primary Producers of Healthcare Waste.

All staff we spoke with had undergone an annual appraisal due to some staff changes; however only 80% of staff on the Lancaster ward and 70.6% of staff on the Richmond ward had undergone an appraisal in the previous year. Staff told us they found the appraisal system useful to discuss their progress and career aspirations with their line manager.

Multidisciplinary working

Medical, nursing and ancillary staff all described good multidisciplinary working. All of the staff we spoke with where highly complementary of their colleagues. All staff told us that team work across all wards was good and everyone communicated well across the various disciplines.

There was a supportive culture of multidisciplinary working between nurses, specialist nurses, doctors, and allied health professionals within the hospital. This included both inter hospital multi-disciplinary working and between the hospital and the community.

All Oncology patients received a clinical MDT review of their care; whilst these were co-ordinated within the NHS, the hospital did not always ascertain a full copy of the patient's record which meant at times the action plan was not comprehensively recorded.

Seven-day services

Medical staff had access to out of hour's services for radiology, pharmacy, and non-clinical support via an on call system.

Good

Medical care

The chemotherapy service was provided between 8am to 8pm, Monday to Friday. Patients were also offered an on call oncology service. This was available to all oncology patients and acted as a triaging system.

Arrangements were in place if prescribed medicines were required outside of the pharmacy opening.

Access to information

Key polices were listed on the hospital's intranet, for example infection prevention and control, medicines management and chemotherapy guidelines.

Staff were able to show how they obtained results of blood tests and x-rays electronically.

We found that chemotherapy service provided a wide range of information which supported patients and their relatives to make decisions about their care and treatment and the services available to them.

Discharge letters were sent to the patient's GP with details of the treatment provided, on the day of each consultation. Letters detailed follow up advice, arrangements and medicines provided. These were also copied to the patient for their information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

During the inspection no patients were subject to a deprivation of liberty application, but staff were able to discuss with us their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards(DoLS)

Records reviewed showed discussions with patients and verbal consent was documented.

Staff recorded confirmation that the patients was given appropriate information regarding the charges and treatment before they underwent the treatment they had been offered.

Records we reviewed confirmed that written consent was obtained prior to treatment and monetary charges were explained to them.

Are medical care services caring?

Good

We rated caring a good because

Care and treatment were delivered to patients in a person-centred and sensitive way.

Patients and their partners/relatives were actively involved in care plans, and patients told us they felt involved in the decision-making process.

People's individual preferences and needs were reflected in how care was delivered. Feedback from patients was complimentary; they felt care was delivered with compassion and dignity.

Staff were motivated and keen to provide the highest care that promoted people's dignity. Patients received advice and support after discharge from an endoscopy procedure, a chemotherapy treatment in oncology and on the medical ward.

We noted that relationships between people who used the service, those close to them and staff were particularly caring and supportive.

Provisions to support patients whilst in hospital were in place, a beautician visited the hospital to carry out any beauty treatments. A wig and scarf service to support patients with hair loss from Chemotherapy was also available and Macmillan support was offered to oncology patients.

Compassionate care

Staff recognised the importance of delivering good patient care and understood the impact it had on patients and those close to them. Friends and family test (FFT) reported 99.8% said they were treated with dignity and respect.

Staff were welcoming and treated patients with care and compassion. We observed good rapport and interactions between patients and all staff. For example chemotherapy patients described the continuity of care as good, as they saw the same team of medical and nursing staff when they visited.

Good

Medical care

Staff took the time to interact with people who used the services and spoke with them in a respectful and considerate manner. Patients were asked about their preferences for sharing information with family members.

We saw and heard examples of compassionate care. Every patient we spoke with was extremely positive about the care they received.

Patients we spoke with applauded the care they received and were complimentary of the staff.

Through observations we saw that staff were attentive and delivered compassionate care.

Endoscopy staff described ways in which they reassured patients who were anxious about the procedure. For example staff maintained dialogue throughout procedures, with explanation and reassurance.

All questions we asked patients and carers were answered positively. For example patients in the Richmond Suite told us staff called them after treatment to check if they were feeling well and if they weren't they would continue to monitor them with regular calls.

The Friends and Family test demonstrated that over 98.2% of patients recommended the hospital between May 2015 to May 2016. This was above the national average across both NHS and private patients. The hospital reported a 51.2% response rate of short FFT postcard forms and 21.8% for long forms.

To maintain privacy bedroom doors were kept closed for any patient discussions.

Feedback showed that the five most deteriorated Satisfaction Scores from May 2015 to May 2016 were choice of food, temperature of food, quality if food served, correctness of food order and bathroom facilities.

Understanding and involvement of patients and those close to them

Staff gave examples of improving patient care by describing ways in which they had involved patients in their care plan. For example the Richmond suite encouraged relatives to stay with patients throughout their admission or appointment where appropriate to reduce anxieties about cancer treatments.

Patients across both wards had named consultants, named nurse and HCA looking after them. This was to ensure continuity of care. Patients we spoke with said that staff always introduced themselves and made them feel that they were involved.

Patients and carers told us they felt supported and were given appropriate and timely information to participate in their care and treatment. For example insured patients were told what was and what was not covered by their insurance and arrangements were made if they wanted care they were not insured for by directing them to NHS Services.

All the patients we spoke with felt involved in their care and were kept informed about their treatment. Care plans were shared with patients. The FFT results in May 2016 showed 97.5% of patients said they were informed about medication side effects compared to 94.8% in May 2015.

The hospital patient satisfaction survey showed overall 99.7% of patients felt they were involved in their care and treatment.

However the patient satisfaction report reported 4% of patients said they the information pack given to them prior to admission did not contain all the information they required. The report did not state what information was missing and it did not breakdown which areas of the hospital this feedback related to.

Emotional support

The service provided emotional support to both patients and their families who attended the hospital. The oncology services provided their patients with quarterly afternoon teas which were held at the hospital to help patients come together and share their experiences.

All patients we spoke with said they were able to telephone the ward after discharge, for further help and advice about any concerns or questions they had.

The oncology nurses actively communicated with clinical nurse specialists and counselling services when patients required their services. We spoke with one patient who said during treatment for bowel resection a year ago staff were helpful and supported his care with 24 hour advice and specialist emotional support services. The patient also added that this hospital was not local but the care was worth the commute.

Good

Medical care

Staff discussed how the emotional and social needs of a patient were assessed as part of their care. Results from this assessment were incorporated in the care plan.

Visiting times were not restricted, family and friends were encouraged to visit their relative regularly for emotional support.

A beautician visited the wards to provide patients with beauty treatments, including haircuts and manicures. This was so that patients had access to these facilities as inpatients.

Oncology nurses had good links with external companies to support their oncology patients. For example a wig and scarf service was available at the hospital to support patients with hair loss from Chemotherapy.

Macmillan support was offered to oncology patients, the ward was accredited a MacMillan award for the work they had done to improve oncology care.

The hospital did not have a dedicated multi-faith room but instead offered patients quiet room for prayer or meditation, upon request at the hospital reception.

Are medical care services responsive?

Good

We rated responsive as good because:

The medical services responded to the needs of the local population by providing services to insured, NHS patients and self-paying patients.

Over 90% of patient were satisfied with the admission process, nursing and medical care they received and room facilities.

There were no waiting lists for oncology services at this hospital.

The hospital met their CQUIN targets, achieving 96.6% in all three areas; leadership, dementia and pre assessment.

Patients' religious and cultural needs were met and were taken into account when planning and delivering services.

An interpreter service was available for patients whose first language was not English.

Complaints were managed in a timely way, and lessons were learned and shared.

However,

Patient letters were normally written in English even if English was not the patient's first language.

Service planning and delivery to meet the needs of local people

Endoscopy procedures were carried out on insured (private), NHS funded and self- paying patients.

The senior team were engaged with the local clinical commissioning group to support effective planning of the services.

Patients had their chemotherapy delivered via intravenous lines, staff told us they rarely used medical appliances that were installed beneath the skin, or peripherally inserted central catheters (PICC) lines.

Relatives were offered refreshments if they wished to stay with their loved one.

The hospital saw a high number of international patients. Staff we spoke with were culturally aware and had a flexible approach to cater for patients' individual needs such as their religious/spiritual celebrations or fitting in around visitors who may have travelled some distance.

Access and flow

To improve access and flow, patients admitted from the urgent care centre were assigned a consultant upon admission to the ward. This was so that these patients could be reviewed immediately and treatment started.

Patients who were referred by their GP as an outpatient were asked to attend a pre assessment appointment before an endoscopy procedure, to assess the patient and discuss a plan of treatment. This meant the flow of patients could be planned for in advance. Consultants undertook endoscopy procedures within two to four weeks of referral.

The unit had only started collecting data on cancer waiting times, therefore we were unable to statistically analysis if the service was performing within best practice or had improved their practice since the previous year. Data captured for a total of 213 patients in June 2016 showed 150 (70.4%) were triaged within the first 15 minutes of arrival and 18 (86%) were triaged within the first 30 minutes of arrival.

To reduce the amount of transfers out, patients were admitted to the ward if they were medically unfit to be discharged, between June 2016 and May 2016, 94 patients were admitted from UCC to the ward.

Discharge information was communicated to GPs; these contained summaries of any treatment performed and medicines given.

The hospital did not report data on specific waiting times; however we were told that no patients experienced any delays and patients normally had immediate access to a consultant. We spoke with five returning patients who all reported that they always had access to a consultant and they never waited.

There was not sufficient parking near the facilities for patients and very limited spaces for patients who had a mobility disability. However there was a concierge service available to escort patients with mobility issues into the hospital if required

Meeting people's individual needs

Whilst on inspection we noticed that the hospital served a wide ethnic population, staff attended equality and diversity training as part of their mandatory training. Awareness and knowledge was evident in discussions about meeting individual needs of patients; for example staff understood the cultural importance of specific dietary requirements.

Patients were asked if they required an interpreter before they were booked for treatment, this was so that the hospital could arrange for an interpreter. The hospital did not provide in house interpreting services, but staff had access to translation services 'Language Line' which provided support over the telephone. However patient letters were normally written in English even if English was not the patient's first language.

All areas we visited had good access for people with physical disabilities, including wheelchair users. The wards had rooms to accommodate bariatric and wheelchair patients; these rooms were wider and staff had access to specialised equipment.

Staff were trained in mental health and recognised that patients with learning difficulties or dementia needed supported. Very few patients with learning difficulties or living with dementia attended the hospital but when they did, staff told us they would always try to ensure these patient groups were not left waiting long and would be offered a separate room for privacy and dignity if needed. Staff told us additional staffing would be rotated to reflect the need for extra support and a discussion with family and friends would take place to identify if further resource were needed.

Staff screened all patients over 75 years of age for dementia and ward staff described how they accommodated for this patient group. All wards we visited achieved their Commissioning for Quality and Innovation [CQUIN] target of 100% at the time of the inspection. This meant that all patients aged 75 years and over were screened, assessed and referred on to specialist services.

The Richmond Suite provided the facilities to treat chemotherapy patients with respect and in comfort. The suite consisted of 9 en-suite bedrooms one of which was used as an isolation room for neutropenic patients. The suite had 5 chairs rooms which allowed daycase patients to stay in comfort when treatment and care was being delivered. To ensure patients felt comfortable family and/or friends were encouraged to stay with the patients during treatment. All rooms we visited had extra seating for carers and magazines were provided in the waiting room.

The Oncology service covered Diagnostics, Intravenous and Oral Chemotherapy, Chemotherapy Instillations, Monoclonal Antibody Therapy, Trans-arterial and Chemoembolization. All services were provided by Oncology Specialist Nurses and chemotherapy Nurses supported by Oncology Consultants and Haematology Consultants. Oncology patients were given contact details of the on call oncology nurse, this was so that patients on active treatment were supported and arrangements could be made to admit patients if it was necessary. A patient we spoke with informed us that the oncology advice he received from the on call nurse whilst on holiday was invaluable. The nurse continued to monitor the patient's condition whilst the patient arranged to come home and a direct admission on to the Richmond suite was arranged.

Chemotherapy was provided to patients with solid tumours for Breast, Bowel, Ovarian and Bladder cancers and Haematological conditions. Patients were supported from the point of diagnosis, through surgery, Chemotherapy and followed up for up to five/ten years post treatment.

Patients were offered complimentary therapies such as Reflexology and Relaxation Therapy to provide a holistic

approach to cancer recovery. In May 2016, the ward reported that 51% of patients would recommend the ward to friends and family, however the feedback was not chemotherapy specific. The ward was introducing a chemotherapy specific feedback form to overcome this.

The Hospital provided in house Physiotherapy and a Lymphedema service was available to patients.

A weekly beauty service provided by a local beautician was in place at the time of the inspection, the beautician visited patients at a time convenient to them.

The Hospital also had links with a local company who provided a wig and scarf service to support patients with hair loss from Chemotherapy.

A range of information leaflets were available to patients in the waiting area on the Richmond suite, however they were in all in English.

Learning from complaints and concerns

Information in relation to the complaints procedure was delivered to staff as part of their induction. Senior managers who investigated complaints were trained in the investigation process.

The wards we visited displayed posters informing patients about how to raise a concern or make a complaint. The information was also in the patient information brochure, which was given to inpatients.

The Richmond Suite had received four complaints between January – June 2016 all of which had been action and closed. The Lancaster ward had received three complaints in total for the period January 2016 to June 2016, all of which were closed.

Senior staff discussed complaints at the clinical governance meetings, senior nurse group and heads of department meetings. Any shared learning outcomes, recommendations and actions from the complaints were discussed at staff meetings.

Are medical care services well-led?

Good

We rated the service as good because

Staff in endoscopy and on both wards were clear about the vision for their services, driven by quality and safety. We were given many examples of where staff delivered high quality care.

Oncology nursing team had developed a strategy to improve patient care and staffing, this had been shared with staff in the oncology suite.

Staff reported an open culture, team working was evident and leaders were visible and approachable.

Governance arrangements were robust, regular review of incidents, complaints, audit results and policy development ensured learning was shared appropriately.

Staff on the Richmond Suite involved patients and developed the service by listening to patient feedback. Staff achievement was valued through staff awards.

However,

Not all staff had undertaken an annual appraisal and therefore we were not assured they were aware of the BMI corporate vision and values.

Vision and strategy for this this core service

All areas we visited had clearly defined corporate objectives to support their local aims to deliver the highest quality care to patients they treated. Staff were able to demonstrate how they worked together to achieve common aims during individual interviews.

Staff felt they delivered a valuable service to patients who chose to have treatments at the hospital.

The wards displayed the BMI cooperate vision and values in staff and patient areas.

The vision and values of the hospital and the ward were incorporated into the appraisal system. However not all staff had undertaken an appraisal at the time of inspection. This meant we were not assured that all staff understood the vision and values set for by the hospital.

Governance, risk management and quality measurement for this core service

Provisions were in place to monitor quality of care, risk management and concerns about patient safety. Ward

meetings and monthly governance meetings were used as platforms to discuss performance and priorities. However not all the actions had specified deadlines, or were assigned to specific individuals.

Senior managers were familiar with risks in their department; they described the actions needed to address them and had showed evidence of processes in place to mitigate them. For example issues raised by staff regarding the delay of TTO's and medication being dispensed from pharmacy, whilst patients were on the ward was discussed at the February 2016 Lancaster Suite meeting. The unit manager had asked staff to keep a list of medications that would be beneficial to stock on the ward. This was so that stocking such medications could be discussed with the head of Pharmacy.

We spoke with senior management who advised that they attended the clinical governance (CG) committee every eight weeks. The agenda considered a range of topics, including complaints, incidents, health and safety issues and patient satisfaction. Information from the meeting was cascaded back to departments. We spoke with six members of staff across the wards we visited and staff who attended the focus group all agreed that they were well informed of issues relevant to their department.

Governance processes was incorporated in the hospital's clinical governance policy. The policy covered activities that helped sustain and improve high standards of patient care.

The policy aimed to offer staff with a framework for setting standards, implementing and monitoring and facilitating continuous improvement in the quality of care provided to patients.

Audit results were reviewed by senior management and proposed actions were established in a range of topics such as medicines management, infection control and health and safety.

Leadership and culture of service

We observed well-defined leadership roles within all areas we visited; staff were supportive of each other and operated an open door policy. All the staff we spoke with spoke highly of the senior management team and colleagues.

Staff were familiar with the senior management team and were often visited by them.

Ward managers were knowledgeable about quality issues and priorities and described the challenges they faced on their wards. This was evident in the CQUIN data we reviewed; the wards achieved 100% in all three areas.

Culture within the service

All staff we spoke with appeared enthusiastic and motivated in their role. This was supported by the staff survey results which showed that 74.4% of 209 staff who responded said they continued to work at the hospital because they enjoyed their job.

Staff on the endoscopy unit told us they worked well as a team and that they helped each other with changes as the unit was working towards becoming JAG accreditation.

Staff were able to put forward ideas and opinions and contribute to improving practice, we found evidence of teamwork and commitment from staff to ensure the patients were treated well. The annual staff survey supported this completed by staff nationally, at a local level 209 staff had responded to the staff survey, and a further 81% had said they continued to work at the hospital because of the people.

Staff felt appreciated and valued, they discussed with us the different ways BMI recognised staff for their hard work. At a corporate level BMI championed the 'Above and Beyond' nominations, senior staff were asked to nominate staff in for this award.

Public and staff engagement

Staff offered and encouraged patients and their carers who visited the wards to feedback their experiences about the hospital. We saw the use of a patient satisfaction questionnaire and for NHS patients the Friends and Family Test in use. Patient feedback cards were available in the waiting areas, at the nurses' station and posters were clearly displayed to inform patients.

Senior managers told us they monitor how well their team delivered safe and effective care through the patient satisfaction survey results. Comments both positive and negative were shared with staff to ensure the ward continued to improve. We saw minuted discussions about patient feedback in Clinical Governance reports we reviewed. Staff gave examples where they had suggested improvements to the service; the Richmond ward

introduced themed afternoon tea for patients. This afternoon was for existing, new and old patients who had visited the ward, it was an opportunity to share experiences and talk with likeminded people.

The Richmond Suite was awarded a Macmillan award for the care and facilities they offered oncology patients. Staff we spoke with were proud of being given this prestige award and felt they worked well as a team.

The oncology services had received the Macmillan accreditation in August 2015 for the care and work they offered patients.

Innovation, improvement and sustainability

The Richmond Suite was introducing a chemotherapy specific feedback form so that patients receiving chemotherapy were able to comment on the care and treatment they received as a cancer patient.

The endoscopy suit were working towards JAG accreditation; processes were in place to improve the unit. For example staff competencies were being addressed so that they were in line with the JAG standards for endoscopy training.

The endoscopy unit was improving their surveillance and quality assurance processes to re-configure the existing unit or move it within the hospital in order to ensure it gained JAG accreditation.

Good

Surgery

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

Information about the service

Surgical care at BMI The Alexandra Hospital is delivered on a day case or inpatient basis. There are seven theatres and seven anaesthetic rooms all with laminar flow and laser facilities. Elective surgery is carried out Monday to Saturday, with access to an emergency theatre and theatre team 24 hours a day. Only urgent or emergency surgery is carried out on Sundays. There is a 14 bedded recovery area with level one and level two facilities. Patients are cared for on one of four wards following surgery. The riverside suite is a dedicated pre-operative assessment suite.

A wide range of surgical specialties are available at the hospital including orthopaedics, bariatric, ear nose and throat, cosmetic surgery, neurosurgery and colorectal surgery. There were 19,715 visits to theatre between April 2015 and March 2016. The most common surgical procedures carried out during this time were arthroscopic knee surgery, total hip replacement and total knee replacement.

The availability of critical care at the hospital means that more complex surgery can be undertaken at The Alexandra than other independent health hospitals without this facility.

We carried out an announced inspection of The Alexandra on 5 and 6 July 2016. We also carried out an unannounced visit on 13 July 2016. We spoke with 15 staff, including nursing staff, doctors, support and administrative staff, allied health professionals and housekeeping staff. We also spoke with six patients or their relatives using the services at the time of our inspection and reviewed 11 sets of patient records. We observed care and treatment and looked at information the hospital provided and other information we requested.

Summary of findings

We rated surgery services as good because;

Patients received care from sufficient numbers of well-trained staff. Systems were in place to ensure the competence and compliance of consultants operating under practising privileges. Staff were kind, caring and compassionate and high numbers of patients would recommend the hospital to their friends and family.

Outcomes from surgery were good. Care was mostly provided in a timely way and in line with evidence based-practice. The hospital participated in national audits and benchmarked its service with other providers.

Leadership and culture in surgery services was positive and open. Staff and the public were involved in developments and service improvement initiatives

However;

The safety aspect of the service required improvement. There were insufficient facilities for handwashing and staff did not wash their hands when moving between patients and patient areas. Staff in theatre had not learnt the lesson from a recent medication incident.

Documentation did not meet good practice guidance. The hospital did not review consultant documentation in the medical record as part of their internal audit process.

Further work was required to improve some aspects of evidence-based practice, risk management and quality measurement.

Good

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because;

There were insufficient facilities to ensure staff, patient and visitors could wash their hands. Staff did not routinely clean their hands when moving between wards and departments or into patient rooms.

Medications were not stored securely in theatre and staff had failed to learn from a medication incident.

There had been two never events at the hospital between March 2015 and April 2016 and staff had failed to learn the lesson from the first event.

There was not always documented evidence of medical reviews prior to discharge. Documentation on the World Health Organisation safer surgery checklist was not completed correctly in four out of 11 records.

Risk assessments in relation to surgical site infections and visual infusion phlebitis were not fully completed and documented in theatre.

However;

Nursing staffing was regularly reviewed and calculated based on patient acuity and dependency. Staffing in theatre was in line with national guidance.

There were clear processes in place to access resident medical officers and consultants 24 hours a ay. Clear systems were in place to manage the care of deteriorating patients.

Incidents

Staff were encouraged to report incidents and were aware of how to report an incident. The reporting system was paper based, with a different form for clinical and non-clinical incidents. There had been 262 clinical incidents in surgery between April 2015 and March 2016. This was not high when we compared this to other independent healthproviders. The majority of these incidents were graded as no or low harm, indicating a good reporting culture.

Staff told us they received feedback from incidents they reported via their manager and that incidents were discussed at team meetings. Learning was also shared via a monthly governance newsletter.

There had been two never events at the hospital between March 2015 and March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented. The most recent event was a wrong side nerve block. The incident was investigated in a robust way using a root cause analysis model. The investigation of both events found that the BMI safer surgery policy had not been followed in full. This demonstrated that staff had failed to learn from the incident in March 2015 and had again not followed policy in the most recent event. We saw that action plans had been developed to reduce the risk of a similar event happening in the future and that all but one of these actions was complete for the event in October 2015. The one remaining action was for read and sign sheets to be provided by heads of departments as evidence that ward staff have read and understood the principles of safer surgery policy.

Mortality and morbidity was discussed at meetings of the medical advisory committee (MAC) as well as executive team and senior leadership meetings.

Senior staff understood the duty of candour and we saw that the hospital duty of candour policy had been followed and applied when relevant. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Training on this duty was included as part of mandatory training.

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

The service monitored safety for NHS and private patients via quality governance scorecards. Such scorecards are local improvement tools for measuring, monitoring and analysing patient harms and 'harm free' care. These dashboards detailed information regarding surgical site infections, unplanned returns to theatre and day case conversions to overnight and we saw that this information was displayed on ward corridors.

Although safety thermometer headings were detailed on quality governance scorecards, data was incomplete or missing. For example the scorecard for Stafford suite had no information detailed for falls, pressure sores, compliance with VTE assessment and urinary tract infections since December 2015. There was no data for any of these safety measures on the scorecards for Chester suite or York suite.

The hospital was part of the national Sign up to Safety campaign. This campaign aims to reduce avoidable harm to patients and demonstrated the hospitals commitment to listen to patients and staff, learn from incidents and to make changes to improve patient safety.

Cleanliness, infection control and hygiene

Wards, theatres and pre-operative assessment were visibly clean and tidy. The most recent patient led assessment of the care environment (PLACE) showed that the hospital scored better than the England average for cleanliness.

We saw that staff moved between patient rooms, wards and areas without washing their hands or cleansing them with alcohol gel. On entering wards, there was no access to hand washing facilities for patients, visitors or staff. There was no information in sink areas to inform patients, visitors or staff of the best way to wash their hands to minimise the risk of the spread of infection, for example ten steps to hand hygiene posters. We saw that this had been identified as a risk on the hospital risk register and that plans to refurbish wards would include additional hand wash basins.

There were no designated hand washing sinks in patient rooms. Sinks were located in the patient en suite bathroom however these did not have non-touch taps in place. Sinks with non-touch taps reduce the risk of cross contamination following hand washing.

During the inspection we saw that staff followed procedures for gowning and scrubbing in the theatre areas. Staff cleaned equipment in between patient contacts in theatre.

Visual infusion phlebitis (VIP) scores were not always completed and documentation did not always contain all necessary information about site of cannulation and number of cannulation attempts.

There were clear guidelines for staff to follow to screen patients for the presence of infections such as methicillin resistant staphylococcus aureus (MRSA) and carbapenemase-producing enterobacteriaceae (CPE). We saw that these had been followed in the records we reviewed.

There had been 13 reported surgical site infections between April 2015 and March 2016 from six different surgical specialities. There were two MRSA infections reported during this period but no clostridium difficile infections. All surgical site infections were investigated and discussed at the quarterly infection prevention and control subcommittee.

Regular infection prevention and control and hand hygiene audits were completed in the departments we inspected. On the Lancaster suite, the most recent audits showed 100% compliance. Eighty-two percent of staff had completed infection prevention and control training including training in the use of aseptic non-touch technique. This was below the hospital target of 95%.

We saw that the disposal of sharps, such as needles followed good practice guidance. Sharps bins were signed and dated when assembled and temporary closures were used when the bin was not in use.

Domestic staff told us that patients with a known infection were identified by a symbol on the patient name board and they were also informed by nursing staff. Additional cleaning tasks and cleaning agents were used when cleaning the rooms of patients with known infections.

Environment and equipment

Essential emergency equipment was available in each of the areas we visited and was stored in trolleys with tamperproof seals. However, this equipment had not been checked in line with the hospital policy on one ward. On Stafford suite, the defibrillator had not been checked on three days between 1 May 2016 and 4 July 2016 and the resuscitation trolley contents and medical gases had not been checked on two days.

Patients who had been identified as at risk of developing pressure ulcers were provided with appropriate mattresses and cushions as necessary.

There was sufficient equipment in theatres such as hoists, warming equipment. Staff did not always discuss the need for specific equipment during the pre-operative huddle to prepare the equipment ready for use.

All theatres at the hospital had laminar flow. Laminar flow prevents airborn bacteria from entering open wounds during surgery.

There were systems to maintain and service equipment as required. Equipment we checked had been checked fotr electrical safety and had up to date servicing.

Medicines

Medicines were stored securely on wards, in theatre and recovery. Nursing staff carried keys to access stock medication and controlled drugs at all times. We checked controlled drugs (CDs) stock and saw that the records for these drugs were complete and correct. There were separate log books for ward CDs and patients own CDs. Intravenous fluids were stored securely and correctly. The pharmacy department completed stock checks of medications on wards and in theatres.

When we reviewed incidents involving medications, we saw that in April 2016 there had been an incident when controlled drugs had been left unattended in an anaesthetic room and had gone missing. During our inspection we saw that in two anaesthetic rooms, drugs had been left unattended on a worktop and that the drug cupboards were unlocked whilst theatre staff were at lunch. This meant that the lesson from the incident had not been learnt by all staff. We raised our concerns in relation to this practice this during the inspection and did not observe any similar practices during the inspection.

A hospital audit in May 2016 showed that 90% of patients had a documented record of drug history either at pre-assessment of within 24 hours of admission. However, only 50% of patients had evidence that a medicines reconciliation had been started within 48 hours of admission. Medicines reconciliation ensures that medicines prescribed during an inpatient stay are the same as those being taken prior to admission.

The pharmacy department was open seven days a week with an on-call service available out of hours.

Records

Records were stored securely in the pre-assessment suite and behind nurse stations on wards in lockable cupboards. Records relating to the current admission were stored in individual patient bedrooms. Pre-operative assessments were stored within the medical record to ensure all staff had access to this assessment.

Records maintained by nursing staff and allied health professional records were complete, legible and signed. Ninety-five percent of hospital staff had completed documentation training. Entries made by medical staff rarely contained the doctors name and grade.

However, records we reviewed did not always show evidence of consultant or medical review when this was required. For example, we saw seven out of 11 records that did not contain evidence of a review when a major procedure had been undertaken. We spoke with nursing staff and patients who confirmed that patients had been reviewed but this was not documented in the record. In one case, we saw that a patient had received a blood transfusion due to low iron levels but there was no evidence of a further medical review prior to discharge. This meant that there was no documented evidence that patients had been appropriately reviewed and what the outcome of the review was.

Local audits of documentation and record keeping did not include audit of consultant records. The hospital had previously recognised that there was an issue with consultants maintaining accurate, up to date and contemporaneous records. The hospital told us they had been working alongside consultants to improve standards of record keeping. In May 2016, the hospital hosted an event with the information commissioner to highlight the importance of good record keeping to consultants. This was also discussed by the medical advisory committee (MAC) and detailed in the minutes of this meeting.

Safeguarding

Staff were aware of their responsibilities to raise safeguarding concerns and there was a named safeguarding lead for adults and children at the hospital who had both completed level three training. There was a clear process in place for staff to refer to when concerns were identified and this was displayed on notice boards in the areas we inspected. There were meetings held on a six monthly basis with the local safeguarding board to ensure compliance with guidance and current best practice in relation to safeguarding.

Safeguarding adults levels one and two training had been completed by 92.8% of staff which was below the target of 95%. The adult safeguarding lead had completed level three training.

Mandatory training

Mandatory training was a mix of online and face to face training and covered topics such as infection prevention and control, manual handling and duty of candour.

Compliance with mandatory training varied between wards and theatres. For example, compliance was 95% for York and Stafford suite however the rate was 79% for theatres which was below the hospital target of 90%.

Resident medical officers were expected to maintain their mandatory training levels and this was monitored by the agency employing them.

Assessing and responding to patient risk

We reviewed records and saw that a range of risk assessments were completed pre-operatively and during admission including assessments of the risk of developing pressure ulcers, falls, mobility assessments and bed rail assessments. However, not all risk assessments in patient records were the current version and this meant that nursing staff were not always conducting risk assessments in line with current BMI practice. For example, the bed rail risk assessment had been updated to include consideration of mental capacity in the most recent document but we saw that the June 2011 was still in use in some areas.

Data provided by the hospital showed that only 71% of patients received a pre-operative assessment prior to admission. This meant that 29% of patients did not have an assessment to any potential risk prior to admission.

Data provided by the hospital showed that 100% of patients received an assessment for the risk of venous-thrombus embolism (VTE). We saw evidence in records that risk of VTE was assessed on admission. However, the risk was not always reassessed within 24 hours as set out in NICE quality statement three (QS3). For example out of 11 records we reviewed, three records did not contain a reassessment within 24 hours.

Nursing staff used a modified early warning system (MEWS) to monitor patients. There was a clear process in place to escalate concerns when MEWS scores were raised and staff were aware of when and how to seek a medical review. There was access to specialist advice via the intensive care unit (ICU) outreach team when MEWS scores were five or above. This team provided 24/7 emergency response to deteriorating patients anywhere in the hospital. There was a clear process in place for the management of deteriorating patients who required transfer to an alternative hospital for specialist management.

In the records we reviewed, MEWS scores had been completed and calculated correctly. Concerns had been appropriately escalated to the resident medical officer (RMO) in the one record we reviewed with an elevated score. A sepsis screening tool was available on wards and this was used in conjunction with a sepsis six care bundle when indicated.

Over 98% of nursing staff had completed acute illness management training.

A safety huddle involving all members of the theatre team was carried out before each theatre list. We observed a huddle and saw that this could be structured in a more effective way to improve patient care and safety, for example with the inclusion of whether patients needed warming, what positioning aids would be required and the risk of VTE.

The hospital carried out a monthly audit of the use of the five steps to safer surgery checklist. The most recent audit in May 2016 showed 100% compliance. We observed the surgical team completing the checklist and saw that this was not embedded as a tool to support patient safety. We reviewed the surgical safety checklists in records we checked and saw that these the checklists had not been signed in four out of 11 cases.

Consultants used the American Society of Anaesthesiologists (ASA) physical status system to determine if it was safe for patients to undergo surgery at the hospital. The ASA system is a scale used to assess a patients level of risk prior to surgery based on pre-existing health conditions.

The pre-operative assessment team triaged patients according to BMI policy. Patients were offered a face to face appointment, telephone appointment or screening only dependent on the procedure and on the patient's clinical history. We saw that when concerns were identified about a patient's safety for surgery through pre-operative assessment, the consultant had been contacted and the abnormal electrocardiogram (ECG) had been sent for review. This showed that patient risk was correctly escalated when concerns were identified.

Good

Surgery

At the time of our inspection, there were no dedicated pre-operative anaesthetic clinics. However, where there were concerns about a patient's anaesthetic risk an outpatient consultation was arranged.

Nursing staffing

Nursing staffing was calculated using a BMI wide nursing dependency and skill mix tool. The tool was a guide to be used alongside clinical judgment to inform senior nursing staff of patient dependency levels and therefore required staffing. The system planned nursing levels and skill mix five days in advance. Any concerns relating to nursing staffing were highlighted to the senior management team and heads of department in the comms cell each morning. Planned and actual staffing levels were displayed on boards at the entrances to wards and we saw that levels met the requirements during our inspection.

At the time of our inspection, the hospital was in the process of introducing an alternative nursing acuity tool. It was expected that this tool would enable senior nurses to better plan nursing staffing and allocate workload equitably.

The use of bank and agency registered nursing staff on wards was similar to other independent health providers at between10 and 12% during 2015/16. The use of bank and agency was slightly higher than other providers at 15.8%.

Staffing in theatres was planned in line with The Association for Perioperative Practice (AfPP) guidelines. We reviewed theatre lists and staffing and saw that staffing was line with this guidance. There was a five day booking rule in place where bookings for surgery were not accepted less than five days in advance without discussion with the theatre manager. This meant that the theatre manager could ensure there was adequate theatre staffing in place to cover any short notice procedures.

The use of bank and agency staff in theatres was higher than other similar independent health providers during 2015/16 for registered nurses, operating department practitioners (ODPs) and healthcare assistants (HCAs). Around 38.5% of registered nurse shifts and 34% of ODP or HCA shifts in theatre had been filled by bank or agency staff. The hospital had been working to reduce this and during April and May 2016, this rate was 22.2%. At 1 April 2016 there were 73 whole time equivalent theatre staff in post. Fifty of these were registered nurses.

Agency and bank workers were provided with a local induction when first working on the wards or in theatre.

Surgical staffing

Access to resident medical officers (RMOs) was available 24 hours a day. RMOs worked a twelve hour shift for seven days followed by seven days off. Handovers between RMOs took place at each shift change and were well structured.

RMOs were employed by an agency rather than the hospital. They received a local induction when starting work at The Alexandra. Absences due to sickness or holiday were covered by an alternative RMO from the agency. The lead RMO managed and monitored the rota system to ensure RMOs were not working above the agreed sift pattern.

A cardiothoracic RMO was available when required via the hospital bank system when there were cardiothoracic inpatients. These were middle grade cardiothoracic surgeons who were employed elsewhere. In this circumstance, the RMO worked a 24 hour shift but was provided with a room to sleep in overnight. This meant that a speciality doctor was available out of hours if this was required.

Anaesthetists were provided via an agency and there was access to an on-call anaesthetist within 30 minutes.

As part of a surgeon's practising privileges, they were expected to ensure they were contactable by telephone and available to attend the hospital within an individually agreed time period if required at all times when there were inpatients under their care. There were clear systems in place to ensure that consultant advice was available 24 hours a day and during periods of leave or absence. We saw evidence on the wards we visited that RMOs and nursing staff were aware of consultant cover for patients whose consultants were on annual leave.

The majority of consultants worked within NHS hospitals. As part of their practising privileges, consultants were expected to provide evidence of their competence to undertake surgical procedures, and were only able to perform procedures they regularly carried out in their roles within the NHS.

In addition to this, there was a general surgeon on call via the telephone at all times to provide cover if there were any unplanned returns to theatre and the named consultant was unavailable.

Good

Surgery

Major incident awareness and training

There was a hospital business continuity plan which was used alongside a

Are surgery services effective?

Good

We rated effective as good because;

Care and treatment was delivered in line with national guidance and best practice. Hospital policies and pathways reflected evidence based care and treatment

Local audits were completed and the hospital benchmarked its performance on key patient outcomes.

Pain was assessed and patients received timely pain relief. Patients had their nutritional needs assessed.

The hospital performed within the expected range on patient reported outcome measures (PROMS) for hip and knee replacements.

There were systems in place to ensure the competence of consultants working with practising privileges at the hospital. Staff were supported to develop their skills through additional training. Eighty-two percent of staff had completed the 2015/2016 appraisal and the hospital was on target to achieve 100% compliance for all eligible staff.

Staff worked closely with other members of the multi-disciplinary team and spoke positively about their colleagues.

However;

Consent was formally taken and documented on the day of procedure. The two stage consent process should include formal consent with an appropriate 'cooling off period' followed by confirmation of consent on the day of the procedure.

Do not attempt cardiopulmonary resuscitation forms were not immediately visible within the medical record. In all patient records we reviewed, the DNACPR section had not been completed.

Evidence-based care and treatment

Hospital policies, care pathways and risk assessments followed NICE guidance including guidance on the management of acutely ill patients in hospital.

The medical advisory committee (MAC) provided clinical scrutiny in relation to evidence based care and treatment. If consultants wanted to introduce new treatment methods or procedures, the evidence and guidelines for these procedures was reviewed by the MAC and approved if this was appropriate. Minutes we reviewed showed that the MAC refused permission to carry out procedures where there was insufficient evidence to support the use of the procedures.

The hospital participated in a number of national audits of patient outcomes including patient reported outcome measures, DENDRITE (endocrine and thyroid surgery) and the AQUA orthopaedic audit. There were also plans to submit data to the SPINE TANGO database for spinal neurosurgical patients to allow outcome measurement and national comparison.

Hospitals within BMI compared the patient outcomes regionally and nationally. For example, the hospital compared its rate of unplanned readmissions and unplanned returns to theatre, along with patient satisfaction data and numbers of complaints. They also participated in 'provider visits'. Provider visits were visits from other BMI sites to assess the quality of care provided at the location.

The physiotherapy team collected data using the EQ5-D to monitor patient outcomes. They had also audited outcomes for patients who had been mobilised on day zero (the day of surgery) and demonstrated improved patient outcomes.

Patient temperatures were not being taken and recorded routinely in theatres and therefore best practice in relation to surgical site infections was not being followed. This was also the case for monitoring of VIP scores. We raised this as a concern during our inspection and saw that immediate action was taken to improve this element of patient care.

Pain relief

Pain relief was discussed during pre-operative assessments and patients were provided with pain advice booklets to be used post-operatively.

Pain scores were recorded as part of the MEWS. We saw that pain scores were documented and that pain relief was given in a timely way.

There was access to patient controlled analgesia and controlled drugs when stronger medication was required. There was no specialist pain team at the hospital however, the pharmacy team were available to provide support with the prescribing of pain medications if required.

The hospital completed a regular audit of pain management for day case and inpatient stays. In February 2016, all day case patients reported they had been given regular pain relief. All inpatient cases had been prescribed regular and as required pain medications. Overall, 85% of patients reported that their pain had been managed appropriately.

Nutrition and hydration

Patient's nutrition and hydration needs were assessed in the pre-operative assessment clinic and could be reassessed on the ward if required using the malnutrition universal screening tool. There was access to a dietician if they were deemed at risk of malnutrition.

Food and fluid balances charts were maintained when required.

Nursing staff assisted patients who were unable to feed themselves or drink independently.

Patient outcomes

There were 17 unplanned returns to theatre between April 2015 and March 2016. This was not high when compared to other IH providers.

There had been two unexpected deaths at the hospital between April 2015 and March 2016. These had both been investigated using a root cause analysis model and also referred to the coroner. There were no regulation 28 reports issued to the hospital. Regulation 28 reports are issued by coroners following the outcome of the inquest if the coroner judges that action must be taken to avoid a preventable death in the future.

There had been eight unplanned transfers following surgical procedures to other hospital sites between April 2015 and March 2016. This was not high when compared to other independent health providers. Unplanned transfers were logged as clinical incidents. We reviewed the reasons for transfer and saw that the reasons for transfer were justifiable and unforeseeable. The hospital had also reviewed these transfers and had found there were no themes or trends.

Between April 2015 and March 2016, 78 patients who were planned as day cases stayed as an inpatient overnight ('day case conversion'). Reasons for conversion included complications of surgery, anaesthetic or patient preference. BMI had recently changed the way it collected data about day case conversion rates to allow better understanding of the reasons for conversion. Data in the future will separate clinical from non-clinical reasons.

The hospital was within the expected range for NHS patient reported outcomes (PROMs) for primary knee replacement. Scores for the EQ-VAS index and Oxford knee score were above the England average.

The hospital was within the expected range for NHS PROMs for primary hip replacement.

There were insufficient numbers of patients to compare PROMs data to the England average for groin hernia repairs. However on both measures within the PROM, 33.3% and 35% of patients reported improvement and 38.9% and 40% reported to be worsened.

The hospital used the enhanced recovery programme to promote faster recovery and better outcomes post-surgery. Patients undergoing orthopaedic procedures and bariatric surgery were assessed by physio therapy and occupational therapy pre-operatively. There were plans in place to extend these assessments to include patients undergoing major cardiac, gynaecological or breast surgery from September 2016 in order to promote quicker and improved recovery from surgery.

Surgical first assistants were expected to demonstrate competencies and hold approrpriate certification to undertake this role.

Recently recruited overseas theatre nurses were being supported in their transition into UK work via a theatre development programme, including a six month preceptorship programme.

A number of link nurse roles were in operation including tissue viability, infection prevention and control and blood transfusion. These staff were given additional training in

these areas and cascaded this learning to other staff. The therapy team accessed in house training once per month to update and maintain their skills. These sessions included education sessions from consultants.

Physiotherapists were expected to maintain competencies in respiratory assessment and treatment via yearly updates and observed practice to ensure they maintained the necessary skills to work as part of the on call rota.

There was a BMI wide policy for granting and reviewing the practising privileges of consultants. Practising privileges were only granted to doctors who were licenced, on the specialist General Medical Council register, held a substantive consultant post with the NHS within the past five years and demonstrated relevant clinical experience relating to practice. We saw that systems were in place to ensure consultants without an NHS caseload were appropriately appraised and portfolios maintained via BMI. Additionally, we saw evidence in minutes of the MAC that when new procedures were proposed by consultants, confirmation of competence was sought from the employing trust.

RMOs told us that they were supported by consultants and provided with on the job training by them. All RMOs working at the hospital held advanced life support training.

Multidisciplinary working

There were good multidisciplinary working relationships on wards and within theatres. Staff spoke positively about their colleagues. They told us that communication between pre-operative assessment and the ward was good.

Daily multi-disciplinary team (MDT) meetings were held on wards to discuss patient care, admissions, discharges and plans for the day. We saw evidence of multi-disciplinary working in the records we reviewed.

Physiotherapy and occupational therapy worked closely together, frequently carrying out joint assessments and therapy sessions.

There was good multi-disciplinary working between surgeons and medical consultants when managing patients with co-morbidities such as bariatric patients. The bariatric MDT included specialist nurses, dieticians, physicians and surgeons.

Seven-day services

Routine access to theatres was available six days a week, with availability on a Sunday for urgent or emergency procedures. There was access to an on-call theatre and theatre team 24 hours a day.

Imaging such as plain film x-ray and computerised tomography (CT) was available seven days a week and on call out of hours.

Physiotherapy and occupational therapy was provided to the surgical wards seven days per week. In addition to this, respiratory and orthopaedic physiotherapy was provided on call out of hours.

Pre-operative assessment suite offered appointments from 7.30am until 7pm on weekdays and on Saturdays from 7.30am until 2pm.

Access to information

Staff were able to access hospital policies and procedures via the intranet. There were sufficient numbers of computers on wards.

Discharge letters were provided to the patient and sent to their GP on discharge, to ensure continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital used a two-stage consent process, which included a 'cooling off' period to allow patients time to consider the benefits and risks of surgery. Records we reviewed contained evidence of informed consent. Consent forms were completed and signed on the day of the procedure but consultants told us that the informed consent procedure began in outpatient consultations, with information regarding the risks, benefits and possible outcomes being provided at this time. Consent forms should detail formal consent prior to the day of procedure, with an appropriate 'cooling off period' followed by confirmation of consent on the day of the procedure. Additionally, not all consent forms included details of the risks of anaesthetic.

We saw evidence of one do not attempt cardiopulmonary resuscitation (DNACPR) order and although this had been completed correctly, it was not immediately visible within the medical record. It is good practice to place DNACPR forms at the front of medical records to ensure easy access to this in an emergency situation where there may be doubt about CPR status. We saw that the DNACPR status

Good

Surgery

section in the surgical care pathway was not completed in all records we reviewed. However following our inspection the provider submitted information which confirmed that the established hospital practice is that a DNACPR form would be only in place if the patient had been assessed and deemed appropriate not for resuscitation. So DNACPR documentationwould not be present in all medical records at this point .

Training on the Mental Capacity Act (2005) and deprivation of liberty safeguards was included in the safeguarding vulnerable adults training. This had been completed by 92.8% of staff which was below the hospital target of 95%.Staff we spoke with had an understanding of the principles of the mental capacity act.

Are surgery services caring?

Good

We rated caring as good because;

Patients were cared for with dignity and respect. Staff were kind and compassionate.

Over 97% of patients would recommend the hospital to their friends and family.

Patients were involved in decisions about their care and were given enough information and supported to make informed choices. Family were encouraged to be involved in their care and recovery.

Compassionate care

Patients were treated with dignity and respect by all staff at the hospital, including nursing staff, housekeeping staff and porters. They were greeted warmly by staff on the reception desk.

We saw staff interacting with patients in a caring, kind and compassionate way in each of the areas we inspected. Patients told us staff were excellent and provided a good level of care.

In recovery, we saw staff caring for patients in sensitive and compassionate way. Staff took the time to ensure they provided the right level of care to each patient in a kind and caring way.

Friends and family test scores for the hospital were very high. Over 99% of NHS patients would recommend the hospital to their friends and family. Response rates varied month to month but they were generally lower than the England average for independent health hospitals. For patients who were self-funding their care and treatment or had medical insurance, 97.8% said they would recommend the hospital in May 2016.

Understanding and involvement of patients and those close to them

Patients told us staff kept them well-informed. They were given opportunities to ask questions about their care and treatment both as inpatients and during pre-operative assessments.

We observed telephone calls to patients who were being admitted and heard that they were given full details of where to attend and what time when circumstances had changed.

Nursing staff discussed post-operative care during pre-operative consultations and during their inpatient care to ensure they knew what to expect post-operatively.

Family members were encouraged to visit and were kept informed about when to expect their loved one back from theatre to reduce any worries they may have.

Family members were welcome to attend pre-operative assessments, including pre-operative groups, to ensure they were informed about post-operative care.

Emotional support

Patients who had been awake during their surgery told us they had been reassured during the procedure and were pleased with the care given to them.

Some patients were able to access a specialist nurse for additional support and advice before and after their treatment. This was dependent upon the consultant.

Are surgery services responsive?

Good

We rated responsive as good because;

The hospital worked with local stakeholders to plan services to meet the needs of local people.

Good

Surgery

The hospital had met the overall 18 week referral to treatment target for NHS patients between April 2015 and March 2016.

There were facilities in place to meet the needs of patients with additional needs such as dementia, learning disability or bariatrics. Translation services were available and staff had undertaken training in dementia care.

Information was provided about how to make a complaint. Learning from complaints was shared and overall there had been a downward trend in the numbers of complaints in the previous three years.

However;

The hospital had cancelled 61 procedures for a non-clinical reason between April 21015 and March 2016. Fifty-seven of these patients were offered another appointment within 28 days .

Service planning and delivery to meet the needs of local people

? The hospital worked closely with local commissioners and developed contracts addressing how best to meet the needs of the local NHS population within this service. The hospital was also working todeliver more ambulatory care and improving care for patients living with dementia.

? The availability of critical care meant that patients requiring more complex surgery such as open heart surgery or with co-morbidities could still access this surgery at the hospital.

? Group pre-operative assessment sessions were offered to NHS funded patients on two days per week. Extended opening hours were available in pre-operative assessment suite to allow flexibility for patients to attend around work or care commitments.

Access and flow

The hospital had met the 18 week referral to treatment indicator for NHS patients each month between December 2015 and March 2016. Ninety-four percent of patients were treated within 18 weeks during this time period. Performance had been below the indicator at 87.5% between July 2015 and October 2015.

The most commonly performed procedures at the hospital were arthroscopic operations on the knee, primary total hip replacement and total knee replacement. Other specialities included general surgery, cardiothoracic surgery, neurosurgery and cosmetic surgery.

The hospital was able to offer private patients a choice regarding when they would like their surgery.

If patients had surgery cancelled on the day of the operation, the hospital aimed to rebook the procedure patients within 28 days. The hospital had cancelled 61 procedures for a non-clinical reason between April 21015 and March 2016. Fifty-seven of these patients were offered another appointment within 28 days.

Theatre utilisation for April and May 2016 was 72%. Part of the hospital strategy was to improve theatre utilisation figures.

In pre-operative assessment, there could be delays to appointment times due to unforeseen circumstances, for example if it was difficult to obtain a blood sample from the previous patient. Patients were kept informed of any delays by reception staff.

Nurse led discharges were arranged when appropriate to allow patients to be discharged home in a more efficient way. This was identified on the surgeon's operation note. When patients met the criteria for discharge, this was arranged by the nurse and reduced the need for patients to wait for the surgeon to agree discharge who may be busy in theatre.

Copies of discharge summaries were sent to GPs and patients were referred to other relevant health professions for ongoing care, for example to district nurses or allied health professionals.

Meeting people's individual needs

There was access to face to face translation services for patients who did not speak English. There was also access to sign language interpretation when required.

Double rooms were available to allow carers of patients with dementia or a learning disability to stay with their loved one overnight. Online learning for dementia care was in place and had been completed by 77.8% of staff at the hospital. All patients over the age of 65 were screened for dementia at the pre-operative assessment appointment or on admission. This meant that staff could identify when

additional support may be required and could make a referral to the GP for further assessment. A recent audit showed that 98% of patients had been screened for dementia.

The hospital scored 84% for dementia on the patient led assessment of the care environment (PLACE) which was above the England average of 81%.

A quiet room was available for prayer or meditation and the hospital team had identified a need for a multi-faith room that was in development at the time of our inspection.

Equipment for bariatric patients was available in the pre-operative assessment suite, theatres and the wards, including access to bariatric weighing scales.

The pre-operative assessment suite was located a distance from the main hospital building. A transport service was provided to patients which was particularly helpful to those with mobility difficulties.

Patients told us that car parking spaces were difficult to find, however there was work ongoing to provide an additional car park at the time of our inspection.

Learning from complaints and concerns

There were details about how to make a complaint provided in the patient information guide located in each patient room. Staff were encouraged to resolve any concerns or complaints immediately where possible and ward managers or heads of departments were available to speak with concerned patients.

The number of complaints received showed a downward trend over the past three years. A total of seven complaints had been received in relation to surgery services between July 2015 and June 2016.

There was evidence that the hospital listened to feedback from patients. Wards displayed "you said, we did" information to demonstrate that changes were made to practice to improve patient care and experience. For example, one patient had provided feedback about pain control and the hospital had subsequently implemented a daily review by the clinical pharmacist for any patient with poorly control pain.

There was a corporate BMI policy on how complaints should be handled. Complaints were graded as stage one, two or three with expected timescales for response. Complaints and compliments were discussed at daily comms cells meetings and reviewed at the MAC and clinical governance committees.

No complaints had been referred to the Parliamentary and Health Services Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISCAS).

Are surgery services well-led?

Good

We rated well-led as good because;

Communication between the executive team, senior leadership team and staff in theatres and on the wards was effective in sharing the hospital vision and key messages in relation to governance, quality and patient safety.

Practising privileges were closely monitored by the medical advisory committee. Key issues were escalated to the committee for review and consideration.

There was a positive, open and honest culture. Staff engagement was good and patients and the public were involved in improvement work.

The hospital was innovative in developing the services it provided.

However;

Quality governance scorecards did not provide up to date information relating to all required safety, quality and risk measures.

Further work around governance and quality measurements systems in theatre was required to improve compliance with evidence based practice and provide assurance of patient safety. The newly appointed theatre manager told us they had plans in place to address this.

Leadership / culture of service related to this core service

Surgery services at the hospital were led by a team made up of the director of clinical services and two associate directors of nursing. They were supported by colleagues in governance and operations, and led the senior team in theatres, on the wards and in pre-operative assessment.

Staff spoke positively about the executive director and described the leadership of the hospital as good. They told us there was a 'can do' attitude from the leadership team and this was reflected on wards and in theatres.

The theatre manager was new in post at the time of our inspection but had worked in the hospital for a number of years. The leadership within theatres was therefore in its infancy but staff were positive about the manager's ability to lead the team and drive service improvement. We saw that there were plans in place to improve the service delivered in theatre, for example to develop an equipment matrix and increase the numbers of appraisals completed.

The culture was open and honest and staff felt happy to raise concerns when needed. For example, in theatre a scrub nurse had not allowed a patient to be anaesthetised before the surgical first assistant arrived although the consultant had asked for this to be done.

There was a management and leadership development programme in place to support both current and aspiring leaders to be effective in their roles.

Vision and strategy for this this core service

There was a corporate vision in place for BMI healthcare alongside its operational priorities. The hospital had used this vision to create a statement for the hospital which had recently been shared with staff. The vision was to build on the reputation as the leading provider of private healthcare in the north of England through facilities, acuity, responding to changes in the healthcare environment and exceptional stakeholder engagement. This included working on ambulatory care models, being the market leader in orthopaedics, cardiac surgery and neurosurgery and improving theatre utilisation. Although there was no specific strategy for surgery, the hospital stragety covered key aspects of this service.

The aims of the hospital were "to focus on continual development and improvement of all healthcare services, providing a high quality and safe healthcare service".

Senior staff understood the vision for the hospital but felt that junior staff had less understanding of this.

Governance, risk management and quality measurement for this core service

There was a daily meeting of the executive team and heads of departments labelled as 'comms cells'. This was a BMI wide system. The comms cell was designed to maintain effective communication at all levels of the hospital, to discuss activity for the day, highlight any issues, discuss incidents or complaints and any immediate actions to be taken as a result of these. We saw that comms cells were well attended and were an effective system of sharing information and raising any concerns.

There were formal executive board meetings each week. Monthly meetings were held within departments and with senior members of staff, for example senior sisters, and governance was a standing agenda item at these meetings. A monthly corporate clinical governance bulletin was circulated to staff.

There was a BMI wide risk management plan and associated hospital risk register in place. Risks were classified as operational, reputational and financial. Risk scores were calculated based on the chance of the event happening and the impact the event would have. Guidance was in place to ensure steps were taken to manage the level of risk appropriately. For example, guidance for risks scoring high and rated as red was to stop the activity until steps could be taken to control and reduce the risk. We reviewed the hospital risk register and saw that key hospital wide risks to patient safety had been identified. However, there were no locally held risk registers in the departments we visitedand key risks such as the chance of a never event may not be effectively managed at department level.

Quality governance scorecards were used to monitor key metric such as harm free care, training compliance, complaints and incidents. However, we saw that data was incomplete or missing on these scorecards. We reviewed four scorecards and saw that data was missing on each of these. This meant that key opportunities to manage risk and measure quality may be missed.

The medical advisory committee (MAC) met bi-monthly. Practicing privileges were closely monitored by the MAC and there were good systems in place to ensure that revalidation and appraisals were up to date for consultants. The consultant database was updated on a monthly basis and staff were informed when practicing privileges were removed. A monthly consultant newsletter was circulated to ensure consultants were informed of notable information in relation to governance, quality and risk.

Between April 2015 and March 2016, 33 consultants had their practicing privileges removed. The most common

reason for the removal of practicing privileges was retirement; failure to meet compliance requirements (for example up to date training records) and the consultant had requested removal.

There had been a vacancy for theatre manager in the recent past and we saw evidence that there were new plans in place within theatres to review systems and processes within theatres to improve compliance with evidence based care and treatment and improve assurance around risks.

In pre-operative assessment, there were targets in place for 85% of NHS funded patients to receive an assessment but there was no evidence of monitoring when patients were privately funded.

Public and staff engagement

The hospital used BMIs 'comms cell' meetings effectively to ensure staff were informed of developments within the hospital.

Monthly staff meetings were held with a standard agenda covering issues such as incidents, governance.

Consultants holding practicing privileges at the hospital received a monthly email to update them on changes at the hospital, upcoming events and work streams.

If staff were named in positive patient feedback, the executive director directly contacted the staff member to commend their work.

Staff long service was rewarded by the 'pin' awards, including a celebratory dinner hosted by the executive director for staff with over ten years service. Different coloured pin badges were given to staff to wear on their uniforms depending on length of service.

The hospital used the friends and family test to gain feedback from patients, alongside more detailed inpatient questionnaires. Reports were produced monthly to analyse patient feedback and action plans were developed as a result of feedback. Patient focus groups chaired by the executive director had been established to identify areas for improvement.

Innovation, improvement and sustainability

There were plans to submit patient outcomes to the private healthcare information network (PHIN) from 1 September 2016 to enable the hospital to compare patient outcomes with those of other independent hospitals and NHS hospitals. This will enable the hospital to identify areas of good practice or improvement and will also improve information available to patients to make decisions about where to receive their healthcare.

The hospital was piloting the use of an e-rostering system for nursing staff at the time of our inspection. The hospital was a pilot site for the BMI group.

Work was ongoing at the hospital to improve recruitment and retention of staff to ensure sustainability of the service for the future. This included overseas recruitment to fill vacancies where there were national shortages, for example in theatre.

Work was due to start on a hybrid cardiac catheterisation laboratory. This facility will enable surgeons to work alongside interventional cardiologists to perform open heart surgery alongside less invasive interventional procedures. This method will reduce the amount of surgery required and therefore reduce the risk to the patient.

Requires improvement

Critical care

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

Information about the service

The critical care unit at BMI The Alexandra hospital has been open since 1985 and consists of 12 beds, six within the unit and six high dependency rooms outside the unit. These beds were for level 1 or level 2 patients and were monitored from within the critical care unit. Level 3 patients are nursed one to one care and level 2 patients are nursed two patients to one nurse. The unit specialises primarily in cardiac surgery but also accepts patients after other types of major surgery.At the time of our inspection, the unit did not treat children.

In addition to the critical care unit we also looked at the Chester suite; 24 bedded unit, which included three interchangeable high dependency unit beds. Chester suite was situated adjacent to the critical care unit and the majority of patients were stepped down from critical care. The suite provided care for higher acuity patients with many requiring level 1 care and caters for surgical and medical patients.

We carried out an announced inspection of The Alexandra on 5 and 6 July 2016. We also carried out an unannounced visit on 13 July 2016. We spoke to 8 members of staff, three patients and reviewed five patient's records. We observed care and treatment and looked at both the information the hospital provided prior to inspection and other information we requested.

Summary of findings

Overall we have judged that the Critical Care Unit [CCU] required improvement. This is because:

We found a patient had been prescribed intravenous potassium. The prescription for potassium were incomplete and did not show the amount of dilution required, the level required to trigger the infusion or the duration of the infusion.

Results of safety thermometers were not share amongst staff or patients and data did not appear to be used to guide and improve overall service delivery.

In the critical care (CCU) unit there were four bed spaces adequate for level 3 patients and two side rooms, the sixth bed space was much smaller and had inadequate floor space for a level 3 patients.

We found only two sinks within the CCU; one sink in the main unit and one sink in a side room within a storage area, which did not appear to be a dedicated hand washing sink

We noted that there was no personal protective equipment (PPE); aprons or glove dispensers within the high dependency (HD) rooms.

However:

The critical care service had an outreach team which consisted of critical care staff and associate specialists (SAS). The SAS played an integral part of patient care and provided 24/7 emergency response to deteriorating patients anywhere in the hospital.

Requires improvement

Critical care

Patients were protected from avoidable harm and there were processes and systems in place, which prioritised patient safety.

Are critical care services safe?

Requires improvement

Incidents

Staff were encouraged to report incidents and were aware of how to report an incident. The reporting system was paper based, with a different form for clinical and non-clinical incidents. The majority of these incidents were graded as no or low harm, indicating a good reporting culture.

Data received from the provider prior to our inspection confirmed that in the last 12 months there were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)) and no incidences of hospital acquired Clostridium difficile [Cdiff].

Information received from the provider prior to inspection confirmed that In the last 12 months the percentage of patients risk-assessed for venous thrombosis and pulmonary embolism (VTE) was 100%. The number total number of confirmed cases of hospital acquired VTE during the same time period was two.

Staff in critical care were aware of the process to use and encouraged to report incidents and learning was shared from findings. Records we reviewed confirmed that staff reported incidents, using a paper based system. Records confirmed that the CCU manager would then input thee incident report onto the hospitals electronic database.

We saw records which confirmed that a clinical governance team, would then co-ordinated the investigation of any incidents as required and the results were feedback via a monthly report to management staff.

If lessons learnt from an incident resulted in either a practice or policy change, then information relating to changes, would be generated and distributed to all staff. A sheet would be signed by staff, to confirm that they had read and understood the policy/process change.

In the 12 months prior to our visit the hospital had reported one ‘never event’. ‘Never events’ are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Requires improvement

Critical care

We reviewed records which confirmed that there were regular mortality and morbidity meetings held by senior staff.

We found no evidence to confirm that the critical care unit at BMI Alexandra took part in internal benchmarking within the wider BMI hospitals group, or external benchmarking nationally.

Safety thermometer

The service monitored safety via quality governance scorecards. Such scorecards are local improvement tools for measuring, monitoring and analysing patient harms and 'harm free' care.

The critical care unit collected safety thermometer data for NHS patients. The NHS Safety Thermometer scheme is used to collect local data on specific measures related to patient harm and 'harm free' care to indicate performance in key safety areas. The unit reported no falls in the 12 months prior to our inspection. However we found that the results of safety thermometers were not shared amongst staff or patients and data did not appear to be used. There were no reported incidents of venous thrombi-embolism (VTE), a medical condition where blood clots develop in the veins in the intensive therapy unit (ITU) and high dependency unit (HDU) between June 2015 and June 2016. A VTE risk assessment tool was included in the hospital patient care records, that were audited monthly. Records we reviewed confirmed that compliance for patients being risk assessed for VTE was 100%.

The hospital was part of the national Sign up to Safety campaign. This campaign aims to reduce avoidable harm to patients and demonstrated the hospitals commitment to listen to patients and staff, learn from incidents and to make changes to improve patient safety.

Cleanliness, infection control and hygiene

We observed all clinical areas, were clean and fit for purpose, we note that 'sanitised for your protection' labels were used in the en-suite facilities.

The six high dependency (HD) single rooms, outside the critical care unit (CCU), were all ensuite complete with sinks; however there were no bed side clinical-wash hand basins. This meant that staff would have to use the patient's sinks within the en-suite facilities. This posed a small risk in relation to infection control. We saw evidence that the hospital had recorded 'failure of infection prevention and control process' as a 'patient safety risk' on their 2016 risk register. We noted that one of the documented actions required was for the refurbishment of bathrooms, including hand wash basins.

We observed that there was no handwashing sink on entry to CCU. However we did note that on entry into the CCU, hand gel dispensers, aprons and gloves were readily available. However we also noted that there was no personal protective equipment (PPE); aprons or glove dispensers available within the individual rooms.

We found only two sinks within the CCU; one sink in the main unit and one sink in a side room within the storage area, which did not appear to be a dedicated hand washing sink. In accordance with the department of health, Health Building note 04-02, each CCU bed space should be equipped with a clinical wash-hand basin.

The hospital employed an infection control officer whose role included the daily monitoring of critical care patients. The infection control officer was also responsible for collating the results of hand hygiene audits and care bundle audits. Records we reviewed confirmed that these audits had been reviewed and actions put in place to address any issues identified as part of the audit process.

There were clear guidelines for staff to follow to screen patients for the presence of infections such as methicillin resistant staphylococcus aureus (MRSA) and carbapenemase-producing enterobacteriaceae (CPE). Records we reviewed confirmed that that these had been followed.

Staff we spoke with told us that all areas of CCU were cleaned after each patient and for specific identified infection control issues, a deep clean would be carried out by an outside agency.

The hospitals Patient-led assessment of the care environment (PLACE) scores for cleanliness was 100%, better r than the England average of independent health hospitals.

Environment and equipment

All equipment we saw during our visit was visibly clean, fit for purpose and in a good state of repair.

In the CCU there were four bed spaces equipped for level 3 patients and two side rooms, the sixth bed space was much smaller and had inadequate floor space for a level 3

patients. During our visit we observed a level 2 patient being treated in this smaller bed space. On raising this with the hospital after our visit, they stated that the bed space we referred to was only for level 2 patients. If this is the case, the unit can only accommodate five level 3 patients, not six as indicated by the literature available.

There was a shortage of storage space and in the two side rooms the cupboard space was being used as a storage facility. We noted that the cupboard was insecure which meant that items in it were easily accessible to relatives, visitors and patients.

There was no relative's waiting room within the unit or outside the unit. Relatives visiting CCU patients would have to wait in the relatives lounge in the Richmond Suite on the oncology unit. This, however did not appear to be an issue, as the all relative's we spoke with confirmed that they were happy with the waiting facilities the service provided.

Recommendations within the Department of Health building note (HBN) 04-02 state that interview rooms should be provided within the vicinity of the bed spaces to enable staff to speak to visitors in privacy. We found that there were no interview rooms, or spare rooms which could be utilised as such within the CCU.

As there was no relatives waiting room and no interview rooms, staff told us that on occasions relatives were taken into a small 'staff room' to be spoken to. In addition to this, the staff room doubled up as a staff kitchen and an office. Staff we spoke with stated that this arrangement was not always appropriate for staff or relatives.

We reviewed the resuscitation equipment, which was checked twice daily; the equipment was damp dusted and the security seals on each drawer were checked to correspond with the entry in the record book. Once a week the security seals were broken to enable staff to check the dates on the equipment, the seals were then replaced.

We found the defibrillator in CCU to be in order, records we reviewed confirmed that it was checked twice daily by staff and a user test carried out. The results were printed and saved in a record book. Records also confirmed that the emergency airway equipment in CCU was checked by staff monthly.

We were shown a video laryngoscope and fibre optic scope, which we were told was always available for patients with tracheal Intubation. When not required these were housed within the surgical department.

We found the sluice in CCU was housed near the entry to the unit. The room contained a cleaner and deodoriser product within unsecured cupboards. This room was easily assessable to any visitors and out of sight of staff which meant people could access the cupboard unobserved.

? We noted that the disposal of sharps, such as needles followed good practice guidance. Sharps bins were signed and dated when assembled and temporary closures were used when the bin was not in use.

Medicines

We found one patient had been prescribed intravenous potassium; we reviewed the prescription sheet and noted that this was poorly documented. The prescription record showed no time period over which to administer the potassium, no indication of dilution and no record of the level of potassium to use to commence the treatment. This was highlighted immediately to the sister on duty and the prescription was reviewed and re written. We also raised this with the senior service managers, who acted immediately to address the concerns we raised.

We found that the unit had appropriate systems in place to ensure that medicines were managed, stored and disposed of securely. Medicines were stored in secure cabinets within the unit.

There were two controlled drugs cabinets accessed by a key, which was kept with the unit manager. As part of the inspection process, we carried out random controlled drugs checks, which demonstrated that actual stock matched the stock accounted for in the registers and drugs we looked at, were in date. We found records which confirmed that there were registers in use for the controlled drugs. The pharmacist carried out controlled drug audits quarterly, where the drug stock, prescribing and completion of the drugs register was checked.

There was also a drugs fridge which displayed the internal fridge temperature, which was monitored daily and we saw documentation which confirmed this.

We found that patients own medication from home, was recorded in the drugs register, but not the quantity. It was however, documented on the drugs chart when a patient gave permission for their own medication to be destroyed, taken home, or changed.

Records confirmed that this issue was recently addressed during medicines management audits, which had defined that the patient's own medication was kept in the pod lockers near the patient's bed space. However staff we spoke with said that as the keys to the lockers were missing, the lockers could not be secured and as such were not able to be used safely.

We looked at two prescription sheets, selected at random during our inspection and saw that patient allergies were clearly documented.

Records

? Records were stored securely behind nurse stations in lockable cupboards. Records relating to the current admission were stored in individual patient bedrooms.

?

We looked at five sets of patients records, we found that the records were; clearly labelled, care pathway specific and assessments were completed. The notes we reviewed were comprehensive and well documented. There was separate documentation for care pathway risk assessments, which included falls, skin care, etc.

We reviewed the records of a patient who lacked capacity and found them to be well documented and involvement by staff from across specialisms and the family was recorded.

We noted that the Richmond Agitation Sedation Score (RASS), an objective assessment of delirium, was not routinely recorded on patient observation charts.

We found that the pain score was not routinely recorded, however, staff told us that patients were routinely asked about their level of pain or discomfort. Patients we spoke with confirmed this and told us that their pain was well managed.

We observed that during our visit one patient in CCU had VTE prophylaxis and had been prescribed stockings and enoaptine, but there was no documentation to evidence that a risk assessment had been carried out and no evidence of a repeat assessment at a 24 hour interval.

Patient allergies were clearly labelled on patients notes and we saw examples of this on the notes we looked at, allergies were also recorded on a 'drug cardex' at the side of the drugs trolley. Red wrist bands were also worn by patients to indicate instantly that they had an allergy.

Safeguarding

Staff were aware of safeguarding policies and procedures and could verbalise the process used to escalate a concern. Staff were aware of their responsibilities to raise safeguarding concerns and there was a named safeguarding lead for adults and children at the hospital who had completed level three training. There was a clear process in place for staff to refer to when concerns were identified and this was displayed on notice boards in the areas we inspected

We spoke to a CCU manager who was the safeguarding lead for adults, all CCU staff we spoke with were clearly aware of who to go to, to escalate a concern.

There was a corporate safeguarding adult's policy incorporating mental capacity and deprivation of liberties and 'Prevent', which was available to all staff of the BMI intranet. Staff we spoke with were able to confirm they had accessed and understood the corporate policies.

The safeguarding adult's level 2 compliance, at the time of our visit, for CCU staff was 88%, the BMI target rate being 90%. We were told that there had been recent changes to the BMI module which meant that more staff were eligible to complete level 2 training and this had impacted on the compliance figures.

Mandatory training

Mandatory training was made up of a combination of electronic learning, face-to-face learning, assessments, reading of policies and attendance to workshops and covered topics such as infection prevention and control, manual handling and duty of candour.

Staff we spoke with confirmed they were allocated time to allow them to complete training.

The service did not have a practice educator; however, one of the senior nurses on CCU managed and monitored mandatory training and competencies for staff in CCU.

Mandatory Training figures for CCU staff provided by the provider prior to inspection were reported as 97% compliance as at the 4th July 2016.

Requires improvement

Critical care

Data received prior to inspection confirmed that none clinical staff had also completed training such as basic life support and infection and prevention control. This was confirmed by the staff we spoke with during the inspection.

Assessing and responding to patient risk

All patients were monitored according to the provider's policies and procedures. Staff we spoke with confirmed that they were able to access specialist medical support promptly to support patients whose condition had changed and required review and intervention.

On the Chester suit three handovers took place each day and a 'safety huddle' was carried out between the staff to discuss each patient in detail.

Records confirmed that the hospital used the Modified Early Warning Score (MEWS) which is a simple, physiological score that may allow improvement in the quality and safety of management provided to patients. The primary purpose is to prevent delay in intervention or transfer of deteriorating or critically ill patients. Records we reviewed confirmed that MEWS sheets were audited regularly, data received from the provider prior to inspection confirmed that the had been 100% compliance with the use of MEWS in the six months prior to our inspection.

The CCU had an outreach team which consisted of CCU nurses and senior associate specialists (SAS). The SAS team played an integral part of patient care and provided 24/7 emergency response to deteriorating patients anywhere in the hospital. They were called if an individual patients MEWS score was five or above.

All CCU sisters formed part of the outreach team, this meant that they could be called to anywhere in the hospital at any time, each sister carried a bleep to respond, This had the potential to create shortfalls in qualified staff at ward level. As the nurses we spoke with confirmed that they must leave their own unit when called. Staff told us senior nurses were not always supernumerary, which meant that there was a risk that staffing levels on the unit could be compromised if staff were called away.

Out of hours emergency care was provided by an SAS doctor. If a patient required intensive care then the admitting consultant would discuss admitting the patient with the intensivist. Prior to admitting that patient. Patients who were assessed as unsuitable for the CCU would be automatically transferred to local NHS trusts.

Arrangements were in place for safe emergency transfers into the NHS if required. We saw an example of a patient in July 2015 who contracted MRSA, they was subsequently transferred to an NHS cardiac intensive care centre.

We reviewed records which confirmed that the SAS team consisted of six anaesthetists and two consultants, all with advanced airway skills and intensive care trained.

Level 2 and level 3 patients (surgical and medical) would be seen twice daily by an SAS doctor, who would review their history and conduct an examination. They would also review and make suggestions regarding the patients daily care plan.

Management of sepsis was in accordance to the BMI policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis trust guidance on the initial management of septic patients. Records we reviewed confirmed this.

Nursing staffing

Staffing rates were in accordance with intensive care society guidelines; level 3 patients received 1:1 care and high dependency patients received 1:2 care. The hospital used the BMI nursing dependency and skill mix tool to plan the nursing skill mix required against predicted patient activity and acuity .This tool was used in critical care. It incorporated levels of care from zero to three with an allocated number of hours per patient per level. Any concerns relating to nursing staffing were highlighted to the senior management team and heads of department in the comms cell each morning. Planned and actual staffing levels were displayed on boards at the entrances to wards.

Records we reviewed confirmed that staffing levels were monitored regularly with an appropriate staffing tool and we found adequate staffing to meet people's needs. Staff told us they flexed according to patient load and dependency so shifts were not left uncovered.

At the time of our visit the unit had two registered general nurse vacancies and they told us there would be another vacancy in addition to this in July 2016.

The unit utilised less than 20% of bank and agency staff on any one shift and we senior staff we spoke with told us that all staff they used had previous experience of working in the unit. At the time of our visit the unit had just one whole time equivalent (WTE) member of agency staff covering for staff holidays.

New CCU nursing staff received a four to six week supernumerary period or longer if required depending on previous experience.

New staff attended an acute illness management (AIM) course, providing the staff with the essential knowledge and skills to recognise and initially manage an acutely ill & deteriorating adult patient with a view to preventing cardio respiratory arrest.

There was a large number of courses available to staff and safe airway management day was a new course which staff attended at a local NHS hospital. Records we reviewed confirmed that staff had access courses throughout the 12 months prior to inspection. This was confirmed by the staff we spoke with.

An induction was carried out for any new staff to the unit, which included the issue of an induction pack. This included an orientation check list and initial clinical objectives, which new staff were required to complete within the first month. We reviewed staff files which confirmed they had undergone the induction process.

The coordinating nurse on each shift was identified in a supernumerary capacity; however staff we spoke stated that this rarely happened. This was confirmed by the staffing rotas we reviewed, which clearly showed that the coordinating nurse was active on shift. We raised this with senior management who told us that this was due a combination of staff sickness and ongoing recruitment issues.

On the Chester Suite, a new nursing acuity tool was being trialled, which measured patients acuity relating to clinical hours required for care. The time required for each patient was placed on a scoring system and was used to plan staffing requirements. However as this trial was in its early stages, staff could not tell us weather this was having a positive impact or not.

Medical staffing records we reviewed confirmed that SAS doctors work 12 hour shifts, 7am to 7pm, 7pm to 7am, on a rota basis.

We noted that the number of resident medical officers (RMOs) employed by the hospital was one permanent, five bank staff and six via an external provider.

Training for the RMOs recruited via an agency was provided by the agency in accordance with the content of their contract with BMI Healthcare and the training requirements stipulated. The agency's mandatory training programme included teamwork, data protection, health and safety, equality and diversity, food hygiene and safety, mental capacity, personal safety, safeguarding adults, first aid essentials, fire safety, child protection, infection prevention and control, clinical medicine management, blood taking and transfusion, moving and handling, complaint handling and advanced life support.

Records we reviewed confirmed that prior to medical staff commencing employment at The BMI Hospital; the healthcare agency provided the hospital with a copy of the RMO's file and training record for approval.

The SAS Doctors told us that they handover to the CCU team at 7am every morning and formally review CCU patients daily. Records we reviewed confirmed this.

Staff we spoke with told us that cardiology patients in CCU are seen by their cardiologist in addition to the CCU consultant. We reviewed patient records which confirmed this.

Major incident awareness and training

The hospital was set up in the main to deliver elective surgery and as such did not accept major trauma patients. We were told that BMI do not currently require major incident awareness training as a mandatory requirement.

Records confirmed that all staff were required to carry out annual fire training in line with the hospital policy and evacuation plan. Fire training compliance was 92% as at 17th August 2016.

The hospital followed local and national business continuity management (BCM) policies as a framework to minimise disruption and interruption to the services delivered in the event of a major hospital incident, e.g. loss of water.

In the event of a major incident locally, the service has agreements in place to cooperate with the local NHS trusts to assist where required as a satellite operation.

Requires improvement

Critical care

BMI hospitals nationally had a 'surveillance outbreak policy' which was available on the intranet. During discussions with the CCU infection control nurse it was clear that she had a clear understanding of this policy. We were also able to review the policy as part of the inspection process.

There was a hospital business continuity plan which was used alongside a BMI corporate plan. This had recently been put into action during a mains water outage.

Are critical care services effective?

Requires improvement

We rated effective as Requires Improvement because:

There were a number of care bundle audits carried out monthly, which included; peripheral line, central line insertion and urinary catheter ongoing care, which were sent to the infection prevention and control (IPC) lead on completion. However staff were unclear on how the audit data was used or how it was cascaded back.

Patients were not routinely screened for delirium on admission and this was not in line with Faculty of Intensive Care Medicine (FCIM) guidance.

Staff we spoke with confirmed that no formal multi-discerplinary meetings took place on the unit.

We did not see any evidence of how the hospital was monitoring itself against others. We were told that Intensive care national audit and research centre (ICNARC) data had started to be collated and had been submitted on 1 June 2016; however they had not identified units to bench mark against. There were no data reports available.

However:

73% of nursing staff on the unit held a post registration award in Critical Care nursing.

The ICU had a part time, clinical practice nurse educator in post who supported staff through their post registration award in critical care.

Staff were aware of policies and procedures relating to obtaining consent and the processes relating to best interest and decision making.

The BMI patient satisfaction survey results for April 2016 showed that 85% of the patients asked said that the overall impression of their consultant anaesthetist was 'excellent'. 82% of patients asked, also said that they thought the nursing care was 'excellent'.

At handover on the Chester suite a Situation background assessment and recommendations (SBAR) form was completed.

Patient records showed that patients had access to physiotherapy which was in line with National Institute for Health and Care Excellence (NICE) guidance and intensive care society standards.

Evidence-based care and treatment

Hospital policies, care pathways and risk assessments followed NICE guidance including guidance on the management of acutely ill patients in hospital.

There was a range of policies and procedure and standard operating protocols in place which were easily accessible via the BMI intranet.

We saw staff using specific care bundles, which reflected national guidance. Critical care bundles were part of the care plan completed for every patient in critical care. Staff performed daily checks of care bundles and once completed this would be indicated in the care bundle prescription chart.

There were a number of care bundle audits carried out monthly, which included; peripheral line, central line insertion and urinary catheter ongoing care, which were sent to the infection prevention and control (IPC) lead on completion. However staff were unclear on how the audit data was used or how it was cascaded back.

Hand washing audits were also completed monthly and sent to the IPC lead, but there was no evidence to show that the data was fed back to staff. The data was not displayed for staff or members of the public.

Patients admitted to the unit were not screened on admission for delirium, as recommended by NICE guidance. During illness, hospitalization, or recovery from surgery or stroke, many people experience delirium, a rapidly developing and severe confusion accompanied by altered consciousness and an inability to focus. This was not in line with Faculty of Intensive Care Medicine (FCIM) guidance. This was also not constant with guidelines for

the Provision of Intensive Care Services, 2015 which states that patients must be screened for delirium and that this should be done with a standardised assessment tool and use a multi professional approach. The service did not have a dedicated assessment tool for delirium.

Pain relief

There was no acute pain management team for the unit. Patient's pain was assessed and monitor by staff using the Early Warning Scores (EWS) and managed by the aesthetic team.

Pain management was audited locally each month with a more comprehensive audit being undertaken six monthly.

The BMI patient satisfaction survey results for April 2016 showed that 65% of patients asked felt that the way staff had assessed their level of pain had been 'excellent'.

Nutrition and hydration

A dietician attended the unit to assess patients' needs. This was either following a request by critical care staff or routinely. Staff told us that in the absence of a dietician there was a protocol in place which allowed them to start a liquid diet until a dietician attended to review and make a plan.

We saw evidence of dietician input in the patient notes. Nutritional risk scores were updated and recorded appropriately on the patient's records.

Food and fluid balances charts were maintained in patient notes when required.

The Patient satisfactory survey 2015 to 2016 showed that in 2015 94.6% of patients scored the quality of food as excellent and in 2016 only 83.2%. The number of patients who scored the variety/choice of food as excellent also decreased from 91.9% to 82.4% during the same period.

Patient outcomes

There were no regulation 28 reports issued to the hospital. Regulation 28 reports are issued by coroners following the outcome of the inquest if the coroner judges that action must be taken to avoid a preventable death in the future.

The hospital collected data on incident, near miss, complaints and patient satisfaction on a monthly basis. This information was compared against other BMI hospitals in order to measure performance. The CCU manager was part of the BMI critical care best practice group which linked in with other units within BMI. Formal benchmarking was undertaken via the BMI national critical care steering group, led by the national critical care clinical lead nurse. However, the service had not previously contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could not be benchmarked against other critical care units outside BMI nationwide. Data submission to ICNARC had begun in June 2016.The unit told us that they had begun to collate data for ICNARC and had been submitting data since 1 June 2016, but no data reports were available as yet. However, on speaking to CCU staff who were involved in the collation of data, it was uncertain on what areas they would be bench marked against and how they were going to use the information.

The staff of the CCU told us that they attended critical care network meetings, but there had been no official peer review. Consultants from NHS trusts were also on the critical care and resuscitation committee.

Senior CCU staff linked in with the Greater Manchester critical care network (GMCCN) and attended the meetings. A peer review had not been conducted in the previous 12 months to our visit.

There were no delayed discharges in CCU and HDU between June 2015 and June 2016.The majority of patients returned to their pre-admission residence and previous level of independence on discharge from hospital.

Competent staff

Staff were able to access training internally and externally. There was an online learning system across BMI where staff could access additional training opportunities.

The pharmacist assigned to the unit was band 7, the consensus of critical care pharmacists, the UK clinical pharmacy association and the Royal Pharmaceutical Society is that there should be at least 0.1 WTE band 8a specialist clinical pharmacist for each single level 3 bed and for every level 2 beds.

There were 584 doctors and dentists employed or practicing under rules and privileges for the hospital, of which 584 have had their registration validated in the last 12 months.

All ICU staff were subject to annual appraisals. At the time of our visit, 55% of sisters were up to date with their appraisal and 45% were booked in. 66% of registered

general nurses (RGN's) had completed their appraisal and 33% were booked in and 66% of Health care assistants (HCA's) had completed their appraisal and 33% were booked in.

The consultants who were part of the staff and associate specialists (SAS) team had to have their appraisals signed by the medical director or chief director of their own trust.

73% of nursing staff on the unit held a post registration award in Critical Care nursing; this is above the minimum requirement recommended by the Intensive Care Society [ICS] which is 50%.

The BMI patient satisfaction survey results for April 2016 showed that 85% of the patients asked said that the overall impression of their consultant anaesthetist was 'excellent'. 82% of patients asked, also said that they thought the nursing care was 'excellent'.

The CCU had a part time, clinical practice nurse educator in post who supported staff through their post registration award in critical care.

There were a number of courses held on the unit in order to make sure that nurses competencies were maintained, such as; Nasal high flow, for oxygenated patients, chest drains/central lines and pacing training.

Some training was carried out in conduction with local NHS hospitals; a new course which the staff had signed up for was 'Safe Airway Management Day'.

Training for any new equipment on the unit was conducted at the hospital by the company supplying the equipment.

We were told that new staff to the unit attended an 'acute illness management' course yearly and the Critical Care Skills institute after 12 months to complete the Critical Care Course. Along side this staff attend a 'cardiac surgery day', three times a year. Records we reviewed during inspection confirmed this.

There was always a Sister/charge nurse on duty that holds a critical care qualification and is trained in Advanced Life Support (ALS).

Multidisciplinary working

Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement treatment plans for patients. However we found no evidence to confirm a formalised multidisciplinary approach to patient care.

Staff we spoke with told us that no scheduled, daily multidisciplinary ward rounds took place in the unit. In accordance with the Core standards for intensive care units, consultant intensivist led multi-disciplinary clinical ward rounds within intensive care, must occur every day.(NICE CG83)

There were two WTE physiotherapists for the CCU, who attended the unit twice daily, more often if there was a level 3 patient admitted. They also liaised with the critical care consultant on duty. Records we reviewed confirmed that Physiotherapy and Occupational therapy worked closely together, frequently carrying out joint assessments and therapy sessions.

Staff we spoke with told us that dieticians did not attend the unit in person daily, but they rang for an update on specific patients as and when required. Staff maintained an observation record which they completed throughout the shift. Once completed it would be folded and placed in the patient's records where other multidisciplinary staff could access it.

Staff told us there was a dedicated pharmacist for the unit, who attended daily. This was confirmed by records we reviewed. We noted that the pharmacist was on the unit several times during our inspection.

The unit did not take transfers from other hospitals in the Critical Care Network.

Staff on the Chester suite, told us that multidisciplinary meetings took place weekly, every Wednesday and Friday morning. We reviewed records which confirmed this.

Consent and Mental Capacity Act

Staff were aware of policies and procedures relating to obtaining consent and the processes relating to best interest and decision making.

Staff we spoke to were competent and aware of the mental capacity act and deprivation of liberty safeguarding protocols. One example we were informed of was a patient with Alzheimer's was admitted to the unit. The patient was unable to communicate and a Deprivation of liberty safeguarding (DOLS) was carried out and a safeguarding form one was completed. We saw that all the documentation was in order.

We saw evidence of completion of mental capacity assessments in the individual patient records we looked at.

Requires improvement

Critical care

Are critical care services caring?

Good

We rated caring as Good because:

Patients we spoke with confirmed that Patients were cared for with dignity and respect. Relatives we spoke with told us that staff were kind and compassionate.

We observed staff provided a caring, kind, and compassionate service to patients and their relatives. We noted that staff worked in a way that protected patients' privacy and dignity.

The BMI patient satisfaction survey for April 2016 showed that 92.3% of patients said that they were 'definitely' involved in the decisions about care and treatment.

We were told that patient diaries were in use in the unit, for level 3 patients.

Patients we spoke with told us they were involved in decisions about their care and were given enough information and supported to make informed choices. Family were encouraged to be involved in their care and recovery.

All patients and relatives we spoke to said that their care, treatment and condition had been explained to them throughout their stay.

Compassionate care

The patients and relatives we spoke to in CCU all told us that the staff were caring and respectful. One family member told us that her relative had been were treated with dignity and respect by all staff at the hospital, including nursing staff, housekeeping staff and porters. Another patient we spoke with confirmed this and stated they were even greeted warmly by staff on the reception desk.

Staff told us that patient diaries were in use in the unit, for level three patients. Intensive care patient diaries are a simple but valuable tool in helping patients come to terms with their critical illness experience. Research has shown that diaries enable patients to make sense of their intensive care experiences and they reduce the risk of developing depression, anxiety and post-traumatic stress disorder (PTSD) for both patients and relatives. As there were no level three patients during our visit, we did not see a patient dairy in use.

There was no separate data available for critical care patients from the Friends and Family test results, but the current returns were 50%. Staff told us they do not receive specific critical care feedback from the survey.

The BMI patient satisfaction survey for April 2016 showed results for the hospital as a whole and were not specific to ICU. 92.3% of patients said that they were 'definitely' involved in the decisions about care and treatment. 97.2% of patients said that they were 'always' given privacy when discussing their condition/treatment and 98% of patients asked said that they 'always' felt that they were treated with respect and dignity. A specific comment was made by a patient, who said that they had received good care and there was a good CCU and PICU team.

The hospitals patient-led assessment of the care environment (PLACE) scores for privacy, dignity and wellbeing were 87%, level with the England average.

Friends and family test scores for the hospital were very high. Over 99% of NHS patients would recommend the hospital to their friends and family. Response rates varied month to month but they were generally lower than the England average for independent health hospitals. For patients who were self-funding their care and treatment or had medical insurance, 97.8% said they would recommend the hospital in May 2016.

Understanding and involvement of patients and those close to them

We observed staff introduced themselves and their role to patients who were awake in critical care. Patients told us that they were kept informed of the treatment plans and staff explained procedures before they carried them out. All relatives we spoke to said that their family members care, treatment and condition had been explained to them throughout their stay.

There was no organ donation co-ordinator; however the hospital had links with a local NHS hospital transplant team.

Family members were encouraged to visit and were kept informed about when to expect their loved one back from theatre to reduce any worries they may have.

Requires improvement

Critical care

On the Chester suite we saw leaflets available for patients, in order for them to find further information on numerous medical subjects, including; getting back to fitness, specialist heart care and individual prescription plans.

There was evidence of discussions of patient care with those close to them in the patient records.

Emotional support

There was no CCU follow up clinic, however patients who had been admitted to CCU for heart operations, were contacted two days after discharge by the CCU sister.

The CCU did not routinely offer counselling to patients; however BMI health care did have counselling services available, with information on their website.

Some patients were able to access a specialist nurse for additional support and advice before and after their treatment. This was dependent upon the consultant.

Are critical care services responsive?

Good

We rated responsive as Good because:

Services were tailored to meet the needs of individual people and there was flexibility in the provision of care.

The hospital worked with local stakeholders to plan services to meet the needs of local people.

Staff demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality.

The hospitals Patient-led assessment of the care environment (PLACE) scores for dementia were 84%, greater than the England average.

There were facilities in place to meet the needs of patients with additional needs such as dementia, learning disability or bariatric issues. Translation services were available and staff had undertaken training in dementia care.

At handover on the Chester suite a Situation background assessment and recommendations (SBAR) form was completed.

Information was provided about how to make a complaint. Learning from complaints was shared and overall there had been a downward trend in the numbers of complaints in the previous three years.

The food menu was comprehensive and varied according to different cultural requirements

However:

There were no facilities for relatives to stay over at the hospital.

There was no relative's lounge or kitchen area in order for relatives to make a drink out of hours.

The unit did not have a follow up clinic where patients could reflect upon their critical care experience. This was not in line with Guidelines for the Provision of Intensive Care Services, 2015.

Service planning and delivery to meet the needs of local people

The availability of critical care meant that patients requiring more complex surgery such as open heart surgery or with co-morbidities could still access this surgery at the hospital.

There was no relative's lounge or kitchen area in order for relatives to make a drink out of hours. There was no visitors' waiting room for CCU or HDU but there where places visitors could sit outside of the units, as well as at the hospital's main reception.

The hospital scored 84% for dementia on the patient led assessment of the care environment (PLACE) which was above the England average of 81%.

There was access to face to face translation services for patients who did not speak English. There was also access to sign language interpretation when required.

In quiet periods on the unit the CCU nurses were employed elsewhere in the hospital, we were told by the staff we spoke with that generally staff are displeased when this happens.

Meeting people's individual needs

The hospitals Patient-led assessment of the care environment (PLACE) scores for dementia were 84%, greater than the England average.

Requires improvement

Critical care

We were not informed of any psychiatric support for patients and consultants we spoke to said they were not aware of any access to psychological services for patients.

Visiting times were flexible and visitors could arrange to visit at a time outside the normal hours.

The food menu was varied and was available in alternate languages to cater for none English speaking patients.

A quiet room was available for prayer or meditation and the hospital team had identified a need for a multi-faith room that was in development at the time of our inspection.

Staff told us that interpreter services were readily available. We observed posters within the main reception which confirmed this. We also noted that leaflets could be ordered in several different languages if required.

The unit did not have a follow up clinic where patients could reflect upon their critical care experience. This was not in line with Guidelines for the Provision of Intensive Care Services, 2015 which state that patients discharged from CCU must have access to a CCU follow up clinic.

Relatives and patients we spoke with told us that Patients told car parking was an issue, however we noted that there was work ongoing to provide an additional car park at the time of our inspection.

Access and flow

The bed occupancy combined figures for HDU and CCU reported by the hospital for March 2016 was 88%, the highest in 12 months. The hospital told us that figures generally followed a pattern of a low percentage in the summer months (June 2015 32%, July 2015 44%) and high in the winter months (e.g. January 2015 60%, February 2015 70%).

The BMI patient satisfaction survey results for April 2016 showed that 80.6% of patients asked stated that they felt their discharge process was 'very' organised.

We found that there were no access and flow issues in relation to either the CCU or the Chester Suit.

There were no non-clinical transfers out of the unit to other hospitals, however we were told of one patient being transferred out due to a viral chest infection. We reviewed the CCU's operating policies and these confirmed a service level agreement with local NHS trust in relation the effective transfer of patients.

Records provided by the provider prior to inspection showed that there was no elective surgery cancelled due to lack of CCU beds.

There were 2,196 Level 2 critical care bed days available in the hospital during the reporting period (Apr 15 to Mar 16). 1019 Level 2 critical care bed days used, giving an occupancy rate of 46% for the same reporting period. There were 2,196 Level 3 intensive care bed days available in the hospital during the reporting period (Apr 15 to Mar 16). 231 Level 3 intensive care bed days used, giving an occupancy rate of 11% for the same reporting period.

We saw records which confirmed copies of discharge summaries were sent to GPs and patients were referred to other relevant health professions for ongoing care, for example to district nurses or allied health professionals.

Learning from complaints and concerns

There were details about how to make a complaint provided in the patient information guide located in each patient room. Staff were encouraged to resolve any concerns or complaints immediately where possible and ward managers or heads of departments were available to speak with concerned patients.

There have been only two complaints in the last year in relation to the CCU. One complaint was concerning the anaesthetist attitude and the second complaint was concerning the patient's experience when she was being weaned from the ventilator. Both incidents had a full route cause analysis investigation carried out and a letter was sent to each patient. In the first complaint the member of staff involved presented the file at their next appraisal for learning experience.

The BMI website contained information on how to raise a concern both informally and as a formal complaint and an address, telephone number and email address was clearly provided.

The investigation of complaints was the responsibility of the Executive Director. Complaints were logged onto an electronic system and were investigated before a decision about whether to uphold them was made.

There was a corporate BMI policy on how complaints should be handled. Complaints were graded as stage one,

two or three with expected timescales for response. Complaints and compliments were discussed at daily comms cells meetings and reviewed at the MAC and clinical governance committees.

We noted that no complaints had been referred to the Parliamentary and Health Services Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISCAS).

Are critical care services well-led?

Requires improvement

We related well-led as Requires Improvement because:

Staff we spoke to were not clear on their roles and appeared not to understand what they were accountable for.

The hospital wide risk register did not identify key risks within individual departments. There was not a specific risk register in relation to CCU**;** all risks were collated hospital wide risk.

Senior staff we spoke with found it difficult to explain what audits were undertaken within the CCU and we were not assured that they were fully aware of staffing levels.

However;

Communication between the executive team, senior leadership team and staff was effective in sharing the hospital vision and key messages in relation to governance, quality and patient safety.

Minutes from the CCU and critical care resuscitation meeting are displayed prominently in the staff room for staff to review.

A culture of openness and transparency was embedded in the unit and was evident in staff we spoke with.

Vision and strategy for this this core service

We were told that the hospital is undergoing an extensive programme of investment. Phase 1 of the refurbishment has been board approved. Phase 2 will be submitted for board approval in August 2016, which includes plans for the re-design of the ICU. The plans will directly address the issues around bed spaces. Completion is anticipated during 2017.

There was a corporate vision in place for BMI healthcare alongside its operational priorities. The hospital had used this vision to create a statement for the hospital which had recently been shared with staff. The vision was to build on the reputation as the leading provider of private healthcare in the north of England through facilities, acuity, responding to changes in the healthcare environment and exceptional stakeholder engagement.

The aims of the hospital were "to focus on continual development and improvement of all healthcare services, providing a high quality and safe healthcare service". However while senior staff understood the vision for the hospital, junior staff we spoke with had less understanding of these aims.

Governance, risk management and quality measurement for this core service

There was a daily meeting of the executive team and heads of departments labelled as 'comms cells'. This was a BMI wide system. The comms cell was designed to maintain effective communication at all levels of the hospital, to discuss activity for the day, highlight any issues, discuss incidents or complaints and any immediate actions to be taken as a result of these. We saw that comms cells were well attended and were an effective system of sharing information and raising any concerns.

There were formal executive board meetings each week. Monthly meetings were held within departments and with senior members of staff, for example senior sisters, and governance was a standing agenda item at these meetings. A monthly corporate clinical governance bulletin was circulated to staff.

We saw that there was a BMI wide risk management plan and associated hospital risk register in place. Risks were classified as operational, reputational and financial. Risk scores were calculated based on the chance of the event happening and the impact the event would have. We noted that guidance was in place to ensure steps were taken to manage the level of risk appropriately. For example, guidance for risks scoring high and rated as red was to stop the activity until steps could be taken to control and reduce the risk.

We reviewed the hospital risk register and saw that key hospital wide risks to patient safety had been identified.

However, there were no locally held risk registers in the departments we visited. This meant that there was a risk that key risks may not be effectively managed at department level.

We saw that a range of meetings were held monthly to assist with communication, learning and management of the unit. For example staff meetings involving all grades.

Staff we spoke to were not clear on their roles and did not understand what they were accountable for.

The medical advisory committee (MAC) met bi-monthly. Practicing privileges were closely monitored by the MAC and there were good systems in place to ensure that revalidation and appraisals were up to date for consultants. The consultant database was updated on a monthly basis and staff were informed when practicing privileges were removed. A monthly consultant newsletter was circulated to ensure consultants were informed of notable information in relation to governance, quality and risk.

However we spoke to a manager for critical care who found it difficult to explain what audits were undertaken in CCU and was not aware of any actions that had been implemented following a service audit. The member of staff we spoke with was also unable to answer any questions concerning ICNARC.

Leadership / culture of service

Overall staff spoke positively about the executive director and described the leadership of the hospital as good. They told us there was a 'can do' attitude from the leadership team. Most staff reported that most of the senior leadership within the hospital was both visible and approachable.

The hospitals 2016 risk register listed a risk for poor internal communication and detailed the actions required; to ensure effective communication flows are in place for major corporate projects. These included the evaluation and update of, hospital internal communications and newsletters.

CCU and HDU were managed by the same manager who was supported by the director of clinical services and the executive director. Leadership was stable at the time of our inspection and there were no senior management vacancies.

At 8.30am daily a senior management meeting was held for managers of all departments. All developments from within the past 24 hours were discussed and then cascaded to staff.

We were told by senior staff that BMI has a management and leadership development programme in place to support both current and aspiring leaders to be effective in their roles.

Public and staff engagement

The hospital used BMIs 'comms cell' meetings effectively to ensure staff were informed of developments within the hospital.

The SAS consultants attended a monthly critical care meeting where they shared and discussed experiences and cascaded them to other staff.

Medical staff we spoke with confirmed that consultants holding practicing privileges at the hospital received a monthly email to update them on changes at the hospital, upcoming events and work streams.

We noted that minutes from the CCU and critical care resuscitation meeting are displayed prominently in the CCU staff room.

Staff long service was rewarded by the 'pin' awards, including a celebratory dinner hosted by the executive director for staff with over ten years' service. Staff told us that different coloured pin badges were given to staff to wear on their uniforms depending on length of service.

The hospital used the friends and family test to gain feedback from patients, alongside more detailed inpatient questionnaires. Reports were produced monthly to analyse patient feedback and action plans were developed as a result of feedback. Patient focus groups chaired by the executive director had been established to identify areas for improvement.

A staff survey was completed in 2016 with a 50% response rate. Staff forums were held in June 2016 led by the executive director to feedback the findings of the survey. The hospital estimated that around 150-200 staff had attended these briefing sessions.

Innovation, improvement and sustainability

Requires improvement

Critical care

A new telemetry system had recently been installed in the last 12 months. This service provides real-time monitoring of patients who are at risk for cardiac events.

The hospital was undergoing an extensive programme of investment at the time of our visit which included plans in phase2 for a re-design of the CCU. We were informed that the plans would directly address the issues around bed spaces. Completion is anticipated during 2017.

Start here...

Good

Services for children and young people

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

Information about the service

BMI The Alexandra hospital provides services to children and young people between zero and 18 years as outpatients and undertakes surgery on those aged three to 18 years. There is a dedicated children and young people's unit with seven single room inpatient beds and a day case unit with four beds. Children are also seen on an outpatient basis in this unit in one of two consulting rooms or in the main outpatient area of the hospital.

Between April 2015 and March 2016, 465 surgical procedures were carried out on children aged between three and 15 years old and 131 procedures on 16 and 17 year olds. The majority of these patients were admitted on a day case basis. Children's surgery represented 4% of all surgery carried out at the hospital. There had been 5,587 outpatient attendances by children aged zero to 17 during the same time period.

We carried out an announced inspection of The Alexandra on 5 and 6 July 2016. We also carried out an unannounced visit on 13 July 2016. We spoke with eight staff, including nursing staff, doctors, support and administrative staff, allied health professionals and housekeeping staff. We also spoke with three patients or their relatives using the services at the time of our inspection and reviewed six sets of patient records. We observed care and treatment and looked at information the hospital provided and other information we requested.

Summary of findings

We rated services for children and young people as good in each of the five domains because;

Children and young people were cared for by sufficient numbers competent staff. Parents spoke very highly of the caring and compassionate nature of staff.

Systems to safeguard children and young people were effective. There was evidence that consultants holding practicing privileges for children had been assessed as holding the relevant skills and experience.

Care and treatment was provided in line with evidence based practice and guidance. The individual needs of children and young people were considered and responded to. The recently established children and young people quality care sub-committee provided a forum to learn from incidents, discuss governance and risk management.

However;

The service did not have appropriate procedures in place to ensure children using the diagnostic imaging department received appropriate images.

There was not always documented evidence of medical reviews prior to discharge.

Documentation of the assessment of a young person's competence to consent to care and treatment was not present in the records we reviewed.

We were not assured that staff in theatre had learnt the lesson from a recent medication incident.

Good

Services for children and young people

Are services for children and young people safe?

Good

We rated services for children and young people as safe because:

Systems within the outpatient booking programme ensured a registered children's nurse, trained in safeguarding children level three and European paediatric life support was always available within the hospital, regardless of the location of the child or young person.

Mandatory training levels were high. Staff on the children and young person's unit and in theatre had received relevant and up to date training in life support for children.

Risks to children and young people were effectively managed. The service took pro-active steps to prepare for potential deterioration of a child through regular practice cardiac arrest calls and there were good systems in place to transfer patients to ICU and subsequently a relevant NHS hospital for on-going care.

Nurse to patient ratios on the unit met national guidance and children were cared for by registered children's nurses. Consultants held specific practicing privileges to treat children at the hospital.

The environment on the children and young person's unit kept patients safe. There was access to the necessary equipment to care for children and essential checks were completed in line with hospital policy.

However;

The service did not have appropriate procedures in place to ensure children using the diagnostic imaging department received appropriate images. The service did not have specific procedures for children for each of the pieces of equipment it used.

Practices and facilities in relation to infection control required improvement. Staff did not clean their hands when moving between wards and there were insufficient hand washing sinks available.

Medications were not stored securely in theatre and staff had failed to learn from a medication incident.

There was not always documented evidence of medical reviews prior to discharge.

Incidents

Staff were encouraged to report incidents and were aware of how to report an incident. The reporting system was paper based, with a different form for clinical and non-clinical incidents. Clinical incidents were incidents involving patient care and treatment.

Staff told us they received feedback from incidents they reported via their manager and that incidents were discussed at team meetings and learning was also shared via a monthly governance newsletter.

There had been no never events in respect of children and young people at the hospital between March 2015 and March 2016, although there had been two events in theatres where children are treated. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented.

Senior staff understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There had not been any incidents where the duty of candour was applicable within services for children and young people. Training on this duty was included as part of mandatory training.

Cleanliness, infection control and hygiene

There had been no incidences of methicillin resistant staphylococcus aureus (MRSA), clostridium-difficile (C-diff) or carbapenemase-producing enterobacteriaceae (CPE) within services for children and young people between June 2015 and June 2016. There had been no surgical site infections within this time period.

On entering the children and young persons (CYP) unit, there was no access to hand washing facilities for patients, visitors or staff. There was no information in sink areas to inform patients, visitors or staff of the best way to wash their hands to minimise the risk of the spread of infection, for example ten steps to hand hygiene posters.

There were no designated hand washing sinks in patient rooms. Sinks were located in the patient en-suite bathroom however these did not have non-touch taps in place. Sinks with non-touch taps reduce the risk of cross contamination following hand washing. We saw that the lack of hand washing sinks had been identified as a risk on the hospital risk register and that plans to refurbish wards would include additional hand wash basins.

Regular infection prevention and control and hand hygiene audits were completed in the departments we inspected. The most recent audits showed 100% compliance. However, during our inspection we saw that staff moved between the unit and adjacent ward without washing their hands or cleansing them with alcohol gel.

The most recent patient led assessment of the care environment (PLACE) showed that the hospital scored better than the England average for cleanliness.

We saw that the disposal of sharps, such as needles followed good practice guidance. Sharps bins were signed and dated when assembled and temporary closures were used when the bin was not in use.

Visual infusion phlebitis (VIP) scores were not always completed in the records we reviewed and documentation did not always contain all necessary information about site of cannulation and number of cannulation attempts.

Environment and equipment

The CYP was a bright, spacious environment that was clutter free. Access to and exit from the unit was via a secure telecom system to ensure the safety of children and young people on the unit.

Essential emergency equipment for children and adults was available in each of the areas we inspected and this equipment was checked in line with the hospital policy.

There was access to suitable and sufficient amounts of equipment to care for children on the unit and in theatres.

There were systems to maintain and service equipment as required. Equipment we checked had been checked for electrical safety and had up to date servicing.

Medicines

Medicines for children and young people on the CYP unit were being stored on the York suite at the time of our

inspection as the clinic room on the unit was above the required ambient temperature to correctly store medicines. Medicines were stored securely and in clearly labelled separate containers to the adult medicines.

Stock of medication was managed to ensure there were sufficient supplies and within expiry dates. All medication we checked was labelled appropriately with dates opened and within the expiry date.

We reviewed two prescription cards and saw that neither of these records contained details of the patients' weight although this was documented elsewhere in the record. The allergy status of one patient was not documented on the card.

When we reviewed incidents involving medications, we saw that in April 2016 there had been an incident when controlled drugs had been left unattended in an anaesthetic room and had gone missing. During our inspection we saw that in two anaesthetic rooms, controlled drugs had been left unattended on a worktop and that the drug cupboards were unlocked whilst theatre staff were at lunch. This meant that the lesson from the incident had not been learnt by all staff. We raised our concerns in relation to this practice this during the inspection and did not observe any similar practices following this.

Records

Records were stored securely at nurses stations in lockable cupboards. Records relating to the current admission were stored in individual patient bedrooms.

In the consulting suite, records were either stored with the consultant in their room or in a lockable cupboard in a locked room.

Care pathways contained relevant risk assessments which were completed at pre-operative assessments or on admission. Records maintained by nursing staff were complete, legible and signed. Ninety-five per cent of hospital staff had completed documentation training. However, entries made by medical staff rarely contained the doctors name and grade.

In four of the six records we reviewed there was no evidence of medical review following surgery. Nursing staff acknowledged that consultants did not always document when patients had been seen post-operatively, however they told us that this information was handed over to them verbally. The records audit carried out by the hospital did not include audit of consultant documentation. The hospital had previously recognised that there was an issue with consultants maintaining accurate, up to date and contemporaneous records. The hospital told us they had been working alongside consultants to improve standards of record keeping. In May 2016, the hospital hosted an event with the information commissioner to highlight the importance of good record keeping to consultants. This was also discussed by the medical advisory committee (MAC) and detailed in the minutes of this meeting.

Consultants held their own records of private outpatient consultations, with the hospital holding a record of referral and discharge letters. This meant that the hospital did not hold the full details of outpatient care. The hospital was aware of this issue and there were plans to pilot a system to archive consultant records electronically. The hospital told us that consultants were required to be registered as independent data controllers with the Information Commissioner's Office, as they were responsible for their private patients' notes.

Safeguarding

All registered children's nurses working at the hospital had completed safeguarding children level three. There was a named safeguarding lead for children at the hospital. We saw that there was a clear process in place for staff to refer to when concerns were identified and that this was displayed on notice boards in the areas we inspected. There were six monthly meetings with the local safeguarding board to ensure compliance with guidance and current best practice in relation to safeguarding.

In the consulting suite, 91.3% of staff had received level two safeguarding training which met the hospital target of 90%.

Paediatric consultants provided evidence of compliance with safeguarding training as part of the granting and renewal of practising privileges.

There was a facility within the outpatient booking system to ensure that a registered children's nurse was on duty when a child attended. This ensured that there was access to a children's level three trained professional whenever a child was being cared for in the hospital.

We saw that a safeguarding concern for a child had been identified and that appropriate steps were taken to liaise

with other health workers and social services to ensure the child was safeguarded from abuse. There had been three safeguarding referrals made in the year prior to the inspection.

Access and exit from the unit was via a locked door with an intercom. This ensured that children could not leave the unit unescorted and that access to the unit was restricted to authorised staff and visitors.

Mandatory training

Mandatory training was a mix of online and face to face training and covered topics such as infection prevention and control, manual handling and duty of candour.

Compliance with mandatory training for the CYP unit was 99% which was above the hospital target of 90%. However, in theatres compliance was 79% which was below the hospital target.

Resident medical officers were expected to maintain their mandatory training levels and this was monitored by the agency employing them.

Two nursing staff on CYP unit, two nurses in theatre recovery and all intensive care unit sisters were trained in European paediatric life support (EPLS) in line with BMI policy. Shifts were co-ordinated to ensure there was always an EPLS nurse on duty on the CYP unit. Resident medical officers and the children's nurse in theatre recovery were trained in paediatric advanced life support. In the consulting suite, basic paediatric life support had been completed by 62.5% of required staff which was below the hospital target of 90%. However, 90% of eligible staff had completed paediatric immediate life support.

Assessing and responding to patient risk

The service had standard operating procedures set out the procedures for imaging adults but did not have specific guidelines for imaging children. While staff told us that the number of children using the department was low, there was a risk that children may be exposed to unnecessary radiation. This was because without standard operating procedures for children equipment may not be used properly for the imaging of children.

Nursing staff used a paediatric early warning score (PEWS) to monitor patients, with different parameters set out for different age groups. There was a procedure in place to alert senior staff and the RMO when PEWS scores were elevated. In the records we reviewed, we saw that PEWS scores had been calculated and recorded correctly. Deteriorating patients were closely monitored and there was a policy in place for the transfer of children to a local children's hospital in the event that a child needed specialist care. There was a contract in place with the ambulance service to provide the necessary transport. The procedure set out that the child would be transferred to the intensive care unit until a safe transfer to the children's hospital could be arranged.

All permanent nurses working on the CYP unit had undertaken the paediatric acute illness management training.

A safety huddle involving all members of the theatre team was carried out before each theatre list. We observed a huddle and saw that this could be structured in a more effective way to improve patient care and safety, for example with the inclusion of whether patients needed warming, what positioning aids would be required and the risk of VTE.

Pre-assessment appointments were offered face to face or via a telephone call and completed by a register children's nurse. Relevant risk assessments were completed during these assessments. When concerns were identified at this appointment, nurses escalated this to the paediatric anaesthetist for further assessment. Children who were at increased risk of complications following anaesthetic or surgery or who had experienced previous complications were excluded from receiving care at the hospital for safety reasons and were referred elsewhere.

The service carried out a practice crash call four times per year. This was observed and audited to enable the service to identify where improvements could be made, actions taken and learning shared.

There were policies and standard operating procedures in place for the care of children within the imaging department of the hospital to ensure appropriately skilled staff were available in the event of an emergency.

Parents or guardians were given written information on discharge explaining who to contact if any concerns arose.

Nursing staffing

Children and young people were cared for by registered children's nurses. Support was gained from adult nurses for 16 and 17 year olds when required.

Good

Services for children and young people

Children under the age of 12 were cared for by two registered children's nurses. Children over 12 were cared for by either two registered children's nurses or one children's nurse supported by an adult registered nurse. Staffing for these patients was determined using a pre-admission risk assessment. During our visit to the CYP, the nurse to patient ratio met Royal College of Nursing guidelines.

The outpatient booking system ensured that children could only be booked to attend an outpatient appointment in the general outpatient clinic if a registered children's' nurse was on duty in the hospital. This was to ensure access to a suitably qualified children's nurse if required. Staff in outpatients told us they contacted the CYP unit for advice if required.

At the time of our inspection there were 1.5 whole time equivalent vacancies for registered children's nurses. The service used bank nurses to support the current establishment. We saw evidence that bank staff received a comprehensive induction to the ward on their first shift.

Staffing in theatres was planned in line with The Association for Perioperative Practice (AfPP) guidelines. We reviewed theatre lists and staffing and saw that staffing was line with this guidance.

There was one registered children's nurse in theatre recovery and the hospital aimed to have this staff member on shift during times when children were admitted for surgery. Other recovery staff had completed enhanced training to demonstrate competence in caring for children in theatre for times when this staff member was not on shift.

Medical staffing

Access to resident medical officers (RMOs) was available 24 hours a day. RMOs worked a twelve hour shift for seven days followed by seven days off. RMOs were employed by an agency rather than the hospital. Absence due to sickness or holidays was covered by an RMO from the agency. The lead RMO managed and monitored the rota system to ensure RMOs were not working above the agreed shift pattern. RMOs were not specifically trained to care for children and young people, but were trained in paediatric advanced life support to provide immediate care in a life threatening situation. If the hospital expected a particular child or young person would need additional input from a doctor, there was access to a RMO with these competencies via the agency.

Anaesthetists were provided via an agency and there was access to an on-call anaesthetist within 30 minutes.

Consultants held specific practising privileges for the treatment of children. There were 92 consultants at the hospital in July 2016 who held these practicing privileges.

Most consultants held substantive posts in NHS hospitals. As part of their practising privileges, provided evidence of their competence to undertake surgical procedures on or anaesthetise children and young people, and were only able to perform procedures they regularly carried out in their roles within the NHS.

As part of a surgeon's practicing privileges, they were expected to ensure they were contactable by telephone and available to attend the hospital if required at all times when they had inpatients. There were clear systems in place to ensure that consultant advice was available 24 hours a day and during periods of leave or absence.

Major incident awareness and training

There was a hospital business continuity plan which was used alongside a BMI corporate plan. This had recently been put into action during a mains water outage.

Are services for children and young people effective?

Good

We rated effective as good because;

Care and treatment was generally provided in line with national guidance and evidenced based care. Local audits were completed to ensure compliance with guidance.

Preferences for pain relief were discussed in pre-operative assessment appointments and pain scores were routinely recorded in patient records.

There had been no unplanned readmissions or returns to theatre for children and young people between April 2015 and March 2016.

Good

Services for children and young people

All staff on the children and young person's unit had received and up to date appraisal. Consultants were expected to hold practising privileges for the care of children and young people and there were systems in place to ensure competence in this area.

However;

There was no documented evidence of discussions held to establish the competence of young people to consent to treatment. Consent forms we reviewed were signed on the day of the procedure and there was therefore no evidence of an opportunity for the patient or their parent/guardian to have time to consider the benefit and risks of surgery.

There was no access to a specialist pain team and nurses had not received additional specialist training in relation to pain management.

Evidence-based care and treatment

There was a BMI wide policy in place for the care of children that reflected national best practice guidelines produced by bodies such as the Royal College of Nursing (RCN), the Royal College of Anaesthetists and the Royal College of surgeons. We saw evidence that this had been reviewed to reflect update guidance but had been due for a further review in May 2016.

Local audits of care were completed, for example documentation audits, pain audits and audits to ensure baseline National Institute of Health and Care Excellence (NICE) assessments had been completed.

The medical advisory committee provided clinical scrutiny in relation to evidence based care and treatment. If consultants wanted to introduce new treatment methods or procedures, the evidence and guidelines for these procedures was reviewed by the MAC and approved if this was appropriate.

Hospitals within BMI compared the patient outcomes regionally and nationally. They participated in provider visits which were visits from other BMI sites to assess the quality of care provided at the location.

The ward manager told us there were plans to participate in the Department of Health "You're Welcome" accreditation scheme in the future. This is a scheme with set quality criteria to ensure young people friendly healthcare is provided within the hospital.

Pain relief

There was a child friendly pain assessment tool within the care pathway and we saw that this had been completed appropriately. Patients were offered a range of pain relief and provided with it in a timely way**.**

Preferences for pain relief were gathered during a pre-assessment appointment.

Monthly audits were undertaken to ensure documentation contained details of pain scores. In April and May, 100% of records audited contained evidence that pain had been assessed and a pain score recorded.

There was no specialist pain team at the hospital and staff had not received additional specialist training in the management of pain in children and young people.

Nutrition and hydration

Children and young people were offered a choice of meals that were appropriate to their age group. Parents were also provided with food and drinks.

Fasting advice to patients followed guidelines from the RCN specific to children.

There was access to a paediatric dietician for support with nutrition and hydration when this was required.

Patient outcomes

There were no unplanned returns to theatre or readmissions to the hospital for children and young people between April 2015 and March 2016.

The hospital was not eligible to participate in national audits in relation to the care of children and young people because The Alexandra did not treat children who met the criteria for inclusion.

Local audits showed that between August 2015 and June 2016, 100% of children and young people had received assessments in line with guidance from NICE.

We saw that audit of consent and documentation was a standing agenda item at the children and young people quality care sub-committee although there was no evidence of detailed discussion.

Competent staff

Good

Services for children and young people

Children's nurses were able to access training internally and externally including training specific to services for children and young people. There was an online learning system across BMI where staff could access additional training opportunities.

? In recovery, staff had completed additional training in the care of children and young people.

All permanent employed staff working on the CYP unit had received an up to date appraisal within the last 12 months.

The RMO had not received specialist training in the care of children and young people, however staff told us it was infrequent for the RMO to be involved in the care and treatment of this patient group as the majority of admissions were day cases with nurse led discharge.

There was a BMI wide policy for granting and reviewing the practising privileges of consultants. Practising privileges were only granted to doctors who were licenced, on the specialist General Medical Council register, held a substantive consultant post in the NHS within the past five years and demonstrated relevant clinical experience relating to practice with children and young people. We saw that systems were in place to ensure consultants without an NHS caseload were appropriately appraised and portfolios maintained via BMI. Additionally, we saw evidence in minutes of the MAC that when new procedures were proposed by consultants, confirmation of competence was sought from the employing trust. The outpatient booking system only allowed appointments for children to be booked with consultants who held paediatric practising privileges.

Multidisciplinary working

There were good working relationships with staff on the CYP unit, in outpatients and in theatres. Staff told us consultants were approachable, friendly and felt valued by them.

Patients were referred to physiotherapy when required and we saw evidence of this in one record we reviewed. There was also access to a paediatric dietician.

Seven-day services

Routine access to theatres was available six days a week, with availability on a Sunday for urgent or emergency procedures. There was access to an on-call theatre and theatre team 24 hours a day.

Imaging such as plain film x-ray and computerised tomography (CT) was available seven days a week and on call out of hours.

Outpatient appointments were available on the CYP unit six days per week.

Access to information

Staff were able to access information the needed to allow them provide effective care. There were sufficient numbers of computers on wards to access hospital policies, procedures and relevant guidelines.

Discharge letters were sent to GPs within 24 hours, informing them of the outcome of outpatient consultations or procedures.

Consent

There was clear guidance for staff to follow when taking consent for a child or young person in the care of children policy. Additionally, there was a BMI consent policy in place. This policy clearly stated that there should be a comprehensive record of any discussions regarding the capability of a child or young person to consent to treatment (Gillick competency). Staff understood the principles of the Gillick competency however there was no evidence of assessment of competence to consent.

Records showed that a consent form for an adult or competent child had been used appropriately for a 16 year old. In the case of a 14 year old, consent form two had been used and was signed by the parent or guardian as well as the child. Consent for younger children was taken and document from the parent or guardian correctly.

Consent forms we reviewed were completed and signed on the day of the procedure. Consent forms should detail formal consent prior to the day of procedure, with an appropriate 'cooling off period' followed by confirmation of consent on the day of the procedure. Additionally, not all consent forms included details of the risks of anaesthetic.

Good

Services for children and young people

Are services for children and young people caring?

Good

We rated caring as good because;

Children and young people were treated by kind, caring and compassionate staff who took the time to understand their personal needs and preferences.

Parents or guardians were encouraged to stay with their child on the ward, in the anaesthetic room and on return from recovery. Parents were provided with emotional support and reassurance from nurses whilst their child was in theatre.

High numbers of patients would recommend the hospital to their friends and family.

Compassionate care

Parents told us staff treated their children with compassion, kindness, dignity and respect. Privacy and dignity of children and young people was maintained at all times.

Parents spoke very highly of the care they received during outpatient consultations and during inpatient stays admission and were very complimentary about the caring nature of staff.

Friends and family test scores showed that over 99% of NHS patients would recommend the hospital to their friends and family. Response rates varied month to month but they were generally lower than the England average for independent health hospitals. For patients who were self-funding their care and treatment or had medical insurance, 97.8% said they would recommend the hospital in May 2016.

Understanding and involvement of patients and those close to them

Staff took the time to ensure they understood the personal preferences and needs of children and young people in their care. They sought permission from children before any nursing intervention and interacted with them in a caring, positive and age appropriate way.

Parents told us they were given enough information about care and treatment and time to ask questions. They were involved in the planning of care and treatment and involved in plans for discharge home.

Emotional support

Parents were encouraged to stay with their child throughout their admission. They were able to accompany their child in the anaesthetic room and when returning from recovery, which met the emotional needs of both the patient and their parent.

Parents told us nursing staff supported their emotional needs, for example on return from the anaesthetic room and whilst waiting to be called to recovery to collect their child.

The service provided a 48 hour follow up phone call from a member of the nursing team. This offered an opportunity for staff to provide any additional information or support if required.

Are services for children and young people responsive?

Good

We rated responsive as good because;

Children and young people were cared for in an environment suitable for their needs with a range of toys and facilities for parents to stay overnight. The unit had considered the needs of young people, and evaluated the provision of a room for this patient group.

Staff understood the importance of recognising individual needs and personal preferences and ensured these needs were met.

There were clear processes in place for admission and discharge from the unit. Information was sent to GPs in a timely way to ensure on going care and treatment.

There was a designated children's recovery area in theatre screened off from adult areas.

However;

Good

Services for children and young people

Access to the children and young people's unit was via an adult day case ward where patients were dressed in theatre gowns.

Service planning and delivery to meet the needs of local people

Children and young people were either referred to the hospital by their GP or were self-referred to the hospital. Their was a choice of access to consultants.

Outpatient appointments were available at a variety of times to fit around a child's schooling and parents work commitments, including on Saturdays.

There was no dedicated entrance to the CYP unit. This meant that children walked through an adult ward area to access the unit. We observed that adults in this area were dressed in theatre gowns, including on corridors when being escorted to or returned from theatre.

Access and flow

There was clear guidance within the care of children policy to indicate which groups of children and young people could be admitted to the hospital and what types of procedures would be excluded.

Waiting times for outpatient appointments and surgery dates were low. The majority of patients were self-funded or insured and there were choices of dates and times available depending on the consultants clinic times or theatre lists.

Bed occupancy on the CYP was generally low. Most admissions were for day case procedures. There had been only two or three overnight stays between January and June 2016.

The BMI care of children policy states that children should be first on the list for theatre where the list also involved adults. It also stated that they should not be admitted more than two hours prior to surgery. We were told that this policy was followed at the hospital.

All discharges for day case admissions were led by nursing staff, unless otherwise stated by the consultant. This meant that patients could be discharged in a timely way when the criteria for discharge were met.

Meeting people's individual needs

The unit provided a good environment to care for children and young people. There was a dedicated play room available with a range of toys for younger children to play with. There had previously been a room designed for older children, however it had been noted that this group of patients tended to bring their own activities and stayed within their room rather than use this and therefore the room had been redesigned to offer an additional consulting room.

In the main outpatients department, there was a small area with toys for children under the age of approximately five years.

Each of the single rooms on the CYP unit had a fold down bed to allow parents to sleep if their child required an overnight stay.

In theatre, there were designated paediatric recovery bays that were curtained off from adult areas. Parents were able to accompany their child in the anaesthetic room and from recovery.

Individual needs and preferences were gathered during pre-assessments or from pre-assessment questionnaires. A child focussed health questionnaire was gathered from every patient. This provided nurses with details of any additional needs or preferences and information about the child's abilities such as toileting and mobility. Nursing staff documented these details in the ward diary to ensure all staff were aware of important information about the child's needs. Parents were encouraged to bring children to the unit for face to face pre-assessments to allow their child to visit the unit, and if beneficial, visit theatres.

Registered children's nurses (RCNs) had an awareness of and were able to support children with additional needs. We were given an example of when a RCN attended the radiology department with a child with autism to provide additional support and distraction.

In the 12 months leading up to our inspection, there was one occasion when a patient aged 13 stayed overnight on an adult ward. This was a planned afternoon admission for surgery. The patient was cared for by a registered children's nurse. The hospital had deemed it was inappropriate for the CYP unit to remain open overnight for a single patient.

There was access to face to face translation services for patients who did not speak English. There was also access to sign language interpretation when required.

Good

Services for children and young people

A quiet room was available for prayer or meditation and the hospital team had identified a need for a multi-faith room that was in development at the time of our inspection.

Learning from complaints and concerns

There were details about how to make a complaint provided in the patient information guide located in each patient room. Staff were encouraged to resolve any concerns or complaints immediately where possible and ward managers or heads of departments were available to speak with concerned patients.

There had been three complaints about the care of children and young people between July 2015 and June 2016. None of these complaints had been referred to the Parliamentary and Health Services Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISCAS).

We saw that learning from complaints was identified and shared within services for children and the wider hospital.

There was a corporate BMI policy on how complaints should be handled. Complaints were graded as stage one, two or three with expected timescales for response. Complaints and compliments were discussed at daily comm cells meetings and reviewed at the MAC and clinical governance committees.

Are services for children and young people well-led?

Good

We rated well led as good because;

Communication between the executive team, senior leadership team was effective in sharing the hospital vision and key messages in relation to governance, quality and patient safety.

A children and young people quality care sub-committee had recently been established to provide further support to the governance systems within the hospital.

There were good systems to monitor practising privileges to treat children and young people. The medical advisory committee effectively managed key clinical issues.

There was a positive, open and honest culture. Staff engagement was good.

However;

There was no local strategy for the development of services for children and young people.

Leadership / culture of service

Services for children and young people were led by the unit manager supported by an associate director of nursing.

Staff described the leadership of the unit and of the hospital as good. They told us there was a 'can do' attitude from the senior leadership team.

The culture was open and honest and staff felt confident and supported to raise concerns.

There was a management and leadership development programme in place to support both current and aspiring leaders to be effective in their roles.

Vision and strategy for this this core service

There was a corporate vision in place for BMI healthcare alongside its operational priorities. The hospital had used this vision to create a statement for the hospital which had

recently been shared with staff. The vision was to build on the reputation as the leading provider of private healthcare in the north of England through facilities, acuity, responding to changes in the healthcare environment and exceptional stakeholder engagement.

There was a hospital wide strategy and business plan, however there was no specific strategy for services for children and young people and no direct reference to these services within the hospital strategy.

The aims of the hospital were "to focus on continual development and improvement of all healthcare services, providing a high quality and safe healthcare service".

Governance, risk management and quality measurement for this core service

There was a daily meeting of the executive team and heads of departments labelled as 'comm cell'. This was a BMI wide system. The comm cell was designed to maintain effective communication at all levels of the hospital, to discuss activity for the day, highlight any issues, and discuss

incidents or complaints and any immediate actions to be taken as a result of these. We saw that comm cells were attended by the CYP unit manager and were an effective system of sharing information and raising any concerns.

A monthly corporate clinical governance bulletin was circulated to staff.

The medical advisory committee (MAC) met bi-monthly. Practicing privileges were closely monitored by the MAC and there were good systems in place to ensure that revalidation and appraisals were up to date for consultants. The consultant database was updated on a monthly basis and staff were informed when practicing privileges were removed. There was a paediatric representative on the MAC to address any issues relating to children and young people. This representative also reviewed practicing privileges of consultants involved in the care of this patient group.

The children and young people quality care sub-committee had been established in February 2016 and formed part of the overall governance system within the hospital. Meetings were held quarterly and attended by representatives from a range of departments including the CYP unit, theatre, radiology, physiotherapy, paediatricians and anaesthetists. We saw that meetings had been well attended and followed a set agenda, although minutes were brief and few actions were identified as a result of the meetings.

There was a children's services quality governance scorecard in use which detailed key governance issues such as training compliance, infection rates, complaints and incidents that remained open and highlighted each of these key performance indicators (KPI) using a red, amber, green traffic light system. The scorecard also provided information on the quality of care delivered to patients and compliance with key guidance from NICE. In the four months prior to the inspection, the dashboard was green for each KPI with the exception of one 'amber' for sickness absence on May 2016.

There was a BMI wide risk management plan and associated hospital risk register in place. Risks were classified as operational, reputational and financial. Risk scores were calculated based on the chance of the event happening and the impact the event would have. Guidance was in place to ensure steps were taken to manage two level of risk appropriately. For example, guidance for risks scoring high and rated as red was to stop the activity until steps could be taken to control and reduce the risk. We reviewed the hospital risk register and saw that key hospital wide risks to patient safety had been identified. We saw that there was one risk on the register that specifically related to surgical instruments for children and young people and that there had been sufficient control measures put in place and actions taken to reduce the risk to patients.

Public and staff engagement

The hospital used BMIs 'comms cell' meetings effectively to ensure staff were informed of developments within the hospital.

Formal staff meetings were not frequent on the CYP unit due to the small size of the team. Daily updates were provided following the 'comms cell' meeting and information was communicated using the 'comms cell' board on the unit or shared via the nurses' diary.

Staff long service was rewarded by the PIN awards, including a celebratory dinner hosted by the executive director for staff with over ten years' service. The executive director took the time to contact staff if they were named in positive patient feedback.

The hospital used the friends and family test to gain feedback from patients, alongside more detailed inpatient questionnaires. Reports were produced monthly to analyse patient feedback and action plans were developed as a result of feedback. Patient focus groups chaired by the executive director had been established to identify areas for improvement.

A staff survey was completed in 2016 with a 50% response rate. Staff forums were held in June 2016 led by the executive director to feedback the findings of the survey. The hospital estimated that around 150-200 staff had attended these briefing sessions.

Innovation, improvement and sustainability

There were plans to participate in the Department of Health "You're Welcome" accreditation scheme in the future. This is a scheme with set quality criteria to ensure hospitals provide 'young person friendly' healthcare.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

BMI The Alexandra Hospital provided outpatient consultations and minor surgical procedures. Outpatient clinics covered a wide range of specialities including orthopaedics; general surgery; ophthalmology gynaecology; cardiology; and urology. The hospital provided services for patients of all ages. The hospital had 34 outpatient consulting rooms, a minor procedures unit and two treatment rooms. The hospital provided outpatient physiotherapy services in a dedicated physiotherapy department which had 6 treatment rooms and a gym.

The hospital had a range of diagnostic imaging services. The main hospital building had rooms with X-ray, computerised tomography (CT) scanner, nuclear medicine Single-photon emission computed tomography (SPECT/CT) scanner, fluoroscopy, mammography, ultrasound, nerve conduction and electroencephalogram (EEG) rooms. A magnetic resonance imaging (MRI) scanner was located in a separated building in the hospital's grounds. A mobile MRI scanner and mobile catheterisation laboratory were located in the grounds of the hospital. The neurophysiology department had rooms for nerve conduction and EEG.

Between April 2015 and March 2016, the hospital had 127,755 outpatient appointments. The hospital treated fee-paying patients and accepted NHS appointments where commissioning arrangements were in place.

During our inspection we spoke with 23 members of staff and five patients. We also observed the outpatient and diagnostic imaging environment and reviewed 11 sets of medical records.

Summary of findings

Overall we rated this service as good.

There were systems in place for reporting risk and safeguarding patients from abuse. Staff were aware of how to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team. Staff completion of mandatory training for their roles was high.

Clinical areas and waiting rooms were all visibly clean and tidy. Infection prevention and control practices were in place and monitored.

The departments used evidence based guidance to inform their practice and to approve new procedures. The diagnostic imaging and physiotherapy departments were auditing their practice to monitor the effectiveness of their work.

The service had a system for assessing the competency of medical staff when practicing privileges were granted and reviewing the competency on a yearly basis. Most staff in the departments had had an appraisal within the last year to review their performance.

Staff in all the departments were caring and compassionate. Patients were positive about how they were treated by staff. Staff maintained patient privacy and dignity across the departments. Patients were kept well informed about the treatment they were receiving in the hospital. Staff provided emotional support to patients and chaperones were used.

Services were planned and delivered to meet the needs of patients. The departments were open outside of

Good

Outpatients and diagnostic imaging

working hours and the service was routinely exceeding the referral to treatment targets for patients waiting to be seen as outpatients. Staff understood how they could provide a service to patients with additional needs.

There were appropriate governance processes and reporting structures in place and on the whole, staff spoke positively about the leaders and the culture within the services. While the services did not have formal strategies, they each had plans to develop the services they offered.

However;

The outpatient department were not taking sufficient action when the fridge containing medication was outside of the acceptable temperature range. The departments also did not have their own risk registers.

While the outpatient department regularly checked the resuscitation equipment, the log book did not accurately record when equipment passed its expiry date and some of the equipment in the paediatric resuscitation trolley had passed its expiry date.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

There were clear systems in place for reporting risk and safeguarding patients from abuse. The majority of staff had received appropriate training in adult safeguarding.

Staff were aware of how and when to report incidents that took place in the departments and we saw evidence of incidents being investigated and learning being shared within the team. The diagnostic imaging department took steps to screen patients before exposing them to radiation or contract agents and signs were in place to warn patients they were entering designated areas.

Clinical areas and waiting rooms were all visibly clean and tidy. Infection prevention and control practices were in place and monitored.

Staff completion of mandatory training in all departments was higher than the 90% target set by BMI.

However,

While most of the medications were stored safely and the temperature of fridges which contained medicines was monitored, the service was not taking sufficient action when the temperature was outside of the acceptable range.

While the outpatient department regularly checked the resuscitation equipment, the log book did not accurately record when equipment passed its expiry date and some of the equipment in the paediatric resuscitation trolley had passed its expiry date.

Incidents

The hospital used a group-wide incident reporting policy. We reviewed the policy which included guidance on what to report as an incident and how to investigate an incident. Incidents were recorded on paper forms which were then added to the hospital's central database. In the outpatient and physiotherapy departments different colour forms were used for clinical and non-clinical incidents.

Staff told us that learning from incidents was discussed at team meetings which took place within all the

departments; this was confirmed by the minutes of the meetings. Staff told us that incidents were also discussed at the departments' 'comms cell' meetings which took place daily in the outpatient and physiotherapy departments and three times a week in the diagnostic imaging department. Incidents across the hospital were reviewed and discussed at the hospital's clinical governance committee and medical advisory committee meetings.

Staff gave us examples of learning from incidents, such as improvements to communication given to patients about procedures. We also saw learning from incidents displayed on 'comms cell' boards in staff areas of the departments.

In all departments staff were aware of their responsibility to report incidents. Staff reported incidents through the hospital's paper based system or through their manager who would complete the form. Staff we spoke with told us they felt confident to report incidents, accidents and near misses.

The services did not report any Never Events between April 2015 and March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000. We saw evidence that staff followed the hospital procedures to report incidents to the radiation protection team and the Care Quality Commission.

Between April 2015 and March 2016 there were 279 clinical incidents reported in the service and 63 non-clinical incidents. We reviewed a root cause analysis [RCA] investigation completed following an incident in the diagnostic imaging department. The investigation was detailed, identified the causes and had a clear action plan.

The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The incident reporting policy used by the hospital set out the principles and requirements of the Duty of Candour. The hospital ran training on the Duty of Candour and staff we spoke to understood the principles and requirements of the Duty of Candour.

In the diagnostics imaging department two incidents had engaged the Duty of Candour regulations within the year prior to our inspection. We saw evidence that once the service had identified the incident. Appropriate action had been taken to follow the requirements of the Duty of Candour, including notifing the person affected and investigating the incident it.

We saw evidence that changes were made as a result of the investigations.

Cleanliness, infection control and hygiene

The departments were visibly clean and cleaning schedules were displayed in all the clinic and imaging rooms we visited. However, the cleaning schedules were not completed and signed each day in the rooms in the diagnostic imaging department. In April 2016 the cleaning schedule was not completed on seven occasions in the CT room; twice in the mammography room; nine times in the mobile magnetic resonance imaging (MRI) room; and seven times in one X-ray room and 10 times in another X-ray room. This meant we were not assured that effective monitoring was taking place of the cleanliness within the diagnostic imaging department.

Some of the areas in the departments were carpeted, although not in rooms where treatment took place. These areas were visibly clean and staff told us they were regularly deep cleaned. We discussed the possible issues carpets may cause in relation to infection control with the provider during inspection. The hospital said it had plans to remove these as part of its refurbishment.

Information provided by the hospital about the Patient-Led Assessments of the Care Environment (PLACE), showed that patients had scored cleanliness throughout the hospital at 100% which was above the national average for independent hospitals which was 98%. PLACE assessments see local people visit the hospital and look at different aspects of the care environment

Good

Outpatients and diagnostic imaging

During our visit we saw that some of the bins used for domestic waste in the diagnostic imaging department did not have lids or did not have lids which were foot-operated. This could present a potential cross infection risk to patients using the service.

We saw 'I am clean' labels were used for the mobile scanning and imaging equipment to show when equipment was clean and ready for use.

The hospital had a hand hygiene policy which set out when and how staff should clean their hands. Hand gel was available throughout the service and we observed staff using the hand gel as they passed the dispenser.

We saw that all clinical staff in the departments followed the 'bare below the elbow' guidance to allow thorough hand washing and reduce the risk of cross infection.

Records we reviewed confirmed the infection control nurse at the service carried out an audit of hand hygiene every three months. Although the audit results we were given were carried out more frequently. We reviewed the last three audits and found that compliance was very good, although we could not see any evidence of action taken for non-compliant results.

Environment and equipment

The diagnostic imaging department had contracts for servicing and repairs for the radiology equipment by the original equipment supplier. We reviewed the logs for the servicing of each piece of equipment which were stored in the department and accessible to all staff. We were told the radiation protection adviser visited the department quarterly to review the equipment.

Staff told us that the hospital had a contract with a company who were based on-site who could maintain and repair smaller items of equipment, for example suction units and monitors.

Resuscitation equipment for adults was available in the diagnostic imaging department on the first floor of the hospital, in the MRI scanning centre adjacent to the main hospital building and in the outpatient department. There was also resuscitation equipment for children available in the outpatient department. We checked the three sets of resuscitation equipment, and found records which confirmed that daily and weekly checks had been completed.

On the checklists available on the resuscitation trolleys there was space to record when the equipment would reach its expiry dates. We found that on the trolleys in the outpatient department the checklist said that some of the equipment had passed its expiry date, but in fact most of the equipment had already been replaced. One of two paediatric face masks in the paediatric trolley had passed its expiry date. We raised this with the provider during inspection. When we returned to the hospital, as part of the unannounced inspection process. We found that the checklists had been updated and the face mask replaced.

In addition to the resuscitation equipment, there was an emergency call system in all of the treatment and diagnostic rooms we visited. There was a call bell (to call nursing staff) and an emergency call button to call a resuscitation team. The resuscitation policy said that if someone had a cardiac arrest the member of staff should call press the emergency call button and also dial 2222. The reception would be alerted and the resuscitation team would attend. The emergency call system was tested every day. This assured us that in an emergency, patients could be attended too quickly.

We saw appropriate protective equipment available for staff and patients in the diagnostic imaging department. Lead gowns and gonad protection was available in the X-ray rooms and for the mobile X-ray. These were screened yearly by the hospital to ensure that they were still providing appropriate protection.

Staff in the diagnostic imaging department were monitored using dosimeters (a device used for a device that measures exposure to ionizing radiation). A spill kit (a kit for dealing with minor radioactive spills) was available in the room where radioactive substances were handled and shielding was used including a lead safe, tongs and syringe shields.

All of the rooms where imaging using radiation took place had illuminated notices outside warning staff and patients not to enter when they were in use. This was in line with Ionising Radiation (Medical Exposure) Regulations 2000. This ensured visitors or staff could not accidentally enter a controlled area during a procedure.

Medicines

Medicines in the outpatient department were stored, managed, administered and recorded safely. We audited a random sample of medications and found them to all be in date.

Good

Outpatients and diagnostic imaging

Medicines which were required to be stored at a lower temperature were stored in a fridge in the outpatient department. We saw evidence that daily temperature checks of the fridge and the ambient room temperature were recorded. While the temperatures were recorded daily, on a number of days the maximum temperature and the current temperature were above the maximum. There was no evidence that this had been raised with the pharmacy or any other action taken other than the thermometer reset. During our site visit we notified the pharmacy who replaced the thermometer and planned to monitor the temperatures carefully, and replace the fridges if appropriate.

We were told that the hospital's pharmacy carried out an audit of medicines management in each of the departments every 3 months. From the information the hospital provided, we did not see any evidence of audits taking place between October 2015 and May 2016. This meant that the hospital could not be assured of safe medicine management during this period.

Controlled drugs were stored in one of the X-ray rooms in the imaging department. The drugs were securely stored in a locked cabinet and we saw that daily checks were carried out to ensure medicines were reconciled correctly.

Contrast media was used in the diagnostic imaging department for use in CT and MRI and other scans to improve the images taken. The contrast media was stored in a cupboard in room which with restricted access, however, during our site visit we found that the cabinet that the contrast media was stored in was left unlocked.

Prescription pads were stored in each of the consulting rooms in a safe with a key code. We were told that at the start of each clinic, the consultant would be given the key code for the room they were using. The prescription pads were checked daily by nursing staff and between clinics, if the room was used for more than one clinic within a day.

Staff in the diagnostic imaging department used some Patient Group Directions (PGDs) for contrast media and medicines used in imaging. A PGD provides a legal framework that allows staff who have completed appropriate additional training and signed the PGD to supply and/or administer a specified medicine to a pre-defined group of patients, without them having to see a doctor. A PGD ensures that medicines which are commonly used in a procedure are only prescribed and used safely.

The hospital had a pharmacy on-site, located at the main entrance of the hospital. This was located very close to the outpatient department and had an adequate seating outside.

Records

We reviewed 11 sets of medical records across the outpatient and diagnostic imaging departments. All records were legible, signed and dated and contained relevant patient information. Records were either stored with the consultant in their room or in a lockable cupboard in a locked room.

The hospital told us that there was a long-standing historical issue of the record of outpatient appointments with a consultant not being part of the hospital record for patients. This is because consultants took their own record of an outpatient appointment. The hospital identified that referral and discharge letters were added to the hospital record but not all of the outpatient record. The hospital told us they have plans to address the issue and are starting a trial for a group of patients to archive the full outpatient record with the hospital record with a view to rolling this out hospital wide.

All radiology images were securely stored on a picture archiving communication system (PACS) for easy access by radiographers, radiologists or other staff. This meant that the records were easily accessible and available to staff who needed it at all times.

The diagnostic imaging department carried out monthly audits of general radiography, which included questions about the information recorded and added to PACS. We reviewed the audits for the three months before our inspection and found the service was taking action to address all the areas of non-compliance.

The hospital told us that consultants were required to be registered as independent data controllers with the Information Commissioner's Office, as they were responsible for their private patients' notes. If a consultant was found not to be registered the Medical Advisory Committee (a leadership group of consultants working at

the hospital) would be notified and the consultant's practicing privileges might be suspended and the matter reported to their responsible officer (the person who completes their appraisal).

The hospital did not keep a record of the number of outpatient appointments where the records were not available. While staff told us that this was not a problem, as the hospital did not keep a record it could not verify how many times records were not available or give us assurance that patient records were consistently available to staff in clinics.

The hospital told us it discouraged the removal of hospital medical records from the site. If a consultant wished to view the hospital's patient notes, they were encouraged to do so in the hospital's medical records department and the hospital would require an explanation of what the records were needed for in order to provide only those which were relevant. This gave assurance that the hospital could monitor records that left the hospital and ensure they were only removed with good reason.

Safeguarding

The hospital used group-wide policies for the safeguarding of vulnerable adults and children. We reviewed the policies which we saw set out the types of abuse which staff should be aware of and look out for.

There were separate leads in the hospital for safeguarding of vulnerable adults and safeguarding of children. Both safeguarding leads had completed level three safeguarding training. We saw safeguarding flow charts displayed in clinical areas setting out the steps staff should take if they had concerns about the welfare of an adult or child.

100% of staff in the outpatient, diagnostic imaging and physiotherapy departments had completed level 2 adult safeguarding at the time of the inspection. 97% of staff in the physiotherapy department, 95% of staff in the diagnostic imaging department and 91% of staff in the outpatient department had completed level 2 paediatric safeguarding training. The BMI target was 90% and the hospital target was 95%.

Staff we spoke to had a good understanding about when to report a safeguarding concern and the process who to raise it with. Staff gave us an example of when they had had concerns about the vulnerable adult who had accompanied someone to an outpatient appointment which they had raised with the safeguarding lead.

In the mandatory training all staff completed a 'Prevent' module. Prevent was a special module looking at risk posed to individuals at risk of radicalisation. Staff we spoke with told us there was no specific training for staff on female genital mutilation (FGM).

Staff in the diagnostic imaging department told us it had adopted the 'pause and check' principle, whereby clinicians pause and check the patient and procedure details, before starting to ensure the right person gets the right scan at the right time. Posters were displayed in the department to remind staff.

Mandatory training

Staff were required to complete mandatory training modules which were relevant to their role. Mandatory training modules included infection prevention and control, safeguarding, life support, information governance and health and safety. Training was delivered through the BMI online learning package (BMILearn) in addition to face-to-face sessions.

Each staff member was given a log-in to BMILearn which assigned the mandatory training specific for their role, for example nursing staff needed to complete training on acute illness management, blood transfusion, consent and using medical gases.

BMI set a target for 90% of staff to complete the mandatory training for their role. The hospital had an aspirational target for 95% of staff completing the mandatory training. At the time of our inspection the completion rate for mandatory training was 94% in the diagnostic imaging department, 92% in the outpatient department and 95% in the physiotherapy department.

Consultants were responsible for providing records of the mandatory training they had completed as part of the annual review of their practicing privileges. This could be completed at the NHS hospital they routinely worked at or if consultants only carried out private work they had to arrange their own mandatory training.

Assessing and responding to patient risk

Good

Outpatients and diagnostic imaging

Staff in the departments told us they knew how to respond to patients who became unwell in the department and how to obtain help from colleagues. Staff told us that should a patient become unwell staff would seek support of nursing staff in the department, the resident medical officer or the hospital's emergency team, depending on the severity of the patient's illness.

In the event of an emergency the patient would be stabilised and the resident medical officer would decide whether to transfer them by ambulance to the emergency department's at two local NHS hospitals which were both approximately three and a half miles away.

Clinical staff in the outpatient and diagnostic imaging departments received training in adult intermediate life support. At the time of our inspection information the hospital gave us showed that 90% of staff in the diagnostic imaging department, 85% of staff in the physiotherapy department and 79% of staff in the outpatient department had completed the training. All of the resident medical officers employed by the hospital had advanced life support and paediatric advanced life support.

All of the clinical staff in the departments received training in acute illness management (AIMS) training. Records give to us by the hospital showed that at the time of the inspection 100% of staff had completed the training.

We were assured that the diagnostic imaging department was taking all steps to identify and mitigate for patient risks. We saw the diagnostic imaging department using appropriate safety checks before scanning patients. Patients completed a health-screening questionnaire before having a CT or MRI scan which asked questions about liver function, to ensure that it was safe to give a patient the contrast used in scanning. Patients having an MRI scan were asked whether they had a pacemaker fitted, which could be interred by the magnet used in a MRI scan.

We saw checks were in place to ensure the service identified women who were or may be pregnant. This included questions asked by staff and posters in the department.

There was a service level agreement for the provision of radiation protection advisor with a local organisation. This ensured independent scrutiny of whether the hospital was complying with the Ionising Radiation (Medical Exposure) Regulations 2000. Staff told us the radiation protection advisor was available at all times to give advice and visited the hospital weekly. BMI also had a national radiation protection advisor who could give advice to the diagnostic imaging department. The department had radiation protection supervisors for each of the clinical areas who were responsible for ensuring the service complied with the relevant regulations.

We reviewed records which confirmed that the service had standard operating procedures in place to prevent contrast induced nephropathy (kidney injury caused by the contrast agent used in CT or other scans). This included screening of patients with renal impairment who needed a scan which used a contrast media.

Nursing staffing

Information the hospital gave us showed that on 1 April 2016 the outpatient and diagnostic imaging departments employed 21.2 whole time equivalent nurses and 15.2 whole time equivalent health care assistants.

Between April 2015 and March 2016 the outpatient department employed between 12 and 14% bank and agency nurses. In the first three months of 2016 the outpatient department did not employ any agency staff. We were told that all agency and bank staff needed to complete an induction, to ensure that they understood relevant policies and the environment so staff were capable to work in the hospital.

Staff told us in the main outpatient department three nursing staff and three healthcare assistants worked on both morning and afternoon shifts. Staff told us that they would like more staff as they sometimes had to cover outpatient clinics outside of the main department and the minor procedures unit, which had recently located to the department. Managers in the outpatient department told us that the department was at the time of the inspection recruiting to increase the number of nurses and healthcare assistants.

Medical staffing

There were 584 doctors and dentists operating under practising privileges at the hospital. Of the doctors and dentists with practising privileges 144 recorded more than 10 episodes of between April 2015 and March 2016.

Good

Outpatients and diagnostic imaging

The hospital had a resident medical officer on site 24 hours a day who could provide medical support to the outpatient and diagnostic imaging departments. The provision of resident medical officers was outsourced to an external company

The hospital had a radiologists' and radiographers on call rota to provide 24 hour cover for the general department and a separate 24 hour neuro-radiologist on call provision. The imaging and diagnostics department always had two members of staff on duty during scanning.

At the time of our inspection the nuclear medicine scanning was closing because the department could not arrange cover for staff sickness and leave.

Major incident awareness and training

The hospital had local and corporate business continuity plans with supporting action cards. We reviewed the policies which had plans to handle a number of different events such as loss of electricity, water or computer systems.

A folder containing all of the business continuity plans and actions cards was located in the main reception which all staff could have access to in the event of an emergency. Staff we spoke to were aware of the plan and their involvement in the plan. We were told that in the event of an emergency heads of service would expect to be on call.

Are outpatients and diagnostic imaging services effective?

We inspected but did not rate this domain as we do not currently collate sufficient evidence to compile a rating for this domain.

During our inspection we found that:

The departments used evidence based guidance to inform their practice. We saw that guidance was based on national and professional guidance. Relevant guidance was considered as part of the process to approve new procedures carried out in the department.

We saw records that showed the diagnostic imaging and physiotherapy departments were auditing their practice to monitor the effectiveness of their work. The diagnostic imaging department used diagnostic reference levels (a tool to monitor the radiation doses received by patients) to monitor radiation doses.

The service had a system for assessing the competency of medical staff when practicing privileges were granted and reviewing the competency on a yearly basis. Most staff in the departments had had an appraisal within the last year to review their performance.

While the diagnostic imaging department was in the process of recording the competencies of radiologists on the equipment within the department, this was not yet complete.

The service had procedures for taking written and verbal consent. The diagnostic imaging department carried out audits of consent taken in the department.

Evidence-based care and treatment

We saw examples of policies and procedures in the hospital referring to professional guidance. For example, the chaperone policy referred to professional guidance from the Royal College of Nursing (Chaperoning: The role of the nurse and the rights of patients, 2002), the hand hygiene policy referred to World Health Organisation guidance (World Health Organization, Guidelines on Hand Hygiene in Health Care (2010)) and the safeguarding policy referred to national guidance (Department of Health Clinical Governance and adult safeguarding: an integrated approach (2010).

The diagnostics department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). Local radiation protection rules were available in all rooms for staff to refer to and checks on equipment was carried out.

The diagnostic imaging department regularly standard operating procedures and work instructions to ensure that it was in line with the most recent guidance and best practice. We reviewed the procedures owned by the department, which were all up to date.

The diagnostic imaging department had copies of the diagnostic reference levels stored in a central location accessible by all staff in the department. This is a tool to

monitor the radiation doses received by patients. By using this as a tool the service could ensure its procedures and equipment were used in a way that reduced unnecessary radiation doses to patients.

New procedures which were carried out in the diagnostic imaging department and physiotherapy departments needed to be approved by the medical advisory committee (MAC). As part of the approval process NICE guidelines were considered. An example of a new procedure which was approved was a physiotherapy led injection therapy service.

Pain relief

The minor procedures unit carried out pain management clinics. Consultants would provide pain management advice and treatment for patients who suffered from chronic and acute pain issues.

Some of the other minor procedures carried out in the minor procedures unit were performed under local anaesthetic. Procedures carried out in the minor procedures unit were carried out by a consultant.

Consultants were able to provide private prescriptions for pain relief to patients attending outpatient clinics if it was appropriate. Patients could collect pain relief from the hospital pharmacy.

Patient outcomes

The diagnostic imaging department carried out monthly audits of the images and systems recording the information. We reviewed the last three audits which we saw checked that staff were following safety procedures, completing the necessary records and for the quality of images. We saw from the minutes of the most recent team meetings that the results of the audit and any actions required were fed back to staff. Staff told us that they were also shared with them at the 'comms cell'.

The diagnostic imaging department carried out a monthly review of images which were rejected, which meant they had to be taken again. The results of the review could be filtered by the type of image or radiographer. We saw in the minutes that the results were fed back to staff at the department's team meeting and we were told that they were also reviewed at the annual radiation protection committee. This meant that the hospital and the radiation protection advisor were able to monitor the performance of the department to ensure patients were not receiving unnecessary exposure to radiation.

The diagnostic imaging department told us that it sent a sample of ten percent of the CT and MRI images to an external company to double report on, to ensure the quality of the reporting by the service. This gave assurance that the effectiveness of the radiologists reporting on images and scans.

The diagnostic imaging department was not accredited by the Imaging Services Accreditation Service (ISAS) at the time of our visit. Accreditation to ISAS gives patients assurance about the quality of services, competency of staff and safety of the environment. While the hospital did not have ISAS accreditation it was planning to apply for accreditation in 2017.

The physiotherapy department told us it collected information about the outcomes of patients using a BMI questionnaire. The department also used a separate questionnaire for patients with arm, shoulder and hand injuries. The questionnaires were used at the start and end of treatment so the department could see how effective the treatment had been.

Competent staff

The hospital used a group-wide induction policy, we reviewed the policy which said that contracted and bank staff must complete the hospital's induction when they started working at the hospital. We were told that the induction usually runs monthly, starting on the first Monday of the month. The policy says that as part of their induction staff must complete an induction workbook for their first 90 days at the hospital.

Staff in the outpatient department told us they did not have enough time during the working day to complete the training or there was no suitable place to complete the online modules. They said, in order to complete the training they could complete the online learning at home on their personal computers. However, staff in the physiotherapy department told us they were given two and a half hours a month for continuing professional development, which was plenty of time to complete mandatory training as well as other learning and development.

Good

Outpatients and diagnostic imaging

Staff across the departments told us they were given good opportunities and encouraged to develop by their managers. We were given examples of staff in the imaging and physiotherapy departments who had developed from technician roles to qualified practitioners. Staff in the imaging department were given opportunities to work on different areas of imaging and staff in the outpatient department to work on specialist clinics.

Appraisals for contracted staff were completed by staff using the BMI's online package called 'BMI Learn'. As part of the appraisal process a mid-year and end of year review is completed. At the time of the inspection the hospital told us 100% of eligible staff in all departments had the diagnostic imaging department and physiotherapy department had had an appraisal within the last year. In the same period 87% of staff in the outpatient department had had an appraisal, however, at the same time four staff were either on long term sick or on maternity leave.

BMI had group-wide policy for granting and reviewing the practising privileges of doctors. We reviewed the policy which said practising privileges were only granted to doctors who were licenced, on the specialist General Medical Council register, held a substantive consultant post with the NHS within the past five years and demonstrated relevant clinical experience relating to practice. The policy said that where an applicant had not worked in the NHS within the past five years they would need to demonstrate experience in independent practice and a support network.

We saw that applications for practising privileges were reviewed by the Medical Advisory Committee (MAC) with respect of the credentials, qualifications, experience, competence, judgement, professional capabilities, knowledge, and fitness to practice, character and confidence held on the applicant.

We saw that the MAC reviewed practising privileges each year. For a doctor or dentist to retain practising privileges they must demonstrate they complied with certain requirements. These included registration with the General Medical Council, evidence of insurance/indemnity from a medical defence organisation or insurer, and a current performance appraisal.

The diagnostic imaging department kept a record of all of the radiographer's competencies. We reviewed the records which set out which procedures the radiographer could carry out and which equipment in the department they could use.

The department was in the process of creating record of all of the consultant radiologist's competencies setting out which procedures they could carry out and which equipment in the department they could use. We reviewed the records and saw that at the time of our inspection the department had completed forms for around a quarter of the consultant radiologists. This meant that they could not provide assurance of the competencies of all of the radiologists working in the department.

The department also kept a record for all of the consultant radiologists of the areas of practice which they carried out in the NHS. We reviewed the most recent record which we saw was collected by sending a questionnaire to the consultant radiologists. This meant that the department could check that a radiologist was not working outside of their scope of practice.

The diagnostic imaging department held a record of staff who were entitled to administer radioactive substances. On the inspection we reviewed the record and saw that the department had a certificate from the Administration of Radioactive Substances Advisory Committee which was displayed in the department.

Multidisciplinary working

The hospital told us it had a service level agreement between the hospital and local NHS hospital for the provision of positron emission tomography (PET) scanning. PET scans would be carried out at the NHS hospital which was 4.5 miles away from the hospital.

The hospital told us it had a service level agreement between the hospital and a MRI scanner provider (which was part of another organisation and not subject to this inspection process). The mobile MRI was located outside the MRI department on all but one day of every month.

The hospital told us it had a service level agreement between the hospital and a mobile catheterisation laboratory provider (which was part of another organisation and not subject to this inspection process).

Good

Outpatients and diagnostic imaging

The mobile catheterisation laboratory was based outside of the main hospital building, while the hospital built a new catheterisation laboratory (this was also part of another organisation and not subject to this inspection process).

Staff told us the hospital had a 'one stop shop' breast clinic twice a week with consultant breast surgeons, breast care nurses and consultant radiologists. Patients attending this clinic were able to have diagnostic images taken at the same time as seeing a consultant.

Staff told us there was a 'one stop shop' eye clinic for people with age related macular degeneration. Patients at the clinic could have the diagnostic tests, consultation and if necessary eye injections in the minor procedures unit.

Seven-day services

The physiotherapy department was open for outpatient appointments between 8am and 8pm, Monday to Thursday and 8am and 5pm on Friday. Saturday 9am to 1pm.

The physiotherapy department was open for outpatient appointments between 8am and 8pm, Monday to Thursday and 8am and 5pm on Friday. There was an on-call service for respiratory and orthopaedic patients outside of the normal opening hours.

The general X-ray and CT scanning department was open between 8am and 8pm, Monday to Friday, and 8am and 6pm on Saturday and Sunday. The MRI imaging centre was open between 8am and 9pm, Monday to Friday, 8am and 6pm on Saturday, and 8am and 4pm on Sunday. An on-call rota was in place for X-ray and CT scans outside of the opening hours. The RMO was on site 24 hours a day, seven days a week.

Access to information

Staff told us there was never a problem with accessing information or records with the hospital. In the outpatient department staff said they could not think of an occasion when hospital records were not available, and if they were they said they could be easily retrieved from the medical records department.

Consultants in the outpatient department mainly used their own private patient records during consultations and took responsibility for ensuring the records were available.

Images taken in the diagnostic imaging department were added to an electronic system which was accessible by radiologists with practicing privileges. As the used an electronic system images were available at all times.

Staff showed us that hospital policies and procedures were available on the hospital's intranet page. In the consulting rooms, we saw a memorandum on each computer telling consultants where to find the hospital policies and procedures. Staff showed us that policies and procedures specific to the diagnostic imaging department were available on a shared drive on all computers and were accessible by all imaging staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital told us that clinical staff across all departments received training on the Mental Capacity Act and DoLS during the consent and level 2 safeguarding vulnerable adults' modules of their mandatory training.

BMI had a group-wide policy for the gaining of consent before treatment, a procedure or investigation. We reviewed the policy which set out the criteria for requiring written or verbal consent. Most of the procedures carried out in the outpatient, physiotherapy and diagnostics imaging departments only required verbal consent, although some procedures, such as interventional radiology and some procedures carried out in the minor procedures unit required written consent.

The diagnostic imaging department carried out a monthly audit of consent, for procedures where required written consent. We reviewed the audits carried out between January and June 2016 and found they had identified that consent had been taken and recorded in the patients written notes, but not on the computer system.

BMI had a group-wide policy which we saw set out a summary of the Mental Capacity Act and Deprivation of Liberty safeguards and the relevant considerations.

Staff we spoke to had an understanding of issues in relation to capacity and the impact on patient consent. Staff told us that in the outpatient department if they had concerns about capacity they would speak to the consultant who would usually take the consent of a patient.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

We observed staff in all departments and saw they were caring and compassionate towards patients.

All of the patients we spoke to and patients who responded to surveys in the departments were positive about how they were treated by staff. Staff maintained patient privacy and dignity across the departments.

Staff, signs and leaflets in the departments kept patients well informed about the treatment they were receiving in the hospital.

Staff provided emotional support to patients and chaperones were used across the departments at the request of patients or for intimate examinations or procedures.

Compassionate care

We observed staff communicating and interacting with patients and their family members in a professional and compassionate manner. In the outpatient department we observed consultants and nurses greeting their patients in a warm and reassuring manner before their appointments.

The Patient Led Assessment of the Environment (PLACE) is a measure of the care environment in hospitals which provide NHS care. The assessments see local people visit the hospital and look at different aspects of the care environment. The PLACE score for the hospital between February and June 2015 for privacy, dignity and well-being was 87%, the same as the England average for independent hospitals.

All of the patients we spoke to during our visit told us that they had been treated well by staff. One of the patients we spoke to said that there had been a misunderstanding with a member of staff on one of her visits, but it had been swiftly resolved to her satisfaction.

We observed that staff took steps to promote patient's dignity. The reception desk for the outpatient department was located far enough away from the seating area so patients' private conversations could not be overheard. All clinical activity in all the departments took place in individual consulting rooms or treatment rooms and doors were closed, to maintain privacy and confidentiality.

The hospital had a group-wide policy for the use of chaperones. We reviewed the policy which explained the consultations that a chaperone would be appropriate and guidance and best practice for using chaperones. Signs offering chaperones to patients were displayed in the waiting areas and in the changing rooms in the diagnostic imaging department.

Staff told us that chaperones were routinely used for intimate procedures or at the request of a patient. Staff told us that the outpatient department kept a chaperone log to record in which consultations a chaperone had been present.

The MRI centre and mobile MRI scanner were located in the hospital grounds, but the centre was not connected to the main hospital building. To access the MRI centre or mobile MRI scanner patients had to follow an uncovered walkway, and across a part of the car park for the mobile scanner. This could cause challenges in maintaining a patient's comfort, especially if the weather was poor and also maintaining privacy and dignity.

The division collected friends and family test data from NHS, insured and self-paying patients. The friends and family test is a measure of whether someone would recommend the service to their friends and family. In March 2016 97.4% of people who completed the test said they would recommend the service to friends and family. In April 2016 99.1% said they would recommend the service and in May 2016 98.7%.

Patients who completed the friends and family test in the departments said they would recommend the service to their friends and family because they thought the service was professional, friendly, efficient, excellent and helpful, as well as a number of other reasons.

Understanding and involvement of patients and those close to them

Patients we spoke to and who responded to the friends and family test said that they were given appropriate information about their care and treatment. People who had diagnostic images said that the radiographers explained what the procedures involved.

Good

Outpatients and diagnostic imaging

Patients we spoke to and those who responded to the friends and family test said that their appointments were usually on time, although one person told us his last appointment had been 45 minutes late.

We saw signs in the outpatient department about the cost of treatment and there was a pay office outside of the outpatient department where patients could discuss the cost of treatment and payment options in confidence.

Staff told us that patients who had tests or scans involving a contrast media were given information during the appointment who to contact if they had a problem or felt unwell after the test.

Patients who responded to the friends and family test about physiotherapy appointments gave positive feedback about the exercises and advice given to them to follow after their appointments.

Emotional support

We observed that staff were sensitive and understanding of the emotional impact of care and treatment. Staff told us that they put the needs of patients first.

Staff in the outpatient department told us that as well as providing chaperones for intimate examinations or on request, they would also consider a chaperone if they were giving bad news to provide additional support.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

Services were planned and delivered to meet the needs of patients. The departments were open outside of working hours, to give people flexibility to attend. The department was providing a number of treatments which would previously have been carried out as day surgery in the minor procedures unit.

The service was routinely exceeding the referral to treatment targets for patients waiting to be seen as outpatients. The turnaround times for diagnostic images was usually within 24 hours from the time of the image for inpatients and 48 hours for outpatients.

Staff understood how they could provide a service to patients with additional needs, although they said that there were few patients who needed additional support, for example from a translator.

However,

There were insufficient car parking spaces available to accommodate the number of patients and family members visiting the hospital. Construction was under way to extend the car park.

Service planning and delivery to meet the needs of local people

There was a wide range of outpatient clinics offered (around 26 specialities). Information given to us by the hospital said of the specialities offered 35% of appointments were for orthopaedics; 24% for general surgery; 7% for ophthalmology; 4% for gynaecology; 3% for cardiology; and urology; 2% for ear, nose and throat; gastroenterology; neurology; and neuro surgery; and 1% or fewer for the other specialities offered.

Outpatient clinics were provided to people of all ages. Information the hospital gave us said between April 2015 and March 2016 just over 4% of outpatient appointments were for people under the age of 18, 85% of appointments were for people between 18 and 75 and 11% of appointments were for people older than 75.

Staff in the outpatient department told us it scheduled rooms for consultants who had regularly weekly clinics in the hospital and could also schedule rooms for consultants who requested clinics on an impromptu basis. This meant that the hospital could be flexible if a consultant needed to see patients and did not have a clinic scheduled.

The minor procedures unit opened in the outpatient department in 2016 and carried out minor procedures which would have previously been carried out as day surgery cases. The hospital told us that in May 2016 21% of procedures in the hospital were carried out in the minor procedures unit. The minor procedure unit was used for an eye clinic, pain management clinic, minor plastic surgery, scar revision, dermatology and carpal tunnel syndrome patients. The service is looking to extend its use to other minor procedures. This meant that patients, who may have previously had to have surgery in the hospital as a day patient, could receive their treatment quickly and without being admitted to a ward.

Good

Outpatients and diagnostic imaging

Outpatient clinics were held between 8am and 9pm on weekdays and on Saturdays giving flexibility about when people could attend. Diagnostic imaging was open between 8am and 8 or 9pm and at the weekends giving patients flexibility.

At the time of our inspection the nuclear medicine scanning was because the department could not arrange cover for staff sickness and leave. Staff told us that the service had made arrangements for patients to be transferred to a nearby NHS hospital to have any scan they required and that patients would be accompanied by a member of their staff to the scan.

While the hospital offered free car parking on site, there were not enough parking spaces for the number of patients and visitors. The hospital's senior management team and patients told us the shortage of car parking was an issue. When we visited there were very few available car parking spaces, no disabled bays available and cars parked on double yellow lines and outside of parking bays. During our inspection we saw that building work was underway to extend the car park. The hospital told us the work was due to be complete in August 2016.

The outpatient, physiotherapy and diagnostic imaging waiting areas had sufficient seating for the number of patients when we visited the hospital. A range of different style of chairs in the outpatient department meant patients could choose a chair comfortable for them. Staff told us that when the hospital chose the chairs an occupational therapist had given advice on the most suitable chairs. While there was a range of seating in the outpatient department, the chairs in the diagnostic imaging department were all of the same height and style and the seat coverings looked tired.

The diagnostic imaging department had a number of cubicles to use to change before a scan or procedure. While there were adequate changing facilities there were no lockers where patients could store their clothes and belongings. This meant that patients could not be assured about the safety of their clothing and belongings while having a scan or procedure.

The minor procedures unit had an admission lounge, changing room and discharge lounge in the same area. The changing room had patient lockers and had doors on the main corridor and on the treatment room, meaning that patients could go directly into the treatment room once they had changed into a hospital gown.

There were water dispensers in all the waiting areas and a hot drinks machine in the outpatient department. There was also a canteen in the hospital selling food and drinks.

Newspapers were available in the main reception for patients waiting in the outpatient department waiting area. There was also a small children's play area in the outpatient department waiting area for young children visiting the department.

All of the departments were clearly signposted and while we were on the inspection there were concierges at the entrance to the hospital to provide directions and escort visitors to reception. There were golf buggies which staff told us could take patients to and from their vehicles if they had reduced mobility.

Access and flow

Information the hospital gave said there were 127,755 outpatient attendances between April 2015 and March 2016; of these 88% were funded by insurance or self-paying patients and 12% were NHS funded.

The outpatient department used an electronic system to schedule clinics and track patients from when they had arrived in the hospital and started the appointment. Staff showed us how they could effectively monitor clinics to see whether they were running on time and where patients were in the hospital.

Staff and patients told us they were given flexibility about when they could book appointments. However, patients would have less flexibility if they chose to see a specific consultant (who may only have clinics on certain days) or needed to attend a clinic which did not take place every day.

NHS patients could used the Choose & Book system - an electronic system allowing patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment. This was administered by a team responsible for NHS contracts.

Good

Outpatients and diagnostic imaging

Other appointments were booked at the patient services desk outside of the outpatient department, on BMI's central telephone booking service or through the individual consultant's secretary.

Information from NHS England showed the hospital met the target of 92% of incomplete patients beginning treatment with 18 weeks of referral for each month between April 2015 and March 2016. This is a measure of NHS patients who are waiting to receive treatment.

Records we reviewed confirmed that only five NHS patients did not meet the six week target for diagnostic tests being completed between April 2015 and March 2016.

Staff told us that the hospital did not have a 'do not attend' (DNA) policy. If a patient did not attend an appointment it would be the consultant's responsibility what action would be taken, for example to offer a new appointment or discharge a patient. As the hospital did not keep a record of the number of appointments that patients did not attend it could not tell us how frequently it happened.

Notices in the outpatient waiting area told patients to speak to the reception desk if their appointment was delayed by 10 to 15 minutes. Staff working in the outpatient department told us they would liaise with reception staff to inform patients waiting if the clinic was running behind. They told us that if the clinic was delayed for a long time they would offer vouchers for patients to use in the restaurant.

The hospital did not audit the waiting times for attending a clinic, timing of clinics or cancellation of clinics. While staff told there was not a problem with delays to clinics, as this information was not collected the hospital could not give assurance of the timeliness of clinics.

While the outpatient department did not keep a record of clinics which were delayed, staff told us they kept a record of delays in consultants starting clinics, which was used by the consultant relation team to monitor the performance of consultants.

Staff told us that if a clinic was cancelled, for example if a consultant could not attend, they would try to offer an appointment with a different consultant, from the same speciality, or if this was not possible reschedule the appointment.

The diagnostic imaging department told us it reported images for inpatients back within 24 hours and images for outpatients within one week, although aspired to report images back within 48 hours.

Meeting people's individual needs

The hospital used a BMI group-wide equality and diversity policy. We reviewed the policy which set out the expectations of staff to ensure patients and staff were not discriminated against and the needs of all patients were met.

All staff had to complete mandatory training in equality and diversity. Information given to us by the hospital showed that at the time of our inspection more than 98% of staff in the diagnostic imaging and outpatient departments and 97% of staff in the physiotherapy department had completed the training.

Staff we spoke to understood the need to support people who had additional needs and made adjustments where appropriate. However, staff told us that there were few patients who had complex or additional needs.

Patient-Led Assessments of the Care Environment (PLACE) score for the whole hospital for dementia was 84%. This was higher than the national average for independent hospitals which was 81%.

All clinical staff had to complete a dementia awareness module as part of their mandatory training. At the time of our inspection 97% of staff in the physiotherapy department, 95% of staff in the diagnostic imaging department and 92% in the outpatient department had completed the training.

The hospital had a contract with a provider of translation services. Staff we spoke to were aware there was a translator service and who to go to arrange a translator. Staff told us that there were very few patients who did not speak English as their first language and as a consequence they did not often have to use the translation service.

Most of the written information, leaflets and signs were only in English. These were not available in other formats such as other languages, pictorial or braille. However, staff told us that there were very few patients who did not speak English as their first language.

Good

Outpatients and diagnostic imaging

There were information leaflets in the outpatient waiting area giving information about different conditions and services offered by BMI hospitals.

Staff told us that if an NHS patient needed transport this could be arranged through the team who manages NHS contracts. For other patients the service would provide details of a private ambulance service.

Staff in the diagnostic imaging department said that they had the equipment to scan and take images of bariatric patients. They said that usually the work would be anticipated so they could plan for the patient.

Learning from complaints and concerns

Information provided by the hospital showed that between April 2015 and March 2016 there were two verbal and 11 written complaints about the diagnostic imaging department. In the same period there were ten verbal and 40 written complaints about the outpatient department. There were also two written complaints about the physiotherapy department.

The hospital used a BMI group wide policy for handling complaints. We reviewed the policy which said patient complaints followed a three-stage process. Stage one involved an investigation and response by the hospital within 20 days. Stage two was a review by BMI's central or regional staff of the complaint and how it had been handled at stage one, also within 20 days. Stage three was an independent investigation by the Independent Sector Complaints Adjudication Service (ISCAS), for fee-paying patients, or the Parliamentary and Health Service Ombudsman for NHS patients.

The hospital had a leaflet, 'We'd like to hear from you', which explained how someone could complain. We saw copies of the leaflet in the waiting area of the outpatient department. While the leaflet set out the three stages of the complaints procedure, it only said patients could ask the Independent Complaints Adjudication Service to review the complaint and did not say NHS patients could complain to the Parliamentary and Health Service Ombudsman. Following inspection the hospital provided copies of two separate leaflets one for privately funded patients and one for NHS patients .

The hospital told us that all complaints were sent to the Executive Director to be logged on a database, before being assigned to the relevant head of department of staff member to investigate. The Executive Director then would send the complaint response. The hospital told us it would aim to send responses sooner than 20 days, for example if the complaint was straightforward.

We saw evidence in the minutes that complaints were reviewed and discussed at the hospital's clinical governance committee, medical advisory committee and senior nurses meetings to share findings, trends and learning with service leads and consultants. Learning from complaints was shared at the individual department in the department team meetings, which was recorded in the minutes we saw, and at the 'comms cell'.

The outpatient department gave us an example of learning and action from complaints. The hospital received a number of complaints about charging within the department, specifically when patients had blood tests or minor treatment which they would be charged for in addition to an appointment. The trend of complaints was identified and discussed at the clinical governance meeting. As a result posters were designed and displayed throughout the department informing patients of the charges they would incur.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well led as good because:

There were appropriate governance processes and reporting structures in place. Communication was shared with staff via meetings and the 'Comm cell' systems; there were also opportunities for issues to be escalated to senior staff.

On the whole, staff across the departments spoke positively about the leaders and the culture within the services.

The departments engaged with patients by collecting feedback from surveys and acting on the feedback to improve the services offered.

The department each had plans to develop the services they offered. The diagnostic imaging department was in the process of purchasing a new MRI scanner which would make it the only independent facility with a 1.5T and 3T MRI

scanner. The outpatient department had plans to develop the ambulatory care models further so more treatment which would previously be carried out as day surgery could be delivered in the minor procedures unit.

Leadership / culture of service

Managers in the diagnostic imaging and physiotherapy departments had clinical roles and the manager in the outpatient's department was supported by an outpatient sister. The manager of the outpatient's department had been in post for around six months and the manager of the physiotherapy department had been temporarily promoted to the role.

All of the staff we spoke to in the outpatient department said the managers were approachable, supportive and calm. Staff told us that the managers had open door policies and one member of staff said that she felt valued because the managers always said thank you. Staff told us it was a positive place to work although said that there had been increased pressures since the minor procedure unit opened.

Staff in the diagnostic imaging department told us that they were supported in the roles, that there was very good communication in the department and that they were supported in their career development. However, some staff said that due to the number of patients booked in for tests, they only had time to focus on the scans, at the expense of their career development and keeping up to date with communication. The service told us it had agreed the procurement of a new MRI scanner which would increase capacity within the department.

Staff in the physiotherapy department told us that they felt very supported by the management and we were given examples of staff being supported in their career development.

Staff told us executive team at the hospital were visible and approachable. All of the staff we spoke to knew who the executive team were and staff said they had visited most areas of the hospital while they were working.

Staff told us they were given 'Above and Beyond' cards to recognise actions they had taken above and beyond their normal duties. We saw evidence that an award had been given following positive feedback in the patient survey. Staff were also given different coloured pins to wear on their uniform in recognition of the length of time they have worked at the hospital.

Vision and strategy for this this core service

Staff we spoke to had a broad knowledge of BMI's corporate vision and could tell us where to look for more information. Staff we spoke to also had some knowledge about the departments and hospital plans (such as refurbishment, expanding the business and the use of ambulatory care models).

The departments did not have formal written strategies in place; however, they had a clear understanding of their future plans. These plans were reflected in the hospital's strategy.

The outpatient department told us its plans were to develop the ambulatory care model, refurbish the department and to develop nurse led clinics carried out in the department.

The diagnostic imaging department told us its plans were to develop its scanning and treatment capabilities, to increase the types of diagnostic work and treatment carried out and to develop its staff. The procurement of a second MRI scanner had been approved.

The physiotherapy department told us its plans were to develop the care and treatment carried out and to develop its staff.

Governance, risk management and quality measurement for this core service

There was defined governance and reporting structure in the hospital, which the departments fitted in to. Departments held their own team meetings which took place every fortnight in the physiotherapy department, every month in the outpatient department and every six weeks in the diagnostic imaging departments. We reviewed minutes of the meetings which showed that at the meetings information was fed back from the hospital's clinical governance committee meeting and service leads meeting both of which had representatives of each of the departments.

Good

Outpatients and diagnostic imaging

In the outpatient's department there had been poor attendance at recent team meetings. We were told that meetings had been moved to lunchtime, to coincide with the shift changeover, and that attendance to 80% of team meetings would be required to improve attendance.

The departments all told us they held 'comms cell' meetings on a regular basis, daily in the outpatient and physiotherapy departments and three times a week in the diagnostic imaging department. These followed the daily hospital 'comms cell' meeting held in the boardroom, which was attended by the head of department or representatives of each department.

Staff told us the 'comms cell' meetings in the departments were used to feed back issues from the hospital 'comms cell' and discuss local issues. In the outpatient department the 'comms cell' meeting was held at lunchtime each day and was also used as a handover between the morning and afternoon shifts.

In each of the departments a 'comms cell' board was displayed in a staff area, which displayed important information relevant to the department, such as messages to cascade, learning from incidents, friends and family test results, governance dashboard, 'concerns, cause and countermeasures, team success.

Risks within the departments were added to the hospital's risk register, which BMI's risk policy said should be reviewed every quarter. We reviewed the risk register which reflected the risks to the departments.

The diagnostic imaging and physiotherapy departments each maintained a governance dashboard, which we saw was displayed on the 'comms cell' board in the departments. The dashboard displayed the performance against a number of key performance indicators using a traffic light system, such as audit activity, training, incidents and complaints. The dashboard was updated monthly to show the monthly performance for the year.

While the departments did not maintain and hold their own risk registers there was a 'concern, cause and countermeasure' board in every department, which we saw recorded issues identified by staff which could affect the service. Staff told us that these were reviewed as part of the 'comm cell' meetings.

Public and staff engagement

Staff told us that patients were encouraged to leave feedback about their experience by completing a 'How well did we do?' card. Patients completing the card were asked how likely they were to recommend the service to friends and family (the family and friends test) and given a chance to say in their own words why they gave that answer. We saw that the forms were available throughout the hospital.

The information from the feedback was collated and analysed by a third party company every month. The report was reviewed at the clinical governance committee and service leads meetings. The survey asked who the patient had seen, so the feedback could be directed to the relevant department. We reviewed the reports for the three months prior to our visit which gave information about patient's experiences in the departments so the performance could be monitored.

Staff gave us examples of changes made as a result of the feedback from the survey. In the minor procedures unit coat hooks were added to the changing room and cold refreshments provided in the discharge lounge following feedback from patients.

Staff told us that the 'comm cell' meetings and boards were a good opportunity to engage with the senior management team, as information could be passed to the team at the central 'comms cell' meeting as well as passed down to the departmental meetings. Staff we spoke to in the physiotherapy department said they had attended the central 'comms cell' as a representative of the department.

The hospital gave us a copy of the monthly newsletter to consultants with practicing privileges at the hospital. This gave consultants information about the hospital, for example, the hospital's strategy, staff changes, customer satisfaction and new procedures.

The hospital told us it had started a Patient Focus Group in March 2016 which was made up of representatives from staff in different departments. The aim of the Group was to improve the patient experience across the hospital.

In 2016 the hospital completed a staff survey. The hospital told us the results had been cascaded to heads of department in June 2016 and actions plans for each department were to be discussed at the next service leads meeting after the inspection.

Innovation, improvement and sustainability

Good

Outpatients and diagnostic imaging

The hospital told us it had agreed to purchase a new MRI scanner. The MRI scanning centre will be extended to accommodate the new scanner which is planned to be completed in February 2017. The new scanner will mean that the hospital will be the only independent facility in the region a 3T and 1.5T MRI scanner.

Staff in the diagnostic imaging department told us the department was looking to increase the scope of procedures and tests carried out at the hospital. New procedures were approved by the Medical Advisory Committee (MAC) before they were offered to patients. Staff said an example of this was the approval of selective internal radiation therapy which had been approved by the Medical Advisory Committee. This is a procedure where radioactive substances are put down a blood vessel to target liver cancers.

The hospital offered breast tomosythnthesis which is offered at few independent hospitals. This is a mammography technique where X-ray protections are taken from a range of different angles and reconstructed to produce a 3D image of the breast.

The physiotherapy department told us it had started a physiotherapist led injection clinic at the hospital for patients with upper and lower limb conditions with had not been successfully treated with conservative therapies. The physiotherapists had training in injection therapy and the clinic was approved by the Medical Advisory Committee before starting.

The minor procedures unit opened within the last year as part of the hospital's move to an ambulatory care pathway for minor procedures and treatment. This means patients do not need to stay overnight or go to a ward after treatment. Information given to us by the hospital showed that in May 2016 21% of procedures in the hospital were carried out in the minor procedures unit, freeing up the theatres and wards for other patients. Staff told us the department was looking to extend its use to new procedure such as a sclerotherapy clinic (where medicine is injected into blood vessels to treat them) and cystoscopies (a procedure to examine the bladder).

Managers in the diagnostic imaging department told us the department offers an elective placement to radiography students. Staff in the department also provided training on Ionising Radiation (Medical Exposure) Regulations 2000 to therapists and other clinicians in the North West region.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The hospital **MUST** ensure that an effective system is put in place to ensure that potentially harmful drugs such as intravenous potassium are managed and administered effectively.

Action the provider SHOULD take to improve

The hospital **SHOULD** consider how risks within individual departments are identified and managed locally.

The hosital **SHOULD** consider providing a follow up clinic where patients could reflect upon their critical care experience. In line with Guidelines for the Provision of Intensive Care Services, 2015

The hospital **SHOULD** consider th routine screening of patients for delirium on admission in line with Faculty of Intensive Care Medicine (FCIM) guidance.