The Montefiore 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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
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

Overall summary

The Montefiore Hospital is operated by the Spire Healthcare plc. .

The hospital provides a full range of diagnostic, outpatient and surgical services. Facilities included 8 consulting rooms, 3 operating theatres, all with laminar flow, and an endoscopy suite. There are 20 inpatient rooms, all with en-suite facilities, a day care ward, and a 3 bed extended recovery unit. The hospital also had a dedicated chemotherapy facility with 8-day treatment cubicles. A range of diagnostic services were provided which included MRI, CT, X-ray, fluoroscopy, digital mammography and ultrasound. Sterile services and pathology are provided on-site.

The main specialties provided at the hospital are orthopaedics, general surgery, GI and colorectal endoscopy, ENT, gynaecology, pain management and urology.

We inspected this service using our comprehensive inspection methodology. We carried out announced inspection on 23, 24 and 25 January 2017 along with an unannounced visit to the hospital on 4 February 2017. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: Are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate service performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Services we rate

We rated this hospital as Outstandind overall.

We have rated Surgery as Outstanding.

- Staff proactively reported, investigated and learned from serious incidents.
- There was an open and transparent approach to handling complaints which took account of the Duty of Candour regulations. Complaints and feedback were used to improve the service.
- Patients had their pain needs met by competent staff in a timely manner.
- Medical records demonstrated patient involvement in their care.
- Records also demonstrated valid consent was obtained.
- The care in the surgical department had a multidisciplinary focus.
- Staff were aware of their roles in protecting vulnerable adults from abuse.
- Patients' views about the service was regularly sought. This feedback was used to improve services.

We have rated the care in medicine as good.

- There were processes to report and learn from incidents.
- Patients were cared for by appropriately trained staff who were competent to meet the patients individual care needs.
- Care and treatment reflected national guidance and best practice guidance.
- There were suitable quality assurance processes to measure patient outcomes.
- Patients were involved in planning their care and received a service that took account of their individual preferences.
- Risks were identified and managed to minimise the risk of harm to patients and others.

We have rated the care in outpatients and diagnostic imaging as good.

- Staff reported safety incidents which were appropriately investigated and used to improve the service.
- The environment was visibly clean and fit for purpose.
- All equipment used was well maintained.
- Medicines and prescriptions were handled, stored and prescribed in line with national guidance.

Professor Edward Baker

Summary of findings

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	We have rated the care in medicine as good. Medical care services were a small proportion of hospital activity. There was a process to report and learning from incidents. Patients were cared for by appropriately trained staff who were competent to meet their individual care needs. The care delivered reflected national guidance and best practice guidance. There were suitable quality assurance processes to measure patient outcomes. Patients were involved in planning their care and received a service that took account of their individual preferences. Risks were identified and managed to minimise the risk of harm to patients and others.
Surgery	Outstanding 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staff proactively reported, investigated and learned from serious incidents. There was an open and transparent approach to handling complaints which took account of the Duty of Candour regulations. Complaints and feedback were used to improve the service. Patients had their pain needs met by competent staff in a timely manner. Medical records demonstrated patient involvement in their care. Records also demonstrated valid consent was obtained. The care in the surgical department had a multidisciplinary focus. Staff were aware of their roles in protecting vulnerable adults that may be at risk of abuse. Patients' views about the service was regularly sought. This feedback was used to improve services.
Outpatients and diagnostic imaging	Good 	Staff reported safety incidents which were appropriately investigated and used to improve the service. The environment was visibly clean and fit for purpose. All equipment used was well maintained. Medicines and prescriptions were handled, stored and prescribed in line with national guidance.

Summary of findings

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Outstanding ☆

The Montefiore Hospital

Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to The Montefiore Hospital

The Montefiore Hospital is operated by Spire Healthcare plc. The hospital provides a full range of diagnostic, outpatient and surgical services. Facilities included 8 consulting rooms, 3 operating theatres, all with laminar flow, and an endoscopy suite. There are 20 inpatient rooms, all with en-suite facilities, a day care ward, and a 3 bed extended recovery unit. The hospital also had a dedicated chemotherapy facility with 8-day treatment cubicles. A range of diagnostic services were provided which included MRI, CT, X-ray, fluoroscopy, digital mammography and ultrasound. Sterile services and pathology are on-site. The main specialties provided in the hospital are orthopaedics, general surgery, GI and colorectal endoscopy, ENT, gynaecology, pain management and urology. We inspected this service using our comprehensive inspection methodology. We carried out announced inspection on 23, 24 and 25 January 2017. We also carried out an unannounced inspection on 4 February 2017. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005. The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery core service report.

Our inspection team

The team that inspected the service was led by Geraldine Wilkinson, CQC compliance inspector. It comprised of four CQC inspectors, and three specialist advisors with expertise in surgery, surgical nursing, radiography, infection control and risk management and clinical governance.

The inspection team was overseen by Terri Salt, CQC inspection manager.

How we carried out this inspection

During this inspection we visited the ward, theatres, outpatients, diagnostic imaging and pharmacy departments. We also visited the clinical support services. We spoke with 42 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We reviewed twenty medical records and spoke with 13 patients and 4 relatives. We also received 'Tell us about your care' comment cards which patients had completed prior to our inspection.

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

This was the first comprehensive inspection using our new methodology but the provider was inspected in January 2014 using our previous methodology. The previous inspection found that the hospital was meeting all standards of quality and safety it was inspected against.

Summary of this inspection

Information about The Montefiore Hospital

The Montefiore hospital provides a full range of diagnostic, outpatient and surgical services from 8 consulting rooms, 3 laminar flow operating theatres, and an endoscopy suite. There were 20 inpatient rooms, all with en-suite facilities, a day care ward, and a 3 bed extended recovery unit. The hospital has a dedicated chemotherapy facility with 8 day treatment cubicles. There is a separate outpatient department and physiotherapy service.

The main services provided are inpatient and day surgery, outpatient and diagnostic imaging services. These services are supported by a pathology department which provides on-site testing for haematology, biochemistry and blood transfusion and a diagnostic imaging department which provides MRI, CT, ultrasound, digital mammography, fluoroscopy and general X-ray. There is also an on-site pharmacy.

Nursing and therapy staff work in their departments and generally do not work in other departments in the hospital. A resident medical officer is available to all clinical areas.

Activity (October 2015 to December 2016)

- The majority of patients who used the services provided by the Montefiore hospital were privately funded and the remainder NHS funded.
- Between October 2015 and September 2016 there were 4857 visits to theatre, 3655 surgical procedures and 1523 inpatient attendances.
- There were 22,749 outpatient total attendances from October 2015 to September 2016, of these 31% were NHS funded and 69% were other funded.
- The diagnostics imaging department performed 9,962 examinations in and from October 2015 to September 2016.

Staffing

There were 159 medical staff with practising privileges including surgeons, anaesthetists, physicians and radiologists.

Two regular resident medical officers (RMO), employed under a Spire Healthcare plc contract with an external agency worked on a rota of seven days on duty, seven days off.

The hospital employed 72 full-time equivalent (FTE) registered nurses, 29.6 FTE care assistants and operating department practitioners, and 87.3 FTE other staff as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) was the registered manager of the hospital.

Track record on safety

• There were no never events reported.

• There were 363 clinical incidents reported. Of these, 267 were graded as causing no harm, 20 as low harm, 69 as moderate harm, 5 as severe harm, and 2 which resulted in death.

• Five serious injuries were reported during the reporting period. CQC was notified about all five serious injuries.

• No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) were reported.

• One incidence of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) were reported

• No incidences of hospital acquired Clostridium difficile (C.diff) were reported .

• No incidences of hospital acquired E-Coli were reported.

• No incidents of hospital acquired venous-thrombo embolism (VTE) or pulmonary embolism (PE) were reported.

• No complaints were received by the hospital in the reporting period.

What people who use the service say

The feedback we received about the service was entirely positive. For example comments we received included:

"Staff are always caring and courteous and go out of their way at all levels of the hierarchy".

Summary of this inspection

"Environment is very clean, everywhere".

"I always feel listened to".

"I am treated with dignity and respect ".

"My understanding of my health issues is always acknowledged and discussed".

"Excellent care".

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?	Good
Are services effective?	Outstanding
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

Good

Medical care

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

Are medical care services safe?

Good

We rated safe as Good.

Incidents

- The hospital reported no 'never events' between August 2015 and September 2016. 'Never events' are serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'. The occurrence of a never event could indicate unsafe practice.
- Staff we spoke with in the chemotherapy unit said they reported incidents, including near misses, through the electronic reporting system. Feedback on actions following an incident was given both directly and in the weekly pharmacy safety meetings. The unit reported eight incidents between September 2015 and November 2016. We reviewed the incidents and saw no incidents were related to the delivery of chemotherapy or any allergic or hypersensitive reactions to chemotherapy.
- Staff we spoke with in the endoscopy department said they reported incidents, including near misses through the electronic reporting system. The unit reported three incidents between September 2015 and October 2015 and September 2016.
- No serious incidents relating to medical patients were reported by the hospital between October 2015 and September 2016. Serious incidents are defined by the NHS England Serious Incident Framework 2015 as events in healthcare where the potential for learning is so great, or the consequence to patients, families, carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
- Minutes we viewed from the clinical governance and medical advisory committee (MAC) meetings demonstrated that learning from incidents at other provider sites was discussed to enable shared learning.
- The lead chemotherapy nurse we spoke with had a good understanding of the Duty of Candour requirement and was able to explain how it applied to their specific roles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw documentary evidence that duty of candour was routinely applied by the provider.
- Triple M (Montefiore Mortality and Morbidity) meetings took place twice a month and we saw minutes from these. Staff from across the hospital attend to discuss any potential learning from patient deaths and other incidents.

Clinical Quality Dashboard or equivalent

- The chemotherapy unit had a key performance indicator (KPI) that was completed as part of the Clinical Quality Dashboard. The KPI monitored that all new chemotherapy patients were discussed at a multi-disciplinary team (MDT) prior to commencing chemotherapy. We reviewed data and saw 100% compliance to this KPI. This meant that patients had

their care and treatment options discussed by a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment.
- VTE screening rates for the hospital were above 95% and we saw that there were three incidents of VTE or pulmonary embolism (PE) within the reporting period. We saw that two of these VTEs related to chemotherapy patients, where VTE developed following insertion of an implantable port (a device used to deliver medicine such as chemotherapy directly into the vein). We saw this was discussed at the MAC and findings and lessons learned were discussed.

Cleanliness, infection control and hygiene

- In the 2016 hospital Patient-led Assessment of the Care Environment (PLACE) audit for cleanliness was better than the national average at 100% compared to the national average of 98%.
- A clear decontamination pathway for endoscopes was demonstrated. There was a cyclical process for the cleaning of these, which prevented contamination once the endoscope had been used. There was a drying and storage cupboard for the endoscopes and scope-tracking and traceability records were maintained by an electronic tracing system, which we observed. This indicated each stage of the decontamination process was occurring.
- The endoscopy theatre appeared visibly clean. We saw cleaning checklists indicating when the theatre was cleaned.
- The hospital used green 'I am clean' stickers to identify equipment was clean and ready to use.' We saw 'I am clean stickers' in the chemotherapy unit on blood pressure devices, drip stands, treatment trollies, and the resuscitation trolley. We observed staff clean equipment after use and place stickers on the equipment
- We saw results of hand hygiene audits of which the majority scored 100% compliance. The audits that did not score 100% (four) showed what actions had not been taken such as staff not bare below the elbows, or more pumps of hand gel used than required.
- The chemotherapy unit consisted of eight separate treatment pods, a waiting area with sofas, and a quiet room for reflection and relaxation.
- The chemotherapy unit appeared visibly clean and was very well maintained. Some areas of the unit (corridors and quiet room) had carpet, which could not be as easily cleaned if spills occurred. All the treatment areas we viewed had suitable flooring. We saw carpets were visibly clean and free from stains and records confirmed carpets were cleaned regularly. In the clinical areas including the medicine room and patient treatment pods there was easy to clean laminated flooring which complies with the above guidance.
- Staff in the endoscopy and oncology departments were bare below the elbow in clinical areas and demonstrated an appropriate hand washing technique in line with the 'five moments for hand hygiene, from the World Health Organisation (WHO) guidelines on hand hygiene in health care. In the endoscopy theatre, information was displayed demonstrating the 'five moments for hand hygiene' near hand washing sinks and there was hand soap and hand lotion available.
- We observed alcohol hand gels were available in the patient treatment pods and entrance to the chemotherapy unit. However, we saw no posters around the gel to highlight to staff, patients, and the public to use the gel when entering and exiting an area. Hand hygiene posters were displayed at the main hand washing sink to act as an aid memorandum for staff around the WHO 'five moments for hand hygiene.'

Environment and equipment

- The hospital's Patient-led Assessment of the Care Environment (PLACE) audit for the environment was better than the England average at 98% compared to 93% nationally.
- Safety alerts were received by 'Spire' and cascaded down to the heads of departments within the Montefiore hospital. Any alerts that required action were circulated to managers who updated their staff on changes that needed to be made. We saw in the minutes that relevant patient safety alerts were discussed at team meetings.
- The lead chemotherapy nurse and one registered nurse (RN) we spoke to were trained to administer cytotoxic drugs (Cytotoxic drugs describe a group of medicines that contain chemicals which are toxic to cells, preventing their replication or growth, and so are used to treat cancer). They were aware of the importance of safe handling of chemotherapy drugs and complied with hospital policies and best practice in using personal protective equipment, such as gloves and aprons, when handling and administering chemotherapy drugs.

- Chemotherapy treatments were delivered to the unit on the day of use in yellow, padded, leak-proof cytotoxic bags, with or without ice depending on the storage temperature of the drug. Additional information on the storage temperature of the drug was written on the syringes containing the cytotoxic drugs. The chemotherapy was released to the unit by pharmacy and given to a chemotherapy RN who would safely store the drugs until administration.
- An extravasation kit was available on the chemotherapy unit. (Extravasation is the escape of medicine from the vein causing damage to surrounding tissue, which can cause necrosis and ulceration and required prompt action from staff to minimise damage) The kit was due to expire in March 2017. We saw records confirming two registered nurses and a pharmacist checked the kit monthly.
- The lead chemotherapy nurse and RN we spoke with knew the safety procedures for dealing with cytotoxic spillages. Cytotoxic Spillage Kits (CSK) were available on the unit. We reviewed records and saw the CSKs were checked monthly. The lead nurse told us a training session had taken place recently with bank staff regarding the use of the CSK. Purple cytotoxic sharps bin were available in the medicine room to disposal of cytotoxic contaminated material and equipment.
- Staff only administered chemotherapy in designated patient treatment pods within the chemotherapy unit. The unit contained resuscitation equipment, drugs for the management of emergencies, an extravasation kit, a cytotoxic spillage kit, and eyewash kit with access to running water.
- A resuscitation trolley was available on the unit. We saw the oxygen was in date and the defibrillator was checked. We reviewed records, which confirmed the trolley was regularly checked.
- In the endoscopy theatre we saw that monthly checks were completed to ensure that drugs, fluids and Entonox cylinders (a medical gas used for rapid pain relief) were in date and ready for use.
- The room temperature in the endoscopy theatre was checked daily and we saw that the safe limits for temperature were clearly documented at the top of the daily recording sheets.
- We saw purple lidded sharps disposal bins in the chemotherapy unit that complied with national guidance.
- We saw sharps disposal bins in the endoscopy theatre that were signed, dated and appropriately stored, which complied with national guidance, Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 [5(1)(d)].
- Sharps bins were available in the treatment areas and consulting rooms. This demonstrated compliance with the Health and Safety (Sharp Instruments in Healthcare) 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 containers had been fully completed ensuring traceability of each container.
- We saw that waste was separated in different coloured bags to signify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations.
- We saw a poster in the endoscopy theatre providing instructions for staff in the event of sharps or splash injury. There was a procedure and a clear flowchart demonstrating the appropriate steps to take. There was an agreement in place with the local NHS trust to provide occupational health advice in working hours, and outside working hours staff were advised to attend the local accident and emergency centre.

Medicines

- The Montefiore hospital had introduced an electronic chemotherapy prescribing system in December 2016. This complied with the recommendation of the British Oncology Pharmacy Association (BOPA) that chemotherapy should be prescribed using an electronic prescribing (e-prescribing) system.
- The e-prescribing system in use held all relevant information relating to the individual patient journey and treatment pathway including the medication prescription, pathology results, and patient toxicities. The e-prescribing system would automatically email the Oncologist (who are approved prescribers) to prescribe the patients next treatment. All relevant patient checks prior to each cycle of chemotherapy were put onto the system, which allowed the pharmacist and chemotherapy nurses to make the appropriate checks prior to the manufacturing and delivery of the chemotherapy treatments. This complied with the BOPA standards. (2015).

- On the unit, access to the medicine area was limited to authorised staff. Cytotoxic drugs were stored separately from other drugs. All cytotoxic drugs were for the use of named individuals only.
- We observed staff checked and recorded fridge and room temperatures in the chemotherapy unit to ensure medication and cytotoxic drugs were stored at the correct temperature to prevent the potency or physical make-up of the drug changing.
- There were no non-medical prescribers on the chemotherapy unit.
- For our detailed findings on medicines please see the safe section in the surgery report.

Records

- The chemotherapy unit had a secure electronic patient management system that had been introduced in December 2016. This system held the nursing records. The lead oncology nurse told us this system and the electronic prescribing system did not speak to each other and there were slight overlaps in inputting data. However, the systems were both new and staff were being supported by the developers to customise the systems to meet the service's needs.
- On the patient management system, we observed one patients records and saw the treatment plan at pre-assessment was completed. Before each cycle of chemotherapy a Systematic Anti-Cancer Therapy (SACT) toxicity assessment was completed. The system was RAG rated and any red ratings would be referred to a senior chemotherapy trained staff member or a member of the medical team. This ensured any patient toxicity was actively addressed in a timely manner by specialist staff.
- Each patient attending for chemotherapy had a hand held chemotherapy diary, which was completed at the end of each cycle by the nursing staff.
- We saw the theatre register which was a hard copy book that remained in the endoscopy theatre. Details recorded included time in and out, patient details, type of procedure and a swab instrument count. The consultant and swab nurse then signed this. This ensured traceability of the equipment used.
- We reviewed the records of four patients who had attended the endoscopy unit. The records were comprehensive, well-ordered and contained all of the relevant information including details of consent.

Safeguarding

- No safeguarding concerns were reported to the CQC during the reporting period of October 2015 to September 2016.
- The hospital had a named safeguarding lead who was the matron for the hospital. They were trained to a Safeguarding competency level of three, which was in line with national guidance.
- Safeguarding training (level one and two) was mandatory for all staff. We reviewed the records of the two chemotherapy nurses and saw that both level one and level two training had been completed. Staff told us one to one PREVENT training also took place recently, which involved five members of staff, including the administrative staff.
- For detailed findings on safeguarding training for endoscopy staff who form part of the theatre staff, please see the safe section of the surgery report.

Mandatory training

- The lead chemotherapy nurse told us an online training programme was in place, which told staff which training had been booked and what training had been completed. A large number of training topics was included in the mandatory training programme. This included acute illness management, moving and handling, incident reporting, fire, life support, dementia training, and Aseptic Non Touch Technique (ANTT).
- All staff (100%) in the chemotherapy unit had completed all required mandatory training in 2016. The new training cycle for 2017 had recently started at the time of our inspection, and already 2 staff were full compliant which was a rate of 40%. The hospital had an interim target for Q1 of 25% and an end of year target of 95%
- Bank staff were also required to complete all Spire mandatory training modules, and progress was tracked in line with permanent staff. The target for all staff, including bank workers, was 95% annually.
- Endoscopy staff were part of the theatre department. For our detailed findings on mandatory training of these staff, please see the safe section in the surgery report.

Assessing and responding to patient risk

- The hospital did not routinely admit medical patients. This was because chemotherapy and endoscopy patients received treatment as day-cases and usually

went home on the same day as their treatment. However, the hospital admitted medical patients on an as-required basis where patient needs determined this was in their best interest.

- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed NEWS charts for three medical patients. Staff had completed all three charts accurately with the exception of dating the chart.
- The hospital did not have any level two or three critical care beds. This was appropriate for the type of medical care the hospital provided, as the hospital did not deal with any complex acute medicine.
- In the event that a patient's condition deteriorated, the hospital had a service-level agreement with a local NHS hospital. This allowed them to transfer any patients who needed critical care support.
- All patients receiving chemotherapy had their treatment started by a consultant Oncologist /Haematologist following discussion at the relevant multi-disciplinary team (MDT). We reviewed five sets of records and saw evidence of discussions at a MDT in four of these.
- The chemotherapy service was a nurse led service. Following consultations with the Consultant Oncologist/ Haematologist, patients would attend a nurse led pre-assessment clinic before starting chemotherapy. During the consultation information leaflets regarding the treatment prescribed were given and discussed. Also discussed were possible side effects of the treatment, consent was checked, emergency contact details given, any referrals required were made to the dietician or MacMillan support along with a start date. A variety of baseline tests were undertaken. This process ensured patients were kept fully informed of the systems in place to support them during their treatment.
- Patients were given a red emergency card at the chemotherapy pre-assessment clinic with a list of symptoms that require emergency input including flu like symptoms, shortness of breath or a high temperature. Contact numbers were given for 24/7 emergency cover. Patients we spoke to told us they had been given the card at the pre-assessment clinic.
- All patients referred for chemotherapy were given the choice of the insertion a peripherally inserted central catheter (PICC) or Port-A-Cath (implanted venous access device, placed completely under the skin) to support the frequent or continuous chemotherapy administration. Chemotherapy drugs are very toxic and irritating to the skin, tissues, and veins. By using either of the above access lines, this reduces the possible risk of damage to veins and the leaking into the nearby tissues causing tissue damage. The lead oncology nurse told us that no cases of extravasation (the escape of medicine from the vein causing damage to surrounding tissue) had taken place over the reporting period due to the use of PICC and port-a-caths to deliver SACT.
- During the delivery of chemotherapy medical cover was available from the resident medical officer (RMO) to manage any clinical issues that may develop. The lead oncology nurse was able to describe knowledgably the systems that were in place to support any patients who may have an allergic or hypersensitive reaction to chemotherapy. High risk or complex regimens were delivered regularly on the unit but over the reporting period, no patients had suffered an allergic reaction and required urgent interventions.
- The hospital had a neutropenic sepsis pathway in place, which was due to be reviewed in February 2018. The guidelines for the management of Adult Neutropenic sepsis followed the NICE guidelines on prevention and management of neutropenic sepsis in cancer patients (2013). Neutropenic sepsis is when sepsis occurs due to a reduced number of white blood cells. It is a potential complication of anti-cancer therapy
- The lead oncology nurse was able to show us the pathway and how medication would be prescribed by the RMO with remote instructions from the oncologist to support any patient who may be admitted with neutropenic sepsis.
- No patients had been admitted to the Montefiore hospital over the reporting period with neutropenic sepsis.
- There were appropriate arrangements for telephone triage and managing patients out of hours. The hospital used the UK Oncology Nursing Society (UKONS) triage tool, which is a tool used to risk assess patients who have recently had chemotherapy using a red, amber, green rating system. We saw a SACT checklist for the chemotherapy nurses to go through with patients. A triage log and actions taken record was completed. The

chemotherapy nurse told us that if a patient was advised to visit the local emergency department to receive emergency treatment the chemotherapy nurse would contact the A&E department. The nurse would give an update on the patient's condition including symptoms, when the patient last had chemotherapy and who the patient's oncologist was to ensure the patient receives the appropriate treatment on arrival and the outcomes are communicated to the Oncologist team.

- The chemotherapy nurses assessed all chemotherapy patients before each treatment. This included checking any weight change (because the dose of chemotherapy is based on the patient's body mass index). Blood tests checked. If the patient felt well enough on pre-assessment and the bloods were within the appropriate range the next cycle of chemotherapy would be planned for the next day.
- The chemotherapy nurses told us they carried out appropriate checks before administering chemotherapy.
- Nurses advised patients to notify them immediately about any symptoms of concern.
- In the endoscopy theatre we saw evidence that team brief and de-brief checklists were completed before and after endoscopic procedures. The checks included that all team members were present and had been introduced, the list order was confirmed, whether relevant imaging was available and whether the procedure had been entered onto the theatre register. This ensured that an accurate audit trail was logged.
- We saw that these checklists were audited regularly, with ten audits in December 2016. The majority of these audits scored 100% compliance, with the exception of two non-compliant issues, one where the sign out confirmation of procedure had not been followed, and one on team de-brief where the list was not thoroughly reviewed by the team.
- The hospital used a coloured wristband system to alert staff if any concerns. For example, a green wristband indicated that patient was a falls risk, and a red band indicated that patient had allergies. This meant that staff could quickly identify patients that had additional needs or were at higher risk of harm.
- For intra operative radiotherapy, there was a radiation protection supervisor (RPS) and radiation protection advisor who was contactable by phone or email, if required. This was in line with ionising radiation (medical exposure) regulations (IR (ME) R 2000).
- Local rules were in place for intra operative radiotherapy procedures which we saw. This was in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000).
- Prior to the service being offered at the hospital, we saw that a radiology radiation protection meeting took place which RPS was present at.

Nursing staffing

- The Montefiore Hospital had recently appointed a new lead Oncology nurse who had taken up post in October 2016. The role of the new lead nurse was to develop the chemotherapy service following a period of reduced service provision due to previous staffing challenges.
- At the time of the inspection, the chemotherapy unit has two substantive part time nursing posts (25 and 22.5 hrs per week) with support from two bank staff and one agency member of staff. All nurses were qualified to deliver chemotherapy. Two new members of staff were due to join the team in the coming months with one of the substantive team members due to leave.
- The nursing staffing levels were unable to support the evening oncology clinics. However, the matron, who was also a qualified Breast Care Nurse Specialist, attended some evening oncology clinics and worked clinically to support the service. The lead oncology nurse told us there had been some staffing issues and as the team expands the nurses will work flexibly to support the evening clinics.
- A bank breast care nurse attended the unit two to three sessions per week.
- An additional Chemotherapy Nurse with haematology experience had been recently appointed to support the expansion of the service.
- For our detailed findings on nurse staffing please see this section in the surgery report.

Medical staffing

- This service operated one inpatient ward, which was shared with surgical patients. The medical staffing arrangements are reported on under the surgery service within this report.

Good

Medical care

- 159 doctors were employed by the hospital under practicing privileges. Of these, seven were consultant oncologists, 13 were consultants who performed endoscopies. Other physicians with practising privileges included respiratory, cardiology, nephrology, neurology, pain management, sports medicine, rheumatology, dermatology, endocrinology and care of the elderly.
- Four oncologists supported the chemotherapy unit. This included one haematologist, one medical oncologist, and two clinical oncologists. All consultants worked at the local NHS trust. We were able to review records, which confirmed that all the consultants were oncology and haematology prescribers.
- The consultants were contactable through the electronic prescribing system and the lead oncology nurse told us that they could email or telephone the consultants if an issue were to arise. The consultants were very responsive and there were no delays in gaining support when required.
- Two resident medical officers (RMO) were employed by the hospital. These were provided by an external company ensured 24 hour cover. The RMOs worked 7 days off, 7 days on and cover in the event of sickness was provided by the agency.

Emergency awareness and training

- The hospital had an in date major incident and business continuity plan. This referenced the process to follow in the event of a major incident.

Are medical care services effective?

Good

We rated effective as good.

Evidence-based care and treatment (medical care specific only)

- The chemotherapy nurses were aware of evidence based practice and NICE guidelines, and told us they were notified of updates to these. Corporate policies and protocols were in place which followed national guidance and were entered into the electronic prescribing system. The unit delivered chemotherapy to a number of tumour groups including upper GI, head and neck, urology and haematology cancers but the majority of patients attended with breast and colorectal tumours.
- All chemotherapy was prescribed according to recommended practices with a written protocol containing indications, drug, dose, route, cycle length, and frequency, length of treatment, monitoring requirements and requirements for dose adjustments.
- The oncology service had an 'out of hours oncology service' policy that covered emergency admissions, neutropenic sepsis, the telephone triage assessment tool, and the triage log sheets. This was in line with national guidance and ensured that support and medical services were in place for patients undergoing chemotherapy who experienced side effects out of normal working hours. Patients confirmed that emergency information was given to them prior to starting treatment. The services for patients with breast cancer were provided in line with NICE clinical guidelines (CG80) Early and locally advanced breast cancer: diagnosis and treatment. The guidance states, "All patients with breast cancer should be assigned to a named breast care nurse specialist who will support them throughout diagnosis, treatment and follow-up".
- The chemotherapy unit did not at the time of our inspection have the Macmillan Quality Environment Mark (MQEM) which is a tool used to assess how the healthcare environment meets the needs of patients living with cancer. This was something the unit was keen to work towards in 2017.
- The oncology team were unable to access the 'Somerset Cancer Register' (SCR) due to information governance restrictions between provider organisations. However, Spire Healthcare have introduced an electronic multidisciplinary team meeting platform called ARDEO, which will cover some areas of the 'Somerset Cancer Registry'. The SCR is a national online tool designed to collect relevant data throughout the patient's cancer journey. The collection of this data supported National Clinical Audits, Surgeon Level Reporting and Cancer Waiting Times.

Pain relief

- We spoke to staff in the endoscopy department regarding pain management during procedures. Most patients were provided with conscious sedation during their procedure to ensure they were comfortable

throughout. If a patient experienced pain, additional sedatives and Entonox was available (a fast acting pain reliever) that could be administered. However, staff told us this was not normally needed as the sedation was sufficient.

- Staff told us about an incident where a patient could not tolerate the procedure, and chose for the procedure to be terminated. This meant the patients right to withdraw consent during a procedure was respected.
- In the day care waiting room, we saw leaflets on pain relief and how pain scores are calculated. They advised the patient on how different pain relieving medications (such as analgesics and anti-inflammatories) worked and what was best for their level of pain.

Nutrition and hydration

- The nurses at the pre-assessment clinic gave advice around nutrition but a referral could be made to the dietician for specialist support.
- For patients attending for an endoscopy procedure, patients were advised to ensure they had not eaten for six to eight hours prior to their procedure. We saw the patient information leaflet provided to patients which outlined appropriate dietary information.
- The hospital screened all patients for malnutrition and the risk of malnutrition on admission, using the Malnutrition Universal Screening Tool (MUST).

Patient outcomes

- The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services at the time of our visit. JAG accreditation by the Royal College of Physicians was formal recognition that an endoscopy service was competent to deliver against defined measures in a global rating scale (GRS) for endoscopy standards.
- The theatre manager and endoscopy lead told us the hospital was working towards JAG accreditation, and we saw the most recent GRS audit from October 2016. The GRS is a tool that enables endoscopy units to assess how well they provided a patient-centred service, and is the first step for endoscopy units towards becoming JAG accredited. Whilst the overall results for the GRS audit were 93%, the unit was not currently eligible for JAG assessment, and we saw an action plan in place to improve the score for the next audit. These included actions such as developing audit tools for patient pain scores and developing written criteria for withdrawal of consent during a procedure. These had target dates of June 2017.
- The unit delivered chemotherapy to a number of tumour groups including upper GI, head and neck, urology and haematology cancers but the majority of patients attended with breast and colorectal tumours.Treatment plans were based on best practice and all patient care was documented on their individual electronic records. Treatment for many patients would not only involve chemotherapy, but might involve surgery and Radiotherapy. The main measurable outcome of cancer care was long-term survival.
- The hospital kept figures of the number of patients that died within 30 days of receiving chemotherapy. During the reporting period, the lead oncology nurse told us that two patients had died within the 30 days timeline. The lead oncology nurse told us with one of the patients, the case was discussed at MDT and it was thought to be in the patient's best interest to continue treatment. The lead oncology nurse told us they would challenge a decision if they felt the treatment was no longer appropriate.
- Current best practice for the delivery of intra operative radiotherapy (IORT) is still in the research phase and so patient outcomes are not currently available for patients who have undergone this treatment. However, we saw one set of notes of an IORT patient where as part of the consent process, they agreed to be part of an international study to help inform patient outcomes for the future.

Competent staff

- For our detailed findings please see this section in the surgery report.
- Staff told us they had a good induction to the hospital. We looked at three sets of staff records in the endoscopy department. We saw that each member of staff had received an induction to the department as a new starter, and this was documented by an extensive checklist, which had to be signed by both the staff member and their manager.
- The lead chemotherapy nurse was able to describe that two members of staff had completed the work based training linked to the cancer pathway which was set at

level 6 (degree level) at Sussex University. This meant that staff had a high level of specialist knowledge which would support patients as they moved along the cancer pathway.
- The lead chemotherapy nurse told us chemotherapy staff had attended a two-day 'Spire chemotherapy course', which was, run by Leicester University every other year. This ensured the knowledge and skills of the staff were kept up to date.
- We were able to review the competencies of two chemotherapy nurses during the inspection. We saw that these had been completed in November 2016 and included the safe administration of chemotherapy, the care and management of a port-a-Cath, the aseptic non-touch technique, and the care and management of central venous access devices.
- Intra operative radiotherapy (IORT) can only be delivered by highly trained staff, using specially-designed equipment. The hospital hired in a third party onco-therapy service to provide both the specialist machine and radiotherapist. We saw training records for the radiotherapist and all were in date and had upcoming review dates listed.
- We observed training files for the oncology staff, and noted that chemotherapy competencies were up to date.
- Although the staff did not regularly treat end of life care patients, this service was provided on an individual basis and in accordance with patient choice to patients who have received cancer treatment at this hospital and staff had additionally received training on what to do if a patient had a DNACPR in place or died during their stay.

Multidisciplinary working

- A 'pharmacy safety meeting' took place weekly within the oncology service. The oncology pharmacists and the chemotherapy nurses would discuss the following week's patients treatment plans and new patients which had been referred to the unit. Other areas of the service discussed as a team included any e-prescribing issues and protocols and policies. By having this weekly safety meeting, the patients' safety needs could be planned and met before the patient arrived for treatment.
- The matron was able to describe good MDT working between the chemotherapy unit and the local NHS cancer centre. This included close working with the clinical nurse specialists and clinicians to ensure the maximum amount of information and MDT discussions were sent to the chemotherapy unit prior to the patient attending clinic or pre-assessment appointments.
- The matron told us that good links were in place between the hospital and the local hospice, which meant there was good access for patients who no longer required active treatment and now required supportive or palliative care.
- The Matron told us that following the delivery of bad news to any patients the chemotherapy team would notify the GP of this within 24 hours.
- Intra operative radiotherapy (IORT) was available to patients who met specific clinical criteria. IORT is a technique of delivering radiotherapy during surgery, extending the operation time but significantly reducing the overall timescale for the alternative intervention of surgery and subsequent radiotherapy.
- Patients receiving chemotherapy had their treatment initiated following discussion at the relevant multi-disciplinary team (MDT) meeting. These were held at the local NHS hospitals and outcomes from these meetings were shared with the oncology team. Staff told us they had a good working relationship with the pathway coordinators at the trust to enable efficient communication of these MDT discussions.
- The hospital ran a 'one stop' colorectal clinic, which allowed patients to have a consultation and flexible sigmoidoscopy procedure (an examination using an endoscope to look into the patient's bowel) on the same day.

Seven-day services

- For our detailed findings please see this section in the surgery report.
- A nurse specialist was on call 24/7 for the service. This was rotated between the two specialist chemotherapy nurses and a clinical nurse specialist who were all trained in the use of the national triage tool. We spoke to the nurses who advised that most of the calls were to provide advice around symptom control and reassurance, and if the nurses were concerned they would advise the patients to attend the nearest available accident and emergency centre.

Access to information

- Staff could access local policies and procedures electronically, and all staff we spoke to knew how to

access the information they needed. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.

- We spoke to the booking centre who book both NHS and private patients and they showed us the procedure on receipt of a referral. We saw for NHS patient referrals, the 18 week breach date was indicated so that staff could ensure they booked the procedure within the correct time frame.
- Patient records were available within the hospital for three months after the patients last attendance or admission. If records had been archived in the central store, they could be requested and a designated car would bring the record to the hospital twice a week.
- The oncology unit used an electronic system to record details of patients with a diagnosis of cancer. The system was used to record details of multi-disciplinary team meeting discussions and to ensure patients were on the most effective pathway. This was a system that had been initiated and developed in Spire hospitals.
- Patients who had an oncology appointment at the hospital were given an audio recording of their appointment on a CD with their clinic letter. This allowed them to listen again to the consultation at their leisure and we saw that the audio CD was referenced in clinic letters following patient's appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The theatre department completed consent audits. We reviewed the results and saw that on their most recent audit there was 99% compliance. In the four sets of endoscopy notes were reviewed we saw all four had consent documented prior to the procedure.
- We saw that the hospital followed a corporate policy on consent to investigate or provide treatment dated March 2016. This referenced the Mental Capacity Act 2005 and the two stage assessment to be completed when a patient is felt to lack necessary capacity to consent.
- Staff were aware of do not attempt cardiopulmonary resuscitation (DNACPR) orders. At the time of our inspection, there were no patients on the main ward with a DNACPR order in place. However, one of the sets of oncology notes reviewed had an active DNACPR in place and this was completed correctly and was at the front of the notes.
- We saw staff had completed dementia awareness training in the endoscopy department.
- Spire had a policy for Deprivation of Liberty Safeguards (DoLS), dated April 2016. The policy set out procedures staff should follow if a person lacked capacity.
- Mental Capacity Act training is part of the mandatory training programme, and is delivered by an e-learning module during new clinical staff induction. Data provided by the hospital showed that 71% of chemotherapy nurses (five out of seven permanent staff and bank workers) had completed this training.

Are medical care services caring?

Good

We have rated the service as good.

- The hospital's friends and family test (FFT) scores were similar to the England average of NHS patients across the period April 2016 to September 2016.
- In January 2017, the oncology department introduced a local cancer patient survey, these were designed to replace individual patient satisfaction surveys throughout the hospital, however, the results of the January survey had not been collated at the time of our inspection.
- The hospital's score for the 2016 PLACE audit was score was better than national average for privacy, dignity, and wellbeing at 95% compared to 83% nationally.
- In the recovery area of the endoscopy unit, we saw that disposable curtains were readily available to protect patients' privacy whilst on the unit. We observed these being used when personal care was given, protecting the patient's privacy and dignity.
- Patients attending for endoscopy procedures would walk to the theatre from the changing area. We saw that these patients were provided with a dressing gown and slippers to put on over their surgical gown to ensure their comfort and dignity.
- We observed staff at all levels of the chemotherapy unit were courteous, thoughtful and kind in their dealings with patients undergoing chemotherapy.
- One patient we spoke with, in chemotherapy told us, "The care was outstanding and the nurses and other staff were all lovely." If they needed to see the consultant outside the weekly visits, this was arranged promptly.

- A second patient in the chemotherapy unit told us, "The care was good and the staff could not have made the experience any nicer than it was." "The surrounding was lovely and the nurses visited regularly during the treatment. The staff looked after us very well."
- One relative in the chemotherapy unit was very complementary about the staff, saying they always had time to listen and give support and encouragement to patients.
- The lead chemotherapy nurse we spoke with, had a clear understanding of and empathy for the holistic needs of patients and their families. The hospital matron was able to give us examples of when they went out of their way to provide help and support to both patients and families at very difficult times.
- We observed a patient thanking staff for their help and support during their procedure. We spoke to one patient undergoing chemotherapy treatment at the hospital.

Understanding and involvement of patients and those close to them

- Outside of normal working hours, oncology patients were given contact details for one of two oncology nurse specialists. The information given to patients explained some possible side effects following their chemotherapy and symptoms.
- Patients told us that staff went out of their way to find out information for them; explaining everything clearly, listening and answering questions. They said they were fully involved in decisions about their care and treatment and knew how to access advice and emergency care.

Emotional support

- Matron, the Breast Care Specialist Nurse and all chemotherapy nurses were trained to level 2 psychological support and had undertaken advanced communication skills training. This meant staff were able to provide immediate support to patients receiving any oncological treatments.
- The lead chemotherapy nurse told us that any patient could be referred to see a psychologist via their General Practitioner (GP) or the Macmillan Horizon centre (support and information centre in Brighton). No psychologist was available at the Montefiore hospital. Staff in the oncology unit told us that they had access to a cancer counsellor that they could refer patients to. However, staff told us they had not needed to refer any patients to the psychiatric support in the last year.
- The breast care specialist nurse ran a support group for patients undergoing breast cancer treatment. Other tumour group patients could access support through the local Brighton groups. Information regarding support groups was available from the chemotherapy staff. The lead chemotherapy nurse told us plans were in place to improve the support available to the patients through the appointment of specialist nurses who would develop more robust models of care.
- Two patients in the chemotherapy unit told us that information had been given to them regarding local support groups and complementary therapies during their pre-assessment clinic appointment. However, the two patients we spoke to had not needed to access these services.
- Oncology clinics were held in designated clinic rooms that allowed discreet exit from the department following bad news consultations (not via main reception).

Are medical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital responded to market forces and planned services that local people wanted. We found there was active collaboration with local Clinical Commissioning Groups (CCG's) to respond to requirements for NHS funded patient services.
- A range of services were available that reflected local needs, such as endoscopy. For patients that met a specific set of criteria, intraoperative radiotherapy was available at the hospital. This type of radiotherapy is performed whilst the patient is still under anaesthetic in the operating theatre. During the reporting period, two patients were treated at the hospital with this type of radiotherapy.

- In all of the waiting areas, including the main reception, there was access to free hot and cold drinks which we saw relatives utilising whilst waiting for their partners.

Access and flow

- NHS England publishes Referral to Treatment (RTT) waiting times, of which diagnostic waiting times is a key part. RTT waiting times measure the patient's full waiting time from GP referral to treatment, which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within six weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks.
- NHS patients were booked in line with national referral to treatment targets such as the 18 week target. The breach date is indicated on the referral form from the NHS organisation and staff showed us how they use this to ensure the patient is booked within this time.
- The endoscopy service ran on set days and times. These were Mondays and Thursdays. Staff told us there was currently no demand for additional days but ad-hoc provision could be arranged as needed where a more flexible service was required. During the reporting period October 2015 to September 2016, 472 endoscopic procedures were performed at the hospital.
- Private patients referred for an endoscopic procedure could expect to wait no longer than 22 days. NHS patient referred for an endoscopic procedure could expect to wait an average of 40 days (5.7 weeks), which is better than the target of six weeks wait for an endoscopic procedure.
- The oncology unit was open 9am to 5pm, three days a week (Tuesdays, Wednesday and Thursdays). During the reporting period, October 2015 to September 2016 there were 424 episodes of chemotherapy which equated to 60 patients receiving treatment over the period.
- We reviewed the discharge paperwork in four sets of notes following endoscopy procedures. Discharge paperwork would be sent electronically to the GP - this enabled the hospital to quickly inform the GP of any initial findings or diagnosis. We found all four discharge summaries to be either incomplete or uninformative. In one set of notes, the discharge paperwork listed 'bowel' as the diagnosis; the second set did not list findings or diagnosis, and two of the sets were undated.
- The hospital had recently introduced an electronic discharge summary for GP's which included much clearer and detailed information, and as such paper records were not being completed fully as staff had access to the electronic record should this be required.

Meeting people's individual needs

- A detailed assessment of the patients' needs was undertaken. We saw evidence of these reviewed in the records we viewed during the inspection.
- Staff gave patients written information including their regimen details, treatment plan, and arrangements for monitoring. All patients had a chemotherapy record, which was updated after each cycle of chemotherapy and were a source of information if the patient was admitted to another hospital. Two patients confirmed their records were updated following each cycle of chemotherapy.
- We saw the ward had an end of life care resource box, this included information and resources to support staff caring for patients and their relatives at the end of their lives.
- Doctors and nurses provided patients with advice regarding the common side effects of treatments. This included detailed information on how to manage symptoms of nausea, vomiting, and fatigue. At each appointment, they asked patients about any problems or side effects that had occurred since their previous cycle of treatment.
- Patients could bring a friend or relative to sit with them during their treatment. Patients received their treatment in a purpose built treatment pod which meant privacy was maintained at all times. One patient we spoke to told us the environment was lovely however, they would prefer to see outside when receiving treatment. The nurses responded by placing the patient in a treatment pod that had a view of the outside.
- Food and drink were provided on the chemotherapy day unit from the menu. One patient we spoke to told us they ordered food and the quality was good. Relatives and visitors could also buy food from the hospital menu and hot drinks and snacks were available on the unit. However, the lead oncology nurse told us they had had a recent complaint about the food which had been addressed by the catering team by introducing a greater variety of food.
- Television and free WIFI was available for the patients during their treatment in the treatment pods.

- Scalp-cooling treatment was available to reduce hair loss. Patients were warned that this added to the length of the visit but the system was in available for those that requested it.
- Staff told female patients about a programme of free beauty workshops – 'Look Good Feel Better', which took place at the local NHS trust. Patients had access to this service and would be told by the nurses how to make an appointment to receive this beauty treatment.
- There was scope to adjust chemotherapy appointment times to ensure patients who were working or had child care responsibilities could attend at times that suited them. However, at present the service was only open Tuesday, Wednesday, and Thursday 9- 5pm. As the service develops greater options will be available.
- The chemotherapy unit housed a 'quiet room' that was designed for people to sit and reflect in a peaceful environment. The room had sofas and a therapeutic light box, and music played at a low volume in the background. Whilst the room was in the chemotherapy unit, staff told us that this room was open to all members of staff, patients and visitors to utilise in their time of need. We saw both staff and relatives had signed the 'guest' book in the last 12 months.
- The oncology department were in the process of setting up survivorship meetings for patients who had survived cancer. Whilst this was not set up at the time of our inspection, we saw leaflets available for patients transitioning to life after cancer, such as details of exercise programmes and community events to get involved in.
- Lymphedema is a potential but uncommon side effect of patient's receiving cancer treatment, and results in uncomfortable swelling, often in the arms or legs. Specific treatment and support is required to manage this. Staff told us although they did not have lymphedema nurses on site, they could refer out to this service if required and patients were educated about how to reduce the risk and escalate a concern.
- Staff in the oncology department told us they had good links with local hospices for end of life care.
- Endoscopy patients would access their procedure via the day case unit and waiting area. We saw that the area had separate male and female areas with separate toilet facilities.
- Results of the 2016 PLACE assessment showed the hospital scored 87% for dementia, which was better than the England average of 77%. Dementia was included in PLACE assessments for the first time in 2015, and focused on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The 2016 PLACE assessment also showed the hospital scored 85% for disability, which was better than the England average of 80%. The place assessment for Disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- The hospital had a written end of life care framework and all such services were supported by Matron who has palliative care training in conjunction with the responsible oncologist and/or palliative care consultant.
- The service was supported by a chaplaincy service (SLA with local NHS Trust). Relatives were supported and accommodated and there was a seamless transfer to hospice and community care teams, as applicable. We saw the ward had an end of life care resource box, this included information and resources to support staff caring for patients and their relatives at the end of their lives.
- End of life care was audited by the Matron against a recognised template from the Gold Standard Framework.

Learning from complaints and concerns

- For our detailed findings please see this section in the surgery report.
- The CQC did not receive any complaints relating to medical patients in the reporting period of October 2015 to September 2016.
- There were 14 items of rated feedback on the NHS Choices website for the hospital, but none of these related to medical services.
- The hospital received 60 complaints in the reporting period October 2015 to September 2016, of which one was referred to the ombudsman. The oncology service received no complaints during this period, and the endoscopy service received one (less than 1% of overall complaints).

Good

Medical care

- The Spire Complaints policy set out the relevant time frames associated with various parts of the complaint process. An initial acknowledgment was required with two working days, with a full response within 20 days.

Are medical care services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- There was a management structure which staff were aware of. This meant leadership and management responsibilities and accountabilities were explicit and clearly understood.
- The endoscopy lead reported to the theatre manager, and the oncology nurses reported to the oncology lead nurse. Both the theatre manager and lead oncology nurse reported to the matron for this hospital, who in turn reported to the hospital director.
- All staff we spoke with told us that the senior team at the hospital were visible and approachable. All staff knew who the senior team were. We spoke to one member of staff who told us they had felt able to 'grow' at the hospital, starting in a junior role and progressing with support of the hospital to a more senior role.

Vision and strategy for this this core service (for this core service)

- There was a corporate level vision and strategy for the hospital. The hospital also had a set of hospital values referred to as the 'Montefiore way' which listed 'patient centred' and 'accountable'. Staff were aware of these values.
- There were no separate visions or values for the endoscopy and oncology departments. However, staff told us that gaining JAG status for endoscopy and Macmillan Quality Environment Mark (MQEM) status for the oncology unit was their future ambition.
- There was no cancer strategy in place at the time of our inspection. The oncology lead nurse was new in post and was in the process of developing a formal strategy with the support of the matron.

Governance, risk management and quality measurement

- The service governance processes were the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- The lead nurse for oncology was responsible for the governance of the department, with the support of the hospital governance lead and the hospital matron.
- Themes from complaints and incidents were shared at clinical governance meetings, relevant sub-committee meetings and as appropriate with the Medical Advisory Committee (MAC) meetings. We saw minutes from these meetings showing this.
- We saw the risk register for the hospital. This contained hospital-wide risks as well as departmental risks. There were 14 risks for the oncology department including risks concerning cytotoxic medicines and ensuring all patients were discussed at MDT meetings.

Public and staff engagement

- The hospital told us they held a patient forum and we saw minutes from November 2016. However, this meeting had to be cancelled at short notice and patients instead offered their feedback to the agenda over the telephone. It was not clear how many patients had participated in giving the feedback. Staff at the hospital told us that this was a recent initiative and there was a full programme of this for 2017 and we saw the dates planned for these.
- We spoke to a patient who had been involved in the design of the chemotherapy unit.
- We saw feedback from a student nurse that had worked both on the chemotherapy unit and in the theatre and saw that this had been considered a valuable placement and that staff were 'accommodating and helpful'.
- Staff meetings were held for oncology staff and endoscopy staff (as part of the wider theatre team). We saw minutes from these meetings.
- The hospital participated in PLACE audits.

Innovation, improvement and sustainability

- The hospital provided intra operative radiotherapy as a treatment option for patients with early breast cancer. We were told two patients were treated using this technique during the reporting period.
- The hospital matron told us that there was no cut off point for oncology patients with support being there even when patients had completed active treatment.

Good

Medical care

The ethos of the hospital was that they did 'cancer properly or don't do it at all.' Patient centred care was delivered by optimising every patient's experience. The matron was able to give examples where oncology patients were given the vital support they needed to themselves and their families which reinforced that patient focussed care was being delivered. The hospital director supported this model.

Outstanding ☆

Surgery

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

Are surgery services safe?

Good

Incidents

- Never events are serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Surgery services did not report any never events between October 2015 and September 2016.
- Between October 2015 and September 2016 surgery services reported five serious injuries, which related to a rate of 0.10 injuries per 100 patients. In the same period, surgery services reported 258 incidents, of which 219 were clinical incidents. Of all incidents reported in the hospital, which included surgery services, 74% resulted in no harm to the patient, 6% resulted in low harm, 19% resulted in moderate harm and 1.4% resulted in severe harm. Two deaths were reported in this period, representing 0.6% of all incidents.
- Staff used an electronic reporting system to document incidents. Bank staff had access to the system and received feedback in the same way as permanent staff.
- Staff told us they were encouraged to submit incident reports, including for near-misses.
- Staff acted on learning from incident investigations and improved processes through the clinical audit and effectiveness committee as a result. For example, following an incident in which multidisciplinary notes were not correctly used as part of a patient review, practise was changed to ensure physiotherapy notes were always kept in the nursing notes folder. This meant staff had access to all notes in one location.
- Most of the staff we spoke with said they felt incident reports and risk escalation messages were acknowledged and acted upon by the senior team. Two members of staff said they had stopped submitting incident reports about what they felt was unsafe staffing levels due to previous reports being unresolved. However, at our unannounced inspection we found that action had been taken to address these concerns. Actions included the development of a local policy for safe staffing, which includes identification of red flag situations and clear escalation procedures.
- The hospital management team had only received 5 safe staffing concerns during the inspection period (12 months), 2 relating to the ward and 3 to day care. There was evidence that all 5 incidents had been fully investigated and changes made to practice as a result. Actions included the development of a local policy for safe staffing, which includes identification of red flag situations and clear escalation procedures.
- All of the staff we spoke with said they were invited to meetings regarding incidents regularly and felt confident in submitting reports. One nurse said, “People [staff] are very open here. We get the chance to discuss anything we want, I have no concerns about incident reporting.”
- However, not all staff felt they received feedback from incidents. For example, three nurses said they had submitted incidents and had not received any further individual contact or feedback afterwards. However the

senior hospital team stated that feedback was shared via the staff quality and safety noticeboards and in the monthly 'Heads Up' bulletin which is issued to all departments.

- The matron led monthly morbidity and mortality meetings and all staff were encouraged to attend. RMOs and consultants attended where they were presenting case reviews of their patients. We looked at the minutes for meetings in October 2016 and November 2016 and found they were attended by a broad range of staff from different roles and levels of responsibility. Detailed discussions of patient cases were discussed and clear actions were established. For example, following a review of one patient living with dementia, a new protocol was established to ensure the matron reviewed each patient with reduced cognition and resources and training for staff were increased.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Services used a clinical scorecard to monitor performance and to identify emerging trends with a 'red, amber, green' (RAG) rating system. The scorecard included 41 quality and safety standard measures, including tracking of compliance with risk assessments, mandatory training and consistent use and documentation of patient deterioration observations.

Cleanliness, infection control and hygiene

- During all of our observations staff adhered to appropriate standards of hand hygiene, infection control and the 'bare below the elbows' policy. For example, we observed theatre practitioners used antibacterial gel after transferring patients between theatres and the inpatient ward and all staff washed their hands after contact with patients and moving between bed spaces and private bedrooms. In addition, staff used personal protective equipment appropriately, including sterile gloves.
- World Health Organisation (WHO) six steps of handwashing were displayed above handwashing sinks and in theatre scrub areas.
- Between October 2015 and September 2016, the hospital reported 20 surgical site infections. This represented 0.5% of all surgical procedures, which was better than the hospital maximum target of 0.6%. The rate of infections during primary knee arthroplasty, spinal, breast, upper GI and colorectal, cranial and revision hip arthroplasty procedures was above the rate of other independent acute hospitals we hold this type of data for. During our inspection we observed infection control processes to be in accordance with best practice and a consistent focus from staff on monitoring and reporting. The rate of infections during primary hip arthroplasty was lower than the rate of other independent acute hospitals we hold this type of data for and the rate of infections during other orthopaedic and trauma procedures was similar to the rate of other independent acute hospitals. There were no surgical site infections resulting from revision knee arthroplasty, gynaecology, urological or vascular procedures.
- All of the patient treatment areas, visitor's areas and other clinical spaces we visited were visibly clean and tidy and free from debris. We found a small amount of dried blood on one dressing trolley and dust on a dressing trolley, an acute illness trolley and a clinical equipment trolley. We spoke with a nurse about this who immediately arranged for the trollies to be cleaned. This was an exception during our inspection and at all other times cleaning and hygiene standards were demonstrably consistent.
- Disposable curtains were used for privacy purposes in the surgery day unit and in the extended recovery unit. All curtains had the first use date clearly marked and were routinely changed every six months or more regularly if they were soiled or contaminated. We saw records that indicated this was monitored and occurring.
- We observed staff, including surgeons, preparing for procedures in theatres. All staff adhered to the aseptic technique for using sterile gloves and gowns.
- Staff cleaned and decontaminated theatres according to morning and afternoon checklists. This helped to ensure cleaning standards were consistent. We looked at daily cleaning records for theatres for the six months prior to our inspection. Staff had completed records consistently and there were no gaps in recording.
- Reception staff enforced infection control policies in the ward at the point of entry. For example, we observed staff enforce the hand gel and bare below the elbows policy to visitors to the ward.

- An infection prevention and control link team provided targeted support to staff, patients and visitors and conducted monthly hand hygiene practices and environment audits in each clinical area. In August 2016 theatre recovery and theatres achieved 100% compliance and in October 2016 the inpatient ward achieved 85% compliance. Areas for improvement on the ward included full completion of the WHO Five Moments for hand hygiene guidance and more consistent cleaning of sinks in patient bedrooms.
- Between October 2015 and September 2016, there we no incidents of hospital-acquired methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.Diff).

Environment and equipment

- Resuscitation equipment was available in each clinical area and in the anaesthetic room. We saw staff used checklists to document daily safety checks on equipment with the exception of when day surgery areas were closed.
- Chemical products were stored in line with the Control of Substances Hazardous to Health (COSHH) regulations. This was because cleaning and chemical products were stored in locked areas with restricted access and correct labelling. COSHH risk assessments were readily accessible and up to date, with the next review due in December 2018. The name and contact details of the theatre COSHH representative were on display and up to date.
- Theatre storage areas, such as endoscope storage cabinets and drying equipment, were well maintained with daily documented checks by staff. Appropriate labelling, including hazard and flammable signs, were in situ.
- Staff completed and documented six daily bedside safety checks including oxygen and monitoring equipment. We looked at the records for each room in use during our inspection and found them to be fully completed with corrective action taken when needed.
- Staff followed safety guidance from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) when conducting routine checks on safety equipment. This meant the equipment was maintained in line with manufacturer and national best practice guidance.
- Theatre practitioners checked instruments, swabs and sundries before and after each procedure as part of a safety checklist. We observed this in practice and noted checks were thorough and accurate.
- The hospital participated in the patient-led assessments of the care environment (PLACE), which included all surgery areas. Between February 2016 and June 2016, the hospital performed better than the national average in environmental scores for cleanliness and condition and appearance. For cleanliness, the hospital was rated 100% compared with the national average of 98% and for condition, appearance and maintenance the hospital was rated 98%, compared with the national average of 93%.
- The hospital was designed to ensure patient dignity and privacy is optimised within the clinical setting. All clinical departments and sub-waiting areas had areas for reflection and mindfulness. Consideration for patient privacy is evident in many operational processes.
- There were systems were in place to ensure failed or faulty equipment were addressed promptly. However checks were not always carried out in accordance with the manufacturer's guidance. For example, a urinalysis machine in the inpatient ward should have been checked weekly against manufacturer’s quality control guidance for both routine and pregnancy testing. However, due to a problem with ordering test strips this equipment had not been checked for pregnancy testing since October 2016. We raised this with the senior leadership team and this was rectified immediately and a process put place for this to be managed by the local Point of Care Testing group to ensure on-going compliance.
- All patient areas fully met the requirements of the Department of Health building notes 00-09 and 00-1- with relation to infection control in the built environment and flooring.

Medicines

- We looked at the documentation for safe storage and monitoring of controlled drugs (CDs). CDs are medicines liable for misuse that require special management. In the day surgery unit recovery area, we looked at records

for the seven months prior to our inspection and have been provided with documentary evidence subsequent to the inspection visit that showed appropriate checks were being completed.

- Staff documented daily temperature checks on fridges used to store temperature-critical medicine. We looked at records in every area for the three months prior to our inspection and found recording was consistent. In all cases fridge temperatures were maintained within safe temperature ranges provided by medicine manufacturers. Staff demonstrated appropriate knowledge of contingency plans when equipment failed. For example, a theatre medicines fridge failed on one day prior to our inspection. Staff maintained the 'cold chain' necessary to keep the medicine safe and documented the corrective action taken.
- At all times, including out of hours, nurses were able to administer medicine according to a policy that required two Registered Nurses to check and administer controlled drugs to ensure accuracy and safety.
- Intravenous fluids and 'take away' medicines were stored in locked cupboards that required keypad access. Medicines that had a short shelf life were clearly marked as such.
- Staff audited the prescribing of chemical venous thromboembolism (VTE) prophylaxis against three safety and quality measures in patients who underwent hip and knee arthroplasties. This included prescribing within recommended timescales and for recommended courses of treatment. Between October 2015 and September 2016, 100% of patients had an appropriate prescription and 93% received the prescription within the appropriate timescale. This was better than the target of 80%. During the same period, the hospital did not always meet the 95% target that prophylaxis was prescribed for a recommended period of time. Average compliance during this period of time was 93%, which reflected one quarter of 100% compliance and two quarters of 90% compliance.
- The pharmacy team audited compliance with controlled drugs management and administration every three months. Between March 2016 and September 2016 this team completed six audits, with an average compliance rate of 83%. This included a compliance rate of 74% in the inpatient ward in September 2016, 86% in theatre recovery in July 2016 and 85% in theatres between March 2016 and June 2016. All areas of non-compliance related to documentation and the completion of records.

Records

- We looked at ten pre-operative assessments and anaesthetic records. We found them all to be fully completed with appropriate risk assessments and documented blood tests. This included screening for MRSA and documented monitoring of surgical site locations, cannula size and the name of the person who made insertions. Documentation for patients in recovery were not always fully completed. For example, one patient record did not include their weight, a record of the time they could drink until by the anaesthetist or a signed record of the anaesthetic drugs used.
- In all of pre-operative assessment records we looked at, staff had completed risk assessments for venous thromboembolism, falls, skin care, pressure damage and malnutrition. However, specific care bundles were not always documented in theatres. For example, peripheral vascular device and indwelling catheter care bundles were completed in intra-operative care records not in theatre at the time of treatment.
- Staff used a patient safety booklet to document risk assessments including for venous thromboembolism, bed rails, a skin assessment, pressure ulcers and catheter care.
- Staff audited patient records for levels of compliance with the requirement for daily consultant review against a target of 90%. Between October 2015 and September 2016 performance was variable, with an average of 84% of patient records meeting these criteria. This meant it was not always clear how often each patient had received a consultant review.
- Staff also audited evidence of safe and consistent completion of risk assessments in patient notes. For example, the hospital had a target that 95% of patients had a documented VTE risk assessment. Between October 2015 and September 2016, the hospital performed better than the target with an average of 98% compliance.

Safeguarding

- Each member of the reception team had completed safeguarding adults and children training, (levels one

and two) with a compliance rate of 100%. This meant the team could respond appropriately to any situations or behaviour that concerned them, such as abusive behaviour between visitors in waiting areas.
- All clinical staff had completed safeguarding adults and children training and could demonstrate their role in protecting people from harm.
- A safeguarding lead was in post in the hospital and all of the staff we spoke with knew how to obtain specialist or urgent help when needed.

Mandatory training

- Spire Healthcare requires all staff to complete annual refresher mandatory training. For 2016, 98% of all staff across the hospital were fully compliant with all training required. This was better than the provider's target of 95%.
- Staff were given protected time to complete training and each individual we spoke with was positive about the quality and depth of the training.
- Staff had taken self-protection and de-escalation training to help them keep safe and support patients whose condition resulted in aggressive or violent behaviour. We spoke with staff who said this training, along with clear hospital policies, meant they were well equipped to respond to unpredictable situations. For example, when one patient still under the effects of a general anaesthetic became violent, nurses and physiotherapists worked together to reduce the patient's aggression and re-orientate them to the environment.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Each member of staff had life support training to a level that matched their role and responsibilities. For example, all clinical staff, including health care assistants, had immediate life support training (ILS) and Acute Illness Management (AIM) training and a number of staff including the RMO held advanced life support training to ensure safe levels of training to manage an emergency. All clinical staff had basic paediatric life support training and undertook a minimum of six simulated cardiac arrest scenarios annually.
- Pre-operative assessment nurses and Anaesthetists used the American Society of Anaesthesiologists physical status classification system to assess patients and ensure they were medically fit to undergo surgery.
- Theatre staff provided care and treatment in line with WHO five steps to safer surgery guidance. We observed the WHO process in practice during the inspection. The hospital audited compliance in two stages; the first for process and documentation and the second for observation of practice. The latest available results from November 2016 indicated 94% compliance.
- Staff used the World Health Organisation (WHO) safer surgery checklist at all three stages of procedures in line with international safety guidance. We saw this in practice during all of our observations and when looking at patient records. However, patient records we looked at after procedures did not always include evidence of fully completed WHO checklists. For example, we saw one record did not include detail of glycaemic control or a completed record of the time out. This was also reflected in the latest WHO audit, which found 90% compliance with the need to record glycaemic control and an average of 86% compliance with all sign out documentation requirements. The hospital target for WHO audits was 100% compliance.
- Access and referral protocols were in place to refer patients for psychological assessment where they presented for cosmetic surgery and if the clinician had concerns about their ability to consent.
- The RMO, who had ALS training was always available to provide support in an emergency. This supplemented the management by a consultant anaesthetist who was always present when patients were in theatre or recovery.
- Staff used established safety processes in theatres that helped protect patients from errors and avoidable harm. For example, an anaesthetic practitioner used a pre-operative safety checklist for each patient that included their personal identity details and confirmation of the planned surgery site. In addition, the anaesthetic, circulating and scrub practitioners reconfirmed this information between them prior to the procedure. Staff also ensured a time out took place immediately prior to each procedure. This enabled the whole theatre team to review the planned surgery and ensure all information was correct and cross-checked and that all available equipment was in place.

- We observed a transfer in theatres of a patient from a trolley to a table. All staff wore appropriate personal protective equipment (PPE) and the transfer was in line with safe manual handling guidance. Staff used risk reduction materials including anti-embolism stockings for the patient and gel pads under their heels.
- Staff supported patients to complete a pre-admission safety checklist that included risk factors for MRSA, C.Diff, hepatitis, HIV, carbapenemase-producing Enterobacteriacease (CPE) and Creutzfeld-Jacob Disease. This helped to reduce the risk associated with avoidable infections being introduced to the hospital.
- All nurses had completed a care of the deteriorating patient training programme to enable them to effectively manage patients at risk. This included simulated scenario-based exercises and practical opportunities to establish their competencies.
- Staff used monitoring tools to track patient's condition in each area of clinical practice. For example, nurses in recovery monitored patient condition using the national early warning scores (NEWS), which enabled them to respond quickly to deteriorating patients. Theatre staff recorded patient's temperature every 30 minutes. In day surgery recovery, deteriorating patient pathways were in place that were individualised based on the procedure and staff could transfer patients back to theatres in an emergency.
- Clinical staff recognised the nature of treatment in the hospital meant 'crash calls', the term used for cardiac arrest emergency calls, were infrequent. To ensure staff maintained the up to date skills needed to respond to patient emergencies, simulated crash calls were arranged every month in addition to required updates to mandatory life support update training.
- Staff used a three-tier assessment system to identify and manage patients at risk of falls. Each tier of risk triggered staff to provide a greater level of support and risk management. For example, patients assessed as having a low risk of falls always had a call bell in reach and were provided with non-slip footwear. Patients assessed at medium risk had increased physiotherapist input and were provided with walking aids and patients assessed at high risk had all of these measures as well as 'grip' socks and one-to-one monitoring. Patients at medium or high risk wore a green wristband that enabled staff to readily identify them and ensure their immediate environment was free from clutter and trip hazards. Staff only used green wristbands with the patient's consent or through the best interests process for patients with reduced mental capacity.

Nursing and support staffing

- A team of 17 nurses and health care assistants (HCAs) led care on the inpatient ward and there was a ratio of nurses to HCAs of 5:1. The ward relied on agency and bank nurses to ensure planned shifts were always filled. Between October 2015 and September 2016, an average of 42% of nurses and 17% of HCAs on the inpatient ward were supplied by bank or agency. A senior nurse or senior HCA completed a local induction with each member of agency staff before they were able to work on the ward. This included an orientation to the unit, an introduction to the emergency and escalation procedures and providing an overview of the patient records system. We spoke with six permanent members of staff about this. In all cases nurses and HCAs were positive about the use of bank and agency staff and said their standard of clinical care had always been of a high standard.
- A team of 25 theatre nurses, operating department practitioners (ODPs) and HCAs provided care in theatres and there was a ratio of nurses to ODPs and HCAs of 2:1.
- Between October 2015 and September 2016 theatres did not employ any bank or agency staff. Three sisters led care in theatres and were supported by nurses in different specialties, such as in orthopaedic surgery and anaesthetics. Staffing levels in theatres were established against the Association of Perioperative Practice safe staffing guidelines 2014.
- Two registered nurses worked in the pre-operative assessment unit and a new lead nurse had been recruited.
- Ward sisters planned staffing levels based on historic ward data and using an adaptation of the Shelford Safer Staffing Tool and the National Institute for Health and Care Excellence red flag algorithm in relation to safe staffing for nursing in adult inpatients. Where additional needs were identified during the pre-assessment stage, staffing levels were adjusted accordingly. Staffing levels in the operating department adhered to Association for Perioperative Practice (AfPP) guidelines.

- Nurses on the inpatient ward conducted handovers three times daily, which included attendance from the multidisciplinary team, the RMO and consultants where necessary.
- Physiotherapists joined morning nurse handovers and conducted their own handovers between shifts. Joining nurse handovers was an initiative implemented following an increase in falls. This strategy helped nurses to understand the findings of each patient's pre-assessment, which physiotherapists were involved with. This meant physiotherapists had greater oversight of each patient's journey and enabled them to more effectively contribute to safe discharge planning.
- Two registered nurses led care in the day surgery recovery unit which was open flexibly from Monday to Saturday at times to suit day surgery activity. Break cover is provided by the supernumerary ward in-charge nurse as required.
- Nurses also told us they often had to work overtime if theatre lists overran into the afternoon and evening. There was one instance where a shift ran from 6.30am to 9.30pm but this was an exception. Staff are required to escalate any concerns for working hours to Matron or Hospital Director.
- The senior nurse in charge of the inpatient ward held responsibility for the day-to-day operation of day surgery recovery area and the hospital's procedure was to enable day surgery recovery nurses to be relieved for breaks by ward nurses. However, staff told us this rarely happened in practice because staff could not be released from the ward.
- In addition, one nurse was left in the unit alone when their colleague left to collect patients from theatre. This meant staffing levels did not always meet the minimum safe requirements established by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guideline 20136, which require two members of staff to be present at all times. The provider told us that due to the close proximity of the DSU cover for breaks could be provided from either this area or from the supernumerary nurse on the ward.
- The British Association of Day Surgery recommends that nurse staffing levels be set locally according to operational need as part of a multi-skilled, multidisciplinary workforce and operational group to review operational problems. Although all patients had access to the hospital's multidisciplinary clinical and rehabilitation teams, staff we spoke with did not always feel that nurse staffing levels were sufficient for the demands on the service.
- As a minimum, a surgical first assistant, an ODP, two scrub nurses and one circulating practitioner formed the theatre team in addition to surgeons and anaesthetists. Staffing was increased from these levels in accordance with needs of each operating list.
- The nurse in charge of each clinical area had access to an on-call senior manager at all times. This provided a point of escalation in the event of a major incident or unexpected event that impacted the service.
- As at October 2016 there were no staff vacancies in theatres, no vacancies in the HCA team in inpatient areas and 16% of nursing posts in inpatient areas were vacant.

Medical staffing

- All patients received consultant-led care, which is supported by the RMO on a day to day basis. On-call consultant cover was available for all patients 24-hours, seven days a week with a 30-minute call out standard.
- RMOs worked shifts of continuous seven days and had on-site accommodation. The ward sister was responsible for triaging calls for the RMO out of hours to ensure they were contacted only when clinically appropriate and so could work safely with sufficient rest.
- There was evidence of daily input from the RMO and the patient's consultant in all inpatient records we looked at.
- Handovers between the nursing team, the RMO and physiotherapy team took place daily and the RMOs and physiotherapists provided each other with individual feedback on each patient.
- We observed four pre-theatre briefings. In all cases the briefings were well organised and helped the team to plan for patients on the list. The surgeon discussed each patient and their planned procedure and ensured the necessary anaesthetic plans and diagnostic resources, including x-rays, were booked and in place. We observed staff used a checklist to guide the briefing and this was fully completed and signed before the whole team agreed to proceed. This represented a proactive safety system to ensure all staff were suitably prepared and understood the clinical plan.

- Four medical practitioners held practising privileges for cosmetic surgery, all of whom were on the General Medical Council specialist register.

Emergency awareness and training

- Fire safety management and evacuation plans were in place and up to date. However, staff described varying experiences of evacuation training. One non-clinical member of staff did not know if they had taken evacuation training. Two receptionists described the evacuation procedure in detail, including the use of radios and the role of key staff who would be in the building at any given time. Simulated evacuation training had been provided in December 2016 however five of the ten members of staff we asked about this said they did not know about it.
- All of the staff we spoke with were aware of the staged fire alarm system but there were inconsistencies with staff understanding and knowledge of their immediate action in an emergency. For example, four members of staff we spoke with described different versions of the expected action they would take in an emergency and only half of the ward staff we spoke with knew there was an evacuation lift available.
- Fire doors were controlled in line with safety guidance. However, doors to a linen room and equipment room were incorrectly marked with signs that noted they should be kept locked when not in use for fire safety when this was not a requirement. Staff members were aware that these did not need to be locked but the signage required updating to avoid confusion.
- Reception desks were fitted with panic alarms which triggered a local response procedure. Engineers were available on-call 24-hours, seven days a week and monitored closed circuit television cameras around the hospital. We spoke with six staff on the inpatient ward about this as they were the only staff in the building overnight. Each member of staff said they had always felt safe and secure on night duties and demonstrated knowledge of out of hours emergency procedures.

Are surgery services effective?

Outstanding ☆

We rated effective as Outstanding.

Evidence-based care and treatment

- The hospital had a clinical audit programme that included 46 audits of relevance to staff and patients in surgery services and four audits that were only carried out in these services. Audit results were tracked and presented in the clinical scorecard and used to identify areas of good practice and areas for improvement against hospital and provider targets. This included audits against national guidance such as pre-surgery pregnancy testing.
- Between October 2015 and September 2016, 98% of relevant patients had a pregnancy test, which was better than the target of 95%. In the same period, 96% of patients had a national early warning score documented, which was better than the target of 95%.
- The hospital contributed to the National Joint Registry (NJR) for joint replacements. The NJR collects information on joint replacement surgery and monitors the performance of joint replacement implants.
- The Montefiore Hospital provided data from the surgical activity of nine orthopaedic surgeons to National Joint registry between 1 April 2015 - 31 March 2016. Data we reviewed demonstrated good patient outcomes for these who underwent a joint replacement. The 90 day mortality and revision rates for patients who had a joint replacement, were all within the expected national ranges for Knee and Hip surgery.
- NJR also reviewed the quality of the data submitted to the registry. The Montefiore was exceeding the national average in three areas. Compliance with consent records was reported as 90.7% which exceeded the national expected target of 85%. Records that had a valid NHS number were reported as 95.2% which was higher than the national expected average of 92%. The time taken by the provider to submit the data was reported as 8 days, which was significantly better than the national expected time frame of 30 days.
- The hospital participated in national benchmarking against other hospitals in the provider's network, including for clinical review. In addition the provider was developing a national benchmarking tool to enable them to compare practice and patient outcomes nationally.
- Systems were in place to ensure staff remained up to date with policy and national guidance changes. For example, a folder for physiotherapists was kept in the team leader's office and each member of staff checked and signed this daily before starting their shift.

- Staff responsible for pre-operative procedures prepared in line with best practice guidance issued by the Association for Perioperative Practice (AfPP), including the recommendations for safe practice 2016. For example, we saw practitioners make a visual count of each item of equipment required before a planned procedure, confirm this verbally and record it on a pre-printed theatre checklist.
- Staff provided pre-operative guidance using a pre-surgery fluid fasting policy. This had been established in line with Royal College of Anaesthetists best practice guidance. Staff documented evidence that this had been discussed with patients during their pre-admission discussion and was included in the printed information given to patients in advance of procedures.
- Physiotherapists established care pathways, rehabilitation plans and training in line with the Chartered Society of Physiotherapy best practice guidance. This included multidisciplinary assessment and record-keeping and development of treatment plans that were individualised.
- The provider issued a monthly safety bulletin to all staff that included updates to National Institute of Health and Care Excellence (NICE) guidance. The clinical effectiveness committee reviewed this and added additional updates relevant to local practice, such as changes in surgical skin preparation guidance. Updates to national guidance was a standing agenda item for the monthly clinical audit and effectiveness committee. Senior clinical and governance staff used this meeting to identify policy or guidance changes that were relevant to the services provided by the hospital. For example, in November 2016 the committee identified an update to NICE national guidance on sepsis and clinical guidance on the use of opioids in palliative care.
- The end of life care policy followed the national gold standards framework .
- National guidance for the use of emergency equipment and management of emergency conditions were stored locally with resuscitation trollies, cardiac arrest trollies and difficult airway trollies. This included Resuscitation Council (UK) guidance for life support and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance for the management of severe local anaesthetic toxicity.
- Surgeons and assessments nurses involved in cosmetic surgery were preparing to contribute to the National Breast and Implant Register, the implementation of which was awaiting approval from the provider's central team at the time of our inspection.
- Surgery services participated in six national audits including patient-reported outcome measures (PROMs) for hip and knee replacement, national blood transfusion audits and commissioning for quality and innovation (CQUINS) payments framework as set by local commissioning groups. The hospital also participated in the provider's national audit programme and contributed to data collection for Public Health England for surgical site infection.
- The hospital used the Royal Marsden Manual of Clinical Nursing Procedures to enable access to high quality, evidence-based clinical guidelines and at the time of the inspection, there were plans to introduce the online version.
- The hospital had introduced a super-enhanced pathway for patients undergoing a knee arthroplasty. To provide optimum pain control and early mobilisation the hospital used elastomeric devices containing local anaesthetic.

Pain relief

- Clinical staff discussed pain relief with patients as part of the pre-operative assessment and during post-operative discussions. We saw staff completed this effectively when patients could not communicate verbally after a procedure. For example, when one patient was distressed in the recovery unit, staff used non-verbal communication to assess their level of pain and administered intravenous pain relief appropriately.
- The hospital monitored patient experience of pain relief through the patient questionnaire and tracked results on a monthly basis.
- Staff used a pain assessment chart to manage pain for inpatients who triggered additional monitoring after initial assessment using a simple pain scale. This system prompted staff to re-assess pain at specific intervals after administering analgesic medicine and also triggered escalation to the nurse in charge and the RMO. Staff had updated the pain assessment chart to more closely monitor pain relief following feedback from patients.

- The hospital audit patient records for the appropriate completion of pain scores. Between October 2015 and September 2016, 98% of patients had effective pain scores recorded. This was better than the hospital target of 95%.

Nutrition and hydration

- During our observations we saw surgeons were responsive to patient needs with regards to safe monitoring of fluid balance levels and the scrub nurse was able to monitor these accordingly.
- In all of the patient records we looked at staff had recorded pre-operative fasting instructions given to patients. Each patient was given a bottle of water and 30ml cup on admission along with a fluid fasting recording sheet. Staff empowered patients to document the time of each 30ml drink they had to ensure they did not drink too much and therefore risk delaying their surgery.
- Specialist allied health professionals were available on-demand, including at short notice, if clinically appropriate and on referral from a consultant or resident medical officer (RMO). This included a dietician and speech and language therapist (SaLT). The catering team liaised with dieticians and the SaLT when planning menus or supplemental nutrition plans for patients.
- Meals were available that met peoples clinically assessed dietary requirements.

Patient outcomes

- The hospital contributed to the patient reported outcome measures (PROMs) for primary knee replacement, primary hip replacement, groin hernia and varicose vein surgery procedures. Between October 2015 and September 2016, 71% of knee replacement patients and 100% of hip replacement patients reported improved generic health status after their procedure. For the same procedures, 63% of knee replacement patients and 67% of hip replacement patients reported an improvement in their health using a visual scale. Using the Oxford Knee Score, 100% of knee replacement patients reported an improvement in function after treatment and 88% of patients reported a comparable improvement using the Oxford Hip Score.
- The provider had engaged with the Private Healthcare Information Network (PHIN) to prepare to submit data in accordance with the legal requirements regulated by the Competition Markets Authority (CMA). A PHIN steering group had been established with input and oversight from a senior governance level. A project manager was in post who submitted weekly reports to the chief information officer and the hospital was on track to be able to deliver in the four data sets required nationally by quarter one of 2017.
- The multidisciplinary team began discharge planning in advance as part of the pre-assessment process. This meant patients had a realistic goal to aim for their rehabilitation and were supported to achieve this by the whole ward team. This included healthcare assistants who completed pre- and post-surgery observations and reviewed discharge planning notes with the nurse in charge.
- In response to patient feedback about the discharge process, staff introduced a new discharge checklist. This included 15 points which should be documented to ensure patients experienced an effective discharge, such as a consultant review and a check that all invasive devices had been removed. We looked at seven completed discharge checklists, including three during our weekend unannounced inspection. In all cases the checklists were fully completed, signed by an appropriate member of staff and had documented input of a consultant and the RMO.
- The physiotherapy team had conducted an audit of patient experience using a specific elasticated tubular support bandage (ETSB) for use in rehabilitation after a knee arthroscopy. The team conducted the audit after identifying inconsistent use between consultants to establish a standardised policy. Although the ETSB could reduce pain and swelling, physiotherapists noted that clinicians often differed in their opinion of its use. The audit was therefore established to seek patient's perspective. The audit found 88% of patients who used the ETSB said it improved their confidence, which meant they could return to work and social activities more quickly. In addition, 68% of patients said their swelling was reduced by the ETSB. The physiotherapy team used the results to plan future improvements in patient outcomes. For example, the team leader was planning to embed use of the equipment into the knee arthroscopy policy and had updated guidance for staff on use of the ETSB generally to improve patient comfort.

- Physiotherapists conducted follow-up assessments for surgery patients who were discharged into the community. This included reviews during return outpatient appointments and post-operative meetings to review rehabilitation plans.
- Staff were involved in the trial of new initiatives to improve compliance with pre-operative starvation times including staggered admission times, telephone calls to patients the evening before surgery and a new patient information leaflet highlighting starvation instructions.
- In the same period 14 patients experienced an unplanned return to the operating theatre, which represented 0.27% of patients. This was comparable to the hospital's target of 0.25%. Staff investigated each unplanned return and identified learning from these. For example, ward staff were instructed to ensure all patients received wound care instruction on discharge.
- Between October 2015 and September 2016, surgery services reported 11 unplanned transfers to another hospital, which represented 0.7% of inpatients. This was slightly worse than the hospital target of 0.1%. This represented a low risk threshold to proceed with surgery when there were unmet pre-admission criteria. Staff investigated each unplanned transfer and identified areas for learning. For example, an operational policy for pre-admission assessment had been developed that included requirements for the escalation of adverse observations and concerns. In addition, a maximum level for patient body mass index was implemented to ensure surgery services could safely provider care. Staff used an established policy for transfers out of the hospital that included a transfer safety checklist and a contract with the local ambulance provider. Transfer bags were in place in theatre recovery that included emergency medicines and equipment to help transfer patients safely.
- Between October 2015 and September 2016, surgery services reported eight unplanned patient readmissions within 28 days of discharge. This represented 0.1% of day case and inpatient attendances, which was better than the hospital's target of 0.3%. Staff reviewed the circumstances of each instance and identified areas for learning. For example, ward staff improved the detail included in wound care instructions given to patients after discharge and surgeons improved recording of previous patient risks on pre-assessment consent forms.
- Patients in the extended recovery unit (ERU) were cared for using a dedicated pathway that included observations at least every hour or more frequently depending on the patient's condition.
- The hospital transfusion committee audited all surgical blood transfusions for adherence to best practice guidance. In the year to November 2016, surgery services achieved 100% compliance against a hospital target of 85%. Audits were also used to highlight areas for further improvement. For example, theatre staff were reminded to always record estimated blood loss and ward nurses were reminded to included details of a blood transfusion in the GP discharge summary.
- The hospital monitored surgical complications. This included unplanned readmissions, transfers and surgical site infections already presented in our report. It also included anaesthetic complications and thrombo-embolitic events. Between October 2015 and September 2016 there were 80 reported complications of which 45 related to orthopaedic surgery and 10 related to general surgery. Four complications related to breast surgery, one related to bariatric surgery, five related to clinical oncology, four related to cosmetic surgery, two related to gastrointestinal surgery and three related to plastic surgery.
- The hospital monitored the discharge process against a target that 55% of inpatient discharges occurring before 11am. Between October 2015 and September 2016, an average of 47% of patients met this target. The service had started to audit the numbers of patients discharged from day surgery within six hours of admission in October 2015 but had not yet established a target for this. Between October 2015 and March 2016, 51% of day case patients were discharged within six hours of admission.
- Between October 2015 and July 2016, 100% of patients who underwent a hip replacement over the age of 75 and who were funded by the NHS were fitted with a cement prosthesis. This was significantly better than the hospital target of 75%.

Competent staff

- Between January 2016 and December 2016, 90% of staff in surgery inpatient departments and 84% of staff in theatre departments had an appraisal. At the time of our inspection full end of year data was not available and both staff groups were on track to have 100% compliance. We asked six staff about the appraisal

process and in each case received positive feedback. For example one member of staff said they felt their appraisal had been a "supportive process" that "enabled me to reflect and plan my goals for the next year."

- New staff underwent a structured induction period and new clinical staff had a supernumerary period of work during which they worked under the supervision and support of mentors. The supernumerary period was flexible to meet the needs of staff and ensure they were confident before taking patient responsibility themselves. During this period mentors conducted clinical competency checks, including in medicine administration.
- Staff who worked for the hospital and for other providers, such as an NHS hospital, had access to appropriate training and clinical supervision. For example, some physiotherapists worked through a bank arrangement and were also in post in NHS services. We spoke with two bank physiotherapists who said they had to undertake the hospital's own in-house training to maintain their bank contract annually and had access to any additional training they felt would be beneficial.
- As a sustainability strategy, staff had been recruited from a diverse range of experience and backgrounds with flexible conditions to help them develop. For example, one nurse we spoke with had worked both in the UK and overseas and said they chose this hospital because, "It was exactly what I needed. I had a different specialty before but they [senior team] offered me the chance to develop and I took it. The transition was excellent, human resources were brilliant." The senior team supported staff to develop and progress internally. For example, a non-clinical member of staff had joined the service at an entry-level grade and progressed to a supervisory role with responsibility for a team. An experienced nurse who came from a different type of clinical background said, "They [hospital] took a chance on me, invested in me and believed in me. I had an amazing induction and now I'm part of the team."
- Staff were proactive in offering colleagues from different specialties or staff groups bedside teaching opportunities. For example, a physiotherapist supported an agency nurse who was unfamiliar with a care plan so that the patient continued to receive individualised support. Pharmacy technicians were available to provide one-to-one support to staff and nurses we spoke with said this helped them to improve their medicine administration skills.
- The theatre team did not meet the NATSSIP requirement that all staff had human factors training. To address this, the theatre manager and governance lead had arranged to attend this training the following month and would then discuss a local roll out and implementation plan for other staff. Spire Healthcare have since implemented a roll-out programme across the Group. .
- The theatre scrub practitioner carried out a dual role as a preparation and drape practitioner. In accordance with Perioperative Care Collaboration guidance 2012, the hospital had an established policy for this and there was documented evidence of completed assessments of the individual's clinical competencies.
- Nurses who worked in the ERU completed training in line with the national competency framework for registered nurses in adult critical care 2015. The hospital had modified this framework to ensure it met the needs of the patients cared for in the ERU and staff were assessed by a named mentor. A clinical nurse specialist in critical care delivered practical training for staff on the use of equipment and care pathways, including continuous positive airway pressure (CPAP). There was a short-term plan in place to ensure that all staff would be trained to provide level one care to ERU patients, in line with Faculty of Intensive Care Medicine Intensive Care Standards.
- The inpatient ward team worked collaboratively together to maintain a 'focus board' in the staff area. This was used to highlight a monthly topic of learning or development for the whole team and was based on events or incidents in the department. For example, at the time of our inspection the team had prepared the board with a focus on falls prevention. This included details of current best practice guidance in risk assessments as well as advice they could use to keep patients safe.
- Staff were supported and empowered by their senior team to direct their own professional development. For example, nurses could make an application to their team leader for specialist training and this was approved if they could justify the clinical and professional benefit.

- Agency nurses were introduced to the reception, housekeeping and catering teams as part of their induction. This meant they were able to work effectively in an environment that might be unfamiliar to them.
- Physiotherapists conducted periodic peer reviews on each other and provided structured feedback afterwards.
- Theatres staff who formed the weekend on-call team had specific competencies to enable them to respond to emergencies and organise urgent surgery. Staff only worked in this team when they had completed theatre competencies and had been assessed on their clinical competencies in emergency procedures and care.
- The theatre manager used a competency checking system to ensure surgical first assistants (SFAs) who worked in the department but were employed privately maintained core skills and competencies.
- Two theatre staff per year were supported to undertake the SFA course accredited by a university and delivered by a professor of education in clinical practice.
- Surgical staff competence was scrutinised by the medical advisory committee before practicing privileges were granted. Practising privileges were routinely reviewed at the MAC meetings and this was evidence in the meeting minutes we viewed.
- We were provided with examples of how the hospital board and MAC addressed concerns with individual clinicians to ensure the service delivered was safe, reflected best practice, local and corporate policy. We reviewed document evidence that demonstrated any concerns raised, were effectively and appropriately addressed in a timely manner.

Multidisciplinary working

- A team of 14 physiotherapists provided care and rehabilitation treatment to patients, including for pain and swelling management. The physiotherapy team were involved with patients from the pre-assessment stage, which enabled them to spend more time with patients and the clinical team.
- Staff described an effective multidisciplinary working environment. For example, when a consultant changed the type of knee dressings they prescribed, they asked for practical input from the physiotherapy team. Another consultant worked with the physiotherapy team to help establish more realistic goals for patients who needed elbow rehabilitation.
- Staff from different teams routinely conducted patient reviews together to help establish joint expectations and care plans. For example, physiotherapists said they often conducted joint reviews with consultants and the RMO that also helped to improve patient morale because they appreciated the joint approach to care and treatment.
- We observed two patient handovers between an anaesthetic practitioner and an inpatient ward nurse. In both cases staff confirmed patient details, including procedure information and aftercare instructions.
- Between October 2015 and July 2016, an average of 97% of patients diagnosed with cancer had a multidisciplinary team review. This was better than the hospital target of 80%.

Seven-day services

- Physiotherapists were based on the inpatient ward seven days a week, including two physiotherapists on a Saturday and Sunday. This service was available between 8am and 5pm Monday to Friday, 8.30am to 3pm Saturdays and 8.30am to 3.20pm on Sundays. The physiotherapy team leader was able to increase staffing levels according to patient need due to a number of bank staff who could work flexibly.
- The hospital had on-site pharmacy support Monday to Friday, from 9am to 5pm, and a policy in place for out of hours pharmacy provision.
- All clinical staff have access to a centrally held consultant contact database, that also includes cover arrangements. Information held on the database is kept up to date by the PA to Hospital Director.
- On-call cover was provided by a senior manager, senior nurse, radiographer, biomedical scientist, housekeeper, theatre team, engineer and oncology nurse 24-hours, seven days a week.

Access to information

- Effective systems were in place to ensure staff responsible for care and treatment at each stage of the care pathway had access to pre-assessments, risk assessments and medical history information.
- Consultants who worked under practising privileges in the hospital had access to all patient records, including multidisciplinary notes and nursing observations.
- Patients were given a copy of the discharge letter sent to their GP, which included a record of any medicines prescribed.

Outstanding ☆

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff documented consent to investigation and treatment in line with National Joint Registry guidance. Where consent to a procedure had been obtained more than 24 hours in advance, a clinician obtained and documented this again prior to the procedure. This was in line with national best practice guidance.
- Consent was clearly documented in all 23 of the records we looked at.
- A safeguarding link nurse was in post on the inpatient ward and all of the staff we spoke with were aware of the type of support and guidance they could provide. This included patient-specific guidance for Deprivation of Liberty Safeguards (DoLS) to supplement the training all staff undertook.
- A care pathway for patients with a DoLS authorisation was in place and included guidance for staff on conducting a best interests assessment with appropriate multidisciplinary input.
- Consent processes included scope to involve an independent mental capacity advocate where the patient could not provide consent themselves.
- Compliance with consent documentation was audited on a monthly basis using a sample of patient records. The latest available results were from November 2016, when the audit found 99% compliance with consent requirements.

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Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- As part of our inspection, we asked patients and visitors to complete Care Quality Commission comment cards. We received 10 cards from the inpatient ward, all of which described compassionate care. One patient noted, “Staff were kind and caring and treated me with respect.” Another patient noted, “First class care. From my first initial consultation I felt confident and relieved I had booked in here. As you walk in you feel immediate calmness from the reception staff. I like the fact that every member of staff took pride in their work – the cleaners, catering staff, the receptionists, nurses and doctors.”
- We observed theatre staff treat patients with compassion and understanding. For example, during one procedure the scrub practitioner sat with the patient and provided calm and confident reassurance throughout. The surgeon gave the patient a full explanation of what they planned to do beforehand, including the use of a local anaesthetic. In theatre recovery, staff reassured and comforted a patient who became confused and distressed after their procedure. For example, they reminded them where they were, made them more comfortable with pillows and checked their pain needs.
- The physiotherapy team received consistently positive feedback from their patient survey. Comments made from September 2016 to November 2016 included, “Treatment was excellent, always positive and encouraging” and, “The physios were very understanding of my feelings.” One patient noted, “Gentle and firm with me. I really appreciated their care and humour.”
- The hospital participated in the patient-led assessments of the care environment (PLACE), which included all surgery areas. Between February 2016 and June 2016, the hospital performed better than the national average in privacy, dignity and wellbeing, at 95% compared with the national average of 83%.
- During our observations of bedside nurse handovers, we saw nurses tailored their communication to the mood and disposition of the patient. In all cases nurses were polite, warm and engaging and encouraged patients about their progress.
- All patients were asked to complete a privacy, dignity and diversity questionnaire prior to admission which asked questions such as preference for name, telephone calls, visitors, door open or closed, male or female nurse, assistance meeting religious, spiritual or cultural needs, notes left in room, information to GP etc. Copies were forwarded to the ward, physiotherapy team and main reception.

Understanding and involvement of patients and those close to them

- The discharge process included a documented record that staff had asked the patient about any questions they had and provided information. The process also included a record that each patient knew how to contact the hospital after discharge with any questions. In all seven records we looked at, this had been completed. Staff provided each patient with two discharge meetings to ensure they understood their care plan and had the opportunity to discuss any concerns or questions.
- Patients commented positively on their experiences on all 10 feedback cards. One patient noted, "I have had exceptional care and advice from this hospital, every need has been listened to by friendly and caring staff." Patients also commented on being involved in their care. One patient noted, "My surgeon and anaesthetist visited me and explained what was going on." Another patient noted, "The physiotherapists were just fantastic and they explained everything so clearly, it really helped reduce my anxiety." One patient noted, "The nurses were amazing. Nothing was too much trouble and they always answered my call bell really quickly."
- Physiotherapists worked to an ethos of providing realistic patient-centred care. This meant they established aims and goals with each individual person and changed processes or plans where a patient wanted to re-establish their expectations.
- Staff in the physiotherapy service completed a quarterly audit of feedback provided by patients using a survey that the team had developed themselves. Between June 2016 and November 2016, 100% of the 500 survey respondents felt they had always felt involved in decisions about their care. In addition, 98% said they were clear about the exercises they had to do once they got home after discharge and 99% said the number of physiotherapy sessions they received was 'about right.'
- During three bedside handovers we observed, nurses involved patients by explaining what the handover was for and discussing the plan for the day. In each case the nurse asked the patient if they had any questions or wanted to discuss anything.
- We observed a patient transfer from theatre recovery to the extended recovery unit (ERU). We saw staff explained the process to the patient, including what the equipment was for and why they were being transferred. Nurses included the patient in the handover, including what they could expect to happen next.

Emotional support

- Staff had a demonstrable understanding of the emotional support needs of patients and their relatives and consistently worked to meet these, including in challenging circumstances. For example, staff supported the family of a patient who unexpectedly deteriorated and needed palliative care to visit the hospital and spend time with them. The hospital facilitated this by providing specialist community psychology team support, ensuring the patient was able to die in the place they chose safely and by ensuring the patient and their family had access to bereavement support.
- Patients who received chemotherapy had access to emotional support provided by the hospital 24-hours, seven days a week. This enabled them to talk to a clinical member of staff who could provide reassurance and guidance at any time.
- Surgery services provided palliative care as a specific pathway for admission. Senior staff nurses had completed care and compassion training to help them support patients and relatives from a psychological perspective if an individual's condition deteriorated after admission.
- A pastor visited the hospital weekly and was trained in both general counselling and religious counselling. This meant patients and relatives had access to spiritual and emotional support regardless of their beliefs.
- Patients are offered a visit to the ward or Extended Recovery Unit (ERU) prior to admission if desired to reduce anxiety.
- Breast care patients are offered psychological support

Are surgery services responsive?

Outstanding ☆

We rated responsive as outstanding.

Service planning and delivery to meet the needs of local people

- The hospital responded to market forces and planned services that local people wanted.
- There was proactive collaboration with local (Clinical Commissioning Groups (CCG's) and local NHS organisations' to ensure the service could to respond appropriately to requirements for NHS funded patient

services. Hospital management took pride in ensuring the Montefiore hospital worked collaboratively with local NHS providers, rather than being in a position of direct competition. This ensured it was in a position to support local NHS services and meet the needs of local people.

- Patients were cared for and treated in a purpose-built environment. In the inpatient ward this included bedroom features such as independent air conditioning systems, wireless internet access, a reclining chair, space for relatives or visitors and an en-suite bathroom with shower.

Access and flow

- The majority of patients who used the services provided by the Montefiore hospital were privately funded and the remainder NHS funded. Between October 2015 and September 2016 there were 4857 visits to theatre, 3655 surgical procedures and 1523 inpatient attendances.
- Theatres were open between 7.30am to 5.30pm Monday to Friday and during the same times on Saturdays on demand. All theatres were available for emergency procedures out of hours. The hospital provided flexible access times to clinics, including for pre-assessment, at weekends and evenings.
- Staff used a hospital bed planner to assist planning for access and flow, including responsiveness to staffing levels.
- The matron, an anaesthetist and/or the relevant surgeons maintain oversight of complex admissions or those with multiple comorbidities and approved these individual admissions. This meant a senior clinical team ensured admissions were made only when the hospital could safely meet their needs.
- Between 14 November 2016 and 27 January 2017, the day surgery recovery unit recorded 437 patients. Staff told us bed plans were established five days in advance but extra patients were often added to this with the approval of a senior manager. Electronic records were used to ensure all staff had the most up to date information at all times. Some staff we spoke with felt late bookings presented a safety risk because there was no scope to increase resources or staffing levels in the unit but the hospital management team could provide evidence that resources were increased where required and staffing levels were reviewed on a daily basis.
- The physiotherapy and pharmacy teams planned to add a member of each team to the 1pm daily handover on the inpatient ward as a strategy to improve discharge planning.
- Between October 2015 and September 2016, 29 procedures were cancelled for non-clinical reasons. This represented 0.7% of all booked procedures, which was slightly worse than the provider's target of 0.4%. In all cases patients had their procedure rescheduled within 28 days. We looked at the details of 21 cancellations made between July 2016 and September 2016, of which 13 were unavoidable and eight were avoidable. The clinical audit and effectiveness committee had identified nine actions to be taken to reduce the risk of future avoidable cancellations as a result. This included more structured communication between surgeons and administrators to ensure the correct equipment was booked in advance and the development of a patient information sheet for gastroscopy.
- In the same period, 93% of patients were seen within 18 weeks of referral. This was an NHS England national target for referral to treatment standard, with a national target that 90% of patients be seen within this time. This was an average figure and reflected nine months in which the hospital met or exceeded the target and three months in which the target was not met. Where the 90% target was not met, the average compliance rate was 89%.
- The design of the building and emphasis from the team on ensuring practical access and flow for patients was commendable. This was because the original design had a prominent focus on upholding dignity, confidentiality, easy access to departments, and ensuring a positive patient experience.

Meeting people's individual needs

- Printed information was available to patients on the ward that gave more information about common conditions and procedures, after-care and where to go for help after discharge. A cancer series was provided that included easy-read booklets on physical examinations and blood tests and healthy living such as reducing alcohol intake.
- On admission patients received a personal hygiene pack that included shower gel, shampoo and towels.
- On admission, patients were orientated to their bedroom and encouraged to personalise it as their space. Bedrooms were designed to be as least clinical as

possible, whilst retaining clinical safety. There were facilities for relatives to stay in the patient's bedroom if required. The hospital encouraged this arrangement for patients with impaired cognitive ability (such as dementia) or for patients who are anxious or fearful.

- The entrance to each clinical area included a display of photographs of staff, their roles and the names of staff on duty on that shift. This display included details of facilities for visitors, the chaperone policy, translation services available printed in various languages and the ward strategy.
- Staff had introduced a new discharge planning checklist to ensure each patient had their needs met prior to leaving the ward. For example, staff provided two pairs of anti-embolic stockings and ensured each patient know how to apply and wear them. A range of information leaflets and guides were available on the ward and staff proactively provided copies as part of the discharge process. This included guidance on wound care, pain-relieving medicine and blood clots. The discharge pack was individualised to each patient. For example, wound care information was specific to each patient's needs and blood clot information was based on their individual level of risk.
- Nurses in the pre-operative assessment unit offered services to help patients prepare for procedures, including by phone and face to face. This service was available from 8am to 6pm Mondays, Tuesdays and Thursdays, from 8am to 4pm on Wednesdays and from 8am to 2.30pm on Fridays. A new member of staff was in their supernumerary period and once they completed this, the Friday service would be extended to 6pm.The hospital stated that appointments are available outside of standard hours should this be required to meet individual needs.
- A team of chefs prepared meals in-house between 7am and 7pm seven days a week. This included healthy meals using locally-sourced vegetables and a flexible menu that could be modified to meet each patient's preferences and clinically-assessed dietary needs. Overnight, ward staff had access to hot meals that could be heated in the ward's dedicated kitchen. Six catering services were offered per day, including morning and evening beverage services and an afternoon tea service in addition to routine mealtimes. A ward host ensured each patient's meal order was taken in advance and could also offer alternatives or changes at any time. Relatives and visitors were able to eat meals with patients and ward hosts facilitated this.
- The matron was the hospital lead for dementia and all of the staff we spoke with knew they could contact her for patient support. Staff also had access to a communication tool on the ward that helped them develop techniques to interact with patients who could not communicate verbally. This included visual aids and prompts to help staff identify patient's likes, dislikes and concerns. A local dementia screening tool was in place and we saw evidence staff used this appropriately when cases of suspected dementia were not identified during pre-assessments.
- As patients admitted to surgery services were planned elective cases, staff had the opportunity to plan in advance to provide additional support for patients diagnosed with dementia. This included use of the hospital passport, which was completed in advance and enabled staff to read about the patient's likes and dislikes ahead of their admission. Similarly, staff identified patients who needed language support at the pre-assessment stage and arranged for an interpreter to be available for the duration of their care and inpatient stay.
- Staff used a discreet magnet on the patient information board to help identify individuals who needed support with complex needs such as dementia or a learning disability. Clinical staff shared this information with colleagues who were involved in providing a service, such as catering staff. This meant non-clinical teams could adapt their approach and communication and ensure each patient had equitable access to the service.
- Staff had access to mental health nurses and psychologists if needed and on referral from a clinician.
- The hospital participated in the patient-led assessments of the care environment (PLACE), which included all surgery areas. Between February 2016 and June 2016, the hospital performed better than the national average in scores relating to the environment for patients living with dementia and disability. For example, the hospital was rated 87% for the dementia-friendly environment compared with the national average of 77.4% and 85% for facilities for patients with a disability compared with the national average of 79.9%.
- Two theatre porters were available Monday to Friday during theatre lists and by advance arrangement on

Saturdays. However, as a strategy to ensure continuity of care, nurses were responsible for transferring patients between areas such as theatre recovery and the inpatient ward. Staff we spoke with said this sometimes caused additional pressure on the teams. For example, the service standard for patients was that they would be transferred from theatre recovery within 20 minutes of being assessed as safe. However, the inpatient ward could not always release sufficient staff within this time to collect patients and transfer them. In such cases the lead in theatre recovery called the ward for an update every 20 minutes. Staff on both teams said this added additional pressure to their workload without positively impacting patient care.

- Staff demonstrated responsiveness to individual needs during the handovers we observed. For example, the nurse in charge had obtained guidance from the pharmacy when a patient was admitted with their own medicine related to recovery from drug addiction. In another case, nurses had spent time with the relatives of one person who was undergoing assessment by a memory clinic for reduced cognitive function. This helped staff to understand the patient's current needs and also helped their relatives to prepare for the possible effects of delirium after surgery. Another patient was due to be admitted who had disclosed a high level of anxiety and staff ensured they were on hand to greet the patient and discuss their worries.
- During handovers and planning meetings, we saw staff discussed the social needs of patients, including checks of their home situations and any concerns around people who were involved in their care.
- The inpatient ward had a visitor lounge area that included a hot drinks machine and water dispenser. This was a calm and comfortable area for relaxation and included information on the ward performance such as the number of pressure sores, number of falls and unplanned returns to theatre.
- We observed a pre-theatre briefing and saw the theatre manager reinforced the requirement to monitor the time of lists, ensure patients received fluids and maintain communication with the inpatient ward about transfer times.
- The physiotherapy team had invested equipment that enabled them to treat patients using the 'rest, ice, compression, elevation' care pathway with an intermittent compression and cold therapy system. The physiotherapy team had prepared targeted training for nurses, including practical supervision and printed guidance.
- Physiotherapists provide patients with crutches to practice using at home in advance of a planned admission. This meant patients were ready to start using mobility support equipment immediately after their operation. Physiotherapists documented this process as a specific rehabilitation pathway and included individualised education and consent.
- Detailed, printed information was provided to patients on admission and discharge, including for day care patients. This had been developed with feedback from patients and their relatives and included details of what to expect in the hospital, the roles of staff patients were likely to meet and the different services available to them. The information included guidance for relatives on visiting arrangements and had been developed to be flexible whilst ensuring patients had sufficient rest and recovery time. This information was provided in a reassuring tone. For example, information on pain relief encouraged patients to talk their nurse about this as soon as they felt pain and reassured patients that dependency on pain medicine was not a risk for them.
- Complimentary therapy was available in the hospital, including reflexology, aromatherapy and acupuncture. A consultant was required to authorise this treatment to ensure it was safe and clinically appropriate.
- A team of chefs prepared meals in-house between 7am and 7pm seven days a week. This included healthy meals using locally-sourced vegetables and a flexible menu that could be modified to meet each patient's preferences and clinically-assessed dietary needs. Overnight, ward staff had access to hot meals that could be heated in the ward's dedicated kitchen. Six catering services were offered per day, including morning and evening beverage services and an afternoon tea service in addition to routine mealtimes. A ward host ensured each patient's meal order was taken in advance and could also offer alternatives or changes at any time. Relatives and visitors were able to eat meals with patients and ward hosts facilitated this.
- Privacy, dignity and diversity were embedded in patient care, both through delivery and in patient records. For example, staff talked with patients about their spiritual, religious and cultural needs during the admissions

process and once again after treatment. Staff also paid attention to detail when planning care such as by asking each patient if they preferred personal care from a male or female nurse and noting this in their records.

- Staff used a daily living assessment to ensure each patient's wider personal needs could be met. This included consideration of needs relating to communication, breathing, eating and drinking, toileting, moving around, relationships, fears and anxieties. The physiotherapy team used the tool to assess each patient's home living situation including information on the environment and whether they had safe access to move around without risking injury.
- A dedicated team of reception staff were available in the inpatient ward from 7am to 10pm daily. This team supported patients with appointments, contacting clinical staff and provided on-demand information about services and planned admissions. We observed this team on each day of our inspection. Every member of staff demonstrated detailed knowledge of the ward, hospital and provider and provided an expert non-clinical support service.
- The physiotherapy team were proactively involved in the pre-admission process for relevant patients such as those having hip, knee, foot and ankle surgery. This meant advance discharge planning could be completed to ensure the support in place met individual needs. For example, physiotherapists arranged community occupational therapists and equipment in advance. This meant no patients experienced an inappropriate discharge. The physiotherapy team leader audited discharge planning in late 2016 and found 75% of patients had received all aspects of the discharge plan.
- Patients with cognitive impairment were asked to complete a Hospital Passport, which provided detailed information to enable individualised care to be delivered.
- Each bedroom had an en-suite wet room allowing individual independence as much as possible. There were 4 assisted bedrooms with extra-large wet rooms to allow for disabled patients. Patients had control over their environment with temperature, lighting, bed adjustment (electric profiling beds in every bedroom), television and radio / entertainment and call system.

Learning from complaints and concerns

- The provider's complaints procedure was readily available in all clinical areas and waiting areas. In addition all staff were trained to resolve minor issues raised with them verbally by patients or visitors and the hospital replied to complaints submitted through social media. The hospital acknowledged all complaints within two days of receipt and provided patients with an estimated timeframe for resolution. Escalation procedures were readily available for patients in the event they were dissatisfied with the hospital's response, including through the NHS Ombudsman and the Independent Sector Adjudication Service. The hospital included the requirements of the duty of candour in the handling of complaints, including communicating honestly and openly with people when things went wrong.
- Staff acted on complaints from patients to improve the service. For example, one patient complained that the electronic controls for their bed were too complicated. The inpatient team discussed solutions and implemented a patient induction for each individual admitted to the ward. This included information on all of the facilities and features in the room, including bed controls.
- The senior team monitored compliance with the two-day standard for acknowledgement of complaints. This improved significantly between October 2015 and September 2016, from 65% compliance in quarter one to 95% compliance in quarter three. This resulted from an improved tracking system and more consistent communication.
- The senior team disseminated learning and improvements from complaints to all staff through one-to-one meetings, leadership team meetings, the medical advisory committee and clinical governance committees. Staff also received a 'lessons learned' newsletter that presented complaints and their investigations. Recent changes made as a result of learning from complaints included staggered admission times and increased engagement from pharmacists during ward rounds to provide medicine counselling.
- Senior staff used monthly clinical audit and effectiveness committee meetings to review complaints and agree resolution and learning.

Are surgery services well-led?

Outstanding ☆

Surgery

Good

We rated well-led as good

Leadership / culture of service related to this core service

- The leadership team in the inpatient ward had changed unexpectedly in the year prior to our inspection. This occurred following the unplanned departure of the ward manager. To ensure the ward maintained consistent management support and structure, three senior sisters formed a triumvirate management structure. The matron, who was head of clinical services, maintained oversight of this team and provided structured support through fortnightly meetings.
- The senior leadership team proactively encouraged staff at all levels to challenge decision-making and contribute their own ideas and experience to every situation. This was embedded in the recruitment process for new staff and included in the induction of every consultant, which was led by the matron. There was evidence this approach to governance had worked effectively. For example, the matron had challenged a surgeon to find a precedent for a specialist procedure when they had initially declined a complex surgical procedure. This ultimately led to a successful procedure.
- All of the staff we spoke with described a positive and inclusive working environment and culture. The physiotherapy team was made up of permanent and bank staff and each individual said this worked well as a coherent team. One physiotherapist said, "We're happy to do extra work because we're so well looked after and we can see the difference we make to patients."
- Although staff described a working environment in which they were empowered to make decisions, a clear leadership structure was in place for when staff needed help. This worked well in practice. For example, when a nurse and physiotherapist had a concern about the work of an agency nurse, the nurse in charge intervened to ensure the agency nurse was appropriately supported.
- All of the staff we spoke with described an inclusive and supportive working culture and said the matron was approachable and readily accessible. One nurse said, "[The matron] is very flexible when we want to see her… it doesn't matter what shift you're on, if you need to talk she'll be there." One member of staff said, "Everyone helps and is very open to change and suggestions. People recognise what you do and I feel valued for the work I put in." Staff at all levels of responsibility said they felt respected by their colleagues. One nurse said, "The consultants are great – very approachable and we have access to them whenever we need. They're sociable and join us for our team events."
- Rates of staff sickness were very low, with 0% sickness absence for theatre nurses, health care assistants and operating department practitioners between October 2015 and September 2016. During the same period, nurse and healthcare assistant sickness in inpatient areas ranged from 0% to 20%.
- Between October 2015 and September 2016, there was no staff turnover in theatres and a 27% turnover of nurses in inpatient areas. There was a 28% turnover of HCAs and other staff in inpatient areas in the same period.

Public and staff engagement

- Staff included a patient satisfaction survey in each discharge pack and encouraged patients to complete these on site. This enabled staff to act on any immediate feedback and maximised responses. There was evidence staff implemented changes and improvements as a result of patient feedback. In addition to the improvements to the discharge planning processes detailed elsewhere in this report, the hospital had also appointed a lead nurse for pre-assessment and the head chef had introduced an on-demand hot meal ordering service so patients could order food at short notice. This information was on display in the hospital entrance and at the entrance to the inpatient ward to demonstrate how the hospital used patient feedback.
- The hospital used '**Be Heard**' cards, which were available in all departments and communal areas around the hospital along with designated post boxes. They were designed to capture real-time service user comments (positive and negative), and could also be used by staff. Completed Be Heard card were reviewed by the Senior Management Team and logged with commendations shared with the entire hospital team and any formative feedback used as an opportunity to learn and improve.

Considerable efforts have been ongoing to improve the overall response rate, along with patient satisfaction outcomes.

- A patient experience committee met every three months to discuss patient feedback and experience. This committee had facilitated recent changes to the service, including a more patient-centred admissions process and more detailed, accessible printed information for patients.
- The senior team had facilitated a series of patient forums made up of former patients and the senior management team. This enabled the team to build an understanding of patient perspective and how they experienced and have reflected on their hospital treatment.
- The senior team engaged with staff, proactively asked for their feedback and made changes to the service as a result. For example following feedback that staff in different departments would like more opportunity to meet and improve communication, the senior team established a weekly operational meeting. The theatre manager led the meeting, which was attended by representatives from the inpatient ward, diagnostics, pharmacy, catering, housekeeping, bed management and the sterile services department. We attended one meeting and saw it provided each department with the opportunity to plan patient care and staff resources for the week ahead as part of a multi-professional team. This included planning each patient's journey through the hospital, including inpatient bed space, catering needs and take-home medicines.
- Attendance at these meetings was mandatory and was used to discuss admissions and operating lists for the upcoming week along with associated staff requirements for all departments.
- Staff in the inpatient ward and theatres felt their input was sought out and that they were included in development plans. For example one nurse said, "Everyone gets a chance to have their say through the staff survey. But we have the chance to speak our mind every day; there is never a time when we are not considered in how the service is run."
- The physiotherapy team received consistently positive feedback from the patient survey. Between June 2016 and November 2016, 99% of the 500 patient respondents rated the service as excellent or good and 100% said the their physiotherapist had demonstrated excellent knowledge and skills.
- All of the staff we spoke with said they felt involved with the organisation and said regular newsletters and staff forums helped to keep them up to date with changes and developments. In addition, the hospital encouraged staff to visit other hospitals in the provider's group to observe practice and talk with colleagues as a strategy to develop and improve the service.
- The physiotherapy team had developed a patient survey for those who had undergone a total hip and knee replacement to collect more detailed information than could be identified from the hospital survey.
- A staff forum met monthly and included a representative from surgery services. All staff were encouraged to contribute to the forum and information on recent topics of discussion were posted in staff rooms.
- Staff had prepared a visitor engagement display in the inpatient ward waiting area to encouraged more people to provide feedback and suggestions. This display demonstrated how feedback was used to develop the services, such as changes to how patients could order food and the implementation of a pre-assessment lead.

Vision and strategy for this this core service

- Staff understood the provider's overall vision and also demonstrated knowledge and passion about the hospital's local vision and strategy. For example, the team worked within a set of values called 'The Montefiore Way' that included being empowered, accountable, collaborative and exceptional and patient-centred in their approach to care.
- Staff shared strategies of improving care based on benchmarks, ensuring continual learning and focusing on internal staff development and promotion. This formed part of a broader 2017 strategy for clinical services that included goals such as to gain quality environment accreditation for cancer care and to reduce the length of stay for patients who underwent joint replacement.
- The inpatient ward planned to expand the level of care provision in the extended recovery unit (ERU) from level one care to level two care. This would mean the ERU could offer safe care to patients who had a higher level of dependency.
- The short-term plan for the inpatient ward was to ensure a new leadership structure worked as effectively as possible and to ensure all nurses completed training to care for patients in the ERU. The senior team had also

completed planning to invest in training to enable more nurses to take on specialist link roles such as for pain management and care of patients who had undergone colorectal surgery.
- Staff had displayed the vision, mission and values of the service in patient and visitor areas.

Governance, risk management and quality measurement

- The hospital director, medical advisory committee and senior management team formed the leadership groups for hospital governance. A series of sub-committees and management groups (MGs) held responsibility for specific areas of safety and governance. A health, safety and risk committee led a medical gas MG, waste management MG and health and safety representatives group. A clinical governance committee led five clinical committees including a clinical audit and effectiveness committee (CAEC). We looked at the minutes of the latest CAEC meeting from November 2016 and found it was well attended by a senior member of staff from each area of surgery services.
- The senior team in each clinical area or department managed and tracked local risks with the use of a risk register. This included details of the responsible member of staff for each risk, the date of the last review and action taken to mitigate the risk. At the time of our inspection, 26 risks were active on the risk register for surgery services. This included two risks for pre-assessments, 16 risks for theatres and eight risks for the inpatient ward. All risks had been reviewed within an established timescale and had controls in place to reduce their likelihood and impact.
- We found effective managerial systems and processes to monitor practicing privileges at the Montefiore. Evidence demonstrated any identified risk was addressed effectively, and promptly.
- Monthly staff meetings took place in the inpatient ward and theatres. This included a review of incident reports and key learning, patient and staff feedback and learning from other hospitals in the provider's group. We looked at the minutes for five staff meetings across surgery departments. In each case these were well-attended and there was evidence of documented progress against action plans from health and safety and management committee meetings, infection control audits and risk assessment development work.
- The senior team on the inpatient ward used a weekly meeting to discuss the key focus for the week ahead. This helped to establish and reinforce new processes or updated policies. For example, senior nurses used the focus meetings to introduce staff to an updated pain assessment tool and pre-surgery fluid fasting protocol.
- The lead pre-operative assessment nurse met monthly with staff from the ward administration team, medical records, theatres, senior ward nurses, inpatient bookings, the NHS bookings team, outpatient senior staff and the finance manager. This helped the lead nurse to establish a more structured department following a period without a manager in post. This was in addition to monthly departmental meetings that enabled the lead nurse to foster a cohesive team.
- A'team hug' took place each morning at 7.30am and all theatre staff on duty were required to attend. Discussion included activity for the day, any foreseeable issues, staffing, operating list changes, kit requirements (including turnaround issues), expected deliveries (such as loan kit), expected visitors and breaks. Discussion also included a review of any issues arising during the previous day, including any immediate learning opportunities. This daily 'team hug' had a structured template and was documented in the daily communication book. Feedback from all team members was encouraged ensuring that everyone could raise issues or concerns freely.

Innovation, improvement and sustainability

- The matron was implementing plans to attract resident medical officers (RMOs) to the hospital on a permanent basis. This was part of future sustainability planning to reduce the need to recruit new RMOs and to ensure long-term continuity in the department.
- The hospital offered a varied GP education programme based on content determined through GP surveys and discussions to ensure topics are relevant. For example, Consultants had recently delivered training sessions to local GPs on the surgical options available for their patients who had experienced orthopaedic trauma.
- There was an effective sustainability strategy in place that supported recruitment from a diverse range of experience and backgrounds with flexible conditions to help them develop.
- The hospital participated in the provider's national 'Inspiring People' scheme that recognised staff for innovative work and contribution to patient experience.

Outstanding ☆

Surgery

- The design of the building and the thought and effort invested in ensuring excellent patient flow, was commendable. This was because the original design had a prominent focus on upholding dignity, confidentiality, easy access to departments, and ensuring a positive patient experience. The successful implementation of the plan was a result of collaborate working, that was driven by clinical input and experience.
- Consideration was also given to reducing the stress and anxiety experienced by patients in waiting areas. A large calming art installation was placed in the main reception area. The installation was ever changing so patients never experienced the same image twice. There was also a quiet room available with 'calming sounds' for those who preferred to sit alone or share a private moment with loved ones. Patients we talked with were very complimentary about the design of the building, the surroundings and their patient journey.
- The hospital had made considerable efforts to improve consultant daily record-keeping (a key performance indicator), including the introduction of the consultant daily review sheet which has been a popular addition with surgeons and was widely adopted at the time of our inspection. The template ensured that the surgeon considered the NEWS score, pain management, emesis, medications, fluid balance, mobility, blood test results, imaging, recovery pathway and discharge at every visit and recorded this appropriately.
- To improve documentation audits, improve bedside handovers and ensure all staff understood and prioritised patient safety, the hospital had a locally-devised patient safety booklet (PSB) which included clinical risk assessment tools and care management tools (for intervention and escalation), and followed the patient from pre-operative assessment through to discharge. The PSB was used during nurse to nurse handovers along with care pathway documentation.
- The hospital became a provider of Student Nurse placements for the University of Brighton in November 2016. This approval was based on a comprehensive education audit undertaken bythe University.
- Intraoperative radiotherapy (IORT) was offered as a treatment modality in some early breast cancers. This enabled surgical excision and radiotherapy treatment at the same time. Montefiore hospital has performed the most IORT procedures in the UK. The hospital used patient feedback and perception of the IORT experience to improve the experience. This was published at the National Cancer Research Institute Cancer Conference in 2016.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good

Incidents

- The hospital did not report any 'never events', related to the outpatients or diagnostic imaging departments in the period from October 2015 to September 2016. 'Never events' are serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'.
- There were 114 clinical incidents reported between October 2015 and September 2016 in the outpatients and diagnostic imaging departments. Eleven non-clinical incidents were reported in the same period, which is similar to other independent acute hospitals CQC holds data for.
- The hospital had an adverse incident/ near miss reporting policy dated August 2015. All staff had read the policy and indicated so, by signing to show they had done so. We saw records to confirm this.
- All staff we spoke with had a good understanding of the incident reporting process. They could give examples of what they would report. For example, a blood sample that had been labelled incorrectly. Staff had a meeting, checked staff competency against the process for undertaking the procedure with the process. The patient was informed and duty of candour discharged.
- Staff described 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. Staff explained that service users 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.
- Under regulation 4(5) of Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000, providers are obliged to submit notifications of exposures 'much greater than intended' to CQC. We received no notifications from January 2015 to October 2016. Staff had a clear understanding of what was a reportable incident. A Radiation Protection Advisor (RPA) was available for advice, by telephone or mail, if required.

Cleanliness, infection control and hygiene

- All areas of the outpatient and diagnostic imaging departments we visited were visibly clean and tidy.
- The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance.
- The most recent patient led assessment of the care environment (PLACE) score, completed in 2016, was 99.72% for cleanliness, which was better than the national average of 98%.

Good

Outpatients and diagnostic imaging

- Housekeeping staff understood their responsibilities, cleaning frequency and standards. All areas were cleaned each morning. We saw checklists, which showed this was happening. The Housekeeping Supervisor, undertook monthly audits to ensure the appropriate standards of cleanliness were maintained and we saw documentation to indicate this was happening.
- The hospital had an infection prevention and control of infection manual, dated Nov 2015. Staff had read and understood the manual, which was indicated by signing a sheet in a folder, which we saw.
- Staff in the outpatient and diagnostic imaging department also completed daily checklists of rooms, to ensure equipment within treatment and examination room was clean at the start of the day. Individual members of staff were allocated certain areas of responsibility and this was changed regularly, to ensure staff covered all areas of the department.
- We saw disinfectant wipes were available in each room. Equipment was cleaned with these, between each patient use and a green sticker placed on it to show this had been done. We saw equipment with green stickers on indicating equipment was clean and ready for use. They were signed and dated, which indicated when it had been cleaned and by whom.
- There were hand washing sinks available, in all patient examination areas. Soap and disposable hand towels were available next to sinks. We saw information displayed demonstrating the 'six steps for hand hygiene' near handwashing sinks.
- Chairs in waiting areas, consultation, and examination rooms were covered with fabric which could be wiped clean. The fabric on every piece of equipment we checked was intact. Soft furnishings (for example, seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam-free, or heat-sealed.
- Waste in the clinic rooms was separated and placed in different coloured bags to identify the different categories of waste. Housekeeping staff removed clinical waste daily and placed it in bulk storage bins. We saw all waste was kept appropriately in locked, bulk storage bins on the clinic premises until collected.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with Health and Safety (Sharp Instruments in Healthcare) 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. Every bin we saw had the temporary closure mechanism engaged. The temporary closure device on the bin to prevent accidental spillage of sharps if the bin is knocked over. We saw the labels on sharps bins had been fully completed which ensured traceability of each container. A poster advising staff of what actions to take in the event of a needle stick injury was on display by every sharps bin that we saw.
- Some areas of outpatients used endoscopes (an instrument used to examine the interior of a hollow organ or cavity of the body). Scopes were cleaned between each patient use with a triple cleaning system and processed through the endoscope washer at the end of each clinic use. There was a full tracking and tracing system in place. The records we saw showed each time an endoscope was clean with the three stages completed and by which member of staff, which indicated all steps were being completed. This process was completed within a designated room for the process.
- All ultrasound probes were cleaned between each patient using the triple cleaning system. We saw records were complete and indicated which staff member had carried out the cleaning, when and that all steps had been completed.
- We saw storage areas were visibly clean, well ordered and free of clutter. There were no items on the floor, which assists cleaning.
- Consultation rooms consisted of two rooms. One of the rooms was for consultation only, and had a carpeted floor. The adjoining room was for patient examinations. It had flooring, which was seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant.
- Carpets were cleaned every six months and we saw records, which indicated this was happening.
- Staff had carpet shampoo equipment to clean on the spot if required.
- We saw disposable curtains in clinical areas and labels on curtains indicated they had been changed within 6 months. In addition, we saw checklists to indicate all disposable curtains throughout the hospital were changed every 6 months.

Good

Outpatients and diagnostic imaging

- We saw hand-sanitising gel was available at point of care in all clinic rooms. We saw staff using hand sanitiser when entering and exiting clinical areas. This meant the hospital could be confident staff were following national guidance to prevent the spread of infection. We heard staff informing patients and their relatives of where hand sanitiser was available and why they should use it.
- We saw staff in clean uniforms and all staff we saw that interacted with patients were bare below the elbow. They demonstrated 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. The most recent hand hygiene audit result in December 2016 indicated the outpatient department scored 91%, which was below the WHO target of 95%.
- Personal protective equipment, such as gloves and aprons was available in all outpatient and diagnostic imaging areas.
- Attendance of staff in outpatient department staff to infection, prevention and control training was 100%.
- Attendance of staff from the diagnostic imaging department was 96%, which had equated to one new member of staff who had yet to attend their training.
- The outpatient department and the diagnostic imaging department had a link person for infection, prevention and control. Link nurses are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice. They attended additional training and shared learning with colleagues. In addition to this, they attended a hospital infection prevention and control study day 4 times a year. Staff discussed audits, any action arising from audits and any outstanding actions from the last meeting. We saw minutes of these meetings, which indicated this was being discussed.

Environment and equipment

- There was a main waiting area at the hospital, where reception staff would direct patients to the relevant area. The outpatient and diagnostic imaging departments had dedicated reception desks, with individual waiting areas.
- The most recent PLACE audit score for the hospital was 97.7% for condition, appearance, and maintenance, which was better than the national average of 93%. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds.
- We saw the environment in the main reception area, outpatient and diagnostic imaging waiting areas appeared to be in good condition and well maintained.
- Every department within the hospital undertook a quarterly environmental health and safety audit, and an annual internal health and safety management audit. The hospital was also inspected biennially by external experts.
- Equipment was serviced annually. We saw service records and stickers on equipment showed it had been serviced within the last 12 months. Staff recorded any issues with equipment and engineers indicated what they had repaired or replaced. We saw records, which indicated this communication was on-going.
- We saw electrical testing stickers on equipment, which indicated equipment was safe to use.
- Diagnostic imaging equipment underwent regular quality assurance checks and we saw this was occurring. This provided assurance that equipment was working to the required standard.
- We saw an individual room was available for patients to have blood tests in. This was in line with Health Building Note (HBN) 12, 4.42, which recommends areas providing blood tests should provide individual cubicles for patients.
- 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, such as height and weight. All examination and treatment rooms we looked in were spacious and well equipped. However, the outpatient department had limited storage space and some equipment had to be kept in treatment rooms.
- Equipment trollies were stocked with standard equipment for each clinic. In addition to this, staff pre-prepared trays with equipment in for specific clinics or consultants.
- All consumables were in date. Staff rotated stock and regularly monitored expiry dates to ensure stock did not go out of date.

- Resuscitation trolleys were available and easily accessible in both the outpatient and diagnostic imaging departments. They were tamper proof, the seal was secure and staff checked it daily. We saw that checklists were complete.
- First aid and eye splash kits were available throughout the outpatient and diagnostic imaging departments.

Medicines

- The hospital had a medicines management policy dated April 2016. The purpose of the policy was to make suitable arrangements for the recording, safekeeping, handling, and disposal of drugs.
- No controlled drugs (CD'S) were kept or administered in the outpatient department. CD's are medicines liable for misuse that require special management.
- Staff stored prescription pads in a locked cupboard. The key to the cupboard was stored in a locked cupboard secured to the wall. Only authorised staff could access the key. Staff recorded each prescription given. We saw the register for recording of prescription pads; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, security of prescription forms, 2013.
- Medications were stored in a locked cupboard. The nurse in charge carried the keys and when she was not present, for example overnight, stored the keys in a security tagged pouch secured in the ward key safe.
- A member of staff, who highlighted expiry dates when they were approaching that date, checked drugs weekly. Pharmacy restocked drugs weekly.
- We saw that appropriate medicines were stored in dedicated, locked medicines fridges. We saw records, which showed daily temperature checks were undertaken. This provided assurances the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range.
- Patient Group Directives (PGD's) allow some registered health professionals (such as nurses) to give specified medicines to a predefined group of patients without them having to see a doctor. We saw PGD's were in date and signed by those allowed to give medicines.
- For our detailed findings on medicines, please see the Safe section in the surgery report.

Records

- The hospital had an information management and records policy which had recently been reviewed and updated.
- From June 2015 to July 2016, 1% of patients were seen in the outpatient department without the full medical record being available.
- There was a robust system of the management of patient records in the outpatient department. A GP referral was received into the booking centre. The referral was scanned onto the electronic patient information management system and a paper copy put into the patient record. We looked at 10 sets of patient records and all had a GP referral in them. The record was stored in a locked cabinet in an area with swipe card access until the patient attended clinic. Staff then took the record to the outpatient department and stored it in a locked cupboard, until the clinic started. We saw the cupboard was locked until the records were needed and then taken to the clinic room. We did not see any unattended records during our inspection.
- When patients attended clinic, doctors wrote details of the clinic attendance on carbonated continuation sheets. They dictated the clinic letter, which was sent to administrative assistants to type up. These records were kept in locked rooms with swipe card access. Administrative assistants put a copy of the continuation sheet and the clinic letter in a file and took it to the medical records department. This was done within 48 hours of the patient's appointment and we looked at 10 records, which showed this was happening. The medical records team put the continuation sheets and clinic letters into the patient record, which was kept securely in the medical records department. We looked at 10 sets of records and saw that they all contained copies of continuation sheets and clinic letters.
- The medical records storage area was tidy and well ordered. Records were stored on site for three months following the patient's last attendance and then sent to a centralised store.
- Medical records staff pulled notes for follow up clinic appointments and took them to the outpatient department where they were stored in a locked cupboard until needed.
- A secure car brought records from the central store twice a week to the medical records department. This meant records were accessible.

Good

Outpatients and diagnostic imaging

- Each consultation room has a clear folder in it for confidential waste. This was cleared into the confidential waste bin at the end of the clinic. We saw staff doing this.
- All images from scans and X-rays were stored on a Patient Archiving Communication System (PACS). Staff needed a passcode to access this and only authorised staff had access.
- One hundred percent of staff in outpatients and diagnostic imaging had attended information governance training in the last 12 months.

Assessing and responding to risk

- Medical cover was provided by the resident medical officer (RMO) who would attend to any unwell patients in the outpatient or diagnostic imaging departments, if required. All RMO's held a current advanced life support (ALS) certificate.
- All Registered Nurses in the outpatient department had attended immediate life support training and other staff had all completed basic life support training which was in line with the hospitals resuscitation policy, dated March 2016.
- The hospital had a policy for risk management, dated February 2016. It gave examples of risk and stated staff should read risk assessments and sign to show they had read it. We saw a folder with staff signatures, which indicated staff had read the policy.
- We saw risk assessments completed in the outpatient and diagnostic imaging departments. Both areas had raised risks on the hospitals risk register, which were reviewed regularly by managers at clinical governance committee meetings (CGC). We saw the minutes of the CGC, and confirmed this.
- Staff identified actual and potential clinical risks, which linked in with the hospitals risk register. All risks had review dates. Risks were discussed with staff and in some instances, they sign to say they understood the risk and the action put in place to lessen the risk. All risks were discussed regularly at staff meetings and we saw minutes of meetings, which showed this was happening. All staff we spoke with could raise a risk, they were all aware of what to do, who to inform, what and where to document.
- We observed good radiation protection compliance as per national policy and guidelines during our visit. The department displayed clear warning notices and doors were shut during examination. There was swipe card entry to examination rooms and only authorised staff had access.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited, which were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff had signed them to show they had read them. Diagnostic imaging staff had a clear understanding of protocols and policies, which were all in date.
- The diagnostic imaging department had a radiation protection supervisor and radiation protection advisor (RPA) who was contactable by phone or email, if required. This was in line with IR (ME) R 2000.
- Radiation regulation review had taken place in September 2016, and we saw documentation to indicate the diagnostic imaging department had completed the actions arising from the review.
- Diagnostic reference levels (DRLs) are used to help manage the radiation dose to patients so that the dose given was appropriate for the clinical purpose. DRL's were reviewed yearly with the medical physics expert and we saw this was being done. All staff used diagnostic reference levels and we saw they were lower than national reference dose levels. This meant that good quality images were being produced with lower patient exposures to radiation.
- Radiation protection equipment, such as lead aprons were in good working order. They were checked regularly and we saw documents, which indicated these checks were undertaken.
- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical checklist for interventional procedures. We saw completed checklists and saw that all steps had been documented.
- We saw posters advising patients to inform staff if they could be pregnant. Staff asked patients when their last menstrual period was and documented this in the referral, which was scanned onto the electronic patient administration system.
- In the outpatient department, staff did a pregnancy test prior to patients undergoing a gynaecological procedure, which is in line with best practise.

- Pause and check signs were in place around the diagnostic imaging department to remind staff to check patients' identification fully and we saw staff at reception and prior to scans, carry out these checks.
- All patients' toilet doors opened in both directions, which can assist attending to patients if they collapsed in the toilet.

Safeguarding

- The hospital had a safeguarding vulnerable adults policy dated October 2016. We saw staff indicated they had read the policy by signing a sheet in a folder.
- Staff attended vulnerable adult training and safeguarding children training (level one and two) as part of their mandatory training and 100% of staff had attended in the last 12 months.
- The hospital had not raised any safeguarding alerts in the last 12 months. There have been no safeguarding concerns reported to CQC from October 2015 to September 2016.
- Nursing and diagnostic imaging staff demonstrated a good awareness of what to do if they had safeguarding concerns. They could explain what to do if they had concerns and who to contact.

Mandatory training

- Staff were required to undertake mandatory training courses. They were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk. Staff told us they were given protected time to complete mandatory courses.
- We saw that 100% of all staff in the outpatient department had attended all their mandatory training course within the last 12 months. Staff told us access to training was easy and they were given time to complete the training.
- Overall compliance for mandatory training was 99% for diagnostic imaging staff. A member of staff had started working at the hospital recently and at the time of inspection, had not completed all their mandatory training modules.

Nursing staffing

- There were sufficient staff with the qualifications, skills, and experience to meet the needs of patients in the outpatient and diagnostic imaging department.
- The outpatients department had one sister, one senior staff nurse, four staff nurses, two full time health care assistants (HCA's), two part time HCA's, four administration staff, and one bank staff nurse was available.
- The outpatient sister told us there was always a trained nurse at the beginning and the end of the shift. There were always four staff on the early shift and four on the late shift. We saw a staff rota for four weeks, which showed this was occurring and which nurse was in charge each day.
- There were no bank or agency health care assistants working in outpatient departments from July 2016 to September 2016.
- There were no vacancies in the outpatient department.

Allied Health professional staffing

- At the time of inspection, there were no vacancies in the diagnostic imaging department. The department was planning to increase the establishment in response to increase demand.
- The department used no agency staff from October 2015 to September 2016. One bank member of staff worked regularly in the department for a few sessions a week.

Medical staffing

- The hospital had full radiologist cover provided by 18 radiologists working under practising privileges.
- The radiologists covered all speciality groups and attended in person or could view and report images remotely. The hospital also provided a 24-hour urgent reporting service.
- The diagnostic imaging department held a register of consultant contact numbers for contact in urgent situations.
- For our detailed findings on medical staffing please, see the Safe section in the surgery report.

Emergency awareness and training

- We saw the hospital's business continuity plan dated 2015. This was to ensure all staff understood their response and action to be taken in the event of an incident. The policy provided contingency plans to ensure the comfort and safety of patients, staff,

contractors and visitors under disruptive circumstances. These could be caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage or due to external circumstances beyond the control of the hospital such as a bomb threat.

- Staff we spoke with knew where the major incident policy was kept. They had all signed to say they had read it.
- Staff told us if they had a patient emergency, they pulled the call bell. The response from bleep holders was rapid. The resident medical officer (RMO) and senior manager on call would attend as well as other nursing staff. In the most recent emergency, staff told us the response was 'instantaneous'.
- Staff had a good understanding of the process for evacuation in the event of a fire.
- The major incident and business continuity plan described responses to other types of incident (such as bomb threat, lockdown). Each department had a 6 monthly fire drill and all staff attended an annual fire safety refresher session.
- Staff in the diagnostic imaging department simulated the evacuation of a patient from the MRI scanner every six months and we saw they had suitable equipment to carry out the evacuation.

Are outpatients and diagnostic imaging services effective?

Good

We inspected, but did not rate effective, as we do not collect sufficient evidence to rate.

Evidence-based care and treatment

- Policies were developed in line with national guidance and best practice evidenced from professional bodies, such as the Royal College of Nursing, National Institute for Health and Care Excellence (NICE), College of Radiographers and the Royal College of Radiologists (RCR). All the guidelines we reviewed were easily accessible on the hospital intranet and were up to date.
- The outpatient and diagnostic imaging departments participated in a variety of clinical and non-clinical audits to demonstrate compliance with best practise, professional standards, and NICE guidelines.
- These included CT dose levels, drug fridge temperature audit, hand hygiene audit, room cleaning audits and DNA (did not attend) rates. Findings were reported to the departments and through to the governance meetings. Named staff followed a rota of audits. We saw these had all been completed and signed by the member of staff who completed the audit.
- The diagnostic imaging department had policies and procedures in place. They were in line with regulations under IR (ME) R 2000 and in accordance with the Royal College of Radiologist's standards.
- The Radiation Protection Advisor (RPA) and the radiation protection supervisor provided annual reports. They were discussed at the radiation protection meeting and we saw minutes of these meetings, which showed this was occurring. This was in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000.

Seven-day services

- The diagnostic imaging department provided an on-call service for the hospital for urgent scans and X-rays.
- Information technology support was available 24 hours a day, seven days a week for the diagnostic imaging department. This was in line with Standard 8 of Standards for providing a seven-day acute diagnostic radiology service. Which states; Radiology information systems (RIS) and picture archiving and communication systems (PACS) support should be available seven days a week.

Pain relief

- In the outpatient and diagnostic imaging department doctors could prescribe pain relieving medicines if required.
- In the diagnostic imaging department, there were a variety of pads and supports available to enable patients, having examinations, to be in a pain-free position.
- The hospital provided a pain clinic for patient suffering with long term or chronic pain. A variety of pain relieving medication and injections were offered to patients. The diagnostic imaging department provided the support for medical staff to carry out injections under X-ray or ultrasound guidance, in line with best practice.

Patient outcomes

Good

Outpatients and diagnostic imaging

- We saw the hospital audited patient outcomes by participating in national and local audit programmes. The hospital was committed to partaking in the patient led assessment of the care environment (PLACE) and learning from this audit formed part of an ongoing action plan for the hospital.
- Patient outcome forms were given to patients at the end of their consultation. Consultants indicated on the form what further treatment, appointment, investigation or none was required. Administrative staff entered the outcome on the patient information system, so it was clear to see what outcome of the clinic visit was.
- For our detailed findings on Patient outcomes, please see the Effective section in the surgery report.

Competent staff

- All new staff completed an induction programme. Staff received an induction booklet, which they completed, along with competency checklists. All staff were given a keyring with information about duty of candour, safeguarding, and prompts for managing patients living with dementia. This demonstrated the hospital ensured new staff had all the information and competencies they needed to do their jobs.
- We saw completed competency certificates and they had been signed by a senior member of staff to indicate staff were competent to perform these tasks.
- We saw certificates to indicate staff had completed external courses, for example, radiation protection advisor and supervisor course, which indicated staff were competent to perform these roles.
- Nursing, physiotherapy and radiography staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC). All professional registration documentation was checked annually and we saw all members of staff were registered.
- Some staff were being supported through their training to become registered nurses and assistant practitioners in radiography. An overseas radiographer was supported in obtaining a UK qualification and Healthcare Assistants in both areas have been supported to undertake associated training.
- In the outpatient and diagnostic imaging departments, staff attended additional training in order to become link persons to provide support and learning for other members of staff. There were links persons for infection, prevention and control, dementia and health and safety.
- We saw training matrices displayed in all diagnostic imaging rooms. They indicated which piece of equipment members of staff were competent to use. This meant the hospital could be confident staff were safe and competent to use medical equipment on patients.
- Radiology staff also documented which doctors were competent to use the diagnostic imaging equipment and we saw these records.
- Radiology staff worked with trained staff in other hospitals to maintain their competency performing scans, which were not frequently performed at the hospital. They also carried out peer reviews with these staff to monitor one another's performance.
- The diagnostic imaging department had a record of staff who could refer for examinations and which examinations they could refer for. This ensured that only staff who had received the appropriate level of training could refer patients for certain examinations.
- Non-medical referrers, such as physiotherapists are required to attend an IRMER training study day. We saw the date of attendance of staff on this course and the refresher dates.
- Training for the dementia link staff included 'Stepping Inside Dementia' provided by Alzheimer's Research UK and additional training to become 'Dementia Friends'.
- One hundred percent of outpatient staff, eligible had an appraisal in the last year.

Multidisciplinary working

- Staff told us they worked well as a team in their departments and all other areas of the hospital. We saw a strong multidisciplinary approach across all the areas we visited. We observed good collaborative working and communication amongst all staff in the outpatient and diagnostic imaging departments and with other staff around the hospital.
- Communication within and between departments was good. Because of the small nature of the service, staff knew who to contact with any particular query of if they wanted to discuss any aspect of patient care.

Access to information

Good

Outpatients and diagnostic imaging

- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). Pathology test results could also be accessed electronically.
- PACS was available on wards and in theatre, so images could be viewed prior to and during a patients procedure
- Staff requested patient images from other hospitals using an image exchange portal. This provided a secure transfer of information between providers. This also prevented unnecessary examinations and exposure to radiation being made.
- Staff accessed the hospitals policies and minutes to meetings on a shared computer drive. Staff had individual logons and passwords. We saw staff locking computers prior to walking away from their desks. This meant they were keeping information secure in line with good information governance,
- Patient records were available within the hospital for three months after the last attendance or admission. If records had been archived in the central store, they could be requested and a designated car would bring record to the hospital twice a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Spire Healthcare had a policy for consent to examination or treatment, dated January 2016. The policy included the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits.
- We saw signed consent forms in five medical records, which showed patients had consented to treatment in line with the hospital's policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- Spire had a policy for Deprivation of Liberty Safeguards (DoLS), dated April 2016. The policy set out procedures staff should follow if a person lacked capacity. Staff had access to flowcharts to prompt them of the process.
- Mental Capacity Act was part of the role specific training programme staff attended. Data provided by the hospital showed that 100% of staff had attended the training.
- 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.
- Doctors gave patients two appointments prior to gaining consent for cosmetic procedures. These appointments were at least two weeks apart to give patients time and information they needed to reach a voluntary and informed decision about whether to go ahead with the procedure. This was in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery, 2016.
- For our detailed findings on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the Effective section in the surgery report.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate care

- See information under this sub-heading in the surgery section. In this section, we cover the results of hospital wide patient surveys.
- Part of 'The Montefiore Way' was that care was 'patient centred'. We saw that staff took note of patients' wishes or preferences in regards to whom they shared information with in their family. This helped to ensure people were treated with dignity and staff respected their privacy in line with quality standards set by the National Institute of Care and Health Excellence.
- We saw staff in all roles were friendly, polite, and professional. They treated patients with dignity respect and confidentiality at all times.
- Spire Healthcare had chaperone guidelines, dated July 2016. We saw signs in the patient waiting areas informing patients they could have a chaperone, if required. Staff would record if a chaperone had attended a consultation, by stamping the medical record and signing it to indicate who had acted as the chaperone. We saw this was happening in the 10 medical records we reviewed. Staff told us there were

always enough staff on duty to be able to act as chaperone. When staff attended as a chaperone, they switched on a green light, which illuminated outside the room to indicate a nursing staff member was inside.
- We saw all staff were friendly and helpful. Patients told us;" Staff are "Very helpful, exceptionally friendly."
- The environment was well designed to maintain dignity and confidentiality for patients. For example, there were signs at the reception desk requesting patients wait a short distance from the desk, so that others could not be overheard.
- Oncology clinics are held in designated clinic rooms that allow discreet exit from the department following bad news consultations (not via main reception). This allowed them privacy following receipt of news which may be upsetting.

Understanding and involvement of patients and those close to them.

- We saw appointment letters, which contained clear information about appointments and what to expect. Booking administrators sent information about how to get to the hospital and specialist information depending on which clinic they were attending. They also sent out information about which telephone number to use, should they have a query, so patients did not have to go through the central switchboard each time they called.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need. They said, "The whole process is open, never left an appointment not knowing what was happening next or next steps." They told us "I felt well informed, knew what was happening next".
- There were leaflets available that explained payment options, and procedure of who to contact if there are any questions, or queries. Staff told us they would provide quotes and costs, and ensure that patients understood what the costs involved. The hospital website also clearly described the different payment options available.

Emotional support

- Nurses gave us examples of when they would attend clinic appointments with patients to provide emotional support if required. Staff told us they were able to provide patients and their families extra time if necessary and could take them to a separate area of the department, if required. They had sufficient staff to provide extra support to patients, without affecting the delivery of the service.
- Staff showed us how they could access counselling services and other psychological support for a patient if it was needed. Information was available for patients to access emotional support from other sources.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- There were 22,749 outpatient total attendances from October 2015 to September 2016, of these 31% were NHS funded and 69% were other funded.
- The Montefiore Hospital worked collaboratively with local commissioners of service to enable NHS patients to access care and treatment without delay, and to allow people to have a choice where they received their care. By offering services to NHS patients, The Montefiore Hospital helped local NHS providers to manage their outpatient and imaging waiting lists more effectively.
- The outpatient department was open from 8am to 9pm Monday to Friday and 8am to 2pm on Saturdays, offering patients a wide choice of times for their appointments. Patients told us; "They are very responsive regarding the date and time of your appointment." Another told us, "We were given a lot of choice around appointment times to come into hospital when it suited us."
- The diagnostic imaging department was open from 8am to 8pm, Monday to Friday and from 8am to 6pm on Saturday. The on-call radiographer provided scans at other times, if they were required.
- In addition, the diagnostic department offered a walk-in service for scans for which preparation was not required. For example, CT and X-rays.
- Clinician clinics were often arranged to facilitate effective multidisciplinary working and seamless patient care. This included breast oncologly clinics and breast

surgery clinics at the same time, bariatric clinics and dietitian clinics at the same time and dual orthopaedic trauma and plastic surgery clinics. Onco-radiology and oncology clinics are held at the same time to allow diagnostics at the same time as consultation.
- The pharmacy was open from 8:30am to 5pm from Monday to Friday and Saturdays as required.
- The hospital has a fully-accredited pathology department which provides full transfusion, haematology and microbiology services.
- Treatment rooms where urological or gynaecological procedures were carried out had en-suite facilities. In addition to this, there was a small hatch in the toilet door for urine samples to be passed through.
- The changing rooms in the diagnostic imaging department had access from the waiting area. Patients went through a second door into the examination room, so no patients were seen sitting in gowns, within the department.
- However, there was no on-site parking and patients told us; “Parking was a nightmare.” The hospital website informed patients of no on-site parking, but gave information about street parking, prices and time restrictions.

Access and flow

- A legal requirement by NHS England gives patients the right to access services within a maximum waiting time. This applies to NHS funded patients only.
- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. On average, 97% of patients were on incomplete pathways from June 2015 to July 2016, which was better than the target of 92%.
- Non-admitted pathways are waiting times for patients whose treatment started during the month and did not involve admission to hospital. On average, 98% of patients started non-admitted treatment within 18 weeks of referral from June 2015 to July 2016, which was better than the target of 95%.
- The hospital had a robust referral process in place. GP referrals came into the department via email, post and fax. Booking centre staff logged the referral onto a spreadsheet. They called patients to offer an appointment and if patients were unavailable by phone on three occasions, a letter was sent, informing patients of the attempt to contact. Once patients had an appointment booked, the referral was scanned onto the patient information system, which outpatient staff could also access, if the referral or records were inaccessible for any reason.
- NHS patients could also book their own appointment directly via an electronic referral system, following a referral from their GP.
- The hospital monitored the length of time patients waited in outpatients and found that patients were seen within 10 minutes of their appointments. If a consultant were delayed unavoidably, staff would inform patients what was going on. Staff told us they would get cake from the canteen if there was a considerable delay.
- No NHS patients waited six weeks or longer from referral for MRI, CT or non-obstetric ultrasound from October 2015 to September 2016.
- Reports for scans or examinations, overall, were available within 48 hours. In-patient reports were available same day as examination. We saw that some scans had not received a report in this time. The radiology manager explained the reason for this was that additional clinical expertise was required, but an interim report had been provided until the final one was confirmed. The radiology manager has oversight of report waiting times and reasons for those waiting longer than the target, which was monitored weekly. At the time of inspection, 97.8% of scans had a report within five working days and 99.5% in seven working days.
- Patients were referred to the diagnostic imaging department by the outpatient department, GP or patients could refer themselves. Radiographers entered the examination details onto the system, performed the examination and then the radiologist provided the report, which went onto the Picture Archive and Communication System (PACS).
- Clinician clinics were arranged to facilitate effective multidisciplinary working and seamless patient care, such as breast oncologists and breast surgeons at the same time, bariatric surgeon and dietician clinics at the same time and dual orthopaedic trauma and plastic surgeon clinics.

Meeting people’s individual needs

- See information under this sub-heading in the surgery section. In this section, we cover access for disabled people.

Good

Outpatients and diagnostic imaging

- The most recent PLACE audit scored 87.2% for dementia and 85.35% for disability, which was better than the England average. The PLACE assessment for Dementia was included for the first time in 2015, and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The place assessment for Disability was included for the first time in 2016, and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- We saw a variety of health-education literature and leaflets produced by national bodies was available. 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 told us they could access leaflets in other languages if required.
- A dementia link person had been nominated in outpatients and in imaging. They had attended training and became a dementia champion. The dementia care lead shared their learning with their colleagues in outpatients.
- We saw signs in the reception and waiting areas, in 10 different languages offering interpretation and translation services. These languages matched local population census details of the most popular in the local area. Staff told us interpreters were available by telephone and face to face to meet individual needs and preferences in any language.
- Waiting areas were clean and comfortable with seating, televisions, complimentary hot and cold drinks available. Patients told us; "I really like the refreshment facilities." Toilets and reading material were available in the reception area. General information leaflets relating to services provided were also available in the waiting areas.
- We saw the outpatient and diagnostic imaging departments were accessible for patients using wheelchairs or for those with limited mobility. Wheelchair lifts were available oversteps and lifts available adjacent to stairs. There were wheelchairs available for patients to use whilst in the hospital. Disabled toilets were available in all waiting areas.
- There was enough seated areas for the number of patients attending during our visit, and there were options of different style seating to meet the differing patient needs such as sofas for additional comfort/ space, higher seating for orthopaedic patients and chairs with or without arms.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section. In this section we cover the hospital complaints processes and how complaints were managed.
- From October 2015 to September 2016, there was one formal complaint in the outpatient department and two in the diagnostic imaging department.
- Staff told us if they dealt with any informal complaints or concerns from patients, they would document the issues and outcomes and pass them onto the matron. Matron then reviewed it for any learning or further action.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good

Leadership and culture of service

- Staff in outpatients reported to the outpatient sister, who reported to the Matron. Staff in diagnostic imaging reported to the diagnostic imaging manager, who reported to the Matron. Matron reported to the hospital director
- 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. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- All senior team members present at staff induction days with particular focus on culture. Staff told us they found this a beneficial part of induction.
- Staff spoke highly of their managers, both immediate and senior.

Good

Outpatients and diagnostic imaging

- Staff demonstrated 'The Montefiore Way', which was patient centred, empowered, accountable, collaborative and exceptional. The development of 'one-stop' clinics meant that patients needed only one appointment rather than several.
- Staff felt empowered to challenge behaviours. For example, staff noticed a clinic regularly started late and the doctor regularly spent longer than the appointment time with patients. They spoke with the doctor and altered the length of appointment time.
- Staff in diagnostic imaging felt the handover from the previous manager to the current one was seamless and maintained stability within the department.
- There was no sickness for outpatient nurses or health care assistants from October 2015 to September 2016. In the diagnostic imaging department, there was no staff sickness absence or staff turnover in the last year. This was lower than the average of other independent hospitals CQC hold data for and suggests good morale and staff wellbeing.
- All nursing staff, except for one, in the outpatient department had worked in the hospital since it had opened.

Vision and strategy for this this core service

- See information under this sub-heading in the surgery section. In this section we cover the hospital's vison and values.
- The outpatient and diagnostic imaging department strategy fed into the hospitals vision to be recognised as the best independent healthcare provider in Brighton and Hove. They were to achieve this using their 2020 goals. These consisted of five objectives, which were to be rated as outstanding by CQC, grow the business, to be acknowledged as providing an outstanding patient experience and ensuring patient safety.
- The hospital also aimed to be a leading provider in cancer care, cardiology, diagnostics, endometriosis, and orthopaedic services.
- Both the outpatient and diagnostic imaging were looking to recruit more staff in order to contribute to delivering these goals. The development of 'one-stop' clinics had improved the patient experience. The outpatient and diagnostic imaging departments were looking to increase the number of 'one-stop clinics' they offered.

Governance, risk management and quality measurement

- For our detailed findings on governance, risk management and quality measurement, please see the well-led section in the surgery report. In this core service, staff were clear about their roles, how they fitted within the hospital structure, and who held the relevant lines of reporting responsibility.
- Staff had a good understanding of how to recognise risk and raise it to the hospitals risk register.
- The outpatient and diagnostic imaging departments carried out a variety of audits according to an annual plan . We saw action plans were monitored and staff implemented elements of action plans where appropriate. We saw they were up to date with that plan.
- The hospitals scorecard was display on a noticeboard in the staff area of outpatients and diagnostic imaging. Staff we spoke with understood the scorecard and how their department contributed to the key performance indicators.

Public and staff engagement

- See information under this sub-heading in the surgery section. In this section, we cover the hospital's arrangements for engaging with the local population, and with their staff.
- We saw a clinic corner board in the staff area for outpatient and diagnostic imaging staff. It displayed the hospital scorecard, patient safety alerts and information about audit, including results. A service quality and safety information board in the same area displayed information about patient living with dementia, complaints, and lessons learned.
- Staff told us the induction process was good, they had buddy support, which involved another member of staff giving help and advice when needed, there were lots of training opportunities and they were given time to do training.
- Staff in this service told us they were made aware of the hospitals vision, mission and values at induction and this was reinforced through the 'Enabling excellence' appraisal programme. Staff were encouraged to demonstrate the values throughout their behaviours and felt the appraisal was a beneficial process, which enabled and encouraged them to identify areas for development.

Good

Outpatients and diagnostic imaging

- We saw a staff engagement board near the entrance to the staff restaurant. It advertised social events and displayed 'you said, we did', examples of staff feedback acted on by managers. For example, staff felt success wasn't acknowledged enough, so managers shared the hospitals scorecard and displayed it in each department, which we saw.

Innovation, improvement and sustainability

- The outpatient department were supporting a health care assistant to undertake training to become a registered nurse.
- The diagnostic imaging department were training a health care assistant through a national vocational qualification to become an assistant practitioner.

Outstanding practice and areas for improvement

Outstanding practice

- Staff teams were consistently and demonstrably passionate about and motivated by the provider's vision and strategy and had contributed to the development of local values. Staff shared strategies of improving care based on benchmarks, ensuring continual learning and focusing on internal staff development and promotion that helped to ensure everyone involved with the service, including patients, benefited as a result.
- There was long-standing, consistent evidence that staff actively sought out patient and visitor feedback and made substantive improvements to the service as a result. This included the implementation of a patient experience committee and patient forums led by former patients and their relatives. Changes made included implementation of a lead nurse for pre-assessment, an initiative from the head chef to introduce an on-demand hot meal ordering service so patients could order food at short notice and improved discharge pathways.
- There was extensive evidence of effective, embedded multidisciplinary working and auditing. This included a proactive physiotherapy team that proactively sought out opportunities for mutliprofessional learning and training and demonstrated how this improved patient experience and outcomes.
- The hospital had a proactive internal and national audit programme and contributed to data collection for Public Health England for surgical site infection. Audit results were tracked and presented in the clinical dashboard and used to identify areas of good practice and areas for improvement against hospital and provider targets.
- Surgery services participated in six national audits including patient-reported outcome measures (PROMs) for hip and knee replacement, national blood transfusion audits and commissioning for quality and innovation (CQUINS) payments framework as set by local commissioning groups.
- The hospital participated in national benchmarking against other hospitals in the provider's network, including for clinical review. In addition, the provider was developing a national benchmarking tool to enable them to compare practice and patient outcomes nationally.
- The monthly clinical audit and effectiveness committee had a standing agenda item that incorporated updates to national guidance. Staff were provided with a monthly safety bulletin to ensure they were up to date with guidance changes relevant to their clinical areas.

Areas for improvement

Action the provider MUST take to improve

Start here...

Action the provider SHOULD take to improve

- The provider should ensure that all staff have consistent and up to date knowledge of fire and emergency evacuation procedures.
- The provider should ensure individuals who feel staffing levels are unsafe are supported through appropriate risk management and escalation processes.

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.

This section is primarily information for the provider

Enforcement actions

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.