

BMI Mount Alvernia 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



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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection of BMI Mount Alvernia Hospital on the 19, 20 and 26 July 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services, medical services, out-patient and diagnostic imaging services as these incorporated the activity undertaken by the provider, BMI Healthcare Limited at this location.

We rated all four core services as good overall.

Are services safe at this hospital/service

Incidents were reported, investigated and learning evidenced. Reports were communicated to all staff.

Patients were cared for in a visibly clean environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored. There were no outbreaks of serious infection reported.

There were processes for assessing and responding to patient risk. The service had enough staff with the skills and experience to care for the number of patients and their level of need. The majority of staff had completed the provider's mandatory training programme. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use. Staff demonstrated good medicines storage, management and administration.

There was room for improvement with safety in surgery where we found that the side of the patient due to be operated on was not always clearly or accurately documented on daily operating lists. We also found that staff did not consistently adhere to the World Health Organisation Safe Surgery checklist.

We also found not all staff had not attended major incident or business continuity training.

Are services effective at this hospital/service

We found care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes.

Staff worked with other health professionals in and out of the hospital to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.

There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day. There was comprehensive assessment of patient needs. This included clinical needs, physical health, nutrition and hydration needs. Patients received adequate pain relief.

Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.

There was a proactive audit programme that included national, corporate, hospital and departmental audits. Results were shared throughout the hospital and collated to identify themes.

Are services caring at this hospital/service

Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.

Summary of findings

Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect. Patients felt well informed and involved in their procedures and care, including their care after discharge.

Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support from staff.

We observed patients treated with compassion, care and dignity. Patient feedback was positive and staff demonstrated commitment to continuous improvement.

Are services responsive at this hospital/service

There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs. For example those with spiritual needs, those requiring bariatric equipment, patients whose first language was not English, or support for people living with dementia or learning disabilities.

The services were delivered in a way that met the needs of the local population and allowed patients to access care and treatment when they needed it. Waiting times, delays and cancellations were minimal and well managed. Patients told us staff were responsive to their needs.

Complaints management was a priority in the hospital. The process was transparent and open with learning communicated across the hospital.

Are services well led at this hospital/service

There were clear organisational structures and roles and responsibilities. The senior management team were highly visible and accessible across the hospital. Staff described an open culture and said managers were approachable at all times.

Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.

There were good governance, risk and quality systems and processes that staff understood. The committee structure supported this with reports disseminated and discussed appropriately. Staff from all departments had a clear ambition for their services and were aware of the vision of their departments.

Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services. The hospital had a risk register which was reviewed at the governance committee meetings. However, the risk register was not divided into separate departments.

The management team had an understanding of the Workforce Race Equality Standard (WRES) as there is a national requirement to produce key data relating to race equality in the workplace. BMI had started to collect data nationally which they currently held, for example the numbers of staff from black and ethnic minority groups. The management team was in the process of implementing reporting processes to capture the data to enable them to fully comply with WRES reporting requirements.

However there were areas of where the provider needs to make improvements.

The provider must:

- Ensure that staff are trained to the appropriate level for safeguarding children. Children attend the hospital as patients and visitors.

The provider should:

Summary of findings

- Provide each individual department with a separate and relevant risk register.
- Enable all staff to attend major incident or business continuity training and attend simulation exercises.
- The outpatient department should adequately risk assess environment and equipment.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Summary of each main service

We found the medical services at BMI Mount Alvernia to be good. This was because:

- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable. The oncology unit was awarded the Macmillan Quality Environment Mark, which identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. It had been developed in partnership with patients living with cancer and the Department of Health. It is a core component of the English Cancer Reform Strategy.
- The hospital provided end of life care training and had an on going education programme which was attended by staff.
- The palliative care team worked with ward staff to provide holistic (the treating the whole of something and not just a part) care for patients with palliative and end of life care needs in line with national guidance. This meant a multidisciplinary approach was maintained.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. The service was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is the quality improvement and assessment tool for the GI endoscopy service.
- Oncology services demonstrated compliance with National Institute for Health and Care Excellence (NICE) guidelines.

Good



Summary of findings

- The medical services had an appropriate level of competent staff.
- Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind and caring manner. Patients told us they felt relaxed when having their treatment.
- The hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life.
- Staff at the hospital provided focused care for dying and deceased patients and their relatives. The hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- Managers were visible, approachable and effective. This had resulted in a well-led service that had a clear vision and strategy to provide a streamlined service for medical and end of life care patients.
- The hospital had a clinical governance committee and medical advisory committee (MAC) both responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.

However

- The safeguarding lead was not trained to level 3 for safeguarding children as per national guidelines.
- Staff had not attended major incident or business continuity training, or attended any simulation exercises.
- The risk register was hospital wide and not divided into separate departments.

Surgery

Good



We rated the surgical services at Mount Alvernia Hospital as good because:

- The hospital had good systems and processes in place to keep patients free from harm. There was a good track record on safety.
 - Staff understood the incident reporting process and their responsibilities to report, investigate and learn.
-

Summary of findings

- There were processes for assessing and responding to patient risk and safe protocols for patient transfer. There was a comprehensive assessment of patient needs. There were sufficient skilled and experienced staff to care for patients.
- The hospital worked to current national guidance. The hospital participated in national audits and had a proactive programme of hospital and departmental audits. Results and recommendations were shared throughout the hospital with change and learning evidenced.
- Patients were treated with compassion, care and dignity. They were well supported and provided with good information.
- Services were provided to meet the needs of the local population and allow access to care and treatment. There were minimal delays or cancellations for treatment and these were well managed.
- Complaints were investigated and discussed openly with staff.
- The organisational and committee structures supported good governance systems and processes. Staff described an open culture within the hospital and were clear on roles and responsibilities.
- The hospital collected patient feedback and demonstrated ongoing work by all staff towards continuous improvement in the patient experience.

However:

- The safeguarding lead was not trained to level 3 for safeguarding children as per national guidelines.
- The side of the patient due to be operated on was not always clearly or accurately documented on daily operating lists.
- Staff had not attended major incident or business continuity training, or attended any simulation exercises.
- The risk register was not compiled so that department risks could be identified.

Outpatients and diagnostic imaging

Good



We found the outpatient and diagnostic imaging services at BMI Mount Alvernia to be good. This was because:

Summary of findings

- The hospital had good systems and process in place to keep patients from harm.
- A wide variety of modern equipment was available for staff to deliver a range of services and examinations.
- Staff managed medicines in line with best practice and stored them securely.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient and diagnostic imaging departments had sufficient numbers of appropriately trained competent staff to provide their services.
- Staff dealt with patients in a kind, caring and considerate manner. Patients were happy with the care they received.
- The hospital was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Results of investigations were available quickly and double checked by members of staff.
- Managers were visible, approachable and effective.
- The hospital had a clinical governance committee and medical advisory committee both responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.

However:

- Children attended the outpatient department, but neither the safeguarding lead nor any staff had attended level three safeguarding children training as per national guidelines.
- The assessment and response to risk was not managed consistently throughout outpatient and diagnostic imaging services.

Summary of findings

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Good

BMI Mount Alvernia Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to BMI Mount Alvernia Hospital

Mount Alvernia Hospital is an independent hospital which is part of BMI Healthcare Limited. It is situated in Guildford, Surrey. Mount Alvernia Hospital was established in 1935 by a Group of Franciscan Sisters, and acquired by BMI Healthcare in 2005. The hospital initially concentrated on community and maternity services although the latter were stopped in the eighties. It has since grown to provide a wide range of acute clinical services in recent years and significant investment in the hospital has seen the development of many new services including cancer services.

BMI Mount Alvernia Hospital has 76 beds, most of which are private rooms with en-suite bathrooms. The hospital has a diagnostics facility including CT, MRI, full field digital mammography, nuclear medicine, radiotherapy and a mobile PET CT service as well as on-site pathology with

additional services provided by a third party provider. The hospital has a suite of three main theatres supported by an ambulatory care unit with endoscopy theatres attached.

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. We inspected four core services at the hospital which incorporated all the activity undertaken. These were surgical services, medical services, which included end of life services and outpatient and diagnostic services.

The registered manager of the hospital is Nick Fox who has been in post for two years at the hospital. The provider's nominated individual for this service is Elizabeth Sharp. The controlled Drug Accountable Officer is Nick Fox.

Our inspection team

Our inspection team was led by:

Inspection Lead: Vanessa Ward, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

- Including a surgeon, a theatre nurse, a nurse with experience of managing outpatient departments in independent hospitals and a radiographer.

Why we carried out this inspection

We carried out a comprehensive inspection of BMI Mount Alvernia Hospital on the 19, 20 and 26 July 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of

surgical services, medical services, out-patient and diagnostic imaging services as these incorporated the activity undertaken by the provider, BMI Healthcare Limited at this location.

How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys

and audits. We placed comment boxes at the hospital prior to our inspection which enabled staff and patients to provide us with their views. We received 21 comments from patients.

Summary of this inspection

We carried out an announced inspection on the 19 and 20 July 2016 and an unannounced visit on the 26 July 2016.

We interviewed the management team. We spoke with a wide range of staff including nurses, resident medical officer, radiographers and administrative and support staff totalling 82 personnel.

We also spoke with 14 patients and two relatives who were using the hospital.

We observed care in the outpatient and imaging departments, in operating theatres and on the wards and reviewed patient records. We visited all the clinical areas at the hospital.

Information about BMI Mount Alvernia Hospital

There were 5,377 inpatient and day case episodes of care recorded at BMI Mount Alvernia Hospital in the reporting period (April 2015 to March 2016); of these 9% were NHS funded and 91% other funded. 10% of all NHS funded patients and 20% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 23,466 outpatient total attendances in the reporting period (Apr 15 to Mar 16); of these 5% were NHS funded and 95% were other funded.

The ten most common medical procedures between April 2015 to March 2016 were Image-guided injection(s) into joint(s) (319), Diagnostic oesophago-gastro-duodenoscopy(OGD) includes forceps biopsy, biopsy urease test and dye spray(192), Insertion of portocath/vasoport unit (108), Diagnostic colonoscopy, includes forceps biopsy (106), Removal of portocath/ port-a-cath/vasoport unit (60), Ultrasound guided biopsy/(ies) (55), Ultrasound guided drainage of fluid collection (45), Epidural injection (lumbar) (44), Diagnostic oesophago-gastro-duodenoscopy and immediate colonoscopy includes forceps biopsies, biopsy test and dye spray (43), Transformational epidural (41).

The ten most commonly performed surgical procedures between April 2015 and March 2016 were Diagnostic endoscopic examination of bladder (incl any biopsy) (276), Excision of lesion of skin or subcutaneous tissue - up to 3 (154), Rhinoplasty - cosmetic only (98), Facet joint injection (under x-ray control) - 5 to 6 joints (91), Hysteroscopy (including biopsy, dilatation, curettage and resection of polyp(s) +/- contraceptive coil insertion) (87), Primary total hip replacement with or without cement (74), Bladder instillation of pharmacologic agent

(including cystoscopy) (71), Excision of lesion of skin or subcutaneous tissue - up to 3 (70), Arthroscopic meniscectomy (incl debridement)(67), Biopsy of skin or subcutaneous tissue (62).

There were 195 doctors and dentists with practising privileges at the hospital. Between April 2015 and March 2016 29% of these carried out over 100 episodes of care during 2015, 31% carried out between 10-99, and 25% between one and nine episodes of care. This meant that 15% did not carry out any procedures during the same period. During the same period eight doctors or dentists had had their practising privileges removed and two had had their practising privileges suspended.

There were 45.8 full time equivalents (FTE) registered staff employed, including nurses, 18.2 FTE support staff including care assistants and operating department practitioners (ODP), and 92.5 FTE other staff.

233 clinical incidents occurred in surgery, inpatients or other services at the hospital in the reporting period (April 2015 to March 2016). Out of the 233 clinical incidents 94% occurred in surgery or inpatients and 6% in other services. The hospital reported no incidents as severe or death. For the time period, April 2015 to March 2016 assessed rates of clinical incidents (per 100 bed days) were increasing and higher than other independent acute providers we hold this type of data for. This could be attributed to the hospital making a significant effort to promote a culture of reporting and learning during this time.

During April 2015 to March 2016, there were no serious incidents or never events at the hospital. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were 149 other clinical incidents within this year.

Summary of this inspection

The rate of clinical incidents (per 100 inpatient discharges) has risen from the beginning of the period. No safeguarding concerns have been reported since January 2015.

In the same year, there were no unexpected deaths and no were no reported cases of serious infection such as MRSA.

Inpatient VTE screening rates were 100% in the reporting period (April 15 to March 16). With no incidents of hospital acquired VTE or PE in the reporting period (April 2015 to March 2016).

There have been no safeguarding concerns reported to CQC in the reporting period (April 2015 to March 2016).

CQC directly received three complaints in the reporting period (April 2015 to March 2016).

The hospital received 25 complaints in the reporting period (April 2015 to March 2016) which is a decrease from 2014/15. One complaint has been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) this relates to a patient who used the service in 2013. The assessed rate of complaints (per 100 day case and inpatient attendances) is significantly lower than the other independent acute hospitals we hold this type of data for.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Incidents were reported, investigated and learning evidenced.
Reports were communicated to all staff.

Patients were cared for in a visibly clean environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored. There were no outbreaks of serious infection reported.

There were processes for assessing and responding to patient risk. The service had enough staff with the skills and experience to care for the number of patients and their level of need. The majority of staff had completed the provider's mandatory training programme. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use. Staff demonstrated good medicines storage, management and administration.

There was room for improvement with safety in surgery where we found that the side of the patient due to be operated on was not always clearly or accurately documented on daily operating lists. We also found that staff did not consistently adhere to the World Health Organisation Safe Surgery checklist.

We also found that staff had not attended major incident or business continuity training, or attended any simulation exercises.

Requires improvement



Are services effective?

We found care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes.

Staff worked with other health professionals in and out of the hospital to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.

There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day. There was comprehensive assessment of patient needs. This included clinical needs, physical health, nutrition and hydration needs. Patients received adequate pain relief.

Good



Summary of this inspection

Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.

There was a proactive audit programme that included national, corporate, hospital and departmental audits. Results were shared throughout the hospital and collated to identify themes.

Are services caring?

Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.

Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect. Patients felt well informed and involved in their procedures and care, including their care after discharge.

Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support from staff.

We observed patients treated with compassion, care and dignity. Patient feedback was positive and staff demonstrated commitment to continuous improvement.

Good



Are services responsive?

There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs. For example those with spiritual needs, those requiring bariatric equipment, patients whose first language was not English, or support for people living with dementia or learning disabilities.

The services were delivered in a way that met the needs of the local population and allowed patients to access care and treatment when they needed it. Waiting times, delays and cancellations were minimal and well managed. Patients told us staff were responsive to their needs.

Complaints management was a priority in the hospital. The process was transparent and open with learning communicated across the hospital.

Good



Summary of this inspection

Are services well-led?

Good



There were clear organisational structures and roles and responsibilities. The senior management team were highly visible and accessible across the hospital. Staff described an open culture and said managers were approachable at all times.

Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.

There were good governance, risk and quality systems and processes that staff understood. The committee structure supported this with reports disseminated and discussed appropriately. Staff from all departments had a clear ambition for their services and were aware of the vision of their departments.

Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services. The hospital had a risk register which was reviewed at the governance committee meetings. However, the risk register was not divided into separate departments.

The management team had an understanding of the Workforce Race Equality Standard (WRES) as there is a national requirement to produce key data relating to race quality in the workplace. BMI had started to collect data nationally which they currently held, for example the numbers of staff from black and ethnic minority groups. The management team was in the process of implementing reporting processes to capture the data to enable them to fully comply with WRES reporting requirements.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Medical care

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

Information about the service

Medical care services provided by Mount Alvernia Hospital are medical inpatient care, end of life care, endoscopy and oncology day care.

In the period April 2015 to March 2016 inpatient attendances were 1,251. Inpatient accommodation is provided over three floors in individual rooms with their own bathrooms, three of which can convert to twin occupancy. There were 12 beds each in St Clare ward (mixed medical and surgical), St Elthelbert (surgical) and St Francis ward. St Clare ward was the main ward for inpatients. At the time of inspection St Francis was not in use.

The hospital's endoscopy unit and ambulatory care unit both had six beds. Endoscopy involves looking inside the body for medical reasons using an endoscope. An endoscope is an instrument used to examine the interior of a hollow organ or cavity of the body. From April 2015 to March 2016, the hospital performed 276 endoscopic procedures.

The oncology unit, based in St Martha's, covers diagnostics, intravenous and oral chemotherapy instillations. Oncology is a branch of medicine that deals with the prevention, diagnosis and treatment of cancer. Treatment can include the use of chemotherapy, which is the treatment of disease by the use of chemical substances, especially by cytotoxic and other drugs. The hospital administered 1,473 episodes of chemotherapy April 2015 to March 2016.

End of life care encompasses all care given to patients who are considered to be in the last 12 months of life, patients whose death is imminent and care after death. End of life care services are provided by ward staff and the director of

nursing is the end of life care lead for the hospital. Ward staff are supported by the palliative care team arranged through a service level agreement with the local acute trust which started in March 2016. The palliative care team consist of a clinical nurse specialist who visits the hospital two days a week and telephone support is available 9am to 5pm seven days a week. Palliative care consultants deliver consultant led care. The consultants provide medical advice and support when present at the hospital and by telephone via the on-call rota when not.

The majority of patients seen for palliative and end of life care are patients with a primary diagnosis of cancer. From April 2015 to June 2016, ten deaths had been reported at the hospital. Eight deaths were recognised as end of life care patients and were under the care of the palliative care team.

The hospital clinical team is made up of medical staff, nurses and a resident medical officer (RMO) who is on duty 24 hours a day. A senior nurse is available at all times to assist patients following discharge and arrange admissions for patients who require hospitalisation for unplanned medical and surgical treatments.

The oncology service is provided by specialist nurses, consultants, physiotherapists and therapists. Patients are supported from diagnosis, through surgery, chemotherapy and followed up for up to five to ten weeks post treatment. A 24 hour oncology triage/helpline is provided. Supportive therapies, spiritual support and supportive care for end of life are available.

The hospital does not provide care for those patients who require higher dependency (known as level 2) critical care.

Medical care

Patients assessed as higher risk of developing postoperative complications or who may require enhanced interventions and monitoring are referred to a suitable facility.

During our inspection we visited St Clare inpatient ward, St Martha (oncology unit), ambulatory care unit and endoscopy.

We spoke with 13 members of staff and observed the care provided by medical, nursing and support staff in the departments visited. We spoke with three patients and one of their relatives. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital.

Summary of findings

We found the medical services at BMI Mount Alvernia to be good. This was because:

- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were visibly clean, tidy and fit for purpose. The environment was light, airy and comfortable. The oncology unit was awarded the Macmillan Quality Environment Mark, which identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. It had been developed in partnership with patients living with cancer and the Department of Health. It is a core component of the English Cancer Reform Strategy.
- The hospital provided end of life care training and had an ongoing education programme which was attended by staff.
- The palliative care team worked with ward staff to provide holistic (the treating the whole of something and not just a part) care for patients with palliative and end of life care needs in line with national guidance. This meant a multidisciplinary approach was maintained.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.
- Medicines were stored in locked cupboards and administration was in line with relevant legislation.
- The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. The service was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is the quality improvement and assessment tool for the GI endoscopy service.
- Oncology services demonstrated compliance with National Institute for Health and Care Excellence (NICE) guidelines.

Medical care

- The medical services had an appropriate level of competent staff.
- Staff completed appraisals regularly and managers encouraged them to develop their skills further.
- Staff interacted with patients in a kind and caring manner. Patients told us they felt relaxed when having their treatment.
- The hospital and its staff recognised that provision of high quality, compassionate end of life care to its patients was the responsibility of all clinical staff that looked after patients at the end of life.
- Staff at the hospital provided focused care for dying and deceased patients and their relatives. The hospital had an end of life care link person. Facilities were provided for relatives and the patient's cultural, religious and spiritual needs were respected.
- Managers were visible, approachable and effective. This had resulted in a well-led service that had a clear vision and strategy to provide a streamlined service for medical and end of life care patients.
- The hospital had a clinical governance committee and medical advisory committee (MAC) both responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.

However:

- The safeguarding lead was not trained to level 3 for safeguarding children as per national guidelines.
- Not all staff had attended major incident or business continuity training, or attended any simulation exercises.
- The risk register was hospital wide and not divided into separate departments.

Are medical care services safe?

Good 

We rated medical services good. This was because:

- The hospital provided us with the incidents reported with evidence of learning achieved and the resulting changes in practice that took place. Staff gave us examples of how they reported incidents and the feedback they received. Staff informed us that they were encouraged to report incidents to enable learning as an organisation.
- Patients were cared for in a visibly clean environment that was well maintained. There were arrangements to prevent the spread of infection and compliance with these was monitored. There were no outbreaks of serious infection reported.
- There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use.
- Staff demonstrated good medicines storage, management and administration. There were systems that ensured patient's medicines were given safely, on-time and according to the consultant prescription. Medicines were stored securely as per national guidelines.
- We found that patient's records were complete and accurate and there were systems to identify patients whose condition may be deteriorating to allow early intervention.
- The hospital had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the provider's mandatory training programme. Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances.

However

- The safeguarding lead was not trained to level 3 for safeguarding children as per national guidelines.
- Not all staff had attended major incident or business continuity training, or attended any simulation exercises.

Medical care

Incidents

- No never events were reported in the period April 2015 to March 2016. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- The hospital reported they had no serious incidents reported in the period April 2015 to March 2016.
- There were seven deaths reported in the period April 2015 to March 2016 and one of these were reported as unexpected and was subject to a formal investigation. All deaths were reported to CQC and investigated fully by the provider. Since March 2016 three deaths had been reported to CQC.
- Eight of the 10 deaths were expected and were recognised as end of life care patients. They were under the care of the palliative care team.
- The hospital had an incident report writing policy and staff used a paper based incident reporting system. Staff had a good understanding of how to use the system. We asked staff to give us examples of incidents they had reported. Staff told us feedback from incidents was discussed at ward meetings. We saw minutes of meetings which confirmed this. Lessons learnt were printed monthly and displayed on the notice board in the office on St Clare ward. When all staff had signed to indicate they had read this, it was removed and filed, which we saw. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn.
- The hospital told us since December 2015 the leadership of the hospital had made a significant effort to promote a culture of reporting and learning. This was reflected in the increased reporting rates for clinical and non-clinical incidents.
- A total of 233 reported clinical incidents occurred in surgery, inpatients or other services at the hospital from April 2015 to March 2016. Of these incidents 94% occurred in surgery and inpatients.
- Assessed rates of clinical incidents (per 100 bed days) increased and were higher than other independent acute providers for the period April 2015 to March 2016. The rate of clinical incidents April to June 2015 was 6.2 and January to March 2016 10.9.
- Data provided by the hospital showed from December 2015 to June 2016 there were 249 incidents reported and 202 were clinical. Oncology accounted for 19 incidents and inpatient wards 113 incidents during this period. Clinical causes reported ranged from administration errors, natural circumstances, complications post-surgery, equipment malfunction, lack of clinical assessment and discharge planning failure. No harm severity of the incidents accounted for 57.6%, low severity 35.6% and 6.1% classed as moderate. Five incidents related to end of life care. Four were patient deaths and one related to the wrong syringe being used in a syringe driver. All incidents outlined any remedial or other action taken immediately following the incident.
- There were 61 non-clinical incidents reported in the period April 2015 to March 2016 and occurred in surgery, inpatients or other services. Of this total 46% occurred in surgery or inpatients.
- Assessed rates of non-clinical incidents (per 100 bed days) increased and were higher than other independent acute providers for the period April 2015 to March 2016. The rate of non-clinical incidents April to June 2015 was 1.72 and January to March 2016 3.42.
- Data provided by the hospital showed from December 2015 to June 2016 37 (14.9%) were non-clinical incidents. Causes of incidents included equipment (10), security (6), vehicle (2), personal accident (2), ill health (2), violence/abuse/harassment (3), water safety (1), fire (1) and other (3).
- We saw that all staff had signed to say they had read the duty of candour policy. Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This 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. Patients and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken.

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

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- The hospital used the NHS Safety Thermometer which is a national improvement tool for measuring, monitoring and analysing harm. It measures the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE).
- Day case patients' are excluded from the NHS Safety Thermometer. None of the patients undergoing an endoscopic procedure in the reporting period (April 2015 to March 2016) stayed overnight.
- We saw the records of the 100% inpatient VTE screening rates for April 2015 to March 2016. There were no incidents of hospital acquired VTE or pulmonary embolism in this period.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from WHO guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, supplied with soap and disposable hand towels. Sanitising hand gel was readily available. Information was displayed demonstrating 'five moments for hand hygiene' near hand washing sinks.
- We saw personal protective equipment was available for all staff and staff used it in an appropriate manner.
- The hospital had a policy for the management of a patient's body following their death with a suspected or confirmed infection. This had clear guidelines about the potential risk from body fluids and specific advice for caring for the deceased.

Cleanliness, infection control and hygiene

- The hospital had a quality and risk manager, health and safety advisor and infection control lead who worked closely with staff in order to maintain standards of service and agree actions for improvement when deficiencies were identified. The hospital had a full time infection prevention control (IPC) link nurse. The IPC lead worked three days a week in that role, the other two days as an oncology nurse.
- All the areas we visited looked visibly clean and were tidy. The most recent patient led assessment of the care environment (PLACE) score, completed in 2016, was 100% for cleanliness which was better than the national average of 98%.
- We observed staff following best practice in line with the Royal College of Nursing essential practice for infection prevention and control, guidance for nursing staff. We observed staff undertaking aseptic techniques such as inserting cannulas and administering chemotherapy.
- In line with Department of Health (DH) guidance 'Saving Lives' the hospital used a system of care bundles to guide and manage the use of indwelling devices such as intravenous cannula. The use of these bundles ensured that such devices were cared for using a best-practice approach and that the risk of serious infection was minimised. The records we saw showed that the relevant care bundles were used and completed at the specified times.
- The hospital audited hand hygiene of ten members of staff across the whole hospital on a monthly basis. This was an observational audit and was adapted from the WHO 'five moments for hand hygiene'. We saw the results of the audits which showed from February to April 2016, three members of staff were non-complaint. Two incidents related to not washing hands before patient contact and the third regarding a nurse wearing nail varnish. All three were successfully re audited and reflected on their practice.
- We saw the DH high impact intervention (care bundles) was completed monthly from February to May 2016. The Quality Improvement Tool (QIT) was audited for endoscopy environment and decontamination (September 2015), standard precautions (September 2015), hand hygiene environment (September 2015) and antimicrobial prescribing (February 2016).
- Some chemotherapy drugs are harmful to patients and staff. We saw the oncology unit had kits readily available to deal with chemotherapy spills. Staff had received training in how to use the kit and we saw records which indicated staff checked the kits weekly to ensure they were ready for use.
- We saw there were cleaning schedules in individual treatment rooms and toilets, which were fully completed. Housekeeping staff showed us their

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cleaning schedules which clearly set out the tasks to be performed and their frequency. They were required to sign when each task was completed and their supervisor checked their work.

- The endoscopy unit was cleaned daily in the evening, even when the unit was not open. Equipment in the treatment room had green 'I'm clean' labels indicating that equipment was clean and ready for use.
- Waste in the clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with the DH Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1)d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had been fully completed which ensured traceability of each container.
- There were no incidences of E-Coli, MRSA and MSSA bloodstream infections or cases of C.difficile related diarrhoea reported in the period April 2015 to March 2016 at the hospital.
- At the pre assessment stage, staff screened all patients for MRSA, a type of bacterial infection that is resistant to a number of widely used antibiotics. The test was repeated every three months. If a patient was positive, they received treatment for MRSA as per protocol and a procedure not performed until the patient was clear of infection. We reviewed five sets of patient records; all five indicated that screening was done at the pre assessment stage. The result of the screening test was available in all five records prior to the patient undergoing the procedure.
- The endoscopy suite had separate clean and dirty utility areas for the preparation and cleaning of equipment which minimised the risks of infection to patients. Staff transported dirty endoscopes from the treatment area to the dirty area in a covered, solid walled, leak proof container. This was in line with the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope reprocessing Units, QPSD-D-005-2.2.

- In the endoscopy department, we saw there were adequate systems to ensure that endoscopes were safely decontaminated. We saw documentary evidence showing that the use of scopes was tracked and the use of a specific endoscope was linked to each procedure. Staff we spoke with could explain the correct decontamination process. We saw the scopes were stored safely in a drying cabinet for up to three days, and there was a process for ensuring they were reprocessed at the appropriate time.
- We saw water sampling test results, which indicated staff tested the final rinse water from an automatic processor was tested for its microbiological quality at least weekly. This was in line with HTM 01-06: decontamination of flexible endoscopes.
- We observed chemotherapy was prepared in an aseptic pharmacy department to guard against the risk of infection being introduced when it was administered. We saw the chemotherapy prepared was compliant with relevant guidance.

Environment and equipment

- The oncology unit was awarded the Macmillan Quality Environment Mark (MQEM) in 2014 which is valid for three years. This stipulates units must be welcoming and accessible to all; they are respectful of people's privacy and dignity; they are supportive to user's comfort and well-being and listen to the voice of the user.
- The oncology unit had 16 accommodation rooms which were a mixture of individual curtained bays and single bedrooms. This allowed patients to receive their chemotherapy in single facilities or in a group setting depending on patient need and choice. The area had its own consulting rooms, counselling room, therapy rooms, and a separate waiting area. This met recommendations of Health Building Note 02-01: Cancer treatment facilities.
- The store room on the oncology unit was visibly clean and uncluttered. The health care assistant (HCA) was responsible for monitoring stock and ordering as required.
- The temperature of the clinical room was checked and recorded daily when the unit was open in the oncology unit.

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- We saw equipment service records which indicated 100% of equipment had been serviced in the previous 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw portable appliance testing (PAT) stickers on electrical equipment, which indicated electrical equipment was safe to use.
- The PLACE scores were 93%, which was the same or higher than the England average for condition, appearance and maintenance of the hospital.
- Staff reported no problems with equipment and felt they had enough equipment to run the service.
- We were told there were no issues around securing the necessary equipment for end of life care patients, for example pressure relieving mattresses. End of life care patients requiring an air mattress received this promptly to prevent the development of pressure ulcers.
- Syringe drivers were available across the hospital. The syringe driver is a portable battery operated device to help reduce symptoms by delivering a steady flow of injected medication continuously under the skin. It is useful way of delivering medication for an end of life care patient when they are unable to take medication orally. The hospital used an appropriate syringe driver which fulfilled the safety guidance by the National Patient Safety Agency Rapid Response Report (2010).
- Emergency equipment was located on all wards and in the endoscopy unit. The resus trolleys were secure and we saw the records of checks. All equipment needed was available, as indicated by an equipment list. All consumables were in date. The trolley was checked on the wards daily. The trolleys on the oncology unit and endoscopy units were checked on the days the units were open. The records stated clearly 'not in use' on the days the unit was not open.
- All appropriate rooms and cupboards had numerical key pads and self-closing doors. The numbers were changed every four months as per BMI Healthcare policy.
- The hospital had a six bay ambulatory care unit.
- Inpatient accommodation was provided over three floors in individual rooms with their own bathrooms. Three of these could be converted to twin occupancy. There were 12 beds each of the wards.
- The endoscopy unit had six individual bays. Each bay was curtained, contained a bed and locker. A lockable cupboard was available behind the nurse's station for valuables. Each bay had its own observation monitoring equipment and call bell.
- Endoscopy unit patients had access to separate male and female toilets and a disabled toilet.
- Endoscopy patients had separate changing rooms and areas to store their belongings before and during their procedure. The recovery room did not have the facilities to separate male and female patients. Staff told us they try to arrange appointments so genders were not mixed.
- The endoscopy lead told us the number and size of endoscopes met the needs of the service. We saw a variety of scopes available to perform a variety of examinations.
- The room temperature and the temperature of the fridge in the endoscopy treatment room was monitored daily, when the department was open, to be within range and this was recorded.
- In the endoscopy unit we saw that equipment was maintained by an external contractor and we saw the equipment was labelled to show it had been maintained at the required frequencies.

Medicines

- The hospital had a pharmacy which provided both inpatient and outpatient services. All wards and clinical departments had a medicine stock top up service which was run weekly by the pharmacist technicians.
- The pharmacy department visited the ward areas daily from Monday to Friday and Saturday mornings. They checked all drug charts to ensure safe and effective use of medicines. They organised the medicines given to patients on discharge from a hospital stay (TTO's). We were told medication for end of life care patients was easily accessible. A pharmacist was on call out of hours to assist staff when required.
- Medicines were kept in locked cupboards. Access was via digital locks and we were advised that the number was changed every four months to minimise the risk of unauthorised access. Only staff who were authorised access were given the codes.

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- There were dedicated fridges for storing medicines, where required. We saw the fridge and room temperatures were monitored and recorded to ensure medicines were kept in optimal conditions.
- The hospital had a named controlled drugs (CD's) accountable officer. We found CD's were kept securely and stored in suitable cupboards with records maintained. The CD cupboards were locked, with restricted access and were bolted to the wall. We saw that controlled drugs were checked by two members of staff each night.
- The clinical room in the oncology unit contained first line antibiotics and pre-treatment medications in a locked cupboard. The clinical room had a digital lock and slow release door. We saw the door was propped open when a member of staff was in the room. The member of staff removed the prop and the door closed when they left.
- Staff gave chemotherapy drugs directly into a patient's vein. A complication of this is a leakage of the drug from the vein in to the surrounding tissue and is called extravasation. An emergency tray was kept in the clinical room in the event a patient had an anaphylactic reaction or a patient suffered extravasation. This tray was locked away when the clinic was not open. Staff checked the emergency tray regularly and we saw records of these checks.
- Dose banding for chemotherapy was routine and was an example of good cost-effective practice. Dose banding is a national system introduced by NHS England to reduce variation and wastage in chemotherapy. Patients received optimised doses of drugs, rather than ones which are individually calculated.
- When chemotherapy was prepared we saw there was a checking system that ensured the accuracy of the prescription and dispensing of the treatment. There was a system in place which meant only one prescription was prepared at a time to minimise the risk of error.
- Chemotherapy drugs were delivered to the oncology unit in a sealed bag. The drugs were checked by the nurses before being transferred to colour coded trays prior to administration, reflecting current best practice. These medicines were not stored away as they were used almost immediately upon delivery.
- All registered nurses and medical staff were in the process of receiving training about the safe use of medication for an end of life care patient and prescribing anticipatory medication. The prescribing of anticipatory medication is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms.
- Medication guidance had been agreed and implemented as per adult Palliative Care Guidance, 2006 to support the management of dying patients. The guidance was comprehensive and guided staff on the prescribing of medication covering the five recommended areas including pain, agitation, respiratory secretions, nausea and vomiting. Palliative consultants prescribed the medication which ensured patient safety was paramount and that specialised skills supported the prescribing process.
- We observed nurses administering medication in all areas and found they met the Nursing and Midwifery Council (NMC) standards for medicines management. We saw two registered nurses checking chemotherapy prior to administration.
- We saw in all departments across the hospital checks occurred to ensure staff had the right drug, right route of administration and the drugs expiry date. Staff recorded the batch numbers of the drug in the patient record and we saw patient identification checks occurred.
- We looked at five medicine administration records and noted that no prescribed doses of medicines had been missed or omitted. This meant patients received their medicines when they were prescribed.
- We saw the record of one end of life care patient during our inspection. The patient had recently been recognised as end of life care and did not require a syringe driver or anticipatory medication at that point.
- Data provided by the hospital showed from December 2015 to June 2016 there were 249 incidents reported and 202 were clinical. Of these 21 related to medication. Eight regarding the administering of medication, seven documenting medication and six the dispensing or prescribing of medication. All incidents outlined any remedial or other action taken immediately following the incident. Although the number of medical incidents was less than other clinical incidents they were discussed at clinical governance meetings.

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Records

- The hospital used a variety of information technology systems that held patient data. All staff, clinical and non-clinical were required to be compliant with information security and data protection with all services around patients. We saw staff completed mandatory e-learning modules for information governance. Some staff were provided with an NHS email address for confidential transfer of patient data relating to all NHS contracts.
- We saw five records of patients across the hospital. All were completed with appropriate assessments, signatures, allergies noted and all observations were documented and dated. The notes we saw had evidence of pharmacy checking.
- We saw patient records were stored in locked cabinets in locked rooms in the oncology unit.
- Oncology patients carried record books which indicated the chemotherapy type and frequency. It also included their most recent blood test results.
- All patient records contained a laminated sheet explaining the sepsis six (three diagnostic and three therapeutic steps) action to be delivered within one hour of the initial diagnosis of sepsis.
- Patients receiving care from the palliative care team had their documentation updated when reviewed. This gave information around changes in patient care needs and medicines management. Staff on the wards then implemented the changes required, such as applying a syringe driver or changing medication. We observed that the palliative care team provided a holistic assessment on their first visit to a patient and subsequent visits were documented in the patient's medical notes.
- The hospital had a personalised end of life care plan for patients who were recognised to have a life limiting condition and were expected to die within seven days. The care was to be used in conjunction with other risk assessments. For example, pain management and pain scale, 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form and National Early Warning System (NEWS) chart.
- We saw one record of a patient who was recognised as requiring end of life care. The patient was not on the specific end of life care plan as this was not appropriate. The notes were completed with appropriate assessments, signatures, allergies noted and all observations were documented and dated. The notes we saw had evidence of pharmacy checking the appropriate prescribing and administration of medication.
- We saw the log book for recording of the deceased which was kept in the office on St Clare ward. This was completed by ward staff and the funeral directors. This enabled a record to be kept of identification of the deceased, when they had been moved and the belongings that had been taken with them.
- The hospital audited the medical records in April 2016 to monitor clinical documentation and their compliance with policies and national guidelines. Ten sets of records were audited in each month from January 2016 to March 2016 which resulted in a quarterly analysis of results. The quarterly results indicated there was a completion of required elements between 88-92% of the records audited. The findings of the audit were presented to the clinical governance committee and medical advisory committee. The results were disseminated in team meetings by the heads of department.
- The medical records audit showed there was evidence of good practice and highlighted areas for improvement. These included no documented evidence of a 48 hour follow up phone call following discharge in 13 cases, poor compliance with entry of consultant daily progress notes in 11 cases, no evidence of consultant discharge summary in eight cases and no copy of consultant clinic notes within the main record in eight cases. The audit showed recommendations with an action plan which were to be completed in a timely manner. At the time of inspection there were no patients in the endoscopy unit. We were unable to see any patient records. However we saw the systems in place to ensure the records were monitored and stored safely. Records were kept in a locked trolley on the ward. Once the patient was discharged, the record was transferred to the medical records department. Authorised personnel only could access this department.
- Staff on the endoscopy unit kept full scope-tracking and traceability records. These indicated each stage of the decontamination process. We saw the audit scope log

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book was completed and up to date. The service audited these records and we saw results of these audits, which indicated all stages of the process were completed. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).

Safeguarding

- There had been no safeguarding concerns reported to CQC from April 2015 to March 2016.
- BMI Healthcare had policies for safeguarding adults and children and these were accessible to staff. Safeguarding training was mandatory for all staff and achieved via e-learning. Training for both adults and children was at induction and then at two yearly intervals.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was.
- The training target for safeguarding was 90%. The hospital told us 95% were trained to level 1 and 93% to level 2 for safeguarding vulnerable adults. Safeguarding children level 1 was 95%, and 93% level 2.
- One member of staff was trained to level 3 safeguarding vulnerable adults who was the director of nursing and the safeguarding lead. Nobody at the hospital was trained to level 3 safeguarding children.
- However, there was a service level agreement in place with a neighbouring BMI Hospital facility. A lead registered children's nurse, who held safeguarding for children level 3, was available to Mount Alvernia Hospital for advice, action and support.
- The responsibility of a safeguarding lead is to ensure providers have the right systems and process in place to make sure children and adults are protected from risk or actual abuse and neglect. National statutory guidelines 'Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children' (2015) states safeguarding leads are to be trained to level 3 for vulnerable children as the lead takes the responsibility for the organisations safeguarding arrangements. However, the hospital's safeguarding lead was trained to level 3 for vulnerable adults only. This is considered a risk as children could

accompany an adult who were visiting the clinic. Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the services, including visitors.

Mandatory training

- We saw the training records for staff (excluding medical staff) for mandatory training.
- The target for mandatory training set by BMI Healthcare was 90%. Mount Alvernia hospital had a total of 93.1% in all departments of the hospital. Nursing staff 94.4%, pharmacy 100%, ward staff 90.3%, oncology 82.9% and endoscopy 100%.
- We saw there was an electronic monitoring system which flagged when staff's mandatory training was due to expire. Managers described how they used the system to ensure staff remained up to date.
- The mandatory training programme was tailored to each staff job role. Most training was electronic based and included a knowledge check and required updating annually. Staff told us they had no problems completing on-line training. The training programme was comprehensive and contained all the training subjects that would be expected. For example, safeguarding adults and children, dementia awareness, informed consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Assessing and responding to patient risk

- We looked at the records of medical inpatients and saw a range of risk assessments were used which used nationally recognised and validated tools. These included assessments for risk of pressure damage (Waterlow) and malnutrition (MUST, the Malnutrition Universal Screening Tool). We saw these assessments were reviewed as required by the hospitals care bundles. Other risk assessments included those concerned with falls, manual handling and the use of bed rails.
- We saw the risks of VTE were assessed for each patient and appropriate prophylactic measures were in place as a result of this, for example the use of anti-coagulant

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medication when required. There had been no reported incidents of VTE from April 2015 to March 2016. This showed there were effective processes for managing the risk of VTE to patients.

- Guidance from NICE CG50 Acutely Ill Patients in Hospital, recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. The hospital used the National Early Warning System (NEWS) and we saw in the records this was routinely used for inpatients where appropriate.
- The hospital audited the use of NEWS in February 2016. The purpose of the audit was to identify whether the NEWS observations were completed accurately, and where concerns were identified, escalated to a more senior member of the nursing or medical team. The results of the audit were compared with the audit results from August 2015. The findings indicated an overall improvement. The audit made further recommendations to continue with areas of improvement. The action plan had intended outcomes, named responsibility and due dates.
- NEWS scoring was not used in the endoscopy unit as the patient was not in unit long enough for this to be of effective use. The endoscopy care plan contained a separate warning/assessment system. If it was clinically appropriate a separate risk assessment sheet could be used with the care plan.
- We saw there was adequate resuscitation equipment and it was easily accessible. Staff knew where they were located.
- Medical cover was provided by the RMO 24 hours a day seven days a week. The RMO was selected on their experience to enable them to manage and respond to risks relating to the wide mix of patients at the hospital.
- A senior nurse was available 24 hours a day seven days a week as a contact point for both staff and patients. This included helping to resolve patient queries and to accept out of hours admissions.
- In addition to clinical and consultant arrangements, the senior management team operated a rota for on call support out of hours. There was an on call rota operated by the pharmacy, radiology and physiotherapy teams should support be required. There was also an on call emergency theatre team.

- For end of life care patients, where the progression of their illness was evident the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible at all times.
- The personalised end of life care plan used the Modified Richmond Agitation – Sedation Scale (m-RASS). This scoring system is a tool for measuring consciousness and delirium. This would assist staff to administer the appropriate medication and support.
- The patients in the oncology unit were provided with a telephone number enabling them to have access to support and advice 24 hours a day. The phone was held by a nominated qualified member of staff.
- Within 24 to 48 hours of a patient discharge the ward clerk would contact the patient by telephone to check if all was ok. The hospital had introduced a pre-printed telephone query sheet which provided staff with prompts and actions to be taken. This telephone record was kept in the patients records. This meant there was system to ensure that appropriate actions were taken when concerns were identified.

Nursing staffing

- The hospital used an electronic system for calculating and recording nursing staff requirements and actual hours used. The system was used to plan the skill mix 24 to 48 hours in advance. A spread sheet was completed and reviewed on a daily basis. The actual hours worked by members of staff were also entered to enable the hospital to understand variances from the planned hours and the reasons for these. We looked at the reports on the oncology unit.
- The nursing manager for inpatient wards explained to us how they organised the off duty to ensure sufficient staff were on duty and also accommodated individual staff members preferences. Staff were allowed to allocate six days or shifts as a 'wish list'. The majority of time this was granted by the management and this gave them some flexibility in allocation of the remaining shifts. Staff were given the choice if they preferred to work long or short days and these were accommodated if work load permitted.

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- Nursing staff we spoke with told us they considered there was sufficient nursing staff to meet the needs of patients. Patients echoed this view and told us any requests for help or care were responded to promptly.
- Clinical staff were supported by unqualified staff members including health care assistants, porters and reception staff.
- As at 1 April 2016, 19.4 whole time equivalent (WTE) nursing and midwifery registered staff employed and 11.1 WTE health care assistants for inpatients. The inpatient departments had a ratio of nurse to health care assistant of 1:0.57.
- Staff turnover for inpatient departments was 9.1% nurses from April 2015 to March 2016. This was not high when compared to other independent acute hospitals.
- The hospital told us there was no staff turnover for inpatient health care assistants in the last year.
- The use of bank and agency for staff for nursing and healthcare assistants in inpatients departments was lower than the yearly average of other independent acute hospitals. The bank to agency ratio for inpatient nurses at the hospital April to June 2016 was 1:3. Information was not provided by the hospital regarding bank to agency ratio for inpatient health care assistants.
- A full time nurse manager was responsible for all inpatient wards.
- St Clare ward was the main ward for inpatients. All staff reported to this ward at the start of their shift and were allocated to their identified ward. This meant that each ward had sufficient numbers of qualified staff in each area to provide relevant patient care.
- St Clare ward reported they had limited sickness and six vacancies at the time of inspection. The vacancies were due to retirements and migration of staff to other departments in the hospital.
- The oncology unit employed a manager, one senior sister, two oncology nurses, two staff nurses (due to start their oncology training in September 2016), one HCA and a receptionist. The unit had one vacancy for a HCA.
- The oncology unit had two agency nurses who worked regularly for the ward. This provided continuity of care for patients and ensured these staff could work safely as they were familiar with the systems and processes of the unit.
- We saw the staff rotas for the oncology unit which indicated two members of staff were in the department each day the unit was open. If a member of staff was off sick, their shift would be covered by another member of staff working overtime. This was in line with safe staffing for nursing in adult inpatient wards in acute hospitals, NICE guideline SG1.
- A palliative clinical nurse specialist visited the hospital two days a week. Telephone support was provided 9am to 5pm seven days a week. This meant specialist knowledge was available at all times for patients receiving end of life care.
- The handover of shifts on inpatient wards took place at 7am, 1pm and 8.30pm. This involved the team who were finishing their shift handing over verbally to staff in the patient's room. This ensured an effective, accurate and patient centred approach to care and gave the opportunity for patients to meet staff who would be looking after them on the next shift.

Medical staffing

- Consultants were supported by an on-site resident medical officer (RMO) who provided a 24 hour medical presence.
- The RMO was on duty 24 hours a day and was based on site a week at a time. The RMO was provided to the hospital by an agency which was the preferred provider to BMI Healthcare. The hospital received assurances that all appropriate training had been undertaken. All RMOs who worked at the hospital were registered with the General Medical Council (GMC) and held a current ALS (advance life support) certificate and EPALS (European paediatric advance life support) certificate.
- Three palliative care consultants delivered consultant led care. The consultants provided medical advice and support when present at the hospital and by telephone via the on-call rota when not. This meant specialist knowledge was available at all times for patients receiving end of life care.

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- The hospital told us they had 195 consultants working with agreed practice privileges. This related to consultants in post at 1 April 2016 with more than 12 months service.
- The hospital showed us their Practising Privileges Policy for Consultant Medical and Dental Practitioners, 2015, a corporate policy by BMI Healthcare. The hospital confirmed that all medical staff had been fully trained to perform procedures which they regularly performed within their NHS practice.
- The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. There should be evidence that the provider has complied with legal duty to ensure that the regulation¹⁹ in respect of staffing and fit and proper persons employed are complied with. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw that these agreements were in place for all medical staff with practising privileges.
- It was the responsibility of the consultant to be contactable at all times when they had patients in the hospital. They were required to be available to attend within an appropriate timescale according to the risk of medical emergency of the patients' diagnoses or procedures they had undergone. At times of annual leave cover was provided by a designated consultant colleague. Staff told us that out of hours contact with consultants was not a problem and they were amenable to being called.

Other Staffing

- Apart from medical and nursing staff, other staff who worked in the hospital staff was equivalent 92.5 WTE staff.
- From April 2015 to March 2016, there was 1.8% staff turnover for other staff in the hospital. This was not high when compared to other independent acute hospitals.

- The endoscopy unit was staffed by a lead endoscopy practitioner, two full time HCA's and a bank endoscopy practitioner. Two registered nurses from the recovery unit admitted and discharged all patients within the unit.
- The lead endoscopy practitioner told us they could flex staff and the endoscopy list to ensure the appropriate number of suitably trained staff was available for each procedure.
- The pharmacy department employed seven contracted staff. This was made up of two pharmacists, four technicians and a manager. One bank staff was employed to support continuity of service during holiday and busy periods.

Major incident awareness and training

- We asked the hospital for a copy of their local emergency preparedness resilience policy (EPRP). We were told this was not available as the hospital was not part of the resilience forum.
- Not all staff had attended major incident or business continuity training, or attended any simulation exercises. However, in our discussions with them staff could articulate what they would do in the event of an event that adversely affected business continuity.
- The hospital had a response team who would respond to an emergency situation. The team all held bleeps and would respond immediately when required. The daily ward meeting in the morning on St Clare ward allocated the response bleeps and a fire marshal was designated.

Are medical care services effective?

Good 

We rated medical services to be good for effective. This was because:

- We found care and treatment reflected current national guidance. There were formal systems in place for collecting comparative data regarding patient outcomes.

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- Staff worked with other health professionals in and out of the hospital to provide services for patients. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.
- Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. The hospital used a personalised end of life care plan to guide staff and put people and their families at the centre of decisions about their treatment and care. Guidelines included prescribing anticipatory pain relief alongside guidance for other common symptoms.
- Patients received adequate pain relief. Their nutritional status was assessed and patients received food and drink which met their needs in sufficient quantities.
- There were arrangements that enabled patients to access advice and support seven days a week, 24 hours per day.
- Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.
- At the time of inspection there were no inpatients with a 'do not attempt cardio-pulmonary resuscitation' (DNACPR). However medical and clinical staff we spoke with understood the decision making process and described decisions with patients and families.
- The hospital did not have Joint Advisory Group (JAG) accreditation for the endoscopy unit at the time of inspection. The service had registered with JAG who had yet not formally reviewed the hospital and the hospital did not have a date for this.

Evidence-based care and treatment

- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example National Institute for Health and Care Excellence (NICE) guidance CG161: falls in older people assessing risk and prevention, QS24: nutrition support in adults, QS3: VTE in adults reducing the risk in hospital, QS66: intravenous (IV) in adults in

hospital therapy and QS90: urinary tract infections (UTI) in adults. NICE guidance was reviewed at clinical governance meetings and if relevant discussed with clinicians to ensure best practice.

- There were policies in place describing the management of neutropenic sepsis which were compliant with NICE guideline CG151 (neutropenic sepsis: prevention and management in people with cancer). Staff we spoke with were aware of the need to get patients to a facility that would enable the commencement of antibiotics within the hour.
- We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework, either locally or at corporate level. The palliative care team consisted of palliative care consultants and a palliative nurse that demonstrated a high level of specialist knowledge. They provided the wards with up-to-date holistic symptom control advice for patients in the last year of life.
- The hospital was working towards achieving the Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020 and NICE End of Life Care Quality Standard for Adults (QS13). The hospital had an action plan to support palliative and end of life care, May 2016. The plan had support for and evidence of actions and was updated when completed. Actions included the nomination of a palliative care link nurse, all nursing staff to attend and complete end of life care training and set up an end of life care steering group. At the time of inspection a link nurse had been nominated and the other actions were on going.
- The hospital had responded to the withdrawal of the Liverpool Care Pathway (LCP) and the publication of 'One Chance to Get it Right'. The hospital had a personalised end of life care plan for patients who were recognised to have a life limiting condition and were expected to die within seven days. At the time of inspection, no patients were on this care plan.
- Patient records we reviewed showed the care patients received was consistent with NICE guidelines and protocols in use at the hospital.
- We saw an alert system could be quickly cascaded through the hospital to ensure they were working within

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the national framework for the Medicines and Healthcare Products regulatory Agency (MHRA). This is responsible for ensuring that medicines and medical devices work and are acceptably safe.

- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation at the time of inspection. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. JAG had yet not formally reviewed the hospital and the hospital did not have a date for this.
- The hospital had a robust audit programme throughout all clinical departments. Audits were completed and reported to the departments and through to the clinical governance committee and clinical effectiveness meetings. Trends were identified and action plans created to improve the service to patients which was communicated back to the clinical departments for their action.
- The hospital partook in national audits: safety thermometer, VTE, NCEPOD (The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice and identifies potentially remedial factors).

Pain relief

- We saw effective pain control was an integral part of the delivery of care. Pain scores were documented on the NEWS charts in patient's records and managed accordingly. Patients had regular assessments for pain and appropriate medication was given frequently and as required.
- Patients we spoke with told us they received adequate pain relief.
- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance on opioids (a strong pain killer) for palliative care.
- The pharmacy team supported pain management at ward level providing advice and support to patients and clinical teams. All medications given to patients on discharge were communicated to the patients GP in the discharge letter.

- The hospital said they gained feedback on pain management from all patients and took steps to respond positively to feedback.
- The palliative care team managed pain control for patients on the oncology ward. Ad hoc issues were managed by the patient's consultant or RMO who were called to reassess patients and amend medication prescriptions.

Nutrition and hydration

- We saw risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool MUST (Malnutrition Universal Screening Tool) which identified patients who were at risk of poor nutrition or dehydration. It included actions to be taken following the nutrition assessment scoring and weight recording. If a patient scored two due to a low BMI, 10% weight loss in six months or had little or no food in the previous five days or more, they were referred to the dietician.
- We were told that discussions around the nutritional support that end of life care patients needed included discussions with the patient and the family. Their views and preferences around nutrition and hydration at the end of life were explored and addressed along with the risks and benefits. We were told separate menus were available which included soft and pureed food and food to meet cultural requirements.
- Staff told us mouth care management was carried out on all end of life care patients. The personalised end of life care plan had prompts for this. Mouth care packs were available on the wards.
- End of life care patients were supported to eat by nursing staff, if required. Relatives were also encouraged to support family members at meal times.
- The dietetic service was provided on a sessional basis by the local acute NHS hospital. The dieticians formed part of the multidisciplinary team. They reviewed patients and appropriate advice was given and actioned.
- We saw food and fluid intake was monitored using food charts and fluid balance charts. We were told patients

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who were unable to feed themselves were assisted by the nurses and health care assistants. At the time of inspection all inpatients were independent and did not require assistance with feeding.

Patient outcomes

- The hospital told us they audited patient outcomes by participating in national and local audit programmes. Locally, a quality dashboard was produced in addition to making local data available to the hospital on a monthly basis. This demonstrated various indicators including transfers out, returns to theatre, surgical site infection rates, average length of patient stay, day case conversion rates and readmission rates.
- Any downwards trends or unexpected deviations would be reviewed by the governance committee and medical advisory committee (MAC). Further advice could be sought from BMI Healthcare's group medical director and national director of clinical services.
- The hospital reviewed morbidity and mortality rates, patient satisfaction feedback, incidents and complaints, activity data and staff surveys.
- The palliative clinical nurse specialist and consultant told us that the majority of patients they see for palliative and end of life care were patients with a primary diagnosis of cancer.
- We did not see any evidence that end of life care data was collected and used to develop the service. We were told end of life data on referral patterns, patient demographics and patient activity was not collected and not sent to the National Council of Palliative Care Minimum Data Set.
- Results on patient outcomes were compared with other locations within the region and across BMI Healthcare through the corporate clinical dashboard. This used data from the incident and risk reporting database. This allowed the hospital to review both their own data and compare this with hospitals of a similar size within BMI Healthcare to enable them to plan patient care.

Competent staff

- The hospital had over 300 contracted and bank staff including nurses, physiotherapists and dieticians, all of whom had the relevant qualifications and memberships

appropriate to their position. There were systems which alerted managers when staff professional registrations were due and to ensure they were renewed. These were demonstrated to us.

- The Medical Advisory Committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies. The surgeons received supervision and appraisals. Senior managers ensured the relevant checks against professional registers and information from the Disclosure and Barring Service (DBS) were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the MAC notes.
- The hospital had an appraisal policy to ensure that all staff understood their objectives and how they fit with the departmental and hospital objectives and vision. In 2015, 90% of registered staff and 86% of HCA's had completed an appraisal. In 2016, at the time of inspection, 89% of registered nurses and 92% of HCA's had completed an appraisal. All the staff we spoke with had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with the NMC.
- The hospital encouraged staff to experience other areas of the hospital when patient occupancy allowed. This enabled staff to experience other areas of expertise, for example oncology.
- Staff had customer care modules specific to staff groups for example nursing, administration and physiotherapy. Training was provided on respecting equality and diversity.
- Agency staff had access to up to date printed policies and guidelines in the ward areas. Agency staff who worked on the oncology unit completed a comprehensive induction and competency assessment and we saw checklists that demonstrated this had occurred. The manager told us competencies were checked to ensure they had completed specialised training in chemotherapy.

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- Staff underwent an annual competency assessment in relation to chemotherapy and we saw from staff files and training records these were completed and in date. This meant staff had the specialist skill they required to effectively treat and care for patients.
 - We saw competency certificates in endoscopy which indicated staff were competent in a variety of procedures and in the decontamination of equipment.
 - End of life care training was not mandatory across BMI Mount Alvernia. However, the palliative clinical nurse specialist had provided training on palliative and end of life care training for nursing staff. This enabled staff to feel confident to care for dying patients. We saw the records that 19 staff had attended. The majority of staff had completed an e-learning module and gained a certificate. The hospital told us they planned to provide end of life care training for all staff including non-clinical.
 - The hospital had an allocated end of life care link nurse who had attended specific training at the local acute trust. The link nurse had an increased awareness of palliative and end of life care issues. They disseminated their knowledge to all nursing teams across the hospital.
 - The wards had a resource folder with end of life care information as a reference for staff. This contained the out of hours contact details, care plan, training and learning opportunities and syringe driver information. It also contained information leaflets on pastoral care, travel insurance and organ donation.
 - The hospital was working with the palliative care team to provide training for the use of syringe drivers. The manufacturer had been contacted to provide training on the actual device. The palliative care team was organising a training session for staff for the appropriate use of syringe drivers. This included the indications for use, reasonable starting dose for medication, basic conversion from oral to injectable medication and emphasis on the hospital to always contact the palliative care team for help and advice. We saw this training had been booked for the end of July 2016.
- and dietician. This was arranged via a service level agreement with the local NHS trust. The staff were skilled and experienced in assessing and treating patients using medical care services at the hospital. This arrangement ensured there were good links between the services and specialist input and continuity of care.
- Staff could refer patients to allied health professionals and counselling services if they were required.
 - Inpatient wards had a multi-disciplinary communication sheet. This was completed on a daily basis for information to be passed to members of staff on subsequent shifts. For example a reminder of meetings or specific information relating to a patient. Staff had to sign the forms to show they had read the information and action had been taken.
 - The hospital had a service level agreement with the local acute trust for palliative care services. The palliative team worked closely with the oncology unit and inpatient wards to provide effective joint working for palliative and end of life care patients.
 - We were told the medical staff liaised with colleagues in the NHS if the findings following procedures indicated further medical support might be required.
 - The hospital had a service level agreement with the local acute trust for palliative care services. The palliative team worked closely with the oncology unit and inpatient wards to provide effective joint working for palliative and end of life care patients.
 - The staff on St Clare ward told us the palliative clinical nurse specialist was very good and supportive.
 - We attended a multidisciplinary meeting for the discharge planning of a patient who had been assessed as end of life care. This was attended by the director of nursing, ward sister, physiotherapy, occupational therapy and palliative care clinical nurse specialist. The patient was aware of the meeting but declined to attend. An action plan was agreed to enable the patient to return home in the following five days if appropriate.

Multidisciplinary working (in relation to this core service)

- Patients could be referred to a full range of allied health professionals including speech and language therapist

Seven-day services

- The hospital had medical cover from a resident medical officer (RMO) and a senior nurse 24 hours a day seven days a week as a contact point for both staff and patients.

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- Patients had access to telephone advice 24 hours a day, seven days a week.
- The pharmacy was accessible 24 hours a day, seven days a week. Out of normal working hours a senior nurse and RMO had access to the department. The pharmacy provided an on call 24 hour service for advice and medical information. The on call pharmacist would attend the hospital if required in an emergency.
- A palliative clinical nurse specialist visited the hospital two days a week. Telephone support was provided 9am to 5pm seven days a week.
- An on call system managed by the palliative care consultants ensured that access to advice at all times was available for patients who were end of life care.
- The chapel was open 24 hours a day for those of any faith who wished to pray or spend time in quiet reflection. The pastoral care worker could be contacted by the ward staff or main reception when required.
- The hospital had a Safeguarding Adults Policy which incorporated the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the Mental Capacity Act (MCA) 2005 legislation and set out procedures that staff should follow if a person lacked capacity. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. MCA and DoLS training was part of the safeguarding mandatory training.
- Patients signed consent for chemotherapy agreements and we saw these in patients' records. We saw they outlined the expected benefits and risks of treatment so patients could make an informed decision.
- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests.

Access to information

- Endoscopy patients received a letter on discharge. This included the reason for the procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. A copy of this letter was sent to the patients GP and a copy was kept at the hospital in the patients' medical records. This meant there was a continuity of service and all medical teams were kept informed.
- Patients receiving chemotherapy treatment carried their own record which enabled other clinicians to see the treatment they had received. Details of recent blood tests were also kept in this record.
- The hospital used electronic prescribing for chemotherapy. This meant the ward and pharmacy had access to the patients information without removing the prescription charts from the wards.
- We saw the two BMI Healthcare policies: the management of the deceased and end of life care and palliative policy and these were in the process of being ratified centrally.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The most recent PLACE score for dementia care in the hospital completed in 2016, was 85%. This was the same or higher than the England average.
- Medical and clinical staff we spoke with understood the 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decision making process and described decisions with patients and families. They told us they provided clear explanations to ensure that the decision making was understood. At the time of inspection there were no patients who had a DNACPR in place.

Are medical care services caring?

Good 

We rated caring for medical services as good. This was because:

- Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.
- Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect.

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- Patients felt well informed and involved in their procedures and care, including their care after discharge.
- Patients and their relatives were involved in their care and were given adequate information about their diagnosis and treatment. Families were encouraged to participate in the personal care of their relatives with support from staff.
- Emotional support was provided by staff in all areas. Staff knew who to signpost relatives to for bereavement support.
- Patient's surveys and assessments reflected the friendly, kind and caring patient centred ethos. Our observations of care confirmed this.

Compassionate care

- The PLACE scores for privacy, dignity and wellbeing were 84% which were below the England average. However, we saw staff treating patients in a kind and considerate manner. We saw staff knock and wait before entering patient's rooms in all areas of the hospital. Patients and their relatives told us staff always treated them with dignity and respect.
- All patients were asked to complete a patient satisfaction questionnaire that incorporated questions of all aspects of their care and experience. The hospital measured national survey information, for example the Friends and Family test (FFT), and used all patient feedback to guide investment plans, treatments offered and the overall patient experience.
- The hospital had a patient satisfaction group that met monthly to review trends and particular comments. Lessons could be learnt and improvements made to ensure compassionate care was provided across the hospital.
- The FFT scores for NHS patients from October 2015 to March 2016 was 100%, except in December 2015, when it was 90%. There was a high response rate in the same reporting period with the exception of October 2015 when the response rate for NHS patients was lower than the England average.
- The hospital provided reports with their FFT results for all patients, NHS and private funded for January to

March 2016. In January 2016 there were 305 responses: 98.02% were satisfied and 1.8% dissatisfied; February 2016 98% satisfied and 2% dissatisfied; and March 2016 98.6% satisfied and 1.4% dissatisfied.

- We saw approximately 80 thank you cards displayed on St Clare ward. Comments included: "You are the A team", "You were all working so hard to make my stay comfortable", "I appreciated your kindness, support and company" and "You made me feel very relaxed".
- St Martha ward, the oncology unit, had thank you cards displayed and a book in the private room which contained a further collection of cards. Comments included: "Thank you for all your care, support and hugs and laughter over the last six months", "You made an unpleasant experience bearable", "Thank you for your care, support and friendships throughout dad's treatment. It was such a difficult time for him" and "It was helpful just knowing you were a phone call away".
- We observed staff introducing themselves to patients and their relatives.
- Staff we spoke with demonstrated a strong commitment to empathy and enhancing the environment for dying patients.
- On St Clare ward we saw the quick response by staff to a patient's emergency bell which had been activated.

Understanding and involvement of patients and those close to

- Staff discussed side effects of treatment with patients in a kind and considerate manner.
- Oncology patients could ring a dedicated number if they felt unwell at home. They carried a record book with details of what to do if they experienced feeling unwell. This was in line with the Manual for Cancer Services: Department of Health; 2004.
- Patients received full explanations and details about the procedures they were to have. We saw leaflets with this information on.
- We spoke with three patients and one of their relatives in the hospital. One patient had recently been diagnosed as end of life care. They told us staff were caring and professional. They felt involved in their care

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and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.

- Relatives were encouraged to participate in the care of patients when this was appropriate. For example, we observed relatives assisting with mouth care and personal care.
- Patients undergoing an endoscopic procedure would attend the pre assessment clinic to receive a full explanation and medicines necessary for them to have their procedure at this appointment.
- The hospital did not have a formal bereavement survey. However, the hospital had recently produced a patient information leaflet: Coping with bereavement. This was specific to Mount Alvernia Hospital and was a guide to help with practical issues when someone dies. It included information on registering the death and contact details of the local registry office.

Emotional support

- The palliative clinical nurse specialist from the local NHS trust provided specialist palliative support to patients, their relatives and staff. The palliative care team were contactable seven days a week.
- Bereavement support was provided directly to relatives by the nursing, consultant and palliative care team whilst the patient remained in the hospital. Relatives were signposted to the relevant agencies that could support them. A relative told us they had been provided with information on who to contact if they required emotional support.
- The pastoral care worker was able to provide practical, emotional and spiritual support. Patients were offered chaplaincy support on request or put in touch with a minister of their faith.
- Staff told us debriefing sessions were encouraged for staff. Staff involved in a difficult case were encouraged to talk about their experiences and support each other.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance.
- An oncology patient told us they could relax when they were having treatment.

The oncology unit had a private room where patients, their relatives and staff could have a private conversation.

Are medical care services responsive?

Good 

We rated medical services good for responsive. This was because:

- The hospital provided a service that reflected the needs of the local population and ensured flexibility, choice and continuity of care.
- The palliative care team was embedded in all clinical areas of the hospital. They were professional, responsive and supportive to patients, relatives and other members of the multidisciplinary team. The team responded promptly to referrals to assess the patient and plan care.
- There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs. For example those with spiritual needs, bariatric equipment, patients whose first language was not English, or support for people living with dementia or learning disabilities.
- There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment care and the experience of patients and their supporters.

Service planning and delivery to meet the needs of local people

- All patients requiring end of life care received holistic care. This included being nursed in a single room with en-suite shower facilities that had space for relatives staying overnight.
- Visiting times for end of life care patients was unlimited and there was access to an outside area where patients and relatives could reflect and enjoy time together.
- Complimentary therapies were available for patients and they also had access to physiotherapists, occupational therapists, dieticians and speech and language therapists. This meant patients wider needs were met.

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- The endoscopy unit was open daily Monday to Friday when sufficient patient numbers permitted. We were told that occasionally the unit was open until 6pm to accommodate for late sessions.
- The oncology unit was open Monday to Friday 8am to 6pm. Patients had access to telephone advice 24 hours a day, seven days a week.
- The pharmacy was open 8.30am to 5.30pm Monday to Friday and 9am to 12am on Saturdays.
- Inpatient wards offered en-suite accommodation. There were televisions available and internet connections for patients to use.
- The oncology unit was open in the evening on some days which gave patients a choice in the time or day of the week they had their treatment.
- Visitors of inpatients were welcome at almost all times between 9am and 9.30pm. Outside of these hours visiting was by agreement with the nursing staff.
- A café was located in the main reception of the hospital for patients and their families to purchase snacks and drinks. The restaurant was accessible to all. We saw cold and hot drinks were available in all waiting areas we visited.
- We found patients and those supporting them had access to hot and cold drinks at all times. We saw drinks machines were available in waiting areas and we noted inpatients always had a drink within reach.
- Hotel service assistants on the wards discussed the menu with patients and collected their choices. Patients had the opportunity to order meals that were not on the menu. The ward had a book for special meals requests which was passed to the chef. Cultural and therapeutic diets were available. For example, gluten-free, Kosher or Hal-al.
- The most recent PLACE score, completed in 2016, were below the England average for food (74%), organisational food (70%), and ward food (77%).
- Catering at the hospital was provided by an outsourced service. The hospital was aware this had caused disturbance in the provision of service. The bottom five deteriorating patient satisfaction results all related to this function. The hospital was working with the catering company to ensure patient satisfaction results returned to the previous level that was achieved before the introduction of the present catering service.
- The hospital had lounges and gardens for patients and visitors use. The oncology unit had a separate room which patients, relatives and staff could use for private conversations.
- For patients who were having specialist cancer treatment, the hospital ensured they had the relevant trained staff available at pre assessment and in the unit to ensure that safe and effective care was given to patients. Cancer patients were supported with a variety of specialist nurse roles and a holistic therapy service was provided.
- The oncology unit provided a therapist service. This was provided by a local cancer charity who also provided counsellors. A therapist was at the hospital Monday to Friday between 9am and 2pm. They offered oncology patients one free hour session and any further involvement was billed by the hospital. The therapists had consent forms for each type of treatment and kept in the patients' medical notes.
- Oncology patients had a choice of receiving their treatment in an area with other patients or an individual room if they wished. Patient's relatives and loved ones were encouraged to stay and were provided with food and drinks.
- The hospital provided endoscopy services to both NHS and private funded patients.

Access and flow

- The majority of inpatients were seen initially in outpatients and from there if required would be admitted. All patients who were admitted were either pre-assessed face to face or by telephone. Patients for small procedures, young persons and otherwise fit adults, the hospital conducted an interview by telephone. This meant the hospital was responsive to sharing the patient pathways and ensured that all relevant information was given to the patients.
- The oncology unit provided about 123 episodes of chemotherapy per month, and this capacity met the current demand.
- Oncology patients accessed treatment through their insurance companies or privately. Patients received a pre assessment clinic appointment where the doctor decided on the treatment regime, with a nurse in attendance. This would decide how many days a week the patient would attend for treatment.
- The hospital accepted patients for end of life care both inside and outside normal working hours. The palliative

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care consultants were available, on call, to receive referrals at all times. We were told referrals were received with or without a cancer diagnosis. Data on the percentage of patients who were referred with a cancer and non-cancer diagnosis were not collected. Therefore we were unable to establish the mix of patients requiring end of life care.

- The hospital did not have an end of life care alert system to alert staff to a new admission. However, very few patients were admitted to the hospital for end of life care. Patients admitted were usually known to the oncology team and the admission was often expected.
- No systems were in place to support those patients who did not have a cancer diagnosis. However as very few patients were admitted for end of life care new admissions were flagged up daily and referrals made to the palliative care team.
- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. An occupational therapist was responsible for complex discharges of patients who required funding from NHS continuing healthcare. They would also assess and arrange for the appropriate equipment and ensure it was in place when discharged.
- We were told the number of patients achieving their preferred place of care was high and patients were discharged within 48 hours if equipment was required. However no data was available to confirm the percentage of patients that received their preferred place of care and how rapid the discharge was.
- We saw the care pathways in use directed staff to consider all aspects of discharge planning for inpatients. We saw sections had been completed which meant patients were protected from the risks associated with poorly planned discharge from the hospital.
- Nurses on the wards would refer to the community teams if a patient required additional assistance when they returned home. For example, medication, palliative care and wound care.
- The GP's of endoscopy patients were sent a copy of the discharge letter on the same day as the procedure.
- The hospital reported there had been 23 incidents of patients admitted as a day case and required an overnight stay October 2014 to October 2015. The hospital audited the incidents in November 2015. The purpose of the audit was to confirm that the cases were managed appropriately and to identify any contributing factors. The medical records of 22 of the reported

incidents were reviewed. The conclusion of the audit showed the decision to keep the patient overnight was made in the best interests of the patient and with consideration of the minimum discharge criteria.

- Eleven incidents had been reported by the hospital of patients who had been transferred out to another facility July 2015 to March 2016. Seven incidents related to patients who had complications post-surgery, two medical patients who had bowel obstruction, one outpatient who was unwell and the suitable equipment to test this was not working and an end of life care patient who had deteriorated and required further treatment in critical care. All eleven incidents were investigated and showed findings, root cause and lessons learned.

Meeting people's individual needs

- Oncology patients had access to a range of leaflets explaining their condition and treatment. Most of these were produced by national charities. No leaflets were displayed in other languages. However the manager told us these could be obtained from the charity if required.
- Patients attending the oncology unit could experience a range of complimentary therapies. These included Indian head massage, reflexology and acupuncture. We saw these therapies being provided and staff and patients we spoke with valued them and felt they were of great therapeutic benefit. These services were provided in partnership with a local cancer charity.
- We saw a range of information was available for patients. These included post-operative pain advice booklets, information published by Macmillan regarding cancer and the endoscopy service.
- Patients admitted to the wards were provided with a letter from the senior sister. This welcome letter explained the process of admission, facilities on the ward and hospital and provision of meals. It also explained the staff handover arrangements on the wards and medication rounds.
- The hospital provided a pastoral care worker who would provide spiritual support to patients regardless of their religious denomination. Staff were aware how to contact the service.
- The hospital had a multi faith chapel. A visitors and prayer request book was at entrance. The chapel was available for quiet reflection.

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- In the event of death of a patient the hospital had a service level agreement with a local undertaker. They could be contacted at any time and would collect the patient from the ward. If a relative wanted the patient to be moved to a different location this could be arranged with the funeral directors.
- Staff explained to us how deceased patients were cared for after death. We were told the family could stay as long as possible after death has occurred. Relatives were given the choice of whether they helped in the after death care or whether they left this to nursing staff. The RMO verified death in front of the relatives and the medical certificate of cause of death was available to the family before leaving the hospital.
- St Clare ward had a resource box regarding the death of the patient and this was accessible to all staff in the hospital. This contained the blank medical certificates, cremation forms and guidance, local funeral director contact details, register office information, BMI policy for the management of the deceased, after death patient check list, pastoral care information and log book for recording of the deceased.
- Advance care planning (ACP) was based on the cancer network guidelines. The information was available for staff and was available on the wards for completion. The palliative care nurse told us support was given to patients who wished to complete an ACP. No formal training had been given to staff to support the development of the ACP and this task was left to the palliative care nurse to complete with the patient.
- Staff could tell us how they would access professional translation services for people who needed them. However we were told these were rarely needed.
- Staff told us they could access leaflets containing information about endoscopic procedures in other languages if required.
- Staff received training on respecting equality and diversity in their mandatory training.
- We asked staff about any arrangements to support people living with a learning disability or dementia. Staff identified the needs of these patients at the pre assessment appointment.
- We saw there was an individual room opposite the nurse's station on all three inpatient wards. This room was a larger room and had space for an additional bed. Staff told us this was appropriate for relatives who wished to stay with a patient who was living with dementia or learning disabilities.

- The hospital had equipment that could cater for a bariatric patient up to a certain weight. The management of bariatric patients was risk assessed and equipment was suitable for patients with a BMI of less than 50. They had wider chairs, appropriate beds, theatre tables and a wheelchair. Patients would be assessed before admission if more appropriate equipment was required.

Learning from complaints and concerns

- The hospital recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- We saw all patient rooms had a patient guide which included a section which covered the formal complaints procedure. Copies of the BMI leaflet 'Please tell us' were located throughout the hospital to make patients and their relatives aware of how they can highlight any concerns.
- There were three items of rated feedback on the NHS Choices website for the hospital in the period April 2015 to March 2016. CQC directly received four complaints in period April 2015 to April 2016.
- The number of complaints received by the hospital April 2015 to March 2016 was 25 which was a decrease from 2014/15 (43). One complaint had been referred to the Ombudsman which related to a patient using the service in 2013.
- The assessed rate of complaints (per 100 day case and inpatient attendances) was significantly lower than the other independent acute hospitals CQC hold data for.
- The hospital told us that due to the size of the hospital it was normal practice for complaints to be discussed as they were received and reviewed in the daily morning meeting. This was attended by the executive director, director of nursing and hospital heads of departments. They told us this ensured a transparent approach which allowed early identification of issues for onward cascade.
- Complaints and compliments were formally discussed at the monthly senior management team meetings, clinical governance meetings, and department meetings as appropriate. The hospital held a monthly patient

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satisfaction meeting, which comprised of various members of staff at all levels from the organisation, where results and improvement actions were discussed. This reviewed patient satisfaction data and where the hospital sat in comparison to its BMI Healthcare peers, complaint trends, onwards action as appropriate and areas for continuous improvements for the patient experience.

- All staff were encouraged and empowered to identify and address any concerns or issues while the patient was still on site. If needed, complaints were escalated to heads of department, director of nursing or the executive director while the patient or their relative was still at the hospital to prevent issues developing into a formal complaint.
- The responsibility for all complaints rested with the executive director who would decide which head of department and/or consultants needed to be involved in the investigation. Based on the nature of the complaint the investigation may be led by either the executive director, director of nursing or the quality and risk manager. An acknowledgement would be sent immediately upon receipt of the complaint explaining the investigation process and timescales.
- The BMI Healthcare complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage the complainant would be given the information of who to take the complaint to if they remained unhappy with the outcome. For private patients they would be signposted to an independent adjudicator and NHS patients treated at the hospital, to the NHS Ombudsman.
- During the complaint investigation the process was monitored to ensure timescales were adhered to and responses provided within 20 working days. If a response was not able to be provided within this timeframe a holding letter was sent so they were kept fully informed of the progress of their complaint. We saw the records of complaints investigations. All complaints information was retained within a paper file, with copies retained electronically and also stored in the hospital information management system.

Are medical care services well-led?

Good 

We rated medical services for well-led as good. This was because:

- The management structure for medical services at the hospital meant the executive director and the director of nursing were responsible for the managers of the oncology and endoscopy services and the wards. The senior management team were highly visible and accessible across the hospital. Staff described an open culture and said managers were approachable at all times.
- The lead for end of life care services at the hospital was the director of nursing. The palliative team and ward staff had a vision to ensure that end of life care was consistent. This was to be delivered in a timely, sensitively, spiritually and culturally aware manner, with appropriate patient and relatives focused care of the dying and deceased patients.
- Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.
- Governance processes were evident at departmental, hospital and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits.
- The hospital had a policy in place for end of life care and management of the deceased.
- Staff from all departments had a clear ambition for their services and were aware of the vision of their departments.
- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.
- The hospital had a risk register and was reviewed at the governance committee meetings.

However

- The risk register was not divided into separate departments.

Vision and strategy for this core service

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- BMI Healthcare had a corporate strategy in place. The hospital had a clinical strategy which was made up of six key themes. These were: putting patients at the heart of what they do; staff were the most important attribute; quality should underpin everything they do; working together; engaging with consultants; and being as cost effective and efficient as possible.
- Staff from the oncology, endoscopy and inpatient wards had clear ambitions for the services they provided and were aware of the visions of the departments. The vision was to provide the highest standard of care, ensuring a patients experience was as comfortable as possible.
- The endoscopy team were working towards Joint Advisory Group (JAG) accreditation. On completion of data collection they could proceed to the next part of the process.
- An action plan was in place with education in end of life care as a focus. An end of life care steering group was planned to discuss relevant issues and consider improvements of the service.
- Policies for palliative and end of life care and management of the deceased had been developed and were in the process of being ratified.
- The director of nursing told us they had identified the need for a director of nursing network with other local hospitals and acute trusts. This had been organised by the CCG and was due to start in September 2016.
- St Francis ward was not in use at the time of inspection. An action plan was in place to open the ward as a medical admissions unit. This was planned for the beginning of August 2016 and would only happen if all actions were completed. For example ensuring there was a clear understanding of the admission process by all staff and to ensure sufficient competent staff were employed. At the time of inspection a sister was in post for managing the ward and was in the process of receiving their training.

Governance, risk management and quality measurement for this core service

- The governance framework ensured an effective organisational structure that supported the delivery of services and minimised the risks across all areas of business.
- There was a robust system of governance. Heads of departments met monthly and discussed incidents, complaints and the risk register. They reported to the hospital leadership team. The monthly senior

management team and heads of department meeting covered a variety of key areas and these were then backed up by departmental meetings and staff forums which ensured good communication across the hospital.

- The hospital had a clinical effectiveness committee which met every other month and fed into the clinical governance committee which also met bi-monthly.
- Clinical quality and governance issues were reviewed at the quarterly MAC meetings. This involved a high level of engagement from the consultants. The MAC was responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.
- The minutes and actions from the clinical governance, MAC, health and safety, infection prevention meetings were reported to the management team through the service leads meeting. The information was cascaded to the wider team through departmental meetings and staff briefings. These were conducted by the executive director and other members of the executive team. They were designed to be informal to encourage a high level of engagement with the staff.
- The hospital utilised a daily informal communication meeting as an effective way to share information and drive continuous improvement. Representatives from all departments met on a daily basis at 9am to discuss the previous day and plan daily hospital activity. This meeting presented the opportunity to discuss daily key performance indicators, incidents, raise concerns and share successes.
- The hospital did not have a formal steering group for end of life care. The director of oncology for BMI Healthcare, director of nursing, oncology manager, palliative care nurse and consultant met in March 2016 to set up the service level agreement and agree the future of the service. We were told the group would meet in September 2016 to review.
- A structured audit programme supported the hospital to ensure patient safety was at the forefront of service provision. Actions were monitored locally and within sub-committees and clinical governance meetings. These ensured lessons could be learnt and actions had been completed.
- The management of the inpatient wards were proactive in their understanding of the risks that could affect the inpatient wards. We saw a separate action plan for the

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inpatient areas which was separate to the hospitals risk register. This included a list of the issues, plan of action; date of completion and by who. Topics on the action plan included recruitment, training, and rotation of staff and development of new services.

- We saw the hospital risk register for April 2016. The risks were divided into categories: patient safety, information management, financial, reputation, governance, operational, leadership and workforce, workforce health and safety, and facilities and infrastructure. The register described the risks involved with their impact, likelihood and risk ratings. Existing risk controls and further actions were listed responsible committee and key lead.
- We were told the hospital risk register was reviewed at the governance committee meetings and ensured if any risks have been identified they were on the register and if any risks had changed they were re scored and identified.
- However, the hospital risk register was for the whole hospital and was not divided into separate areas.

Leadership and culture of service

- There was a clear management structure which staff were aware of. This meant leadership and management responsibilities and accountabilities were explicit and clearly understood.
- The management structure for medical services at the hospital was the executive director and the director of nursing who were responsible for the managers of the oncology and endoscopy services and the wards.
- The lead for end of life care services was the director of nursing. Ward staff told us the palliative care team were visible and provided good levels of education and support.
- Heads of departments oversaw the running of their respective areas and reported to the executive director and director of nursing.
- All staff we spoke with thought their line managers and senior managers were approachable and supportive. Staff told us they could approach immediate managers and senior managers with any concerns or queries.

Public and staff engagement

- The hospital monitored patient satisfaction in all areas of its service delivery. This was achieved through






obtaining patient feedback and views through the forms they placed in each patients room and outpatient areas. The analysis of this information was provided by an external provider and this was arranged through the corporate teams. The hospital received a corporate monthly report which showed response rates, rating within categories and ranking against all BMI hospitals. It also included all the freehand patient comments.

- The hospital had a patient satisfaction group was made up of a number of employees around the hospital. This group continually reviewed the patient satisfaction scores and dealt with areas for improvement.
- We saw the meetings of monthly staff meetings for ward staff. New starters were welcomed, audits, patient survey results and management structure were discussed. We saw these meetings were well attended by staff.
- The hospital encouraged social interaction for staff through a range of events organised specific to the hospital. For example, the Pin Awards, Above and Beyond Awards and charitable initiatives to encourage staff engagement in a social context.

Innovation, improvement and sustainability

- The oncology service benchmarked against other services and reciprocated in peer review with other services. We saw copies of the most recent peer review completed with staff from another hospital. It identified areas of good practise and areas for development. This process identified and encouraged improvement within the service.
- The oncology service received the Macmillan Quality Environment Mark in October 2014 (a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer).
- The hospital had BUPA Breast Care, MacMillan and bowel accreditation.
- A clinical governance bulletin was produced across the BMI Healthcare organisation which supported the hospital monthly to manage risk. The bulletin identified changes in legislation relating to NICE publications and alerts regarding drugs and equipment. It also provided details of issues of best practice at other hospitals so that shared learning could be applied locally.

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

Information about the service

Mount Alvernia Hospital, part of BMI Healthcare, is an acute independent hospital. It provides a range of clinical services for outpatients, day-care and inpatients. Services are available to people with private or corporate health insurance or to those paying for a one off treatment. The hospital also offers services to NHS patients on behalf of the NHS through local contractual agreements.

The hospital clinical team is made up of medical staff, nurses and a resident medical officer (RMO) who is on duty 24 hours a day. A senior nurse is available at all times to assist patients following discharge and arrange admissions for patients who require hospitalisation for unplanned surgical treatments.

Surgical services provided included orthopaedics, breast, gynaecology, urology and cranial. All services are for in and outpatients. Only patients aged 18 years and older are admitted for surgery. Young people between the ages of 16 and 18 are seen in outpatients. In the period April 2015 to March 2016 there were 4,126 inpatient and day case admissions.

Inpatient accommodation is provided over three floors in individual rooms with their own bathrooms, three of which can convert to twin occupancy. There are 12 beds each in St Clare ward (mixed medical and surgical), St Elthelbert (surgical) and St Francis ward. At the time of inspection St Francis was not in use.

There are three main theatres, two with laminar flow and one used mainly for laparoscopic procedures.

During our inspection we visited St Clare's and St Ethelbert's wards, the theatre suite and the pre-assessment unit. We spoke with 35 members of staff that included

consultant surgeons and anaesthetists, theatre staff, ward staff, administrative staff, managers and support services. We observed the care provided by medical, nursing and support staff in the departments visited. We carried out an unannounced inspection the week after our announced inspection.

We spoke with six patients and one relative. We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the hospital.

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Summary of findings

We rated the surgical services at Mount Alvernia Hospital as good because:

- The hospital had good systems and processes in place to keep patients free from harm. There was a good track record on safety.
- Staff understood the incident reporting process and their responsibilities to report, investigate and learn.
- There were processes for assessing and responding to patient risk and safe protocols for patient transfer. There was a comprehensive assessment of patient needs. There were sufficient skilled and experienced staff to care for patients.
- The hospital worked to current national guidance. The hospital participated in national audits and had a proactive programme of hospital and departmental audits. Results and recommendations were shared throughout the hospital with change and learning evidenced.
- Patients were treated with compassion, care and dignity. They were well supported and provided with good information.
- Services were provided to meet the needs of the local population and allow access to care and treatment. There were minimal delays or cancellations for treatment and these were well managed.
- Complaints were investigated and discussed openly with staff.
- The organisational and committee structures supported good governance systems and processes. Staff described an open culture within the hospital and were clear on roles and responsibilities.
- The hospital collected patient feedback and demonstrated ongoing work by all staff towards continuous improvement in the patient experience.

However:

- The safeguarding lead was not trained to level 3 for safeguarding children as per national guidelines.
- The side of the patient due to be operated on was not always clearly or accurately documented on daily operating lists.

- Not all staff had attended major incident or business continuity training.
- The risk register was not compiled so that department risks could be identified

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Are surgery services safe?

Requires improvement 

We rated safe as requires improvement because:

- The side of the patient due to be operated on was not always clearly or accurately documented on daily operating lists.
- Staff did not consistently adhere to the World Health Organisation Safe Surgery checklist.
- Not all staff had attended major incident or business continuity training.
- The safeguarding lead was not trained to level 3 for safeguarding children as per national guidelines.

However:

- Incidents and near misses were reported and investigated. Reports were communicated to all staff.
- The hospital was visibly clean with cleaning systems, checks and audits. There were arrangements to prevent the spread of infection that were regularly monitored.
- There was sufficient equipment that was well maintained. Medicines were managed safely. Mandatory training rates were good.
- There were processes for assessing and responding to patient risk. The service had enough staff with the skills and experience to care for the number of patients and their level of need.

Incidents

- There were no never events during the last 12 months. 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.
- BMI Healthcare Limited, the provider company, sent examples of any never events that occurred at any of their hospitals to all hospitals for discussion and action where relevant. We saw that the national patient safety initiative “Stop before you block” posters were in each anaesthetic room as part of organisation wide learning.
- The hospital reported seven deaths for the period April 2015 to March 2016 of which six were expected but one was unexpected. Although two of these patients had a surgical procedure within 30 days of their death, no

deaths were directly linked to these procedures. We looked at the patient record and the subsequent internal investigation which was thorough. We saw that whilst there was no confirmed cause of death following two post mortems all processes had been followed correctly, including correct procedures and antibiotic prescribing. We saw that this was discussed at the clinical governance committee.

- No incidents were reported as “severe” in the period April 2015 to March 2016.
- The majority of reported clinical incidents related to surgery with 219 of 233 incidents over the period (94%). The hospital quarterly reports showed that the number of incidents rose from 46 in the quarter April to June 2015, to 68 for quarter January to March 2016.
- All staff we spoke with were aware of the incident reporting process and stated they felt able to raise concerns through the process, including reporting on themselves. We were aware of considerable work undertaken to raise awareness of the importance of incident reporting and learning. There was a healthy reporting culture which indicated (but cannot be proved) high reporting rather than a higher number of incidents than other independent hospitals. There was clear evidence in the clinical governance committee minutes we looked at that this was on going work with changes implemented to enable benchmarking with other BMI hospitals and shared learning.
- The number of non-clinical incidents reported over the same 12 month period were also slightly higher than other independent providers which reflected the work undertaken to promote a culture of reporting and learning. Of the 61 incidents, 28 (46%) related to surgical departments.
- Currently the hospital used a paper based document for reporting incidents with proposals to move to an electronic system. Staff we spoke with in the various areas we visited on the inspection were all able to describe the reporting process and the feedback at ward meetings. One example of an incident reported was where a patient for a joint injection arrived with no booking form.
- In theatres, the paper incident forms were sent to the theatre manager who input them onto an electronic database and investigated as required. These were then discussed at theatre meetings, together with learning. We saw examples in minutes we were shown. Feedback was provided to individuals. Incidents for corporate

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learning were fed up accordingly. We were provided with an example where practice had changed as a result of corporate learning where implants were checked with the surgeon before opening.

- The theatre manager also kept a paper record of all incidents which we saw. Examples included near misses such as the wrong side recorded on the booking form and where the operating list was incorrect. We were told that wrong site near misses had occurred where there was a discrepancy between the patient record and the booking form. We were told that the rigorous use of the World Health Organisation (WHO) checklist meant that errors were identified and corrected prior to surgery. However, whilst we observed four examples of good practice we also saw two examples of poor practice in the urology theatre where not all staff were engaged in the WHO checklist process. This meant there was risk of an error occurring.
- Another example staff told us about was where a consultant felt that a consent form was not required for a procedure. Action was taken, the consultant was sent a letter reminding them of the policy and the issue was discussed.
- Incidents reported in the pre-assessment department were sent directly to the quality and risk manager, for example if the full previous medical history was not available for a patient.
- Staff told us that they received feedback regarding reported incidents and this included regular emails highlighting actions and lessons learned as well as discussions at their ward and theatre meetings.
- We were told of an incident where a patient required blood but one piece of equipment had failed. Staff telephoned the support number, took advice and the patient received blood and was well post operatively. Staff discussed informing the patient and spoke to the haematologist. The surgeon saw the patient and fully explained what had happened. The equipment issue was also resolved. We saw evidence that the incident was discussed at the clinical governance committee and the Medical Advisory Committee. Staff we spoke with understood duty of candour.
- Patient morbidity and mortality data was collected and reviewed with those within the criteria presented at clinical governance meetings.

- The hospital used the NHS Safety Thermometer, a national improvement tool for measuring, monitoring and analysing harm. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- Day case patients were excluded from the safety thermometer.

Cleanliness, infection control and hygiene

- No episodes of hospital infections such as MRSA and Clostridium Difficile (C. difficile) were reported in the last 12 months. Inpatients were screened for MRSA. If found positive they were treated before surgery. We saw the protocol and evidence of screening in the patient records we looked at.
- For the period April 2015 to March 2016 the hospital reported five surgical site infections, four orthopaedic and one breast procedure. Orthopaedic surgery accounted for 44% of surgical procedures for the same reporting period.
- The support services manager had overall responsibility for cleaning clinical areas. Housekeeping staff cleaned at nights and worked to housekeeping checklists for each area. We saw that the theatre cleaning checklist was visible and completed. We saw the completed daily cleaning check list in the pre-assessment unit.
- All areas visited were visibly clean.
- The patient led assessment of the care environment (PLACE) for the period February to March 2015 scored 100% for cleanliness, which was better than the national average of 98%.
- Decontamination for theatre instruments was outsourced to a BMI sister company. We were told of a reported issue with the logging and numbers between the hospital and the decontamination unit which raised concern regarding the traceability of items. The process was under discussion for resolution at the time of the visit.
- We saw green 'I am clean' stickers in use on equipment we checked in all clinical areas we visited.
- Water was flushed every Tuesday and Friday to ensure cleanliness and water free of Legionella bacteria.
- We saw that the World Health Organisation Guidelines on Hand Hygiene in Healthcare Five moments for hand hygiene posters were at all hand washing facilities.
- We saw good infection prevention and control practices in theatres and associated areas.

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

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- The infection prevention and control (IPC) lead for the hospital chaired meetings every two months for the link nurses from each department. We saw minutes that demonstrated good attendance. The link nurse we spoke with told us that they attended the meetings and found them valuable and useful.
- The IPC lead attended quarterly Surrey IPC meetings that included representatives from the clinical commissioning groups and other independent health providers with the aim of sharing best practice.
- The IPC lead worked three days a week in that role, the other two days as an oncology nurse.
- There were monthly hand hygiene audits. We looked at theatre audits from January 2016 to date and saw they all scored 100%. This was an improvement on 2015 where a few scored less. The audits were co-ordinated by the infection prevention and control link nurse for theatres. Monthly hand hygiene audits across the hospital demonstrated 100% compliance in the quarterly audit reports we were provided with.
- The IPC lead said that they followed up any repeated non-compliance by individual staff identified by the hand hygiene audits by sending a letter reminding them of their infection prevention and control responsibilities.
- We observed anaesthetic staff washed their hands before commencing anaesthesia.
- Theatres and associated areas were visibly clean, floorings and wall covering intact. There was sufficient space and secure storage.
- All staff we observed followed the bare below the elbow policy.
- We observed the scrubbing procedure with trolley preparation, swab and instrument checking. We saw good aseptic technique for patient preparation and draping. Sharps handled safely. There was good practice using only safety needles for cannulation and infiltration.
- Single use items were checked appropriately. All anaesthetic items were single wrapped and disposable. We saw good recording and documentation practices.
- Blood pressure cuffs were single patient use on the wards.
- Specimen pots were prefilled with the preserving solution so that staff were not exposed to it. Two spill kits (equipment for effective cleaning and safe disposal

of clinical waste, helping to reduce the risk of cross infection) were in the theatre department with guidance and the contents were in date. Spill kits were also available on the wards.

- There were colour coded infection control procedures in place in respect of, for example, waste bags and linens.
- We saw that there was a plentiful supply of personal protective equipment available for staff in all areas we visited. These included gloves and aprons. Cleaning wipes were readily available in appropriate areas.
- Curtains were disposable and last changed May 2016. They were changed every six months unless required earlier due to damage or contamination. The medical equipment list flagged this up one month in advance of the change required.
- Sharps bins we looked at in the three main theatres were clearly marked and dated with the containers placed close to areas where medical sharps were used. They were used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- However, having found evidence of poor performance on the annual sharps audit, we saw this was to be repeated early. The link IPC nurses had been retrained as a result of the audit.

Environment and equipment

- The hospital had three main theatres, two with laminar flow (a system for ensuring clean air flow in theatres).
- The theatre department was controlled through a swipe card system. There was a visitors' book in use. When, for example, surgical equipment representatives were invited to theatre by surgeons they were required to obtain a visitor's pass before entering the area. We asked to see the hospital's visitors' policy but staff were unable to provide this during the inspection.
- We observed one occasion where a representative came to theatre but as the surgeon had not arranged the visit they did not remain.
- We checked the theatre resuscitation equipment which was visibly clean with all medicines and equipment in date. The anaphylaxis kit was seen and in date. We checked the difficult airway trolley which was visibly clean and all devices in date with the appropriate guidelines from the Difficult Airway Society. We checked the malignant hyperthermia kit which was clean, in date and staff could locate the guideline and the medicines

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for treatment, specifically dantrolene. We saw evidence that staff had completed all required checklists to ensure that all the equipment was ready and available at all times.

- An operating department practitioner (ODP) was responsible across the hospital for monitoring and auditing resuscitation incidents and trolleys.
- We saw evidence that theatre equipment service checks were carried out on the equipment we looked at. There was a completed asset register in theatres with the appropriate sign seen on the equipment. The anaesthetic machine checks complied with the Association for Perioperative Practice guidelines.
- Portable appliance testing (PAT) checks were completed annually and we saw certificates and the record on all individual pieces of equipment we checked during the visit.
- However, the electronic database that contained the full list of PAT compliance for the hospital was lost due to a software failure. An external company had been booked to repeat testing and ensure a full list of compliance. Medical equipment under contract did not require PAT testing as this was carried out under the maintenance contracts.
- We saw evidence that equipment was calibrated to ensure accuracy, for example a blood pressure device.
- Patient trolleys had oxygen and suction available for transfer.
- There was a wide range of pressure relieving devices available and in use.
- We saw patslides and transfer sheets in use as per the hospital's moving and handling protocols. There was also air-assisted safe patient transfer equipment available for patients with high body mass index as the hospital provided bariatric surgery.
- There was a CO2 laser that we were told was rarely used. We saw evidence that there was an up-to-date policy and laser protection advisor training. We saw evidence of robust systems for the ordering and management of loan instruments.
- There was work underway to complete a full medical equipment list, and at the time of inspection it was about 50% completed. We saw evidence that the system provided a flag when equipment was due for maintenance. There was a process for any equipment out of service and we saw three examples.
- There were call bells in all the patient rooms and we observed the weekly test during the inspection.

- There was a programme underway to replace all patient chairs on the wards to wipe clean surfaces for improved infection prevention and control.
- We saw that the hospital undertook the annual Healthcare Waste Pre-acceptance audit in February 2016 for the whole site. Conclusions and recommendations were included and the report sent to appropriate bodies.

Medicines

- Medicines were stored securely. All medicines were in locked cupboards in theatres. Intravenous (IV) fluids were kept in lockable cupboards. We saw that the IV cupboards were left open during use for easy access but were told would be locked at night. Once opened, the theatre was secured with key card access.
- We saw controlled drugs were kept in a locked cupboard in theatres. The order book and controlled drug record book were seen and correctly completed.
- For patients undergoing surgery, antibiotics were discussed at the appropriate stage of the WHO Surgical Safety Checklist prior to the procedure.
- We checked medicines management on one of the two wards that were in use at the inspection.
- All medicines were stored securely in locked cupboards. The medicines trolley was locked and secured to a wall when not in use.
- We looked at a sample of medicines and found they were all in date. One opened pack highlighted in red the expiry date later in the month.
- We saw daily checks done for the drugs fridge. There was an alarm should the temperature fall outside the correct range which was clearly stated.
- We saw current editions of the British National Formulary in clinical areas.
- We looked at the controlled drugs register which was well completed. We saw the Home Office Controlled Drug Licence with expiry date 22 November 2016.
- On the wards we saw that patients' own medicines were locked in a cabinet in their room. Patients did not self-medicate whilst in hospital.

Records

- The medical records for all inpatients were securely stored in the hospital in all areas visited. A copy of the surgical procedure and inpatient episode for NHS patients was sent to the relevant NHS hospital.

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- We checked the operating lists on the two days of the inspection. The planned side that the procedure would be carried out on was not recorded in every case. We were told that this information was not always transposed from the patient record. This could pose a risk if other checks were not always completed. However, we were not aware of any such incidents.
- We saw the paper diary for theatre planning. This did contain some personal identifying information and, whilst it was not locked away at night, there was enhanced access to theatres which meant only staff members with an access card could enter.
- We looked at four sets of pre-operative patient records and three sets of post-operative records. We found that record keeping was good.
- We saw the appropriate patient pathways used. These were single, comprehensive paper based documents that incorporated the perioperative care plans. All theatre items including swabs were tracked in this record which we saw fully completed. We also looked at two sets of records for patients discharged the previous day and saw the pathway fully completed with discharge information and letter.
- The patient records demonstrated completeness with, for example, referral, GP information including past medical history, risk assessments, pain score and management, medicines chart, discharge letter and medicines to take home.
- We saw that specimens were double checked for correct patient details. The scrub nurse (registered nurses who assist in surgical procedures) entered the details in the patient record.
- We saw that some signatures were illegible on a controlled drugs patient register we looked at on St Clare's Ward. When we looked at the clinical staff signature sheet this was incomplete and staff were unable to identify one signature we tracked. This meant that it would not be possible to find the relevant person if there was a query.

Safeguarding

- We were informed that there were no safeguarding concerns reported in the period April 2015 to March 2016.
- The director of nursing was the safeguarding lead and we were informed that they were trained to level three for vulnerable adults and level two for children. This is considered a risk as children could accompany adults to

the hospital. The hospital told us that there was a service level agreement in place with a neighbouring BMI Hospital facility for a Lead Nurse for Child Protection, who held safeguarding level three. This meant that the hospital could access advice on safeguarding children issues but did still not meet national guidelines which recommended that all staff working with children should be trained to level three.

- We spoke with two registered nurses in theatres who demonstrated a good understanding of safeguarding and the triggers. They had access to training and support and said they felt able to raise concerns with their manager if necessary.
- Nurses on the wards told us they had undertaken e-learning for both children and vulnerable adult safeguarding and knew how to report concerns.
- The training target for safeguarding was 90%. The hospital told us 95% were trained to level 1 and 93% to level 2 for safeguarding vulnerable adults and for safeguarding children.
- Equipment sales representatives were invited into theatres by consultants and, we were told, known to them. However we could not clarify how the hospital was assured that all representatives had been checked by the disclosure and barring service. This, whilst unlikely, meant that there was the possibility of inappropriate people present with adults rendered vulnerable by anaesthesia.

Mandatory training

- The target for mandatory training set by BMI Healthcare was 90%. Mount Alvernia hospital had a total of 93% in all departments of the hospital with nursing staff at 94%, pharmacy 100% and ward staff 90%.
- The majority of training was e-learning based on an electronic system with a knowledge check. Topics included informed consent, safeguarding vulnerable adults and children and dementia awareness. Other training with an additional face-to-face element included fire training, moving and handling and basic life support.
- Fire safety training was provided in house and was mandatory for all staff. Hospital wide we were shown that 91% of the 300 staff members had completed the theory part of the training. There was a fire warden for each department.
- Staff we spoke with showed us examples of completed mandatory training. One showed us that they were

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100% compliant. Another showed us that their fire training was booked and they were otherwise in date with training such as infection control, basic life support and equality and diversity.

- Staff received emails via their managers if any training was overdue. We were shown e-learning alerts and reminders. Managers were responsible to ensuring staff remained up to date.
- The RMO was supplied by an agency. We were told that it was the agency's responsibility to ensure that all RMOs had completed their mandatory training and this would be evident on their CV. The hospital checked the agency documentation to ensure that they were fully up to date before starting work. The RMO we spoke with confirmed that they had completed their mandatory training and were up to date.

Assessing and responding to patient risk

- Pre-assessment of patients for surgery included a thorough assessment of risk. If there were any concerns the RMO was contacted to see the patient. The RMO reviewed all test results the following day and, if required, would refer the patient to the relevant consultant.
- We saw evidence in the seven medical records we looked at of risk assessments such as skin viability, nutrition and falls. There were risk scores recorded which meant that any high risks were identified prior to admission so that prevention measures could be put in place. Risk assessments were reviewed on admission.
- The hospital used the national early warning score (NEWS) for tracking patients' clinical condition and alerting the clinical team to any deterioration that would trigger timely clinical response. We saw that the pre-operative entries had been completed correctly.
- The RMO provided medical cover 24 hours a day, seven days a week. This meant concerns regarding a patient could be escalated at any time of the day. The RMO could contact the relevant consultant as they were required to be available at any time of day when they had patients admitted to the hospital.
- We were informed that 100% of patients were screened for venous thromboembolism (VTE) for the period April 2015 to March 2016. We looked at seven sets of medical records and saw that patients had been screened for VTE in all cases. The audit results confirmed this for the period January to June 2016.
- There were no incidents of hospital acquired VTE or pulmonary embolism in the last 12 months.
- We observed theatre staff carrying out the WHO Surgical Safety Checklist for six procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are: team briefing; sign in (before anaesthesia); time out (before surgery starts); sign out (before any member of staff leaves the theatre); debrief. It was developed to decrease errors and adverse events, and increase teamwork and communication in surgery.
- On four occasions we saw that this was done well with the whole team involved. Introductions were observed and the sign out was completed with everyone's attention. We saw that the checklist could be initiated by any member of the team. For some procedures the checklist was initiated by the surgeon, and for another it was initiated by the registered nurse.
- However, on two occasions in the urology theatre, we saw examples of poor practice. One example was in the anaesthetic room where the 'sign in' was done by an operating department practitioner (ODP) alone whilst the anaesthetist was making up the drugs and the surgeon came and went. Another example was at the end of a procedure, no 'sign out' was done, the procedure done was not confirmed and the anaesthetist was on the telephone. This meant there was an increased chance of error with decreased teamwork and communication evidenced.
- We were provided with the first two quarterly audit reports for 2016 which demonstrated the monthly audits of the WHO checklist with issues highlighted and discussed at the Medical Advisory Committee and other staff groups as required. The April to June 2016 report showed some improvement.
- We were provided with an example where it was identified that a patient did not have the optimum temperature for surgery. The order of the theatre list was changed to allow appropriate care that ensured surgery could safely go ahead that day.
- One patient described a 'seizure' they had post-operatively and told us staff attended immediately and the consultant came in to see them.
- In case of cardiac arrest or stroke staff called the hospital crash team and an ambulance to take the

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patient to the appropriate NHS hospital. The hospital had a service level agreement with the local NHS trust. This enabled them to transfer any patients who became unwell after surgery and needed critical care support.

- Resuscitation simulations were carried out with the most recent one in June 2016. Simulations are unannounced crash calls (emergency call outs for cardiac or respiratory arrest) with staff attending as if they were real life incidents. Feedback was provided by an external company which staff described as “very useful”.
- We reviewed the medical records for three patients who had returned to theatre following their operation. Two were for known complications that were recognised and treated promptly. The third was investigated and learning identified regarding timely documentation. The outcome for the patient was unchanged.

Nursing, theatre and other staff

- We were told that the BMI Healthcare nursing dependency and skill mix tool is a guide to ensure the right members of staff are on duty at the right time and with the right skills, to ensure high quality patient care.
- The tool was used to plan the skill mix at least 24 to 48 hours in advance. The spreadsheet was completed on a daily basis reviewing the time period midnight to midnight as a rolling 24 hour period. The actual hours worked were also entered retrospectively to understand variances from the planned hours and the reasons for these.
- We saw evidence of the May daily rota for the wards that included average staff utilisation through the day. This data demonstrated actual staff against that required and that there were no agency payments during that month.
- St Clare’s Ward showed actual staffing in line with expected for late and night shifts with an additional registered nurse on the early shift. We were told that staffing was changed dependent on need. On St Ethelbert’s Ward there were two registered and one non-registered nurse on both early and late shifts. Five inpatients were admitted on the early shift with four day cases admitted in the afternoon, a maximum of nine patients.
- Sickness rates for nurses working in theatre departments for the same reporting period were not high when compared to the yearly average of other independent acute hospitals CQC holds this type of data

for. However, rates for ODPs and health care assistants were more variable and higher than the yearly average for six out of the 12 months. Sickness rates for nurses and health care assistants working in inpatient departments were not high.

- There were no vacancies for ODPs or health care assistants as at April 2016. There was one full time vacancy for theatre nurses which was low when compared to other independent acute hospitals. There was one full time registered nurse vacancy on the wards but no vacancies in respect of health care assistants.
- Staff turnover figures for theatre and ward staff was not high when compared to other independent acute hospitals CQC holds this type of data for.
- All shifts were filled on the wards and in theatres between January and March 2016.
- The rates of use of bank and agency staff for inpatient nurses, both registered and non-registered, were mainly lower than the yearly average of other independent acute hospitals we hold that type of data for.
- Theatre staff numbers were in line with the Association for Perioperative Practice guidelines. We saw four staff in theatre for the procedures we observed. A porter was available to collect patients as required. The majority of theatre staff were either registered nurses or operation department practitioners.
- The rates for use of bank staff in theatres were low when compared to the yearly average of other independent acute hospitals we hold this type of data for.
- Ongoing recruitment resulted in some new team members. Staff told us that this enabled them to upskill staff more easily which in turn made for more flexibility. Staff felt that there were sufficient staff and no agency staff had been used for over 18 months. There was occasional use of bank staff.
- Staff were supported in achieving competence based training to ensure flexibility in the workforce.
- We observed that the recovery bay was well staffed and well run.
- The pre-assessment unit was staffed by one sister, two registered nurses and one pre-assessment coordinator. Cover was provided for absence such as annual leave by bank staff. Staff could bleep the RMO if they had concerns about a patient.
- In addition, there was always a duty matron (a senior nurse) available at the hospital as a contact point for both staff and patients, including to help resolve patient queries and to accept out of hours admissions.

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- In addition to clinical and consultant arrangements, the senior management team operated a rota for on call support out of hours. There was also an on call rota operated by the pharmacy, radiology and physiotherapy teams should support be required out of hours, as well as an on call emergency theatre team.

Surgical staffing

- Consultants were required under their practicing privileges to be available both by telephone and, if required, in person whenever they had patients admitted to the hospital. Consultants were required to arranged appropriate alternative named cover if they would not be available.
- Consultants visited their patients daily until they were discharged from the hospital.
- Anaesthetists were available for the first 24 hours following surgery to ensure availability should a patient need to return to theatre.
- A RMO, supplied by an external agency, provided a 24 hour seven day a week service on a rotational basis. The RMO worked closely with the consultants in the care of the patients. Should the RMO become unwell the agency was called to provide cover.
- The director of nursing regularly met with the RMOs and discussed their welfare and any concerns. If there were any concerns regarding the RMOs the agency would be contacted. The hospital received assurance from the agency regarding registration and up-to-date training for the RMOs.
- The RMOs were supported by senior nursing staff. We saw the RMO book on the wards into which staff entered tasks and patient requirements.
- Protocols were in place to ensure rest periods. A team brief took place prior to the RMO settling for the night to ensure all patient requirements had been attended to and any other measures taken to reduce the possibility of calling the RMO at night.
- We saw the corporate BMI Healthcare Practicing Privileges Policy for Consultant Medical and Dental Practitioners, 2015. Adherence to the policy was monitored and any concerns discussed at the Medical Advisory Committee.

Major incident awareness and training

- We asked the hospital for a copy of their local emergency preparedness resilience policy (EPRP). We were told this was not available as the hospital was not part of the resilience forum.
- We found all staff we spoke with demonstrated a very good awareness in the case of fire and described scenario training. We were told there were slide sheets under the mattresses for evacuating patients.
- Not all staff had not attended major incident or business continuity training. However, in our discussions with them staff could articulate what they would do should there occur an event that adversely affected business continuity.
- The hospital had a response team who would respond to an emergency situation. The team all held bleeps and would respond immediately when required. The daily ward meeting in the morning on St Clare ward allocated the response bleeps and a fire marshal was designated.
- There were back-up generators for electricity failure.

Are surgery services effective?

Good 

We rated effective as good because:

- We found care and treatment reflected current national guidance.
- There was comprehensive assessment of patient needs. This included clinical needs, physical health, nutrition and hydration needs. Patients received adequate pain relief.
- The hospital routinely collected and monitored information about patient care and treatment as well as their outcomes. There were protocols in place for patient transfers.
- There was a proactive audit programme that included national, corporate, hospital and departmental audits. Results were shared throughout the hospital and collated to identify themes.
- Patients were able to contact the hospital for advice and information at all times. Patients provided informed, written consent before commencing their treatment.

However;

- Appraisals of theatre staff was low.

Evidence-based care and treatment

Surgery

- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered.
- Care was provided in line with National Institute for Health and Care Excellence (NICE) CG50 for acutely ill patients in hospital. We saw examples of patients transferred out in accordance with the guidance. We saw that physiological observations were recorded at the time of admission in the seven sets of patient records we looked at. The audit against the guidance carried out in February 2016 demonstrated improvement in eight of the 16 areas looked at from the previous audit in August 2015. For example, appropriate escalation had improved from 70% to 90%; all entries signed had improved from 90% to 100%. Six areas remained at 100% for both audits. In two areas the results were worse than the previous audit with reduction from 100% to 90% in both. Appropriate actions were identified.
- We saw examples of guidelines in use such as NICE QS24: nutrition support in adults, QS3: VTE in adults reducing the risk in hospital, and QSD77: urinary incontinence in women.
- NICE guidance was reviewed at clinical governance meetings and if relevant discussed with clinicians to ensure best practice.
- We were shown examples of the Nursing and Midwifery Council guidelines followed by staff with up-to-date protocols on the hospital intranet.
- The hospital participated in a variety of national audits, for example the National Joint Registry (NJR), the NHS safety thermometer and the Patient Reported Outcome Measures (PROMS) which assesses the quality of care delivered to NHS patients from their perspective.
- There was an annual audit plan. We were provided with the two most recent quarterly audit reports covering the period January to June 2016. There were seven monthly audits that included medical records, the WHO checklist, VTE screening and hand hygiene. Results were displayed as well as issues identified and recommendations. These included, for the medical records audit, findings such as no copy of consultant clinic notes where compliance had got worse, and poor compliance with documentation of the consultant daily progress notes which had improved. There were clear

recommendations that the results were to be discussed at the clinical effectiveness committee and the medical advisory committee (MAC) with continued audit and reporting over the next quarter.

- Other audits with different time frames were carried out, such as resuscitation audits every quarter and biannual blood transfusion audits. Improvements and clear recommendations were included in all audits.
- We saw evidence of a number of regular departmental audits carried out. In theatres, the care bundle to prevent surgical site infections review tool was completed quarterly on 20 randomly selected cases. A sharps audit completed by an external company showed theatres scored 100%. The urinary catheter insertion audit in June scored 100%.
- The monthly WHO checklist audits identified the main area of focus to be the importance of each team member identifying themselves at the start of every procedure. This had been discussed at theatre meetings and was subject to on going audit.
- The wards carried out falls audits with learning discussed at ward meetings.
- We also saw the most recent resuscitation checklist three monthly audit with no issues identified.

Pain relief

- We saw the pain descriptor information provided for patients on the wards. This meant that patients could use this to accurately respond when asked about pain by staff.
- Patients we spoke with told us that their pain had been well controlled.
- We saw that pain scores were recorded in the patient records we looked at with management by the RMO. We were told that anaesthetists were available to manage pain control where necessary.
- A pain relief audit of documentation was carried out in May 2016 and will continue to be done twice a year. This showed 81% for day case and 88% for inpatients. The results were considered alongside patient feedback completed on discharge and analysed externally. There was indication of improvement from previous patient surveys and identified the importance of all methods of pain management being considered. Feedback was through the ward meetings and clinical governance committee.

Nutrition and hydration

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- Nutritional screening was done at pre-assessment and on admission so that dietician advice could be sought where required. The Malnutritional Screening tool (MUST) was used and we saw evidence that this was completed in patient records we looked at.
- The dietetic service was provided on a sessional basis by the local NHS trust and formed part of the multi-disciplinary team caring for patients.
- We saw food and fluid intake was monitored using food charts and fluid balance charts. We were told patients who were unable to feed themselves were assisted by the nurses and health care assistants. At the time of inspection all inpatients were independent and did not require assistance with feeding.

Patient outcomes

- The hospital participated in Patient Reported Outcome Measures (PROMs) which is a tool used to measure health gain in patients undergoing hip replacement and groin hernia surgery in England. The hospital's average health gain for groin hernias and hip replacement could not be calculated for this hospital as there were less than thirty records
- The hospital provided us with mortality and morbidity (M&M) data from April 2015 to June 2016 which included unplanned transfers out, unplanned readmissions within 28 days and unplanned returns to theatre.
- We were also provided with surgical complications data which showed 33 for the period July 2015 to March 2016. Where complications were within the M&M criteria these were reviewed and presented at clinical governance meetings.
- There were 11 unplanned transfers of patients during the reporting period April 2015 to March 2016. Five of these related to surgical procedures. All were investigated fully, reported and discussed at the medical advisory committee where appropriate. Learning was identified and disseminated appropriately. One related to the outpatient department. This meant there were 10 unplanned transfers out of 5,377 day case and inpatient attendances across the hospital for that period.
- There were eight cases of unplanned readmission within 28 days of discharge in the reporting period April 2015 to March 2016. The assessed rate of unplanned readmissions (per 100 inpatient attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

We saw two examples of the full root cause analysis of incidents. Learning was clearly identified with actions taken. Where it was due to a known risk/complication of the procedure a full investigation and discussion was also done.

- There were seven cases of unplanned return to the operating theatre in the same reporting period. We looked at three sets of patient records and found early recognition of known risks/complications and prompt management for the patients.
- Physiotherapy patients agreed goals and monitored outcomes for individual patients. We saw evidence for three patients that demonstrated both symptom and condition improvement.

Competent staff

- Staff we spoke with told us they felt well skilled to care for both surgical and medical patients on the wards.
- We saw that induction was completed for new staff. We were told that staff were welcomed and they met the executive director and director of nursing as part of induction.
- Staff were able to access training and told us they were well supported and encouraged to attend courses for their learning and development. We saw examples where administration staff had moved into different departments for development. Examples of further development included courses such as acute illness management and cognitive behavioural therapy.
- We saw the massive blood transfusion protocol in theatres and that staff were appropriately trained.
- One ward, one pre-assessment and two theatre registered nurses we spoke with said they had their appraisals. We saw examples of completed appraisals.
- However, data for the year October 2014 to September 2015 showed only 55% of theatre staff received appraisals. The numbers were low for the current year from October 2015 to September 2016 with 40% appraised so far.
- Staff said they had regular meetings with their line manager and felt well supported. They also received monthly emails with updated information.
- The MAC was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies. The surgeons received supervision and appraisals. Senior managers

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ensured the relevant checks against professional registers and information from the Disclosure and Barring Service (DBS) were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the MAC notes.

- The agency that supplied the RMO provided the CV for a new RMO and this included their training records. This was reviewed by the director of nursing. Each new RMO undertook a full hospital induction.
- The RMO confirmed they had an appraisal and undertook continuous professional development. This was monitored by both the hospital and the agency.

Multidisciplinary working (in relation to this core service only)

- We found good bed management and forward planning with daily meetings and an online system which allowed all staff to plan and see patients booked for admission. These were attended by the executive director, director of nursing and heads of department.
- The pre-assessment nurses, physiotherapists and occupational therapists worked together to ensure completed risk assessments and other preparation was in place prior to the patient being admitted.
- Inpatient wards had a multi-disciplinary communication sheet. This was completed on a daily basis for information to be passed to members of staff on subsequent shifts. For example a reminder of meetings or specific information relating to a patient. Staff had to sign the forms to show they had read the information and action had been taken.
- A service level agreement with the local NHS trust meant that patients could be referred to a full range of allied health professionals including speech and language therapy and dietetics.

Seven-day services

- The hospital had medical cover from an RMO and senior nurse 24 hours a day seven days a week as a contact point for both staff and patients.
- Patients had access to telephone advice 24 hours a day, seven days a week.
- The pharmacy was accessible 24 hours a day, seven days a week. Out of normal working hours a senior nurse and RMO had access to the department. The pharmacy provided an on call 24 hour service for advice and medical information. The on call pharmacist would attend the hospital if required in an emergency.

- There was also an on call rota operated by radiology and physiotherapy teams should support be required out of hours, as well as an on call emergency theatre team.

Access to information

- The hospital monitored the availability of medical records for patients admitted for surgery. This showed that for the last three months there were no incidents of the records not being available. This meant pre-assessment information, including past medical history and test results, were all in place for clinical staff.
- Morning 'huddles' were held to review admissions and discharges planned for the day. This meant that individual patient requirements were communicated to all staff.
- The hospital electronic tracking system meant that all clinical and administrative staff were aware of patient bookings.
- We saw discharge letters to GPs providing information regarding procedures and aftercare in patient records we looked at.
- The hospital held a breast implant register which recorded every breast implant used on every patient.
- Wards had folders with consultant contact details and other relevant information for patient care.
- Immediate diagnostic reporting was available through a service level agreement with the local NHS hospital for cancer patients, for example sentinel node biopsies, as these were sent by courier.
- We saw that policies and procedures were readily available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a Safeguarding Adults Policy that included the Mental Capacity Act (MCA) 2005 legislation, Deprivation of Liberty Safeguards (DoLS) and set out procedures that staff should follow if a person lacked capacity. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. MCA training was a part of the wider safeguarding training.
- We looked at the consent forms for all the procedures we observed and all records we looked at. The forms were fully completed and included any relevant risks and complications. We observed consent discussions.

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- Patients told us they had been consented by the surgeon and the anaesthetist.
- We spoke with two registered nurses in theatre about MCA and DoLS. They demonstrated a good knowledge and understanding of mental capacity and the consent process. We were told it was very rare that patients who lacked capacity to consent for a procedure to be treated at the hospital but they knew the process to follow should this occur.
- Ward staff demonstrated understanding of MCA. Other staff told us that they would contact the patient's GP or consultant if they had concerns about their capacity to consent.
- We saw that patients were always informed before a care action, such as taking blood pressure, was undertaken.
- The PLACE score for dementia care in the hospital was 85%. This was the same or higher than the England average.

Are surgery services caring?

Good 

We rated caring as good because:

- We observed patients treated with compassion, care and dignity. Patient feedback was positive and staff demonstrated commitment to continuous improvement.
- Patients told us they were well informed and were able to ask for further information.
- Patients were well supported.

Compassionate care

- We saw that staff were courteous and treated patients with dignity and compassion.
- We spoke with six patients who said staff handled their dignity very well, were caring and very efficient.
- The hospital scored 100% for Friends and Family Test (FFT) in the reporting period October 2015 to March 2016 with the exception of December 2015. These refer to NHS patients only and are reported by NHS England. However, the hospital provided reports with their FFT results of all patients, NHS and private funded. These were comprehensive monthly reports that covered the whole patient journey and allowed comparison with other BMI hospitals in the region as well as BMI as a

whole. The report for March 2016 showed positive results with high satisfaction score of 99.9% for being treated with respect and dignity and the lowest score of 75% for the choice of food. This was one of only two results scoring less than 82% out of 46 data items.

- Areas that the FFT demonstrated had improved, as well as any issues, were identified and reported on. The report showed that out of the 55 BMI hospitals, Mount Alvernia had improved from position 35 the previous month, to position 19 in March 2016.
- We saw approximately 80 thank you cards displayed on St Clare's Ward and patients frequently sent in gifts such as chocolates to express their appreciation.
- Four CQC comment cards were completed by patients during the inspection. They were all positive stating, for example, that staff were attentive and friendly and that care from all staff was "beyond exceptional". This included housekeeping and catering staff as well as clinical staff.
- Patients told us that they were really well looked after and that staff had the time to care for them.

Understanding and involvement of patients and those close to them

- We observed clinical staff involving patients in their care planning. This included doctors, registered and non-registered nursing staff.
- Patients on the wards had a named nurse caring for them.
- We observed a member of staff providing clear information to a patient on the telephone.
- Patients we spoke with told us they had been provided with sufficient information and that there was enough time for explanations and any further questions.
- One completed comment card said that they had been reassured by the information provided at their pre-assessment appointment. Another stated that staff were, "warm and responsive to my needs".

Emotional support

- A multi-faith chapel was available for patients, staff and visitors. There was a book for people to leave comments and messages and we saw several entries for July 2016.
- We saw there was a leaflet on pastoral care in patient rooms we looked at.
- If required, counselling could be arranged through a service level agreement with the local NHS trust.

Surgery

- Patients told us they felt well supported and would be able to request any further support or pastoral care if they required it.
- Staff told us they could contact local religious leaders should this be required. They demonstrated awareness of the needs of different religions such as Jehovah's Witnesses and Islam. One member of staff told us of a patient request to see a priest and this had been arranged by the sister in charge.

Are surgery services responsive?

Good 

We rated responsive as good because:

- The services were delivered in a way that met the needs of the local population and allowed patients to access care and treatment when they needed it.
- Waiting times, delays and cancellations were minimal and well managed. Patients told us staff were responsive to their needs.
- Complaints management was a priority in the hospital. The process was transparent and open with learning communicated across the hospital.

Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of local people. Orthopaedic procedures and pain treatment for joints were among the most common procedures carried out at the hospital in response to an increase in older people.
- NHS patients accounted for about 10% of total inpatient and day case activity. We were told of ongoing work with the Clinical Commissioning Groups to increase these numbers.
- The hospital had introduced a bariatric service for patients with a high body mass index. This included laparoscopic gastric sleeves. Planning for this service involved other specialties such as dietetics and wound care professionals.

Access and flow

- Patients were generally booked two to three weeks in advance with a policy of not booking a patient within five days of surgery. This meant that all information, investigations and pre-assessment were carried out and results received in time for the date of operation.
- Bookings for procedures were sent to theatres to ensure suitability and availability of staff. Decisions to admit were based on clear criteria as the hospital did not have high dependency or critical care beds.
- Once this information was taken the booking was passed to pre-assessment and patient services to arrange with the patients and pre-assessment clinic staff.
- All patients had pre-assessment before being admitted. Patients having operations such as hips, knees and gynaecological procedures were telephoned and an appointment date agreed for them to come to pre-assessment clinic. They were seen by the registered nurse as well as the anaesthetist, physiotherapist and occupational therapist where relevant. Blood tests and other screening and investigations were done during this visit.
- The RMO checked results the next morning and made a referral to the consultant if required.
- Patients for less complex procedures had a telephone pre-assessment with a registered nurse. If there were any concerns the patient would be offered an appointment in the clinic.
- Patients were booked for pre-assessment on the hospital's electronic tracker system and we saw the list for clinic on the day of the inspection. This meant all staff could access the information.
- The medical secretaries booked the operation dates on the hospital's electronic system. The list order was confirmed with the surgeon, theatre teams and ward staff the day before patients were admitted.
- There were exceptions to the five day rule for patients with cancer or in more urgent need. In these cases staffing and equipment availability were checked to ensure everything was in place for the whole process before accepting the booking.
- A colour coding system was in place to highlight to staff where changes had been made to the operating list. The first list was printed on green paper. If the order changed it was reprinted on yellow paper. Any further changes and the list was reprinted on red paper. This ensured that all staff were updated and aware.

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- The hospital reported one cancelled procedure for a non-clinical reason in the last 12 months. The patient was offered another appointment within 28 days of the cancelled appointment.
- Surgery was also carried out on Saturdays which provided further flexibility for patients.
- Waiting times for NHS patients were managed within the requirements of the referral to treatment pathway. BMI Healthcare policy set a standard of 92% of patients treated within that time. Data provided stated that BMI Mount Alvernia achieved almost 94%. However, for the period April 2015 to March 2016 the months of May, June and July fell well below with 70% in June. We spoke with management and they assured us that this had been due to a data entry error which had been identified and subsequently corrected. The waiting times were monitored closely and there had been no further issues.

Meeting people's individual needs

- A GP summary was provided for elderly patients treated in the hospital. This meant that past medical history and current conditions were known to staff at pre-assessment and onward.
- Any additional patient needs were identified at pre-assessment.
- We saw the information pack sent out to all patients prior to their pre-assessment. This included a medical questionnaire and pre-surgery information, for example food intake and what to bring.
- We saw a range of patient information to support patients.
- Patients were given the choice, where possible, of walking to theatres or being taken in a wheelchair.
- One patient told us they were provided with "a lot of help" in the night following the procedure and staff responded promptly whenever this was requested.
- Patients told us that the hospital accommodated their dates for surgery and that there were no delays experienced. This included NHS patients.
- Staff had access to a translation service should this be required.
- There was open visiting hours on the wards which the patients we spoke with appreciated.
- There was also a garden area for patient use as a quiet place to sit.
- An occupational therapy furniture height checklist was sent to patients booked to have a total hip replacement.

This was completed either prior to or at pre-assessment and meant that the therapist was able to provide appropriate advice on care required following the procedure, together with advice on aids and equipment to help everyday activities once home.

- We saw there was an individual room opposite the nurses' station on all three inpatient wards. This room had space for an additional bed. Staff told us this was appropriate for relatives who wished to stay with a patient who was living with dementia or learning disabilities.
- The multi-faith chapel catered for religions such as Christianity and Islam that included mats and washing facilities. It also served as a quiet place for those with no religion.
- Rooms on the wards contained televisions, information on patients' rights and access to the internet. There was also a welcome letter and general hospital information available.
- We saw patients on the wards well provided for with hot and cold drinks throughout the day with staff bringing jugs of fresh water into rooms in the very hot weather at the time. Drinks machines were available in waiting areas.
- Patients told us that they were regularly offered hot and cold drinks.
- We saw a menu with a selection of choices that included cultural requirements and individual needs such as gluten free options. Patients were able to order meals that were not on the menu.
- Patient allergies were recorded on a form that was passed to the ward hostess to take a copy for the kitchen. This meant that catering and nursing staff were aware of all allergies.
- Catering services were outsourced and there had been a change to another private provider. The Patient-led assessments of the care environment (PLACE) for the period February to June 2015 showed that food scored 77% which was below the national average of 94% for ward food, which reflected this change in provider. This score improved to 85% in the next assessment. However, patients we spoke with said that the food was good. One patient told us they had requested extra fruit which had been provided.

Surgery

- We were told that the hospital were working with the catering services to improve patient satisfaction and we saw evidence of continued ways to improve discussed at the clinical governance committee minutes we looked at.
- We were told that the chef would come to the ward to discuss any particular requirements with an individual patient.

Learning from complaints and concerns

- Complaints were managed and investigated by the senior management team and relevant heads of department who all attended the daily morning 'huddle'. We were told that complaints were discussed at the huddle as they were received which meant staff were aware immediately one was raised. We saw evidence that complaints were discussed at the clinical governance meetings, medical advisory committee, heads of department committee, theatre department meeting and ward meetings.
- Staff at all levels were encouraged and empowered to address any concerns whilst the patient was on site to resolve any issues as soon as possible for the patient and their relatives.
- We saw that 16 out of the 29 complaints hospital wide for the period March 2015 to April 2016 concerned surgery. The most common concerns raised were around communication, clinical care and finance. The hospital collated and reported on incidents together with action taken and learning to be disseminated. This meant managers were able to identify themes and put in place measures to improve services.
- The assessed rate of complaints (per 100 day case and inpatient attendances) was significantly lower than the other independent acute hospitals CQC holds this type of data for.
- CQC directly received four complaints during the period April 2015 to June 2016.
- We saw the hospital's Patient Guide in rooms we looked at. This covered the formal complaints procedure. The BMI leaflets 'Please tell us' were readily available throughout the hospital. Patients were given an opportunity to complete the hospital's patient survey questionnaire.
- Patients we spoke with said they knew how to complain but did not need to as the care and treatment was of a very high standard.

- The hospital held periodic patient satisfaction meetings to review complaints, compliments and survey results. This was chaired by the executive director and identified trends and benchmarking within BMI Healthcare.
- The three items of rated feedback on the NHS Choices website all said they were extremely likely to recommend this hospital.
- The BMI Healthcare complaints policy set out the response timeframes throughout the process and these were monitored and reported on as part of the hospital's governance system. All complaints were investigated and complainants were informed of progress. Information was provided about further alternatives should they remain unhappy at the end of the process.

Are surgery services well-led?

Good 

We rated well-led as good because:

- There were clear organisational structures and roles and responsibilities.
- There were good governance, risk and quality systems and processes that staff understood. The committee structure supported this with reports disseminated and discussed appropriately.
- There was a strong, open leadership throughout the organisation. Staff felt confident about raising issues with their direct line manager and the senior management team.
- The hospital collected patient information and reviewed it alongside other performance data. This was benchmarked within BMI Healthcare.

However:

- The risk register was not compiled so that departmental risks could be identified.

Vision and strategy for this core service

- The hospital had a clinical strategy which was made up of six key themes. These were: putting patients at the heart of what they do; staff were the most important attribute; quality should underpin everything they do; working together; engaging with consultants; and being as cost effective and efficient as possible.

Surgery

- Staff we spoke with demonstrated clear understanding that the patient was at the heart of what they do and worked together to achieve this.
- We were told of the on going work to engage with the visiting consultants and to increase the numbers year on year.
- There was an overarching BMI Healthcare strategy that all hospitals worked to.

Governance, risk management and quality measurement for this core service

- There was a corporate strategy for governance that provided a framework for local governance procedures.
- There were a variety of monthly meetings that discussed risk, incidents and complaints. These included the senior management team and heads of department meetings. Information from these meetings was disseminated to theatre group meetings and ward meetings. In turn information from the departmental meetings was fed up to the heads of department. This ensured that there was good communication throughout the hospital and staff were aware of specific incidents and causes for concern.
- The hospital had a clinical effectiveness committee which met every two months and fed into the clinical governance committee (CGC) which also met every other month. We saw samples of minutes that demonstrated departmental and other meetings fed into the CGC such as theatre and ward meetings, patient experience committee and resuscitation committee. Clinical quality as well as governance was discussed at the quarterly Medical Advisory Committee (MAC) and attendance included the heads of departments such as the theatre manager.
- Staff told us that the quality and risk manager had implemented much more robust processes and systems for governance, including incident reporting, investigation and learning.
- Each department had a clinical governance folder that contained recent minutes from, for example, the clinical governance committee and the theatre group, patient satisfaction data, complaints log and incident reports. There was also the monthly Quality and Risk News with shared learning across BMI. Examples of content included the top three themes for learning such as the accuracy and clarity of documentation. The February 2016 edition included the areas for improvement found at other BMI hospital inspections.
- We saw evidence that staff had signed that they had read the folder.
- Theatre staff meetings and ward meetings were held monthly. We saw minutes that demonstrated good attendance. Staff told us the meetings were useful with the minutes circulated by email. This meant that staff unable to attend had access to the discussions and information.
- There was 100% completion rate of validation of registration for doctors and dentists working or practicing under rules or privileges in the reporting period April 2015 to March 2016.
- We were told there were 118 regular visiting consultants out of a total of 195. Consultant contracts, known as practicing privileges, were managed jointly by the hospital management and the MAC. We saw evidence of discussion of new applications and the outcomes in the June 2016 MAC minutes. There was also evidence of consultants suspended when they had not provided the required documentation requested by the hospital management and reinstated once they had.
- There was a hospital risk register on the hospital intranet in respect of the whole organisation. The executive director monitored the register in respect of Mount Alvernia.
- We saw the risk register for April 2016. The risks were divided into categories: patient safety, information management, financial, reputation, governance, operational, leadership and workforce, workforce health and safety, and facilities and infrastructure. The register described the risks involved with their impact, likelihood and risk ratings. Existing risk controls and further actions were linked to a responsible committee and key lead.
- We were told the risk register was reviewed at the governance committee meetings to ensure that identified risks were on the register and if any risks had changed they were re scored.
- However, the risk register was for the whole hospital and was not divided into separate areas. Staff we spoke with were unable to tell us what was on the risk register.

Leadership / culture of service related to this core service

- There was a clear management structure which staff were aware of. This meant leadership and management responsibilities and accountabilities were explicit and clearly understood.

Surgery






- The management structure for surgical services at the hospital was the executive director and the director of nursing who were responsible for the managers of theatres and the wards. Heads of departments oversaw the running of their respective areas and reported to the executive director and director of nursing.
- We were told by all staff we spoke with that the senior team at the hospital were visible and approachable. All staff knew who the senior team were. All staff told us they had seen change and improvement over the last two years and were very positive about working at the hospital. One comment we received in respect of the senior team was, "It feels totally different." Another member of staff said the hospital was "forward thinking".
- Staff spoke highly of their direct line management and were able to raise issues with them.
- Staff described an open reporting culture with an emphasis on learning. A member of staff said they felt able to report on themselves, for example a medication error.
- No whistleblowing concerns had been reported to CQC in the last 12 months.
- All staff we spoke with described good team working within all clinical areas in the hospital.
- Theatre and ward staff told us that they all worked very well together. Several of the staff had been there over 20 years and we also spoke with new team members. We were told that they also socialise together.
- The hospital monitored patient satisfaction in all areas of its service delivery. This was achieved through obtaining patient feedback and views through the forms they placed in each patients room and outpatient areas. The analysis of this information was provided by an external provider and this was arranged through the corporate teams. The hospital received a corporate monthly report which showed response rates, rating within categories and ranking against all BMI hospitals. It also included all the freehand patient comments.
- The hospital had a patient satisfaction group was made up of a number of employees around the hospital. This group continually reviewed the patient satisfaction scores and dealt with areas for improvement.
- The hospital encouraged social interaction for staff through a range of events organised specific to the hospital. For example, the Pin Awards, Above and Beyond Awards and charitable initiatives to encourage staff engagement in a social context.

Innovation, improvement and sustainability

- The senior management were proactively working to increase surgical activity for both NHS and private practice. We were told of on going discussions with the local Clinical Commissioning Groups and consultants from local NHS hospitals.
- There was considerable emphasis on the patient experience with all staff focussed on the patient at the centre of everything. Constant efforts for improvement were clearly demonstrated.

Public and staff engagement

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at BMI Mount Alvernia cover a wide range of specialities, including cardiology, dermatology, ear, nose and throat (ENT), general surgery, general medicine, gynaecology, haematology, neurology, neurophysiology, nephrology and oncology. From June 2015 to June 2016, the outpatient department provided 615 new patients appointments and 616 follow up appointments for NHS patients. They provided 8, 329 new patient appointments and 13, 939 appointments for patients with insurance or paying themselves.

The hospital told us they did not see children in outpatients. The hospitals statement of purpose indicates the hospital offers outpatient and diagnostic services to paediatrics between the ages of 16 and 18. However, from June 2015 to June 2016, data given to us by the hospital about outpatient attendances showed that 71 children attended the outpatient department. The data indicated one of these children was between 0 to two years old and one was aged three to 15 years old. The others were between 16 and 17 years old. In addition to this, we saw a complaint which related to a 13 year old patient. The hospital told us this was a data error and only 69 16-18 year olds had attended the hospital.

The Consulting Room Suite has 11 consulting rooms including dedicated ENT, ophthalmic and cardiology rooms and audiology booth. Two nurse treatment rooms are available along with a registration desk, two waiting areas one with a coffee shop.

The outpatient department runs clinics from 8am to 9pm Monday to Friday, with occasional Saturday clinics between 9am and 3pm

The imaging department provides a comprehensive range of diagnostic imaging services including all types of general x-rays, digital screening, mammography, bone densitometry, a full ultrasound service. The department also has a 128 slice computerised tomography (CT) scanner an MRI scanner and the nuclear medicine department provides a gamma camera and a mobile positron emission tomography (PET) CT service.

The diagnostic imaging department provides a 24 hour a day, seven day a week service for urgent examination requests.

The Pharmacy Department provides outpatient services from 9am to 5pm, Monday to Friday and Saturday mornings, when clinics are running.

Physiotherapy outpatients is in a dedicated location with individual bays and a gym area. The staff provide hydrotherapy off-site and physiotherapy services are provided at satellite clinics in GP surgeries.

We spoke with four patients and 34 members of staff including, nurses, radiographers, physiotherapists, pathology staff, health care assistants, administrators and managers. As part of our inspection, we looked at hospital policies and procedures, staff training records, and audits. We looked at 18 sets of notes, the environment and equipment staff used.

Outpatients and diagnostic imaging

Summary of findings

We found the outpatient and diagnostic imaging services at BMI Mount Alvernia to be good. This was because:

- The hospital had good systems and process in place to keep patients from harm.
- A wide variety of modern equipment was available for staff to deliver a range of services and examinations.
- Staff managed medicines in line with best practice and stored them securely.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement.
- The outpatient and diagnostic imaging departments had sufficient numbers of appropriately trained competent staff to provide their services.
- Staff dealt with patients in a kind, caring and considerate manner. Patients were happy with the care they received.
- The hospital was responsive to the needs of the local populations. Appointments could be accessed in a timely manner and at a variety of times throughout the day.
- Results of investigations were available quickly and double checked by members of staff.
- Managers were visible, approachable and effective.
- The hospital had a clinical governance committee and medical advisory committee both responsible for ensuring there were robust systems and processes in place in relation to governance and assurance.

However:

- Children attended the outpatient department, but neither the safeguarding lead nor any staff had attended level three safeguarding children training as per national guidelines.
- The assessment and response to risk was not managed consistently throughout outpatient and diagnostic imaging services.

Are outpatients and diagnostic imaging services safe?

Requires improvement 

We rated safety as requires improvement for the outpatient and diagnostic imaging services. This was because:

- Children attended the outpatient department, but neither the safeguarding lead nor any staff had attended level three safeguarding children training as per national guidelines.
- The number of outpatient staff who had completed their mandatory training was not in line with the hospitals target.
- The assessment and response to risk was not managed consistently throughout outpatient and diagnostic imaging services.

However;

- Staff had a good understanding of the incident reporting process. Staff discussed incidents regularly at departmental and governance meetings and learning from incidents was clearly demonstrated.
- Good infection control practices were in place and demonstrated in line with national guidance.
- The outpatient and diagnostic imaging services had a wide range of well-maintained equipment, which staff were competent to use.
- Staff demonstrated good medicines management, storage and monitored the use of prescription pads.
- Records were accurate, legible, complete and were stored securely. The outpatient service was planning to copy all outpatient records and was on track to start this in September.
- The outpatient and diagnostic imaging service had sufficient numbers of appropriately trained staff to provide safe care to patients. The majority of staff had completed the hospital's mandatory training programme.

Incidents

- There were no 'never events' reported by the hospital between June 2015 and May 2016. 'Never events' are

Outpatients and diagnostic imaging

serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.

- From December 2015 to June 2016, the outpatient and diagnostic imaging departments reported 32 incidents, which were a mixture of clinical and non-clinical. Staff had a clear understanding of the incident reporting process. We saw 'incident triggers' information on staff noticeboards for staff to refer to.
- Staff discussed incidents regularly at department meetings and we saw minutes of meetings which indicated this was occurring regularly.
- Staff gave us examples of changes made because of an incident. A patient had received an increased dose of a medicine used in a diagnostic test. Staff reviewed the checking process and identified where the error occurred. The department changed the way they checked the medicine.
- Newsletters from BMI every 3 months detailed how incidents were addressed at the time and lessons learned. We saw these newsletters.
- The hospital reported no ionising radiation (medical exposure) regulations IRMER incidents to the care quality commission (CQC) in the last 12 months. Staff had a clear understanding of what was a reportable incident. A Radiation Protection Adviser (RPA) was available for advice, by telephone, if required.
- Staff had a good awareness of duty of candour but had not had to demonstrate it; they told us they were open and honest with patients. The diagnostic imaging department gave us an example where they informed a patient immediately when they thought the patient had received an increased dose of radioactive medicine.

Cleanliness, infection control and hygiene

- All the areas we visited in the outpatients and diagnostic imaging departments were visibly clean and tidy and there were good infection control practices in place
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016 scored 100% for cleanliness, which was better than the national average of 98%.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene', from the World Health

Organisation (WHO) guidelines on hand hygiene in health care. Information was displayed demonstrating 'five moments for hand hygiene' near handwashing sinks.

- The last hand hygiene audit was discussed at the clinical governance committee in April 2016 and all areas had scored 100%.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note 00-09: Infection control in the built environment. Motion sensor taps were in place. Soap and hand towels were available next to the sinks. Sanitising hand gel was readily available.
- We saw personal protective equipment was available for staff to use.
- We saw disposable curtains used in clinic rooms, dates on them indicated they had been changed within six months.
- We saw carpets in consulting rooms seven, eight, nine, the health screening room, cardiology room and the audiology room. Clinical equipment was available in all these rooms and ready for use. Staff told us clinical procedures did not occur in these rooms. If a procedure was required, the patient would be taken to a treatment room which had flooring which was seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment, 3.109.
- Managers told us the carpets were deep cleaned every six months and sooner, if required. We saw records which indicated the carpets in all areas had been cleaned the month before our inspection. Fabric chairs were cleaned every six months and we saw a cleaning schedule which indicated this had been done.
- We saw there was cleaning schedules in individual treatment rooms which were fully completed and comprehensive.
- Equipment was cleaned between each patient use and a green sticker placed on it. We saw equipment with green 'I am clean' stickers on which indicated it was clean and ready for use.
- Some equipment was cleaned using a triple wipe cleaning system. This was a system of cleaning equipment which uses three types of cleaning wipe to ensure thorough cleaning of equipment has occurred. At each stage of cleaning the type of wipe used, for the

Outpatients and diagnostic imaging

type of equipment and by which member of staff was recorded in a log book. We saw log books which indicated all steps had been completed and by which member of staff.

- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.
- We saw sharps bins were available in treatment areas where sharps may be used. This demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had been fully completed which ensured traceability of each container.
- In the diagnostic imaging department if a patient with an infectious disease required a scan, they would be put at the end of the day and the department would be deep cleaned after.
- However, we saw a machine used for measuring the capacity of a patient's lung. Although it had disposable mouthpiece, the tube into which the patient blew was not. We asked how this was cleaned and were told it was washed in soapy water. No risk assessment had been done for this machine or cleaning schedule drawn up. Assurances could not be given; this piece of equipment was cleaned adequately between patient uses.

Environment and equipment

- The outpatient service had 11 individual consulting rooms and two outpatient waiting areas.
- We saw tidy and spacious waiting areas. One outpatient waiting area had access to a small garden. We saw adequate seating available at a variety of heights and space available for patients to wait in wheelchairs. The hospital had several wheelchairs available for patients to use if required.
- Each consulting room was equipped with a treatment couch and trolley for carrying the clinical equipment required. It had equipment in to provide physical measurements. This was line with HBN 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.
- An audiology room was available and sound proofed to enable hearing tests to be carried out.

- We saw the clinical room was visible clean, uncluttered and the temperature monitored continually. An alarm sounded when the temperature went out of the set range.
- The most recent PLACE score in 2016 for condition and appearance of the department scored 94%. This was equal to the England average.
- We saw copies of service records which indicated all equipment was serviced annually. We saw stickers on equipment which indicated it had been serviced recently. Electrical equipment had portable appliance test (PAT) stickers on which indicated it was safe for use.
- We saw certificates to indicate staff were competent to use equipment which was in line with the hospital's medical devices policy.
- We saw an individual room for patients to have blood tests in. This is in line with Health Building Note (HBN) 12, 4.42, which recommends areas providing blood tests should provide individual cubicles for patients.
- The resuscitation trolley was shared between the outpatient and diagnostic imaging departments. The trolley was tamper proof and all consumables were in date. Staff checked the trolley daily; we saw complete checklists to confirm this was done. The resuscitation officer completed an audit of the trolleys in the hospital every three months. The last two completed in January and April 2016 were both compliant.
- The diagnostic imaging department had a variety of modern equipment to deliver high quality scans. In the mammography room, the equipment had mood lighting to assist in relaxing patients whilst having the scan.
- The MRI and CT scanners were in locked rooms. Staff gained access by key pad and only the appropriate staff had access to these rooms.
- We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this a radiation protection committee reported annually on the quality of radiology equipment, which we saw. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations IR (ME) R 2000).
- Lead aprons were available in all areas of radiology. Regular checks occurred of the effectiveness of their protection. We saw spread sheets which showed checks occurred regularly and equipment provided adequate protection.

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- A wheelchair and trolley were available for the evacuation of a patient from the MRI and CT scanner area in the event of an emergency.
- The emergency call bells were tested regularly and we saw records which indicated this was being done.
- The physiotherapy department had a gym and individual treatment rooms to provide a variety of treatments. The gym was well stocked with a range of equipment to suit patient's different level of fitness and abilities.

Medicines

- Staff stored prescription pads in locked cupboards and a registered nurse held the key. We saw registers in place for every clinic room which had prescription pads; this indicated when a prescription had been issued, to whom and what for. This is in line with NHS Protect, Security of prescription forms guidance, 2013. The hospital audited the use of prescription pads and the most recent audit in February 2016 indicated standards were being met and pads were stored securely.
- Staff monitored and recorded the minimum and maximum medicines refrigerators and room temperatures where pregnancy testing kits were stored. We saw records which indicated this was done regularly.
- In diagnostic imaging, medicines used to perform scans were stored in a locked cupboard with key pad access in a locked room with key pad access. Only authorised, registered professionals had access to the medicine cupboard.

Records

- From June 2015 to July 2016, no patients had been seen in outpatients without the full medical record being available. Consultants carried their own outpatient records. Medical secretaries prepared the notes and they were kept in a sealed bag until the clinic started. After clinic, records were put into a bag which was sealed and we saw this being done.
- The hospital was working towards having a copy of the patient's outpatient record at the hospital. We saw minutes of meetings which detailed how this was to be achieved and was discussed regularly. We spoke with staff in the medical records department who showed us what the record would look like and had a good understanding of how they would manage the record,

so that all the appropriate information would be in it. The plan was to implement the duplication of records on 5th September 2016. The minutes of the meetings indicated this was due to be achieved.

- Records were stored in the medical records department which could be accessed by authorised personnel only. A register was completed to indicate if a record had been removed and where it had gone to.
- We looked in 18 sets of patient records. We saw records were complete, legible and signed. They contained referral letters, results of diagnostic tests and discharge letters.
- In diagnostic imaging, records were stored on a patient arriving communication system (PACS). Only staff with a passcode could access them. Only staff authorised to have access had a passcode.
- We saw confidential waste areas available in administration areas, which indicated confidential waste was managed appropriately.

Safeguarding

- The responsibility of a safeguarding lead is to ensure providers have the right systems and process in place to make sure children and adults were protected from risk or actual abuse and neglect. National statutory guidelines 'Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children' (2015) states safeguarding leads are to be trained to level 3 for vulnerable children as the lead takes the responsibility for the organisations safeguarding arrangements.
- The safeguarding lead with responsibility for safeguarding was not trained to level 3 for children at the time of the inspection, however there was a service level agreement in place with a neighbouring BMI Hospital facility for a Lead Registered Children's Nurse, who holds safeguarding level 3 and who was available to the Hospital for advice, action and support for safeguarding concerns.
- Sixty nine children aged 16 to 18 years attended the outpatient department as patients between July 2015 and June 2016. Clinical and staff working in the department were only trained to level 2. This was not in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010, which recommends that staff working with children should be trained to level 3.

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- In the hospital, 95% of staff had attended level one safeguarding vulnerable adults which was better than the BMI target. Ninety three percent of staff had attended level two safeguarding vulnerable adults training, which was better than the target of 90% and one member of staff was trained to level three safeguarding vulnerable adults.
- Of all hospital staff 95% had attended level one safeguarding children training, which was better than the BMI target. Ninety three percent of hospital staff had attended level two safeguarding children training, which was better than the target score of 90%.
- The hospital did not have level three children's safeguarding training as part of its mandatory training programme at the time of our inspection.

Mandatory training

- Mandatory training was mainly on line learning supported with practical sessions. Staff told us on line mandatory training was a good opportunity to read policies. They told us they did not experience difficulties accessing training or computers to complete on line training.
- In the diagnostic imaging department, 96% of radiology staff had completed mandatory training, which was better than the target of 90%. In MRI, 100% of staff had completed mandatory training and in nuclear medicine, 96% of staff had attended mandatory training.
- In the Physiotherapy department, 92% of staff had attended mandatory training which was better than the target of 90%.
- In the outpatient department, 91% of staff had completed mandatory training, which was better than the target of 90%.

Assessing and responding to patient risk

- We observed good radiation compliance as per policy and guidelines during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. There was key pad entry to examination rooms and only authorised staff had access.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations (IR (ME) R 2000).
- Departmental staff also carried out regular quality assurance checks. This indicated equipment was

working as it should. These mandatory checks were in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000). We saw records of these checks, for each machine, was completed each day.

- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored on a shared computer file which staff had access to. Staff demonstrated their knowledge of where policies were kept.
- Signs advising women, who may be pregnant, to inform staff, were clearly displayed in the diagnostic imaging departments in line with best practice. In addition to this staff completed forms to indicate whether patients were pregnant. We saw three forms and this was completed on each.
- Staff used metal markers instead of digital to indicate whether an examination was of the left of right sided limb. This ensures, if an image is turned around, electronically, the correct side can still be identified.
- The five steps to safer surgery is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. It is for use in any operating theatre environment, including interventional radiology.
- The diagnostic imaging department carried out regular audit of the checklist and in April 2016, scored 100% in interventional ultrasound. This indicated staff completed all steps.
- We saw 'stop and check' signs in all rooms of the diagnostic imaging department to remind staff to carry out patient identification checks.
- In the nuclear medicine department, toilets were available for patients before and after they had received radioactive medicine. This minimized the exposure to radiation and was in line with best practice.
- To ensure nothing was missed, two different consultant staff, read the results of screening mammograms; this was in line with best practice.
- The hospital had a risk register which departments' could add to. Managers told us each department would carry out their own risk assessments.

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- In the diagnostic imaging department, we saw a number of risk assessments had been completed. They included risks assessed for lone working, using computers, temperature control, lighting, fire and seating.
- In the outpatient department, we saw risk assessments had been completed for the control of substances hazardous to health (COSHH). We asked if there were any other risk assessments in outpatients. The manager told us the sister had copies of these. However, the sister told us the manager had them. This indicated no other risk assessments had been completed in the outpatient department.

Staffing

- A registered nurse was available at each area of outpatients. There were six registered nurses and five health care assistants (HCA's). The department did not use agency staff. The hospital's own staff worked as bank staff when required. We saw nurse staffing rotas which indicated there were always registered staff available in each outpatient department.
- The diagnostic imaging departments did not use any agency staff, but used their own staff on bank, if required.
- The resident's medical officer (RMO) would attend to any unwell patients in the outpatient or diagnostic imaging department if required.

Major incident awareness and training

- Staff in Physiotherapy told us they had recently practised the evacuation of a patient in the event of a fire.
- Staff gave us examples of dealing with patients in an emergency and they felt the response from the rest of the hospital was immediate.

Are outpatients and diagnostic imaging services effective?

Good 

We inspected but did not rate effectiveness as we do not currently collect sufficient evidence to rate this.

- The hospital had an on-going, comprehensive audit programme, which monitored areas for improvement regularly.
- Treatments offered to patients were in line with National Institute for Health and Care Excellence guideline (NICE) guidelines.
- Staff were competent to perform their roles and were encouraged to develop their skills further.
- Health professionals worked together to provide services for patients.
- The diagnostic imaging and physiotherapy departments provided an on call services, 24 hour a day seven days a week.

Evidence-based care and treatment

- The hospital had an on-going audit programme. In April, May and June 2016 they had completed all the audits on their programme. Regular audits included; patient health records, medicine management, hand hygiene and infection, prevention and control. We saw copies and results of these audits. Findings were discussed at the quarterly audit report and areas of improvement were discussed. We saw copies of these meetings which demonstrated this was occurring and actions that arose from areas of improvement.
- The imaging department had policies and procedures in place. They were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000) and in accordance with the Royal College of Radiologists standards.
- We saw local rules available in each imaging room. Staff had signed them to indicate they had read them.
- In the outpatient department, staff showed us how they accessed policies on the hospital's computer system. Paper copies were also available in a folder and staff signed to indicate they had read them, which we saw.
- The physiotherapy department offered a knee exercise class and had equipment to enable patients to exercise in a variety of ways. This is in line with NICE, Osteoarthritis: Care and management, CG 177, 1.41.

Pain relief

- In the outpatient department doctors could prescribe pain relieving medication as required.
- In the diagnostic imaging department, there were a variety of pads and supports to enable patients having examinations to be in a pain free position.

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- The physiotherapy department provided acupuncture treatment for pain relief. In the Physiotherapy department, staff used a visual analogue scale for rating pain. Patients rated their pain on a scale of one to 10, before and after treatment to see if an effect could be demonstrated.

Patient outcomes

- The physiotherapy department asked patients to complete a patient reported outcome measure (PROM). This gave a self-rated score of a patient's pain level, mobility and usual activities. The patient completed the score before and after treatment which would indicate a change as result of treatment.

Competent staff

- We saw staff competency certificates for a variety of areas such as; the use of a triple cleaning system, mandatory training and the use of very low temperature liquids. We saw skills assessment for chaperoning, venepuncture and completed induction packs.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- Allied health professional staff could access a variety of training within the BMI network to develop skills further. They also attended regular training sessions within the department. We saw attendance sheets, signed by staff, which indicated they attended training regularly. This contributed to maintaining their Health Care Professions Council (HCPC) registration.
- Managers checked the registration of their staff with the (HCPC) and we saw copies of certificates which indicated all staff required, had registration.
- Cannulation is a technique in which a cannula is placed inside a vein to provide venous access. This is sometimes required to give medicines. We saw complete cannulation records, which was in line with the hospitals cannulation policy.
- Some staff working in diagnostic imaging can give medicine to patients for certain diagnostic tests. We saw certificates which confirmed staff were competent to do so.
- In compliance with IR (ME) R regulations, certificates were held for those staff in the hospital that were able to refer patients for diagnostic imaging tests. We saw

copies of these. This gave assurance that only those qualified to request a diagnostic examination were able to do so. In addition to this, we saw a list of people who could refer for an examination.

- In the diagnostic imaging department, 100% of staff had an appraisal in the last year.
- Four out of five HCA staff had completed an appraisal in the last year.
- One registered nurse had completed an appraisal had theirs booked in the week of our inspection.
- Registered nurse had completed appraisals for the period they had worked

Multidisciplinary working (related to this core service)

- The hospital ran a one stop breast clinic, where a variety of health professionals worked together. This included a breast nurse specialist, consultant breast surgeons, consultant oncologists and a consultant radiologist. It enabled patients to see clinicians, have tests and get the results of tests at one appointment.
- The physiotherapy department attended training sessions with other physiotherapists in the BMI network.
- The diagnostic imaging department received training from specialist radiographers from other hospitals.
- Staff told us they worked well together and had good communication with other health professionals and administrative staff. We saw staff engage in a professional and courteous manner.

Seven-day services

- The diagnostic imaging department provided an on call service for inpatients, 24 hours a day, seven days a week. The service had a system in place if a radiographer was called after midnight the protocol stated they did not work the following morning. Staff told us the calls for the emergency service were minimal.
- The physiotherapy department provided an on call service for inpatients, 24 hours a day, seven days a week.
- The pharmacy department is open every Saturday morning between 9 and 12 midday to ensure effective timely discharge for patients being discharged from the wards and to support any clinics that might be taking place.

Access to information

Outpatients and diagnostic imaging

- Staff in outpatients had morning huddles to share information and discuss any problems from the previous day.
- Staff could access a shared drive on the computer where policies and hospital wide information was stored. They demonstrated this to us.
- The diagnostic imaging department could access investigations from local hospitals by request and was transferred to the hospital securely.
- The outpatient team were working toward copying all outpatient records, so that information would be available even if the consultant was not in attendance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff described the process of dealing with a patient who may not have the capacity to consent to treatment. They were aware of who to contact if they required further advice.
- We saw signed consent forms in medical records, which indicated patients had consented to treatment; this was in line with the hospitals consent policy.
- Staff had training in Mental Capacity Act training as part of their safeguarding vulnerable adults training.

Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as good for the outpatient and diagnostic imaging services. This was because:

- Staff treated patients in a kind, considerate and professional manner.
- Patients told us they were very happy with the care they received.
- The hospital had considered patients privacy and dignity in the design of the main reception area.
- Signs offering chaperones were clearly displayed, the services held chaperone registers and staff were suitably trained to chaperone.

Compassionate care

- The hospital completed its own friends and family test which it reported on each month, we saw copies of

these reports. The most recent report in March 2016 indicated 99% of patients would recommend the outpatient department at the hospital. On average 188 patients responded each month, which equated to 10% of patients that attended the department.

- Patients told us they loved the hospital and received great care. They felt listened to and received good explanations about their care. We saw staff dealing with patients in a kind and caring manner.
- Patients told us staff treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.
- Staff gave us an example of dealing with a patient who had fainted in the outpatient department. They felt it unsafe for the patient to drive their own car home, so arranged for a taxi. In addition to this, they contacted the local council and explained the situation. The local council waived the car parking fees for the patient.
- We saw signs in patient waiting areas to inform patients they could have a chaperone, if required. We saw certificates which indicated staff had chaperone training. Staff would record if a chaperone had been offered and document if a patient agreed or declined. They also recorded who had been a chaperone, to which patient and the day that occurred in a register. We saw the chaperone register which indicated this was occurring. This was in line with the hospitals chaperone policy.
- In all the diagnostic imaging rooms, there were separate areas for viewing scan results. None of these areas could be overlooked, maintaining patient's privacy and confidentiality.

Understanding and involvement of patients and those close to them

- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.
- We saw a variety of health-education literature and leaflets produced by BMI. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient departments.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in clear, simple language.

Outpatients and diagnostic imaging

Emotional support

- Nurses attended clinic appointments with patients to provide emotional support if required. They could give patients and their families extra time needed, if necessary.
- Staff told us, if they had been present when bad news had been broken, they gained support from members of their team.

Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsiveness as good for the outpatient and diagnostic imaging. This was because:

- The services offered a variety of appointment times to suit the needs of patients.
- The physiotherapy department offered a variety of exercise classes and treatments to suit the needs of the patients attending.
- Waiting times for appointments and examinations were short.
- Waiting times for some types of scans were greater than the standard at the request of the referring consultant.
- Radiologists provided reports for scans in 48 hours or less. This indicated patients received their results in a timely manner.
- Staff told us how they could access interpreters and leaflets in other languages. They gave us examples of dealing with people living with dementia and had link nurse within the service.

Service planning and delivery to meet the needs of local people

- The outpatient department was open from 8am and could stay open as late as 9pm if required. It would also open on Saturday mornings, if needed. Patients told they had been offered a choice of times and dates for their appointments.
- The pharmacy department is open every Saturday morning between 9 and 12 midday to ensure effective timely discharge for patients being discharged from the wards and to support any clinics that might be taking place.

- The diagnostic imaging department was open from 8am to 7pm from Monday to Friday and from 9am to 12 pm on Saturday, which gave patients a range of times and days for their appointments.
- The physiotherapy department was open from 8am to 8:30pm, four days week and Friday until 5pm. They provided a wide range of exercise classes to suit the needs of the patients referred to them. They had a computer package that enabled them to provide personalised exercise plans to individual patients. It enabled them to email videos to patients. The department had a range of equipment to help staff deliver high quality care for patients.
- The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. We looked in 10 sets of patient records which indicated this was being done. Reports went to patients and their GP if further investigations were required.
- We saw comfortable looking waiting areas with refreshments and magazines available for waiting patients.
- One stop breast clinics ran which meant patients could have a consultation, examination and results on the same day. This decreased the amount of times a patient would have to attend the hospital.

Access and flow

- Referral to treatment (RTT) waiting times for non-admitted patients beginning treatment within 18 weeks of referral were above 95% in each month of the reporting period from April 2015 to March 2016, this was better than the standard.
- Patients told us they were happy with the speed at which they had received their appointments.
- Physiotherapy patients received their appointment within two weeks or sooner, which indicated they received their treatment in a timely manner.
- A DEXA scan is a special type of X-ray that measures bone mineral density. DEXA stands for 'dual energy X-ray absorptiometry'. The standard is that less than 1% of patients will wait for more than six weeks to have a DEXA scan. From April 2015 to March 2016, 28 patients waited longer than 6 weeks for a dexa scan. This equated to over 2% of patients waiting more than six weeks, which was worse than the standard. Three patients had waited more than 13 weeks in the same period.

Outpatients and diagnostic imaging

- At the time of inspection, we saw appointments available for a DEXA scan in two weeks' time. Staff told us when they received a referral; it was put onto the computer system. They told us patients who had broken bones, did not want to have their scans until their broken bones had healed. This could be from 6 to 12 weeks after the scan had been requested. Some consultants had indicated on the referral form, they did not want the patient to have the scan until several weeks after the referral was sent. We saw 22 forms which indicated they wanted the scan done more than 6 weeks after the referral was sent. One was as late as 5 months after the referral was sent. This indicated the reported diagnostic waiting times were not a true reflection of the actual waits patients could have. We discussed this with the manager, who was going to look into this practise, so true diagnostic waiting times could be reported in the future.
- Once a scan had been carried out, a radiologist provided a report. An MRI took 48 hours to provide a report, a CT scan took 2 days and all other examinations were reported within a day.
- Radiologists attended the hospital to provide reports and one could access the hospitals computer system remotely.
- An audit of medication turnaround times for outpatients carried out in April 2015 indicated that on average medication was available in 6 minutes.
- We were told the outpatient department did not routinely monitor clinic delays. The clinics we observed ran to schedule, we did not see any patients wait more than five minutes.

Meeting people's individual needs

- We did not see any leaflets in any other languages, but staff told us they could access these if required, from a central database.
- The outpatient department had a service level agreement (SLA) with a company which provided interpreters. Staff had a clear understanding of how to do this should they need to.
- Staff gave us an example of caring for a patient living with dementia. They told us a member of the public attended the hospital thinking their relative was in the hospital. Staff checked and found the family member was not in the hospital. Staff waited with the person, whilst other members of staff located a relative. They gave another example, where a member of the public

entered the hospital, but was unsure where they were or why they were there. Staff contacted a relative to come to the hospital and described how they calmed the person while they waited.

- We saw a children's bead toy available in a waiting area, but, we did not see any information leaflets specific for children.
- The diagnostic imaging department had two dementia link nurses for advice and support for staff and patients.
- Equipment in the physiotherapy department was suitable for overweight patients to exercise on.

Learning from complaints and concerns

- The number of complaints received by the hospital from April 2015 to March 2016 was 25, which was a decrease from April 2014 to March 2015, when they received 43. One complaint had been referred to the Ombudsman which related to a patient using the service in 2013.
- The assessed rate of complaints (per 100 day case and inpatient attendances) was significantly lower than the other independent acute hospitals CQC hold data for.
- CQC received three complaints from April 2015 to March 2016.
- Complaints were discussed as they were received and reviewed in the daily morning "huddle", which was attended by the executive director, director of nursing and hospital heads of department.
- Complaints (and compliments) were discussed at the monthly senior management team meetings and we saw minutes of these meetings which indicated this was occurring.
- Copies of the BMI leaflet 'Please tell us' were located throughout outpatient waiting areas to make patients and their relatives aware of how they can highlight any concerns.
- The BMI Healthcare complaints policy clearly set out the relevant timeframes associated with the various parts of the complaint response process. An initial acknowledgement is required within two working days and a full response within 20 working days. Patients were kept fully informed throughout this process if there was a delay. We saw copies of complaints files which indicated this was occurring.

Are outpatients and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Good 

We rated well-led as good for the outpatient and diagnostic imaging services. This was because:

- All staff were proud of the work they did at the hospital. They had a good understanding of the vision for the development of their services.
- There was a clear leadership structure which staff were aware of. They told us their managers were visible and approachable.
- The executive team engaged regularly with all staff and communication was clear and consistent.
- Governance processes were clear and effective from departmental to executive level.
- Staff shared learning across the BMI network.

However;

- It was not clear that risk was consistently being assessed in the outpatient department.
- The management team were unaware young children were being seen in the outpatient department.

Vision and strategy for this this core service

- Staff were aware of the corporate strategy of 'putting patients at the heart of what they do'. They felt the development of their services were a good reflection of this strategy.
- The outpatient department had an action plan in place which they reviewed regularly.
- They made a number of changes in the past year such as removing carpet from the ear nose and throat (ENT) room and were looking towards increasing the skills of the nursing staff in order to be able to provide a wider range of services for patients.

Governance, risk management and quality measurement for this core service

- The clinical governance committee was responsible for ensuring that the appropriate structure, systems and processes were in place in the hospital to ensure the safe delivery of high quality clinical services.
- The clinical governance committee met bi-monthly and discussed incidents, complaints, infection control issues and reviewed the risk register. A member of a local

clinical commissioning group (CCG) regularly attended these meetings. During our inspection, we saw the minutes of four clinical governance committee meetings held.

- The hospital had clear governance processes in place. The hospital held meetings thorough which governance issues were discussed. The meetings included medical advisory committee (MAC), heads of department (HOD) meetings, departmental meetings and infection prevention and control meetings.
- The clinical effectiveness committee was a sub-group of the clinical governance committee with a focus on audit and policy.
- We saw a copy of the hospital audit plan. The head of departments identified staff who could be the link person for these audits within the department. The findings of this audit were presented to clinical governance committee and medical advisory committee. The heads of department disseminated results through team meetings.
- The clinical governance report had incident (and analysis), complaints and patient satisfaction as regular agenda items.
- The Medical Advice Committee (MAC) met quarterly and we saw the minutes of the last four meetings. The minutes showed the key governance areas such as complaints, incidents, health and safety and feedback from the clinical governance committee were discussed each time.
- The HOD met monthly and the minutes of the last four meetings were seen. The minutes showed items discussed included infection control, hospital activity, complaints and incidents.
- Regular quality assurance tests were carried out on equipment to test the output of machines.
- The physiotherapy department carried out a variety of regular local audits to measure the quality of documentation and we saw the results of these.
- The physiotherapy department used patient reported outcome measures (PROM's) to measure the quality of treatment interventions.
- The hospital had a risk register which each department could add risk to. However, each department should have its own risk assessments.

Outpatients and diagnostic imaging

- We saw a variety of risk assessments in the diagnostic imaging department, but in the outpatient department there were only risk assessments relating to COSHH. This indicated risk was not consistently managed in all the departments.
- However, managers told us they did not see children at the hospital, we saw data which indicated children had attended the hospital. Level 3 safeguarding children training was not available for staff.

Leadership / culture of service

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient and diagnostic imaging services.
- The outpatient manager reported to the director of nursing who reported to the executive director.
- The imaging, physiotherapy and pharmacy managers reported directly to the executive director.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Any changes made were communicated through sub team huddles, newsletters and emails. We saw examples of newsletters on staff notice boards.
- The outpatient manager was particularly proud of the changes within the outpatient department within the last two years. They felt staff were engaging more and changes within the department were being welcomed.
- Staff told us the hospital was a good place to work and everyone was very friendly.

- They felt they had sufficient time to spend with patients and were proud of the work they did.

Public and staff engagement

- Morning 'huddles' had been developed, so not only head of departments met together, but they also had sub teams. This was to encourage teams to come together and share information.
- Staff told us managers shared information via email and newsletter. We saw noticeboards displaying information about infection prevention and control, health and safety, deprivation of liberties safeguards and lessons learned.
- The hospital sought patient feedback by placing comment cards in outpatient waiting areas, which we saw. A monthly report was produced which detailed response rates and patient comments. We saw copies of the monthly report.
- The hospital had a patient satisfaction group which was made up of a number of employees around the hospital. This group continually reviewed the patient satisfaction scores and dealt with areas for improvement.

Innovation, improvement and sustainability

- Staff in the outpatient department were engaged in developing and delivering an action plan. This was a series of points which detailed improvements the department
- Areas for improvement had been identified and individuals identified to action those areas.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- Ensure that staff are trained to the appropriate level for safeguarding children. Children attend the hospital as patients and visitors.

Action the provider **SHOULD** take to improve

- Provide each individual department with a separate and relevant risk register.
- Enable staff to attend major incident or business continuity training and attend simulation exercises.
- Have a separate steering group for end of life.
- Have policies in place for end of life care or management of the deceased.
- The outpatient department should adequately risk assess environment and equipment.
- The hospital should ensure outpatient staff achieve the hospitals mandatory training target.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Safe Care and Treatment</p> <p>12-(1) Care and treatment must be provided for in a safe way for service users.</p> <p>(2) without limiting paragraph (1), the things which a registered person must do to comply with this paragraph include-</p> <p>(c) ensuring persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.</p> <p>The provider must ensure that staff are trained to the appropriate level for safeguarding children, as children attend the hospital as patients and visitors.</p>