Bupa Cromwell Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Bupa Cromwell Hospital is operated by Medical Services International Limited. The hospital has 118 inpatient beds and 19 day case beds. Facilities include five operating theatres, a four-bed level three care unit, endoscopy unit, outpatient and diagnostic facilities.

The hospital provides surgery, critical care, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected all of these six services.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced inspection on 18 to 20 September 2018.

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 services provided by this hospital were at the Bupa Cromwell Hospital.

Services we rate

Our rating of this hospital improved. We rated it as good overall.

We found mainly good practice in all the key questions for all the six services we inspected. However, we rated critical care as requires improvement.

The hospital had made significant improvements in the services of medical care and children and young people; both these services had previously been rated as requires improvement. Medical care was rated as outstanding overall.

We found the following areas of good practice across all services:

- The service had improved the systems in place for reporting, investigating and learning from incidents and serious adverse events. There was an open culture of reporting, and learning was shared with staff to make improvements.
- There was sufficient staff with the right skills, training and support to meet the needs of patients and provide effective multidisciplinary care in all the services.
- Staff used a standardised sepsis screening tool and sepsis care pathway. Our review of records showed staff used an early warning score system to monitor patients for signs of deterioration and responded appropriately.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The hospital used current evidence-based guidance and quality standards to plan the delivery of care and treatment to patients. There were effective processes and systems in place to ensure guidelines and policies were updated and reflected national guidance and improvement in practice.
- We observed staff treated patients and their families with compassion and care to meet their holistic needs.
- The hospital planned, developed and provided services in a way that met and supported the needs of the population that accessed the service, including those with complex or additional needs. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were excellent.

Summary of findings

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Managers had implemented systems to strengthen governance, performance and risk management arrangements across the hospital since the last inspection.
- Managers across the services promoted a positive culture that supported and valued staff. The majority of staff told us they felt listened to and well supported by managers and colleagues and were confident to raise any concerns they had.
- The hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

We found areas of outstanding practice

Medical care:

- Staff provided compassionate individualised care. Staff provided extensive support to patients and their relatives and worked hard to meet the holistic needs of their patients through emotional and practical measures.
- The hospital provided extensive emotional support and resources to patients and their families. The oncology and chemotherapy day unit had a qualified Macmillan cancer counsellor and patients really valued the service.
- We saw numerous examples of individualised care and progress made through the involvement of relatives, for example with patients who had suffered a brain injury.

Outpatients:

- The hospital worked with a sight loss charity to provide a braille map for partially sighted and blind patients to enable them to navigate the hospital safely and independently.
- Patients were provided with a single point of contact via a patient care coordinator. This was their point of contact throughout their visit. They were responsible for looking after the patients' welfare, and checking them in with the consultants' reception desk. They also kept the patient up to date with any changes or delays.
- The hospital held cultural sessions for both international patients and staff prior to admission to the hospital. This was to ensure both patients and staff understood cultural expectations, enhanced the patient experience and so they did not offend each other.

We found areas of practice that require improvement:

Medical care:

- Clinical equipment was not regularly serviced and sharps bins were not always dated in a timely manner to indicate when they were assembled.
- Some staff from a certain ethnic group had experience bullying from patients within the same ethnic group. Senior managers were aware of this and told us they had addressed the issue with patients and emphasized the organisation had zero tolerance on abuse or victimization.

Surgery:

- Equipment in some patient rooms was covered in dust.
- The service had a high number of unplanned readmissions within 28 days of surgery.
- The service used two different patient pain score measures; one for theatres and one on the wards.

Summary of findings

- There was no service level strategy in place.
- Junior nurses felt neglected by the executive team and did not speak highly of the culture.

Critical care

- Not all equipment was safety tested and always cleaned and labelled appropriately.
- Staff did not always adhere to infection prevention and control standards.
- The rate of bank or agency staff did not always comply with recommendations by Core Standards for Intensive Care Units.
- The premises did not comply with Core Standards for Intensive Care Units but the hospital had building plans for a new unit.
- Intensive Care National Audit Research Centre (ICNARC) data showed there were more unit acquired infections in blood compared to similar units.
- ICNARC data showed the risk adjusted acute hospital mortality was above calculated expected acute hospital mortality.
- Not all staff knew about the principles of Deprivation of Liberty Safeguards (DoLS) and how to apply them in a critical care setting.
- The service did not always meet the needs of people. The facilities for patients' relatives were not appropriate, but there were building plans for a new unit to correct this by 2019.
- Intensive Care National Audit Research Centre (ICNARC) data showed there were more unplanned readmissions within 48 hours from discharge compared to similar units.
- ICNARC data showed there were more out of hours discharges to the ward compared to similar units.

Services for children and young people

- Staff did not receive any specific training on potential needs of people with learning disability and autism. This was not in line with best practice.
- We observed some staff in clinical areas did not adhere to bare below the elbow dress code.
- We found that the clinical audit programme was limited to mainly nurse led audit and the service did not audited their consent practice.
- There was limited monitoring of clinical outcomes.
- Though clinical guidelines were available on the intranet, the process to search correct information was cumbersome.
- There was no learning disability link nurse.
- The children's service was at an early stage of establishing a formal governance structure and this needed to become well embedded.

Outpatients

- Not all patient records were completed to log patient interactions, assessments, medications prescribed and treatment provided by the consultant.
- Cleaning schedules for consulting rooms were not always completed as required.

Summary of findings

- Infection prevention and control (IPC) audits were below the target, and action plans were incomplete.
- The hospital did not audit evidence based care and treatment outcomes, therefore they could not benchmark against other providers.
- Information and assistance posters were only displayed in English.
- Cancellation rates and do not attend (DNA) rates were not monitored due to secretaries booking and cancelling appointments and not working onsite to be able to record this.
- Patients with dementia, learning difficulties and mental health conditions were not able to be flagged via patient records.
- The management and governance team did not always ensure action plans were up to date as a result of audits that had taken place.

Diagnostic imaging

- The service controlled infection risk well. However, some areas did not have documentation to check they were cleaned effectively.
- The service had suitable premises and equipment and looked after them well. However, there were no separate waiting areas for children in the waiting areas for x-ray, CT, PETCT, MRI and ultrasound. This could result in exposure to inappropriate adult conversation.
- There was a lack of health promotion material available across the diagnostic department
- There was a lack of audit to ensure the correct exposures for plain film x-ray were used.

Nigel Acheson

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	Outstanding ☆	Medical care was a significant proportion of hospital activity. We rated this service as outstanding because it was good for safe and effective and outstanding for caring responsive and well-led.
Surgery	Good ●	Surgery was a significant proportion of hospital activity. We rated this service as good because it was good for effective, caring responsive and well-led, but improvements were required in safe.
Critical care	Requires improvement ●	Critical care was a small proportion of hospital activity. We rated this service as requires improvement because it was good for caring and well-led but improvements were required in safe, effective and responsiveness.
Services for children and young people	Good ●	Children and young people's services were a small proportion of inpatient hospital activity and a larger proportion of outpatient hospital activity. We rated this service as good because it was good for safe, effective, caring, responsive and well-led.
Outpatients	Good ●	Outpatients' services were a large part of the hospital activity. We rated this service as good because it was good for safe, effective, caring and well-led and outstanding for responsive.
Diagnostic imaging	Good ●	Diagnostic imaging services were a large part of the hospital activity. We rated this service as good because it was good for effective, caring and responsive and well-led but improvements were required in safe.

Summary of findings

Contents

Good

Bupa Cromwell Hospital

Services we looked at

Medical care; Surgery; Critical care; Services for children and young people; Outpatients; Diagnostic imaging

Summary of this inspection

Background to Bupa Cromwell Hospital

Bupa Cromwell Hospital is operated by Medical Services International Limited. The hospital opened in 1981. It is a private hospital located in London. The hospital serves the local community as well having a wide national and international patient base.

The hospital had recently appointed a new registered manager, registered in September 2018. Although the appointee had been in post as the hospital director since September 2017.

We carried out an unannounced comprehensive inspection on 18 to 20 September 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, seven CQC inspectors, and a range of specialist advisors with expertise in the areas we were inspecting. The inspection team was overseen by Michelle Gibney, Inspection Manager.

Why we carried out this inspection

We carried out this inspection as part of our independent hospital inspection programme. We followed up findings from our previous inspection in 2016.

How we carried out this inspection

We followed our comprehensive inspection methodology.

Information about Bupa Cromwell Hospital

The Bupa Cromwell Hospital provides a wide range of services. Medical care service and outpatients are significant proportions of hospital activity. The medical services include general medical wards, care of the elderly, endoscopy, VIP suites, specialities wards such as cardiology, gastro-intestinal medicine, lung medicine, dialysis, oncology, chemotherapy day unit, iodine suites gamma knife and neurosciences. The majority of the medical care services are provided on the first and second floors. The VIP suites are used for both medical and surgical patients and are located on the fourth floor. The endoscopy service is also located on the fourth floor. The outpatient department is located on the ground floor of the hospital in recently refurbished accommodation. The department provides a wide range of specialities including oncology, urology, orthopaedics, respiratory medicine, dermatology, cardiology and plastic surgery.

The hospital has one dedicated surgical ward of 19 single rooms and four suites. The main specialities offered are orthopaedic, general surgery and ear, nose and throat.

The critical care unit was a level 3 unit with seven beds, five in a bay and two beds separated by sliding doors. Patients admitted to the unit are normally elective complex surgical patients. Plans were in place for a new unit to be completed in 2019.

Summary of this inspection

The paediatric department cares for children between zero and under 18 years old. The service includes a 13-bedded ward and a dedicated paediatric outpatient department (POPD). The department saw a wide range of specialities including general paediatrics, general surgery, urology, ears, nose and throat (ENT), ophthalmology, orthopaedics, neurology, neurophysiology allergy, cardiology (POPD), clinical genetics, dermatology, gastroenterology, plastic surgery and respiratory medicine. There was a paediatric theatre co-located with the ward.

The hospital offers an extensive range of diagnostic imaging procedures including x-rays, computed tomography (CT) scanning, magnetic resonance imaging (MRI), ultrasound, nuclear medicine, fluoroscopy, interventional radiology, mammography, cardiac catheterisation and a clinical investigations unit.

The hospital is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical Procedures
- Diagnostic and Screening procedures
- Management of supply of blood and blood derived products
- Family Planning

During the inspection, we visited all the ward, outpatient and clinical areas of the hospital. We spoke with approximately 100 staff including: registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with approximately 40 patients and relatives. During our inspection, we reviewed 50 sets of patient records and prescription charts.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected three times, and the most recent inspection took place in December 2016, which found that the hospital was not meeting all standards of quality and safety it was inspected against and improvements were needed.

Activity (June 2017 to May 2018)

- In the reporting period June 2017 to May 2018 There were 9926 inpatient and day case episodes of care recorded at Bupa Cromwell Hospital; of these 1% were NHS-funded and 99% non-NHS funded.
- Eleven per cent of all NHS-funded patients and 37% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 131 502 outpatient total attendances in the reporting period; of these less than 1% were NHS-funded and over 99% were non-NHS funded.

The hospital employed 612 doctors and dentists under the rules of practising privileges. The hospital employed 192 registered nurses, 48 healthcare assistants and 380 other hospital staff. The accountable officer for controlled drugs (CDs) was the chief pharmacist.

Track record on safety

- No Never events
- Clinical incidents: 1210 no harm, 274 low harm, 55 moderate harm, 4 severe harm, 3 death
- Four serious injuries
- Three incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)/
- Meticillin-sensitive staphylococcus aureus (MSSA)
- Four incidences of hospital acquired Clostridium difficile (C.diff)
- Twelve incidences of hospital acquired E.Coli
- 329 complaints

Services accredited by a national body:

- JAG accreditation for Endoscopy
- ISO 9001:2015
- Radiotherapy, Medical Physics, Gamma Knife and Nuclear Medicine Specialised Commissioning Group accreditation for provision of Gamma Knife for NHS patients.
- Human Tissue Authority Accreditation for Renal and Liver Transplantation
- MacMillan Accreditation Working toward Gold Standard Framework for End of Life Care

Services provided at the hospital under service level agreement:

- Pathology
- EMG
- Catering

Summary of this inspection

- Building Maintenance
- Medical Equipment Maintenance

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Not all equipment was safety tested and always cleaned and labelled appropriately.
- Staff did not always adhere to infection prevention and control standards.
- The rate of bank or agency staff did not always comply with recommendations by the Core Standards for Intensive Care Units.
- The unit did not comply with the Core Standards for Intensive Care Units, However, the hospital had building plans for a new unit.
- There was an inconsistent approach to documentation within the paediatric outpatient records
- There were no separate waiting areas for children in the waiting areas for x-ray, CT, PETCT, MRI and ultrasound.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

Are services effective?

Good

We rated effective as good because:

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Inpatient services provided appropriate 24 hour cover where needed
- Staff supported patients who accessed services to live healthier lives and manage their own health, care and wellbeing. Consent, mental capacity act and deprivation of liberty safeguards

However:

- The Intensive Care National Audit Research Centre (ICNARC) data showed the unit performed less well in a number of areas including: more unplanned readmissions within 48 hours from discharge compared to similar units, more out of hours discharges to the ward compared to similar units, more unit acquired infections in blood compared to similar units and the risk adjusted acute hospital mortality was above the expected acute hospital mortality.
- Not all staff were aware of the principles of Deprivation of Liberty Safeguards (DoLS).
- In surgery there was a high number of readmissions 28 days after surgery.
- The service used different patient pain measurement scores in theatres and the wards.
- In the services for children and young people, the clinical audit programme was limited to mainly nurse led audits.

Summary of this inspection

- There was limited monitoring of patient outcomes in the services for children and young people and in outpatients.
- In diagnostic imaging there was a lack of health promotion material.
- There was a lack of audit to ensure the correct exposures for plain film x-ray were used.

Are services caring?

Good

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- The provider planned and provided most services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it. Waiting times from
- referral to treatment and arrangements to admit, treat and discharge patients were excellent.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The critical care service did not always meet the needs of patients. The facilities for patients' relatives were not appropriate. However, there were building plans for a new unit.
- ICNARC data showed there were more out of hours discharges to the ward compared to similar units.
- In outpatients information and assistance posters were only displayed in English.
- Cancellation rates and do not attend rates were not monitored.
- There was no learning disability lead for the hospital.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Managers at all levels in the hospital had the right skills and abilities to run a service providing high-quality sustainable care.
- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The provider systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The provider had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The provider engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

- Some staff from a certain ethnic group had experience bullying from patients within the same ethnic group. Senior managers were aware of this and told us they had addressed the issue with patients and emphasized the organisation had zero tolerance on abuse or victimization

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients	Requires improvement	N/A	Good	☆ Outstanding	Good	Good
Diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Outstanding ☆

Medical care

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

Are medical care services safe?

Good ●

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The medical care service provided mandatory training in key skills such as intermediate life support, moving and handling and safeguarding to all staff on a rolling annual programme via e-learning modules or face-to-face sessions. Staff understood their responsibility to complete mandatory training. There was regular skills and drills training for staff such as patient evacuation during fire emergencies.
- The hospital set a target of 90% for completion of all mandatory training courses. The hospital data showed an overall 95% compliance for the medical service which was better than hospital target. Staff we spoke with confirmed their mandatory training was up to date. Staff were also provided with specific mandatory clinical skills training in their specialist ward. This covered areas such as aseptic non-touch technique (ANTT), sepsis, insulin safety, blood transfusion and cannulation. We saw that staff were compliant with the clinical specific training. For example, the June 2018 cardiology monthly department report showed an overall 91% compliance on department specific training. Staff achieved 100% for blood transfusion, insulin safety and sepsis, 94% compliance on ANTT, 94% for medicine and intravenous (IV) administration, 80% for central venous catheter (CVC) and 73% for venepuncture and cannulation.
- Staff told us they received a reminder for their due and outstanding mandatory training and were given protected time to attend training. They also said if they asked their managers to attend other training or learning sessions, the ward sisters or managers worked to accommodate their request.
- Locum or temporary staff were required to provide evidence of mandatory training compliance from their employers.
- All permanent resident medical officers (RMOs) were managed via a contract with a local NHS hospital and were required to undertake mandatory training in the hospital in addition to their NHS hospital.
- The hospital had a sepsis policy in place and had developed a management of neutropenic sepsis policy in August 2018 to support the management of patient with sepsis and neutropenic sepsis. The sepsis policy included pathway chart for patients presenting with sepsis, management of sepsis form, inpatient sepsis screening flow sheet and action tool. Staff were required to start patients on antibiotics within an hour of suspicion.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The hospital had clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. The hospital had adopted the NHS England safeguarding adult reference guide in

December 2017 to inform their safeguarding policy and training, which included information sharing, mental capacity act (MCA), assessing capacity, deprivation of liberty safeguards (DOLS), pressure ulcer staging, female genital mutilation (FGM), human trafficking, domestic violence (DV) and abuse, and modern slavery.

- Staff told us they had access to the safeguarding policy through the hospital intranet and knew how to access the safeguarding team for advice and guidance when required. The safeguarding team included a safeguarding consultant and nurse. Staff felt supported by the safeguarding team with the safeguarding concerns and referrals they had escalated to them. Staff also felt their safeguarding pathway was effective which include the domestic abuse flow chart seen on the wards.
- Since the last inspection the service had introduced various initiatives such as the safeguarding champions to the clinical areas, hubs spoke model, domestic abuse policy and recently launched the domestic abuse campaign to help support staff, safeguard patients and improve their outcomes. During inspection, staff told us they had nurses and therapists who were the safeguarding champions on the medical wards. These champions offered on-going support and also shared any relevant safeguarding message, policies and guidelines to staff. Also, staff and the safeguarding team had identified concerns around modern day slavery among their patients and their loved ones.As a result, the service had trained staff on modern day slavery, appointed safeguarding champions, and organised campaign and awareness on modern day slavery. The service worked collaboratively with embassies, local authority, social services, police and refuge home to ensure the safety of patients and visitors where modern slavery had been identified. The safeguarding team also liaised with other professionals and agencies such as GPs who were based in the hospital, patients' own GPs, and charity organisations including a local domestic violence charity.
- Staff gave several examples of where they had identified concerns about patients and/or their carers and the safeguarding team had worked with multi-agencies and multi-professionals to ensure the vulnerable adult safety.The safeguarding team told us they had had quite a few disclosures from staff and patients and gave example of good MDT working. For example, when a modern slavery safeguarding concern was raised, this resulted in the patient being placed in a refuge home within four hours of the concern being raised. We also saw examples where staff had worked with police and embassies to safeguard adults and ensured the adults were safe and supported to travel back to their own country.
- The hospital had developed cards and other discreet items that were given to patients or concerned adults that contained a barcode with contact details and how to raise any safeguarding concern they might have.
- Safeguarding was part of the hospital's annual mandatory training and which included safeguarding adults 1 and 2, and safeguarding children 3 and 4. The hospital target for safeguarding training was 95%. The overall safeguarding training compliance for all medical care staff was 82% compared to the hospital average of 65%. The service only achieved the hospital compliance for safeguarding children level 3 for medical staff (100%) and safeguarding adult level 1, which was 97%. The adult safeguarding adult level 2 compliance was 68% and 63% for safeguarding child level 2. Staff told us and we saw that compliance with safeguarding training and significant safeguarding incidents were reviewed monthly at the governance meetings.
- We noted that nurses on ward 1 west (neurology) had received level 3 safeguarding training as young adults were treated on this wards for their sleep or neurological investigation. Senior staff told us the safeguarding level 4 training would be rolled out to more senior staff across the hospital. We saw that 14 senior hospital staff including the safeguarding leads were booked for safeguarding training in November 2018. Staff told us this was an organisational change to reflect the safeguarding concerns identified their population and support staff, this was an improvement since the last inspection where only one senior staff was trained to level 4.This change will ensure they are adequate staff to support staff and patient across the hospital.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Medical care

- The medical wards and communal areas we visited appeared tidy and visibly clean. At the last inspection we found the dialysis unit had no sluice on the ward and there was no documentation or daily or weekly cleaning of equipment on the oncology ward and dialysis unit. During this inspection we saw cleaning schedules in place on the medical ward areas and equipment including the dialysis and endoscopy machines. 'I am clean' stickers were in use in all the medical areas visited. Also, there was a sluice room in the dialysis unit and endoscopy area.
- At the last inspection, we observed that the inpatient en suite bathrooms had bars of soap which were provided for hand washing rather than liquid soap dispenser. During the inspection, we saw that liquid soaps were now provided in the en suite bathrooms and VIP suites.
- The service had an infection prevention and control team (IPCT) that met every fortnight to discuss any IPC concerns, review IPC risk registers and address issues identified at previous inspections. We reviewed the IPC meeting minutes and saw that the IPC risk register was reviewed. The hospital had an IPC lead nurse and staff knew how to access them for support. There were IPC link nurses on the medical wards and who also offered support to staff.
- The service held daily IPC meetings which fed into the IPC monthly committee meeting. From the IPC committee minutes we saw that the committee discussed issues and topics such as: endoscopy and renal water update, decontamination of equipment such as cardiac heater cooler units, human papilloma virus () cleaning of wards and dialysis machines. We noted that the committee discussed and facilitated the connection of water supply to rooms to ensure patients could be dialysed on the wards during emergencies and to improve patient flow. The committee also discussed any patient with, or at risk of, infection in the hospital. For example, 10 patients who were diagnosed with infections were discussed on the 13 June 2018 meeting and nine of these patients were medical care patients. Eight of the medical care patients discussed were oncology patients.
- During inspection, we observed that there were no clinical sinks in the patient rooms for staff to use to wash their hands in line with the HBN inpatient guideline. The risk had been identified by staff and mitigated by the availability of hand gel in the rooms and staff could also wash their hands on the sinks outside patients' rooms on the corridor. We saw that this risk and issue had been escalated and discussed at the IPC committee meetings. The installation of sinks was initially considered as part of the refurbishment plan carried out in the hospital and due to funding the sinks could not be installed in all the patient rooms on the wards. However, additional sinks were installed on the ward corridors to ensure there was one sink per four rooms for staff to use to wash their hands.
- The service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. We observed clinical staff adhere to the hospital's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections. We observed posters on 'go bare below the elbow', sepsis 6 and six steps to hand hygiene were displayed on the medical wards. Each room also had a dedicated stethoscope for the patient to prevent cross contamination and minimise risk of infection.
- There was access to hand washing facilities, hand sanitiser and a supply of PPE, which included sterile gloves, gowns and aprons, in all areas. We observed staff applying hand sanitising gel when they entered clinical areas. We observed that majority of staff disinfected their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61).
- The hand hygiene audits for the period of January to May 2018 showed compliance rates of 97.4% in all clinical areas which was slightly better than the hospital average of 96.8%. We saw that cardiology and chemotherapy day unit (CDU) achieved 100% compliance and the dialysis unit achieved 99%.
- The IPC audit for the period of January to May 2018 showed the hospital reported one surgical site infection on the cardiology ward and five cases of Escherichia coli infection on the oncology ward and dialysis unit. There was one case of Clostridium difficile (a bacteria that infects bowel and cause diarrhoea) reported on the oncology ward. There were no cases of hospital acquired Methicillin-resistant Staphylococcus aureus

(MRSA, antibiotic resistant bacteria) in the last 12 months. However, there were three cases of Methicillin-sensitive Staphylococcus aureus (is a skin infection that is not resistant to certain antibiotics.

- Cleaning of the medical ward areas was scheduled in the morning, evening and in between patient discharge or transfer. Staff also requested the deep cleaning of rooms or bed areas if a patient had MRSA or an infected wound. On the chemotherapy day unit (CDU) patients with MRSA were transferred to the oncology ward for their treatment to reduce the risk of cross infection.
- In the dialysis day unit, water treatment facilities were cleaned weekly. Water quality testing were also carried out for coliforms, E.coli, pseudomonas and total viable count on the medical wards areas such as the endoscopy, dialysis machines and hand washing sinks in areas such as the oncology wards.
- The inpatient rooms were single occupancy on the wards and therefore no additional isolation was required. There were isolation rooms on the day unit and CDU to ensure patients identified with an infection were segregated to avoid the risk of cross infection. Staff used isolation signs on the wards to advise staff and patients when isolation or precautions were needed. On the oncology ward we observed a sign in English and two other languages on a patient door indicating isolation precautions required and to contact the nurse before entering room.
- The cleaning audit for the period of March to August 2018 showed an overall 80% compliance on all medical wards. The ward with the highest compliance was the CDU (94%). Following the audit we saw that actions were developed and monitored to improve staff compliance.
- The hospital took part in the patient led assessments of the care environment (PLACE) 2018 audit. This was the first hospital PLACE audit. The medical service scored 100% for cleanliness and condition, appearance and maintenance of the medical wards.
- Patients spoke positively about the cleanliness of the wards and said staff used PPE during procedures such as connection and disconnection of patients to the dialysis machines. Patients told us this reassured them that they were in good hands and had low risk of getting infected in the hospital. Specific comments from patients on cleanliness and IPC included “staff take off gloves when they leave my bedside and their wash hands”, “when a patient finishes dialysis, I have always observed the cleaner come to clean the mattress, bed frame and the whole bed area”, “staff are very efficient and thorough with cleaning and disinfection”, “swabs for MRSA have been taken twice including my first day here”.
- The decontamination of endoscopy and dialysis instruments was carried out in accordance with the Department of Health (DH) guidance HTM 01-06. Staff we spoke with understood their responsibilities in this process.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- Access to the wards was by means of swipe card or an intercom buzzer system to gain access and exit from the wards. Staff and patients’ relatives on the inpatients wards were given an access card at the reception on the ground floor to gain access to the wards.
- The service had processes in place to ensure equipment was maintained and tested for electrical safety, to ensure it was fit for purpose and safe for patient use. At the last inspection we had noted that not all portable equipment had been serviced and labelled to indicate the next review date. During this inspection, we saw an improvement in the servicing of equipment, however, not all machines had been serviced on the oncology wards and dialysis unit. In the dialysis unit one dialysis machine had no date for next review and six machines were overdue for servicing since March 2018 and April 2018, and the medical fridge and electrical chairs were also overdue. On the oncology ward we observed some the blood pressure machine were due for testing in June 2018 and staff told us there was an on-going project to replace some of the equipment. In the cardiology unit, we observed that a telemetry machine was overdue for servicing.
- Since the last inspection, there had been refurbishment in the hospital such as redecoration of the main reception, CDU and dialysis unit. The inpatient and clinical facilities were designed in line with Department

of Health (DoH) guidance HBN 04-01 and the dialysis unit layout was in line with the renal association and DoH guidance. The oncology and chemotherapy wards now had a waiting area.

- We saw that the service created a gap analysis to identify areas of improvement in the dialysis unit and worked collaboratively with the infection control, safety and clinical teams to improve the environment and IPC. For example, the service had also installed CCTV in the dialysis isolation room since the last inspection to ensure staff were able to monitor patients regularly to ensure patient safety in case of emergencies such as hypotension during the dialysis procedure. There was now an equipment room and handwashing sink in the plant room in the dialysis unit. Following patient and staff feedback about the hot temperature in the dialysis unit, the service had also installed a portable air conditioner.
- We noted the service had changed their isolation process in the dialysis day unit. At the last inspection, two patients were treated together in the isolation room and during this inspection we saw there was only one bed in the room and which helped minimise infection risk to patients.
- The cleaning and decontamination of all reusable equipment in endoscopy and gamma knife unit were all up to date and managed in line with the Department of Health HTM01-06 guidance. There was a monthly audit of gamma knife equipment to ensure levels were correct and if any concerns engineers were contacted and they often arrived within an hour.
- Staff we spoke to were happy and proud of the improvement in the medical care environment particularly around dialysis, CDU, endoscopy and recovery area.
- There was appropriate emergency equipment on the medical wards including resuscitation equipment, drug boxes for specific emergencies such as a sepsis response kit, fire cylinder, fire blankets, oxygen cylinder, hypo box and cardiac arrest. The service had systems to ensure emergency equipment was checked daily and during inspection we saw that staff were compliant with emergency equipment checks. We checked a range of consumable items from the resuscitation trolley, including syringes, airways and naso-gastric tubes and emergency medicines and noted they were all were in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag.
- There were arrangements in place to safely manage waste and clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. We observed that general, sharps and clinical waste bags were changed frequently by staff. Staff used sharps bin appropriately and these were not overfilled, however, we observed a few occasions where newly replaced sharps bins had not been dated and signed by staff in a timely manner.
- In most clinical areas disposable equipment was in date and appropriately stored with the exception of the neurology ward where we found two boxes of anti-embolism stockings in the clinical room that had expired in February 2018.
- The service had two radioiodine suites with separate doors that led to the sluice rooms where staff disposed of any radioactive waste in line with national guidance.
- We observed that all Control of Substances Hazardous to Health (COSHH) items in all the medical wards areas were locked and labelled appropriately to prevent or reduce staff and patient exposure to substances that are hazardous to their health. This was in line with the Health Regulations 2002 regulations and hospital policy.
- The service had a plan in place for the 2018 influenza vaccination programme for staff to minimise the risk of cross infection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- Staff completed regular risk assessments to assess patients during admission and ward rounds using national risk assessment tools in areas such nutrition, falls risk, medical history, mental health history, skin integrity, social needs, high blood pressure, MRSA, venous thromboembolism (VTE), diabetes and high

body mass index (BMI). VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm. This was confirmed in the patients' records we reviewed.

- Patients were also individually risk assessed during admission and their treatment to ensure that treatment plans were tailored to their needs. We saw that staff frequently assessed patients during their procedures such as dialysis, chemotherapy, endoscopy and gamma knife.
- The oncology and haematology patient care plan was used by medical and nursing staff to assess the risk to patients undergoing anti-cancer treatment. Staff carried out a pre-treatment assessment to identify potential risks and also completed a checklist which covered baseline investigations such as renal profile, bone profile, ECG, cardio echo, x-ray and ultrasound. Staff were required to record treatment side effect or toxicities on patients such as bone marrow suppression, taste alteration, neutropenia, bleeding or bruising. The care plan was also used to assess patients' social and psychological needs and their need for support using the distress thermometer. The distress thermometer helped staff to identify any family concerns, emotional concerns, spiritual or religious concern, physical concerns and practical (socio-economic) concerns such as housing and work that may impact on the patients' health and well-being.
- The medical care service carried out a VTE audit for the period of April 2018 and July 2018. The July 2018 audit showed a general improvement from the April 2018 audit. The July audit showed 80% of patients were assessed on admission which was similar to April 2018, 100% of patients were assessed weekly which was an improvement from the April audit (87.5%). The results also showed that 100% of patients at risk of VTE were prescribed with anticoagulants within four hours of procedure and prescribed with VTE prophylaxis in accordance with the hospital policy which was better than the April audit compliance. The June 2018 cardiology monthly department report showed 80% of patients were assessed for VTE at admission and 100% within 24 hours of admission.
- Staff carried blood screening for dialysis patients for hepatitis b, hepatitis c, HIV and MRSA at admission. Patients with MRSA or hepatitis b were isolated in a side room until the infection cleared, which was in line with the Renal Association (RA) Guidelines. The RA recommend that patients with hepatitis c or HIV do not need to be dialysed in a segregated area but more experienced staff should be allocated to dialyse these patients. During inspection, we saw that patients with hepatitis c or HIV were cared for by senior staff and were not isolated and treated in the bay with their own machines. Staff told us they managed the clinic list to ensure MRSA and hepatitis b patients were not receiving treatment at the same time as there was only one isolation room.
- There was a process to ensure resident medical officers (RMOs) were involved in the admission of patients, particularly on the oncology wards, which ensured patients were seen quickly and risks were identified and addressed. The hospital 'emergency admission to the ward flow chart' required nursing staff to inform the RMO within 30 minutes of patient admission and the RMO must assess patients within 60 Minutes. Staff told us that RMOs were normally part of the admission process. All patients were further reviewed within 12 hours of admission in line with the hospital policy.
- The service had a hospital admission policy in place that outlined the admission criteria and out of hours admission. There was an out of hours decision support tool that guided staff on the admission criteria, ensuring patient had a detailed medical report for admission and having the appropriate staffing and skill mix to ensure safe admission and reduce patient risk.
- The medical service had introduced 24-hour triage for the oncology service and patients on chemotherapy were given an alarm or red card to call the triage system when unwell or during emergency. This was in line with the UK Oncology Nursing Society (UKONS) guideline on the oncology and haematology advice line triage tool.
- Staff had received training on emergencies such as fire emergencies and cardiac arrest. We saw various examples were staff had escalated to the outreach team or responded to a cardiac arrest and MDT staff such as the crash team responded immediately and took in turns to do CPR.

- We saw there were systems in place to advise staff of patients that were not for resuscitation. Staff said their electronic system would flag up patient that were not for resuscitation.
- In the iodine suite there was a process in place to ensure that only staff who had received the iodine training had access to the suite to minimise risks and ensure patient and staff safety.
- The service used the National Early Warning Score (NEWS), designed to allow early recognition and deterioration in patient by monitoring physical parameters, such as blood pressure, heart rate and temperature. During inspection we observed that nursing staff used the NEWS and knew the threshold for escalation to the RMO and outreach team. Staff also carried out further investigations such as blood tests as required. Staff told us the service had reviewed and lowered the threshold for escalation and referral of patients who became acutely unwell or were at risk of deterioration. Patient at risk of deteriorating and did not require organ support could now be transferred to intensive care as a result of their lowered threshold. Staff told us this change was made as a result of learning from previous serious incidents in the hospital.
- The result of the NEWS audit for the period of June to August 2018 showed the medical service was generally compliant (80%) on the standards audited. The medical service was RAG rated green using a traffic light rating system and achieved an overall 93% on the documentation standard and 80% on the scoring standards. However, the overall compliance on the escalation standard was 66% and rated red (below 75%). We saw that on the escalation standards neurology achieved 84% compliance and was the only medical wards that met the standard and rated green in that period.
- There were 11 unplanned transfers to the intensive care unit, three unplanned transfer to another hospital and 13 unplanned re-admissions to the service for the period of May to July 2018.
- The service had introduced the inpatient pre-dialysis ward written handover tool which was used in addition to the verbal handover given to dialysis staff during the transfer of patients from the ward to the dialysis unit. This was implemented following previous incidents that had occurred which identified issues around information received during patient transfers and hand over. The handover tool allowed staff to discuss patients' records and investigations that had been carried out on the ward such as drug charts, nursing and medical notes, blood requested, insulin given, anticoagulation and pre-dialysis dry weight. Staff we spoke with told us this had improved patient outcomes and reduced patient risks and incidents.
- Staff responded appropriately to unforeseen incidents. For example, staff and patients told us there was a flood in the dialysis unit the previous week. The business continuity plan was used by the team and patients were contacted to change their scheduled dialysis. The service had spare portable dialysis machines that were used to dialyse patients on the wards by their bedside. There was also a hemofiltration machine that could be used for acutely ill patient in the intensive care unit.
- Staff received training on sepsis and we saw posters of sepsis six (management of sepsis that usually involves three treatments and three tests) and escalation using the internal emergency service during inspection. There were also posters on the wards that had contact details for emergencies that staff could call where there concerns including out of hours.
- We saw that the service responded appropriately following risks identified from audits and incidents reported. For example, there was learning and improvement made to the risk assessment of patient wounds and pressure ulcers following a hospital acquired pressure ulcer incident in neurology. During inspection, we saw improvement in the patient skin risk assessment of recognised pressure areas and the September 2018 audit showed 100% compliance in the skin risk assessment and skin care bundle assessment at admission on the neurology ward. The service also introduced a safer fistula needle in the dialysis using following serious incidents.
- The endoscopy service used the World Health Organisation (WHO) safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm during their procedure. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). The

results of the WHO surgical safety checklist audits for the period of May 2018 to June 2018 showed 100% overall compliance. From observation and record reviewed we saw that WHO checklist were fully completed by staff.

- The service did not conduct peritoneal dialysis (PD) during inspection. Staff told us they have had patients on PD previously and the most recent was two months ago. For the period of July 2017 to July 2018, two patients had received PD on 18 occasions. Staff told us PD was stopped to mitigate patient risk as the service saw few cases of patients in PD in a year and there was no staff competency for PD. This was on the risk register. Dialysis staff were trained on peritoneal dialysis as part of their renal courses, however, there was risk of becoming de-skilled as the hospital did not often see PD patients.
- In the dialysis unit, we noted that some call bells were not working and was on the risk register. The lead nurse and management were aware of this and telephone had been provided in the unit to mitigate the risk and the phones were linked to the team to respond.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The hospital introduced a safe care tool in March 2018 to ensure consistency of the staff to patient ratio to improve patient outcomes and staff satisfaction. Senior managers used the hospital system to allocate staff in advance based on pre-determined nursing demand and acuity of patients. The day unit staffing requirement was determined by the amount of hours each patient would be in the unit. Staffing levels were reviewed at the daily bed meetings.
- Temporary staff were also used to achieve safe staffing levels. Staff told there had been a reduction in the use of temporary staff on the medical wards. There were senior members of staff and clinical nurse specialist (CNS) on the wards who were supernumerary to ensure the flexibility to support staff on a daily basis and when there was staff shortage due to last minute sickness.
- For the period of April 2018 to September 2018, the service reported 10 shifts were unable to be filled by either bank or agency staff.
- The hospital bank and agency usage for nurses in the hospital inpatient department varied from 10% to 23%, which was better (20% reduction) than the previous inspection.The bank and agency usage for health care assistants (HCA) varied from 11% to 35% and was also better than the last inspection (29.4% to 56.4%). Data provided by the hospital showed that bank staff were regularly used rather than agency staff to ensure they were familiar to the clinical area.
- Recent data provided during inspection for the medical service showed the average bank and agency use for the period of September 2017 to august 2018 was 8.1%.
- Staff told us the hospital had a process in place for managing the bank and agency staff to ensure they were able to meet the requirements for complex patients and specialist wards.
- The CDU had seven beds and was normally staffed by five nursing staff which included the CNS, two senior nurses, one HCA and one bank staff in their planned staffing. During inspection, we saw that five staff were on duty on the CDU.
- The dialysis unit had seven dialysis beds or chairs and was staffed with two senior staff nurses, three staff nurses and on HCA. There were normally two to three staff nurses and one HCA on shift depending on acuity. This was in line with the with British Renal Society ratio of 1:3.
- The endoscopy was staffed with three full time senior staff nurses, six nursing staff and one HCA.
- The overall turnover rate for staff was 16.5% and we noted that the highest turnover rate for the service were oncology (35%), dialysis unit (13%) and cardiac ward (13). Senior staff told us that the high figure represented new qualified staff that were recruited and trained in these specialist areas. Staff told us they sometimes experienced challenges with recruiting and retaining newly qualified staff following their preceptorship programme. This was because after training newly qualified staff on the specialist wards they often move to

NHS trusts where they were paid more or to gain more NHS experience. Staff told us the generally staff turnover of staff was good and people had worked in the service for a long time.)

- Senior staff told us they had vacancies but had no issue with staff sickness. The average sickness rate for medical care for the period of September 2017 to august 2018 was 3.6%.
- Since the last inspection, the hospital had recruited an additional palliative specialist nurse which enabled seamless palliative care nurse cover. This was an improvement from last inspection where we had concerns of the provision cover for the palliative care nurse specialist when they were on leave.
- During inspection, the staff vacancy was 10 whole time equivalent (WTE) across the medical ward, and majority of the vacancies relate to the cardiac and general medicine (5 WTE) and oncology ward (3 WTE).

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Consultants worked under practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. The medical advisory board (MAB) was responsible for granting practice privileges and was overseen by the medical director. Consultants with practicing privileges had their appraisal and revalidation undertaken by their respective NHS trusts. Staff we spoke to told us the process for managing practice privileges had improved and was more robust, and the hospital now had oversight on consultant's' scope of practice. Consultants were expected to inform the service of the list of procedures they normally carried out in their NHS hospital and this would be verified and co-signed by one of their NHS colleagues. This was to ensure that consultants were not performing work outside the scope of their regular practice.
- The consultants were required to ensure appropriate cover for their patients and continuity of care when they were away. The on-call rotas were developed to support this process and did not require the clinician to be onsite, but must be within 30 minutes of the hospital while on call.
- The service had a designated palliative consultant who was available 24 hours a day via telephone for palliative care. There was a designated consultant oncologist who was also the clinical director for oncology. There was an oncology speciality doctor for the oncology ward and worked Monday to Friday, 9am to 5pm.
- There was an adult anaesthetic on call rota which was managed by the medical director's office and clinical director for anaesthetics. There was also out of hours anaesthetist cover from 6pm to 8am weekdays and 24 hours at weekends and bank holidays.
- The RMOs were employees of the hospital and were managed via a contract or through an agency. The medical and oncology RMOs now worked 9am to 6pm each week which was an improvement from the previous inspection. The hospital had updated their policy to reflect the new RMO cover arrangements. The senior RMO who covered the general medical wards provided 24-hour support and had breaks and protected time to rest at night (midnight to 7am) and were only called for emergencies. Authorisation for any on-call shifts longer than 24 hours was only by the medical director (or another director in their absence) during exceptional circumstances only. There were daytime medical services RMOs who worked 9am to 6pm and also covered cardiology.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

- The hospital used paper and electronic records to record patient needs and care plans, medical decision-making, reviews and risk assessments. The hospital was going through a process to make all patient records electronic. We saw that some of the care plans and risk assessment were paper records which staff completed and scanned to the patient's records on the electronic systems. We saw that MDT staff could access

patient test results, staff journals and care plans on the electronic system. Staff found the electronic records accessible and useful to update patients' records. This was an improvement from the last inspection.

- The RMOs now had computer passwords that enabled them to access patients' electronic records to see patients' care plans, other professionals' entries and diagnostic results such as bloods and x-rays. This was also an improvement from the previous inspection.
- Patients on the oncology ward and chemotherapy day unit were given a chemotherapy record booklet which they were required to bring to their hospital and GP appointment. This booklet contained information on their personal information, emergency contact, diagnosis and treatment, treatment regime and records, medicines at home and appointment. The booklet also had a space were patients could document their own notes and questions they had on their care. The questions and notes were then explored by staff when patients attend the hospital.
- The cardiology department provided remote monitoring for patients with pacemakers and defibrillators. Data from the patients' implantable devices was uploaded automatically from home to a secure database.
- We saw that staff stored paper and electronic records securely, and when electronic records were not in use staff logged off their computer. We also observed that patient records in specialist nurses' offices and on the wards were stored in a locked file cabinet.
- Staff told us that some overseas patient sometimes came to the hospital with incomplete records of their medical history or current treatment. Staff told us when this occurred they worked with the patient and their relatives and liaised with the patient's own GP or medical doctor from their own country as part of their admission process. Data received from the hospital during inspection showed that less than 1% of patients were seen in the last three months without all relevant medical records being available.
- We looked at 19 sets of patient records and their prescription charts during inspection. Staff documentation on patients' records was concise, legible and written in accordance with the NMC record keeping guidance. There was evidence of discussion and collaboration with patients and their relatives by the MDT staff. We saw evidence that staff carried our risk assessments and reviewed patients' past medical history on the patients notes reviewed. We saw that staff completed the do not attempt resuscitation (DNAR) form to patients indicated not for resuscitation as per hospital policy.
- The service carried out an intravenous (IV) fluid audit in March 2018 where 10 standards were assessed on areas such as records, assessment and management. The result for the medical wards showed an average 91.3% compliance compared to the hospital average of 68%. We saw that the oncology ward achieved 100% while the cardiac ward achieved 90% and neurology achieved 84%. The audits action plan included nominating an IV fluid champion in each area to monitor compliance in practice and to include acute kidney injury and sepsis training as part of the IV therapy training.
- The service conducted a records audit of the cardiology and general medical wards records in June 2018 which showed 89% compliance. We noted that this was an improvement from the 72% compliance in the previous month. Staff told us there had been teaching on record keeping and writing particularly among temporary staff. Staff felt there had been a big improvement on the temporary staff records as a result of frequent audits, teaching and support from senior staff.
- We reviewed all documentation relating to the ionising radiation medical exposure regulation (IRMER) and we noted it was fully up to date and compliant with the health and safety regulation.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

- The service had robust systems in place for the management and reconciling of medicines in line with national standards and guidelines. The service carried out several audits of medicines in order to identify and address safety issues, improve patient outcomes and to offer support to staff.
- The hospital had a computerised ward-based medication storage and control system in place to manage the storage and dispensing of medicines. There

were 13 of these in the hospital and during inspection we saw it in use on the medical wards. This system ensured pharmacist were alerted to out of stock medicines, reduced selection and dosage errors and the patient ID barcode reader was linked to the system. All medicines stored in the computerised storage were locked and could only be accessed by staff by logging to the computer using their user name and password. The system could accurately monitor who had accessed any medicines and medicine expiry dates were recorded and monitored centrally on this system.

- Medicines were also stored in locked fridges and trolleys within locked clinical treatment rooms and only relevant clinical staff could access them. During inspection we observed that all medicines stocked on the wards were managed safely. A centralised medicine fridge temperature monitoring system had been implemented in all pharmacy department refrigerators and this was due to be rolled out to all refrigerators across the site in the next three months.
- All medicines stored in the fridge and computerised storage were all in date. We also saw that emergency medicines, cytotoxic spillage kits and extravasation kits were available on the wards and regularly checked by staff.
- Medicines were supplied by the onsite trust pharmacy. Pharmacy top-up service occurred twice a week. Staff ordered, dispensed and disposed of medicines safely and securely. There were effective arrangements in place to facilitate medicines supplies and advice out of hours. Clinical pharmacy services were available every day 9am to 8pm and the site lead had permission to access the pharmacy out of hours to obtain any medicines which wards had run out of excluding chemotherapy medicines.
- The oncology pharmacy team were part of a network of specialist sourcing facilitators which gave them access to new approved cancer drugs that were used to treat a wide range of tumours and cancer as proven by genomic profiling.
- Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. In all of the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. The pharmacists also counselled patients on how to take their medicines at discharge with leaflets given.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated and staff we spoke with knew how to report incidents involving medicines. Staff knew how to report medication errors. Lessons learnt from incidents were fed back to staff via a governance newsletter, staff meetings and individual safety bulletins. The hospital had a medicines safety officer who linked into the national network and fed back any learning every month. The pharmacy scorecard for the period of September 2017 to May 2018 showed 157 medicines incidents were reported by staff.
- The service carried out a range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, missed doses, medicines reconciliation, and safe and secure handling of medicines. We saw the pharmacy and medication audit plan for both internal and external audits and inspections which showed general compliance.
- The hospital carried out a control drug (CD) and secure storage audit for the period of2017/18. The result showed that staff were mostly compliant against standard audited. The areas for learning identified from the audit were around documentation of the CD register, safety, incident reporting and to ensure the staff signature list was up to date. During inspection we saw that CDs were managed appropriately and checked twice daily. The hospital had a controlled drug accountable officer who submitted quarterly reports to the local intelligence network.
- The 2018 hospital pharmacy intervention audit showed that 53% of the interventions by the pharmacists were related to the medical wards of which 37.4% was cardiology, 10.4% were renal and 5.2% on the oncology ward. The intervention in all the hospital services for these periods were mostly omission (32%), inappropriate drug (10%), frequency error (9%) and illegible or duration of medication (7%). The severity of

interventions were mostly major (48%), intermediate (28%), minor (18%), serious (6%) and saved life (1%). The service addressed concerns following audit through teaching and training sessions.

- The service carried out regular medicines management checklists for medical wards on standards such as the storage and security of medicines, checking of the CDs twice daily, monitoring of medicines temperature and British National Formulary (BNF) and medicines file in treatment room. The 2018 audits of the medicines management checklist for the medical wards showed an overall 82% compliance. The chemotherapy day unit was the only medical area that achieved 100% on all standards audited.
- The 2018 TTO (to take out) audit showed 100% of medicines were dispensed by pharmacist within agreed time.The average time for urgent TTOs to be dispensed was within 23 minutes against the 45 minutes target and non-urgent TTO were dispensed within 80 minutes.
- The National Institute for Health and Care Excellence (NICE) guidance states 100% of patient should have an accurate drug history taken and medicines reconciled within 24 hours of admission. The hospital carried an audit of medication reconciliation on admission in March 2018.The result showed medicines reconciliation within 24 hours of admission for the medical wards was 73% which was similar to the hospital average of 73.3%. We noted that neurology was the only medical ward that achieved 100%. The results were below the NICE standard, however, there had been an improvement in the medical wards compliance from the June 2017 audit (32%) and December 2017 (59%) against the hospital average of 60%. During inspection, we saw that the pharmacists completed full medicine reconciliation for all patients on the medical wards within 24 hours of admission during weekdays, and within 72 hours for weekend admissions.
- The missed dose audit carried out in November 2017 showed 14% of doses were omitted which affected 79% of patients. Of the 14% missed doses, the majority (75%) were related to medical care patients. The main reasons for omission were medicines were unavailable, patients refused medicines or where doctors had omitted the patient dose due to clinical reasons. The result showed that in 32% of hospital cases, staff had not recorded the reason for omission and of these 3.2% were critical medicines. An action plan was in place to address areas for improvement through staff education.
- Fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw that all fridge and room ambient temperatures were within the expected range. Staff were generally compliant in the monitoring of the ambient and room temperature. There was an overall 4 % omission on the fridge and ambient room temperature checks on all the medical wards. For example, on 1 West Ward there was 17 (9%) omissions for the period of March 2018 to July 2018. On the oncology ward clinical room there was eight (2%) omissions and 12 (3%) omission in the oncology computerised storage room in the last 12 months.
- The administration of chemotherapy to both inpatients and day unit patients was managed safely. All chemotherapy was prescribed by a consultant via an electronic prescription. Each prescription was clinically checked by a specialist oncology pharmacist prior to being individually prepared on site by a team of technicians.
- Principles of antimicrobial stewardship were implemented. Any antibiotics prescribed were reviewed and re-prescribed every 48 hours. The pharmacist was part of the weekly ward round with the consultant microbiologist where all patients on site were reviewed if a referral had been made. The pharmacist also attended other MDT meetings and ward rounds. The hospital had a medication safety officer who had an active role in national medication safety networks.
- We reviewed six patient drug charts during inspection. Patients' allergies were recorded on prescription chart in line with NICE guidance. Patients regular medicines prescribed included the route, frequency, all signed by prescriber and no missed doses. Medicines that are taken when needed (PRN) all included frequency and maximum dose in 24hours. However, the consent form used for patients who received chemotherapy therapy did not make clear when a medicine was being administered outside of the terms of its product licence for the last three people who used unlicensed chemotherapy. Although we saw this was noted on the patients' electronic records.

- Patients were given a copy of their discharge summary which included a list medicines prescribed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- From October 2017 to September 2018, the hospital reported no incidents which were classified as never events for medical care.
- In accordance with the Serious Incident Framework 2015, the hospital reported two serious incidents (SIs) which met the reporting criteria set by NHS England from October 2017 to September 2018. These were related to patient transfer and post procedure complication.
- We reviewed the hospital serious incident (SI) tracker submitted by the hospital before the inspection. Two SIs were for the medical care and related to unplanned transfer to the intensive care unit from the oncology ward and a post procedural complication in endoscopy. The tracker detailed action taken and we saw that duty of candour had been met by staff.
- Following an SI and root cause analysis report the clinical governance meeting or complaints committee reviewed these to ensure action plan have been actioned and learning shared through team and learning meetings.
- The hospital had robust processes in place for investigating and capturing all incidents. Senior managers also used the electronic reporting system to identify incidents from complaints, risks identified on the risk registers and feedback received from patients. Senior managers attended daily incidents review meetings were newly reported incidents were reviewed to ensure accountability and senior input in the reviews. We reviewed one serious incident and a root cause analysis for the service and saw the investigation was very detailed and highlighted areas for learning.
- The hospital used an electronic system for reporting incidents. Staff we spoke with said they were encouraged to report incidents, and felt confident to do so. Staff knew how to report incidents and the majority of staff we spoke with had reported an incident. Staff told us that senior managers had oversight of incidents reported on the electronic system followed up reported incidents and gave feedback to staff including those involved verbally and formally via email. Staff told us that the system now had a 'lessons learned' functionality for staff to ensure they always receive feedback.
- For the period of January 2018 to August 2018, the medical service (with the exception of endoscopy and Gamma knife) reported 264 incidents. The majority of incidents were reported by the oncology wards (33%), cardiac wards (31%) and neurology wards (22%). The dialysis unit reported 22 (8%) incidents and while the chemotherapy day centre reported 15 incidents (6%).
- Staff told us as a result of changes in governance leadership and structure, their incident reporting rates had risen significantly by 100% and when benchmarked against NRLS data, the hospital was placed us as the second highest private hospital reporter in the country compared to their peers. Staff told us that senior staff encouraged them to report incidents and they felt supported to challenge any concern about the incident investigation process.
- Staff told us there was a no blame culture and they received appropriate support from colleagues and managers following an adverse incident. Staff told us they were supported following reported incidents through the 'feedback Friday', Schwartz rounds and debrief from the hospital psychologist. The feedback Friday was introduced as the senior managers identified there was limited sharing of learning from incidents, complaints and risks across the hospital. We reviewed the feedback Friday minutes for last 12 months and noted that in 2017, 67% of feedbacks in 2017 and 65% feedbacks in 2018 were related to incidents across the

various departments in the hospital such as endoscopy, catering, medical records and neurology. This meant that staff was aware of hospital-wide incidents and learning.

- Staff were able to tell us about learning from incidents and we saw various examples of learning and changes to practice following reported incidents and SIs. For example, the service developed a safer smoking assessment and updated their policy following a fire incident that involved a patient. Learning from this fire incident was discussed at the feedback Friday in July 2018.
- Senior staff attended monthly mortality and morbidity (M&M) meetings where all inpatient deaths were reviewed, learning was identified and action plans were set up where required. Due to the low mortality in a month across the hospital all hospital deaths were discussed at this meeting, which ensured hospital wide learning. Data received from the hospital showed there had been 57 inpatient deaths and three unexpected deaths across the hospital for the period of October 2017 to September 2018. Deaths were also reviewed by the palliative care nurse and discussed with staff. We reviewed two M&M meetings for the last six months and saw that deaths related to medical care in oncology and neurology were discussed and which showed robust investigation and good multidisciplinary working, consent and DNAR process.
- 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- We saw that staff apologised and gave patients information and support when things went wrong. Staff understood the principle of duty of candour and importance of being open and honest with patient and those close to them when something went wrong, and the need to offer appropriate support to put matters right and explain the effects of what had happened. We saw that the service followed the duty of candour process and patients and relatives when things went wrong. For example, following recent flood incidents in the dialysis unit, we saw that senior staff wrote patients affected during the incident.

Safety Thermometer

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

- The safety thermometer is used to record the prevalence of patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Staff were aware of their responsibility to reduce and reports incidents such as falls, pressure ulcers, urinary tract infection relating to the use of catheters.
- The hospital reported one incident of hospital acquired VTE or pulmonary embolism in the last 12 months before inspection.
- Data from the Patient Safety Thermometer showed that the service reported four new hospital- acquired pressure ulcers for the period of January 2018 to September 2018, and of which one was classified as grade three pressure ulcers. The service reported six patients' falls in the same period.

Are medical care services effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- The medical service had effective systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance and legislations.
- Guidelines were available on the hospital intranet and were updated and guided by the Royal College of

PhysiciansRCOP), London Oncology Alliance and National Institute for Health and Care Excellence (NICE) guidance when reviewed. Staff used specific NICE guidelines and pathways such as chronic heart failure (NICE Quality standard [QS9]: Chronic Heart Failure), chronic kidney disease, diabetes in adults, urinary tract infection and acute kidney injury and acute upper gastrointestinal bleeding in the assessment and treatment of patients. The service had a do not attempt cardiopulmonary resuscitation (DNACPR) decision making framework that guided staff on decision making.

- The oncology clinical nurse specialist (CNS) and some other staff were part of the UK Oncology Nursing Society (UKONS) and had access to evidence based resources, trainings and which had helped introduced best practice into the service. For example, staff had received guidance from UKONS members' interest groups on the use of the management of extravasation of cytotoxic drugs. is the accidental leakage of certain medicines into the body from an IV drip in the vein.
- The oncology CNS introduced the hospital to the vanguard, which is a London cancer network and attended regional meetings where hospitals shared protocols, guidelines and procedure. For example, the service had implemented the vanguard chemotherapy protocols and regime into the service.
- Staff told us there had been improvements in their policies and pathways since the last inspection. For example, the dietitian had developed a referral pathway for patients on chemotherapy. Staff told us the parenteral nutrition policy had been updated and was now safer than is used to be.
- At the last inspection we had concerns on the end of life care provision. During inspection we saw improvements within the service which were underpinned by national guidance and best practice. The service introduced a Gold Standard Framework (GSF) which was a two-year project to provide the highest standard for all patients in the last year of life and which commenced in February 2018. The framework was used to improve early identification, assessment and planning of care of patient in their final stage of life.
- There was an end of life care guidance and policy that set key standard for staff to achieve high quality, consistent and compassionate end of life care based on the needs of individual patients and their loved ones. The policy covered the daily care plan review, symptom control of the dying patient and anticipatory medicines to manage pain, agitation, nausea, vomiting, respiratory secretions and breathlessness. The service also introduced a compassionate care pathway and rapid discharge home (care package) pathway in March 2018 for patients at end of life. Staff attended annual teaching programme on these pathways.
- The service used current evidence-based guidance and quality standards to inform the delivery of care and treatment patients. The service participated in local and national audits programmes and collated evidence to monitor and improve care and treatment when indicated. The hospital participated in national audits such as cardiac rhythm management and percutaneous coronary intervention. This was an improvement since the last inspection where we found a lack of participation in national audits. Where the hospital could not submit national data the service carried out a local audit and benchmarked themselves.
- Senior managers told us that the hospital was working with the Healthcare Quality Improvement Partnership to pilot increased independent sector participation and recently joined the Get It Right First Time steering committee for the independent sector. The hospital also submitted their outcomes to the Private Healthcare Information Network (PHIN) and engaged with them on improving the transparency and reliability of data and increasing their patient reported outcome measures (PROMs) and Questionnaire PROMs submission.
- The hospital participated in peer reviews and joint research with a specialist NHS London hospital. Since the last inspection staff told us there had been peer reviews of the physiotherapist, chemotherapy and pain services.
- The audit committee decided on the audit programme in response to national audits, national guidance, best practice initiative, practice related issues, risks and trends from their electronic reporting system. The committee also reviewed and monitored the local and national audits, policies and performance using the audit action tracker. The resident medical officers (RMOs) were part of the working group for reviewing guidelines such as admission guidelines. We saw that

half of the actions relating to medical care on the audit action tracker had been completed or on-going. We saw that 92% of all hospital policies were in date as at August 2018.

- Staff were informed of changes to national guidance and local policies and procedures through the clinical effective newsletter. We reviewed the clinical effective alert newsletter for the last two months. We saw that staff were informed of changes in the cardiovascular NICE guidelines on mechanical thrombectomy devices for acute ischemic stroke and remote ECG interpretation consultancy services for cardiovascular disease. Updates on local policy and guidance, useful resources and published studies were also shared with staff around areas such as oncology, mental health and pharmaceutical updates. We noted that staff were also informed of their recently published suspected acute stroke pathway. The stroke policy highlighted that the service did not admit patients with confirmed or suspected stroke within 24 hours of onset of symptoms even if symptoms had resolved if the patient has not attended an appropriate acute medical care facility and achieved criteria for discharge. The stroke policy was detailed and referenced the NICE, RCOP, Stroke Association, Department of Health, World Health Organisation (WHO) and the London Ambulance Service guidelines.
- The endoscopy unit was Joint Advisory Group (JAG) accredited. JAG accreditation covered areas such sterilisation and clinical outcomes for upper GI endoscopy and colonoscopy completion rates were all within the national standards.
- The service had also received accreditation on Intensity-modulated radiation therapy which is an advanced type of radiation therapy used to treat cancer and noncancerous tumours.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

- Staff screened and assessed patients' nutrition and hydration on admission, taking their cultural, dietary and religious need in consideration, to ensure they were not at risk of malnutrition. Staff used the malnutrition universal screening tool (MUST) for assessing patients' nutrition. MUST was a nationally recognised method used to identify the risk level of each patient and this was documented in the set of notes we reviewed. We saw that were risks were identified staff referred patients to the dietitian service.
- The dietitian reviewed patient the same day they were referred or next working day if they were admitted at the weekend. The dietitian and speech and language therapists worked closely together and attended multidisciplinary team meetings to discuss patients' nutrition and hydration needs. Patients' dietary requirement were communicated to staff including catering staff during handover and through the use of signs in patients' rooms and white boards on the ward.
- Staff understood the neutropenic diet on the oncology wards, this was an improvement from the last inspection. There was an information sheet for the neutropenic sepsis diet that informed and educated patients on their nutritional needs.
- Staff gave advice and followed up patients where nutrition and hydration concerns were identified through their weight, blood result such as urea or appeared dehydrated. Where severe dehydration was identified the nurses liaised with the medical staff to prescribe intravenous (IV) fluids.
- Diabetic and renal patients were given leaflets that detailed the list of what foods they should avoid and alternative foods they could eat.
- Staff told us they were working with the catering company to improve the renal diet on the set menu. Staff told us and we saw that the menu had some meals that were high in potassium for example tomato and which was not ideal for a renal patient on dialysis. The hospital food was outsourced to a catering company based in the hospital. The dietitian told us they had requested for the catering company recipes with the aim to review and work collaboratively with them to improve the menu.

Pain relief

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

- Staff used various pain tools such as the numeric pain score or smiley face score to assess patient pain depending on the needs of patient. During inspection, we saw that attention to pain control was very detailed from our observation at the ward round.
- The hospital carried out a pain audit in December 2017 using the NICE and RCOA guidelines for auditing pain assessments record. The result showed the medical wards performed better than hospital average on five of the six standards audited which include assessment of pain on admission, use of pain tool and assessment of pain relief. The overall compliance was 82% for the medical wards which slightly better than the hospital average of 81%. Evidence of assessment of analgesia for the medical wards was 90% compared to hospital average of 72%.
- Patients we spoke to told us that their pain was managed appropriately, staff used a pain assessment tool and knew how to recognise pain.
- Staff told us they had access to the hospital palliative team who supported staff and patients in pain management, particularly those suffering from symptoms in the dying phase of life

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

- During the last inspection we noted that the hospital carried out an external audit of the palliative care pathway for the 54 deaths that occurred for the period of 2015/16 and the result was not available. It was published in 2017. The results showed the hospital achieved an overall score of 3.4 (rated good) on the admission phase, ongoing care, end of life care and note keeping. The result showed that on a few occasions exemplary palliative care was delivered at the service, with early palliative care involvement and a patient focussed treatment plan. Areas for improvement included recording and documentation of DNACPR forms, care plans, and recording death in medical notes. Also, palliative care input needed to be received earlier as several patients with advanced cancer did not receive palliative care input until 24 hours of their death. The recommendations included regular mortality review, documentation of end of life, early palliative care referrals, admission pro forma, introducing the end of life steering group and increase in palliative care support. This resulted in the recruitment of an additional palliative clinical nurse specialist. During inspection we saw that these recommendations had been implemented in the service.
- At the last inspection we had concern there was no clearly defined strategy in place to develop end of life service in the hospital and there was no audit on the number of patients dying in their preferred location. The service carried out a follow up end of life care audit in April 2018 where five priorities of care standards were audited: improve quality of care, promote collaboration, improve patient outcomes, optimise cost-effectiveness and reduce avoidable acute hospitalisation. The result showed that staff met the five priorities of care for 78% of patients, but that staff did not recognise 17% of patient who were entering the terminal dying stage. Also, 83% patients recognised as being likely to die had evidence of discussion with professionals about their likely imminent death and 100% of patients had DNACPR orders in place. The result showed there was no opportunity to discuss patients preferred place of death for three patients who were referred to the palliative team very late when they were reaching the terminal stage. The audit highlighted the importance of staff having discussions with patients about their wishes when they still had capacity to make decisions. The audit action plan was for staff to recognise patients who had a poor prognosis and to have an earlier discussion with them. The action plan also stated that the possibility of patient death should be communicated to the patient and their loved ones and documented in patient notes.
- The 2017 audit of patient preference of their preferred place to die showed that most patients did not die in their place of preference. This resulted in the implementation of the GOLD Standard Framework in the hospital.

- Data received from the hospital showed there had been 57 inpatient deaths in the hospital and three unexpected deaths across the hospital in the last 12 months. The palliative care team received 80 new referrals for the period of 2017 (52) and 2018 (28). The local record of referrals was maintained and monitored by the palliative CNS. Records of patients' preferred place to die were kept and monitored in the team diary. This was an improvement from the last inspection in the number of referrals to the palliative team.
- The NICE guidance advised that neutropenic patients with suspected or proven infection must be admitted immediately and commenced on intravenous antibiotics within an hour of presentation. The June 2018 neutropenic sepsis audit showed that the service achieved an overall 96% compliance on the standards audited. Although, the service did not meet the NICE standard of 100%, however it was better than the hospital target of 90%.
- The service carried out a pneumonia audit in March 2018 on five standards to determine if the management of patients admitted with community-acquired pneumonia was compliant with the NICE CG191 guidance. The standards covered diagnostic, investigation, treatment, antibiotics therapy and safe discharge. The audit result showed the service achieved 100% compliant on four of the standards audited. The service achieved 80% on the use of dual antibiotics in treatment and there was no documentation of whether staff considered dual antibiotics therapy on the other 20%.
- The service submitted all their renal data automatically from their laboratory directly to the renal registry to compare data nationally.
- The service carried out an acute kidney injury (AKI) audit in March 2018 to assess the service compliance against national standard for identifying and managing AKI. The result showed an average 41% compliance on the 10 standards audited and poor compliance on documentation of the identification and management. The service achieved 100% compliance on two of the standards; urine output measured and measuring regular serum creatinine level in patient with AKI. The result also showed that 38% of patients suffering with AKI were discussed with a nephrologist within 24 hours of detection of AKI. As a result of the audit, the service developed an AKI quality improvement plan, AKI working group, appointed an AKI lead and commenced staff training from April 2018 to improve the service. We noted that the managers sent daily email alerts to inform staff of patients identified with possible AKI.
- The service carried out an audit on their endoscopy service in line with the Joint Advisory Group standard. The standard recommends services to audit the number of procedures undertaken by each operator, success of intubation, satisfactory placement of PEG, POLY retrieval rate and the sedation and analgesia used for patient under and above 70 years.
- For the period of September 2017 to February 2018, the audit showed the operators had 1,179 cases of which 53% were for gastroscopy, 37% for colonoscopy, 9% for flexi sigmoidoscopy, 0.4% for ERCP and 0.3% for PEG procedure.
- For the period audited, there was 100% successful intubation rate for PEG procedure and 88% for ERCP. The service achieved 99% successful intubation rate for gastroscopy and 97% for colonoscopy.
- The service followed the guidelines for the midazolam and fentanyl sedation and analgesia dosage given to patient age below and over 70 years.
- Certain polyps (abnormal growth of tissue projecting from a mucous membrane) such as adenomas can become cancerous if not removed. It is a national screening and surveillance programme for operators to check for polyp and to send any polyp discovered during endoscopy procedures to pathology for analysis. The audit showed that the average polyp detection rate was 19% for colonoscopy and 17% for flexi-sigmoidoscopy. Staff told us where polyp were detected the operators removed them, which meant the service achieved 100% poly retrieval rate.
- Senior staff told us the service carried/or was carrying out audits on the central venous catheter (CVC) after chemotherapy within 30 days, early breast cancer control rates, spillage audit and extravasion audit; staff told us results were good. We requested for these audits but was not available during the inspection.
- Staff told us the service carried out a recent audit on the use of thromboplastin to reduce delays in providing

chemotherapy to patients with neutropenia. This was presented as part of their cancer MDT and had been adopted to their policy. We requested this audit but it was not available during the inspection.

- The patient reported outcome measure (PROM) audit for colonoscopy in May 2018 showed 93% patients had a choice of sedation.
- Senior managers told us in situations where the service could not participate in national audit due to low volume they were working toward replicating the national data sets internally, and to compare themselves against published reports. The hospital also monitored and reviewed their consultant level data published on national registries from their NHS hospital.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- The service had a comprehensive programme of induction and refresher training for the clinical and non-clinical staff. The service had a framework for assessing staff competency and governance process for managing staff professional registrations.
- All staff underwent a hospital induction and orientation programme, which included mandatory and department specific training. Staff were provided with an induction booklet that orientated them to the area they worked in and they were given a supernumerary period to familiarise themselves with the policies and complete their induction process and mandatory training. New staff were given an induction checklist which they had to complete. The service had introduced a monthly new starter breakfast in April 2018 for new staff for support. This forum also allowed new staff to give the managers insight and feedback about the service from a new staff perspective.
- Staff were supported by their managers to maintain their professional skills, competencies and experience through internal and external training, study days and career progression.
- We saw that all medical staff working or practicing under rules or privileges had completed their professional revalidation. The medical advisory board (MAB) reviewed each application for practicing privileges. The MAB advisory function covered granting, renewal, restriction, suspension and withdrawal of practicing privileges. Consultants completed their annual appraisal at their individual NHS trust and kept up to date with CPD through regular attendance at national and international meetings.
- The RMOs employed by the hospital were senior medical officers in their NHS hospital and had training to meet the requirements of patients. We noted that the oncology RMO was completing training on breaking bad news at PHD level.
- Staff completed a fire evacuation drill in July 2018 (patient evacuation) and February 2018.
- We saw various examples of where clinical and non-clinical staff had been trained internally or externally to improve their competency and career progression. For example, some of the health care assistants had attended phlebotomy training and a massage course on the chemotherapy day unit (CDU). A senior physiotherapist had attended external post graduate diploma training in advanced physiotherapy and had used their knowledge to support patients and share learning and teaching with staff to improve patient outcomes. On the cardiology ward, two nursing staff had been trained on interpreting, analysing and correctly managing ECG results. Following this training the nurses designed the "my personal ECG passport" which was a competent booklet for assessing staff competency. This booklet was introduced on the cardiac ward as a trial with the aim to roll it hospital wide in future. The booklet could be used as part of staff revalidation, appraisals and teaching.
- A neurology staff member was on a two years masters level course on sleep study in a university. The staff member had helped raise sleep awareness and educated staff on sleep hygiene tips, breathing and sleep difficulty.
- There was in house training in the chemotherapy ward for newly qualified or recruited staff with no previous experience in oncology. Staff on the oncology ward attended weekly oncology lecture days and had covered areas such as sepsis, oncology emergencies and fire simulations.

- The oncology team had introduced a 24-hour triage service and eight staff had been trained by their clinical nurse specialist (CNS) to provide this service in oncology and CDU. The CNS had attended the UKONS study day for the 24-hour triage service in oncology and completed the competency.
- The oncology CNS had completed the assessor pack training on the systemic anti-cancer therapy (SACT) competency which was a standard competency introduced in England in January 2018. The SACT had now been implemented in the service since June 2018 and staff were trained on use of this competency and were required to complete the SACT competency before being signed off. Staff were able to use the SACT competency in other hospital.
- There were good training programmes and monitoring of staff competencies on specialist wards such as dialysis unit and endoscopy. On the medical ward we observed staff were required to complete a quality assured self-assessment booklet to assess their competency on patient care and their practice.
- Non-clinical staff told us they had learnt and received in-house lectures on patients' pathway and care. For example, the patient coordinator had received teaching on patients' chemotherapy regimes from nursing and medical staff which not only helped them in allocation of patients to the CDU or oncology ward but how to support and care for them appropriately. The patient co-ordinators had also received hospital IT training and supported and educated staff who had limited knowledge on using some software applications.
- Staff had attended other training such as a dementia awareness workshop, mentorship course, four months oncology training in acute practice, peripherally inserted central catheter (PICC) line and chemotherapy master classes.
- Senior nurses had completed an in-house care of the critically ill course to support other nursing staff. On the cardiology ward a senior staff nurse recently attended a three-day cardio thoracic course on intensive arrhythmia course.
- The palliative team were involved in the annual teaching of staff on the end of life pathways, syringe pumps and the breast MDT teaching sessions with consultants in attendance. The palliative CNS had attended external conferences to learn more about the Gold Standard Framework and visited other hospitals and nursing homes to find out how it had been implemented in other places.
- There were Gold Standard Framework staff champions who contributed to the implementation of the two-year Gold Standard Framework programme that was implemented in the hospital. Staff that had completed this programme wore the star badge and their names on the boards on the ward to help staff and patients identify and meet them for support.
- There were processes in place for managing staff appraisals. The appraisal rate was 97.5%. Senior staff told us two staff were on maternity leave.
- A nurse had completed the mentorship course and supported student nurses on the wards. However, there were no student nurses on the medical wards during our inspection.
- Medical and nursing staff told us they had received revalidation support from colleagues and senior staff. Staff were up to date their professional revalidation. This meant we were assured the service had appropriate measures in place to ensure all staff were up-to-date and fit to practice.

Multidisciplinary working

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

- The medical service multidisciplinary team (MDT) worked together and with external professionals and hospitals to improve patient care and outcomes. Doctors, nurses, pharmacists, coordinators, CNS, health care assistants, the dietitian, and the speech and language therapist (SALT) supported each other and were involved in assessing, planning and delivering patient care and treatment. We saw there was good liaison and collaborative working between the MDT which was evident in the patient notes reviewed. The service also worked closely with social services, police, embassies and local NHS hospitals.
- The hospital had 12 MDT meetings across the services and data provided by the hospital during inspection

showed 17% increase in cases discussed at MDT in 2017. MDT meetings were held monthly or fortnightly and each MDT meeting had a dedicated MDT meeting coordinator who organised the meeting.

- MDT meetings in neurology included nurses, physiotherapists, occupational therapists, SALT, dieticians and consultants. Staff told us the MDT also invited patients and their relative to the MDT when their case was being discussed. There were big monthly MDT meetings and the agenda included cases for referrals and business plans.
- We observed the oncology ward round during inspection and observed that MDT staff such as the consultant oncologist, palliative CNS, physiotherapist, dietitian, pharmacist, specialty doctor and RMO were present. The ward rounds were very detailed and patients were treated as part of the MDT and involved in their care and treatment.
- There were plans for the cancer database to be used live for other MDT meetings such as lung MDT. The hospital also had plan in place to introduce a virtual MDT meeting platform that enabled consultants and allied health professionals to view and contribute to patient care remotely during MDT meeting.
- The hospital had an antimicrobial stewardship team that consisted of a consultant microbiologist, clinical pharmacist, and a consultant nurse for infection prevention and control (IPC) who were responsible for assessing and advising treatment suitability, documenting clinical advice on optimisation and duration of therapy and reviewing patient progress, microbiology and other blood results. Since the introduction of the team in 2014 there had been improvement in patient outcomes and fully compliant cases by 10%.
- The oncology patient coordinator worked with other MDT staff such as consultants, nurse navigator, CNS, international patient centre, nurses and booking team during the admission process and patient stay. The coordinator helped in booking, organising patient medical records and files for the oncology pharmacist and other staff. They also worked closely with embassies and liaised with the IPC team of overseas patients for authorisation for treatment.
- The nurse navigator saw all oncology patients in the clinic with the consultant. The nurse navigator worked closely with patients and other professionals such as nurses and therapists through the patient hospital pathway, ensured patient consent was obtained and informed nurses and doctors what care and treatment needed to be followed up.
- The nursing staff worked with other MDT staff and attended ward rounds and MDT meetings. This ensured nursing staff were aware when there was a change in patient medication, care plan or treatment. Nursing staff documented decisions from the ward rounds and MDT meetings on the journals on the electronic system which could be accessed by other departments such as radiology for continuity of care.
- We saw good example of MDT working. For example, the MDT worked collaboratively together with a patient family to provide care for a patient who had dementia and was at the end of life phase. MDT meetings were carried out with patients' family and staff were also supported and educated to support the patient during this phase.
- MDT staff spoke highly of their colleagues and told us they felt valued and respected. Specific comments from staff on MDT working included that they had a "Good working relationship and we cannot do without each other", "Excellent code blue". Code blue is emergency situation announced in a hospital during a cardiac arrest, requiring a team to rush to the specific location and begin immediate resuscitative efforts.
- Consultants were proud of the close links they had with specialist NHS centres, which enabled them to receive advice and latest guidelines on patient care such as management of sarcoma.
- There was good liaison between the medical specialities and other specialities. For example, a patient with a necrotic foot had received input from a vascular surgeon and plastic surgery. We also saw an example where oncology consultants liaised with surgeons and a cardiologist on the care of a patient. The physiotherapist conducted a lymphedema clinic at the CDU or oncology ward and reviewed patients alongside other professionals.
- The gamma knife service worked with other centres to ensure best practice and improve patient outcome.

- The palliative team had good links with community palliative care nurses. Staff told us the palliative team reviewed all deaths and were very proactive, available and approachable. Staff told us more consultants and nurses on other wards were now aware of the palliative care service and the introduction of the gold standard framework had been a huge asset to improve MDT working and providing education and support to the rest of the hospital. The palliative consultant saw patients referred by other consultants. This was an improvement from the previous inspection.
- Patients who were on the end if life pathway and wished to be cared for at home were discharged to their community palliative team with letters sent to their GP.

Seven-day services

- Patients were admitted to the medical wards under the care of a named consultant who provided consultant level cover. Consultants were supported by RMOs 24 hours a day, seven days a week.
- There was pharmacy cover seven days a week from 9am to 8pm and on-call provision during out of hours.
- The service had introduced a 24-hour triage helpline for the oncology wards and chemotherapy day unit.
- There was 24-hour access to the diagnostic services such as x-ray, ultrasound and pathology. All inpatient imaging requests were actioned within 24 hours.

Health promotion

- Staff supported patients who accessed the medical service to live healthier lives and manage their own health, care and wellbeing. Staff gave health promotion advice with leaflets given in line with national priorities to patients and their relatives on various topics such as exercise, smoking cessation, alcohol reduction and healthy eating.
- We saw specific examples where the dietitian had worked with nurses and patients to improve their care around feeding.Staff worked with a patient with a brain injury to change their eating habit by eating healthier food. Staff developed a plan for the patient and used finger foods and a reward chart to empower patient to pick up their own food as they were unable to use cutlery due to coordination issues.
- The oncology clinical nurse specialist gave health promotion advice on what patients could do to improve their health and well-being such as healthy eating and exercise in chemotherapy to improve their treatment and positive thinking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment. Staff understood their responsibilities regarding consent. We saw that there was an up to date consent policy for staff.
- Staff obtained verbal and written consent from patients prior to the delivery of care and treatment. Patients told us staff gave them enough time to ask questions and they received the verbal information needed to give informed consent. Consent to endoscopy, chemotherapy treatment and invasive cardiac procedures were obtained by staff and documented in the patient notes we reviewed which was in line with best practice and national guidance.
- The service had a flow chart which guided staff on assessing patient capacity to consent and completing Deprivation of Liberty Safeguards (DoLS) assessment when required. Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and DoLS. We saw written evidence of where patients' mental capacity assessments were completed on the wards.
- During our inspection there was no patient subject to the DoLS on the medical wards. However, there had been a patient subject to DoLS in the last six months and we saw that a DoLS application was completed.
- There was a best interest decision document staff were required to fill where best interest meetings and decisions had taken place. We saw evidence that staff had used it during best interest meetings.
- Staff completed a universal form treatment option (UFTO) which showed supported choices that included

patients and their loved ones made during the end of life. We saw these forms were completed and attached to patient note. There was a section relating to mental capacity on the DNACPR form, which was filled out by the doctor completing it. We reviewed a do not attempt cardio pulmonary resuscitation (DNACPR) form during inspection and noted it was completed appropriately by staff.

Are medical care services caring?

Outstanding ☆

Compassionate care

Staff cared for patients with compassion. Feedback from patients was overwhelmingly positive and confirmed that staff treated them well and with kindness.

- We observed staff speaking to patients and families in an appropriate and caring way. Patients told us that all staff introduced themselves by their first name and job title and sought permission to enter their rooms.
- We observed staff in the chemotherapy day unit and across all medical wards greeting patients by their first names. Patients told us that this made them feel valued and that they "weren't just a number."
- Patients' privacy and dignity was respected, especially during physical or intimate care. The ward environment ensured privacy as there were only single occupancy rooms. The August 2018 patient survey showed 96% of patients felt that they were treated with dignity and respect; with 93% agreeing they were given enough privacy when discussing their condition of treatment. The 2018 patient led assessment of the care environment (PLACE) audit showed 100% of patients surveyed felt their privacy was maintained.
- Patient told us that staff always used the curtains on the day units and always asked if they wanted their privacy. We observe that staff ensured women's dignity and cultural dignity were respected and maintained when receiving care on the wards- particularly in the open bay areas.
- On the oncology ward and chemotherapy day unit (CDU) staff used curtains when patients were upset. Staff told us they ensured they created time to speak to patients as sometimes some newly diagnosed patient just wanted a cuddle or to talk and discuss how they felt with staff.
- We spoke to 14 patients and their relatives during the inspection. Patients were positive about their experience within the service. Specific comments received included "everyone goes above and beyond", "staff were always smiling and laughing", "everyone is wonderful from the moment you walk in", "nice, pleasant, kind and considerate manner from all staff", "This place is sensational, I've never had such good treatment anywhere else, "Everyone from the person who sweeps the floor, to the management is terrific', "no complaints, everyone took care of me, they were polite and exceptionally good".
- Patients said that staff encouraged them to use the call bell and they responded promptly. Patients told us that staff worked together to take care of all the patients and not just those they were assigned to. We observed multiple positive experiences with staff interacting with patients and relatives and they were polite and responded compassionately to patients' needs.
- Patients were offered massage on the oncology ward. During inspection we observed a patient receiving massage from a complementary therapist from observation during ward rounds.
- We were told and observed that staff knocked and asked permission before entering a patient's room and would introduce themselves. Patients and their relatives we spoke with told us staff call them by name, knew and remembered them which made them felt valued and respected. For example, a patient told us about an experience where they had phoned about their symptoms and at a later date, when they arrived at the hospital, staff called them by their name and asked about how their medical symptoms were progressing. The patients told us that this kind of care made them feel like they were a person and "not just a number."
- Patients were asked to complete a questionnaire on discharge about their experience, and the results showed high satisfaction in many areas. From December 2017 to May 2018, the Hospital internal friends and family test (FFT) average score was 96% with an average

response rate of 22%; this was an 11% increase in response rate since our last inspection. The June 2018 FFT survey result showed 97.2% of patient said they would recommend service and

- while 98.9% of patient felt the overall quality of care was good, very good or excellent. The FFT rating score for the Gamma knife unit was 98% for the period of 1 April 2017 to 31 March 2018.
- We saw several thank you cards and patient feedback forms thanking the ward staff. One said that the nurses care for a relative was "first class" and that their "care and professionalism made such a difference when one was well." A patient in the chemotherapy day unit sign-posted us to a thank you poster they had completed which expressed their heartfelt gratitude to staff.
- Staff reassured patients who were feeling sick (nausea and vomiting) while on treatment that it was okay to feel that way and they understood it was part of their treatment side effect or sickness symptoms. We observed staff reassuring patients on the ward when they wanted a sick bowl and were unable to walk to the bathroom.

Emotional support

Staff provided excellent emotional support to patients to minimise their distress.

- Staff treated and involved patients and their relatives as partners in assessing and meeting their emotional and social needs, which was understood as being crucial in the patient care. Patients in vulnerable and emotional circumstances had access to specialist services and support which included bereavement, psychology, psychiatry, CNS and chaplaincy.
- All the patients and their relatives and carers we spoke with told us they felt supported throughout their journey from consultation, pre-assessment through treatment and therapies. In oncology, there was a nurse navigator who supported and journeyed with the patient from consultation and diagnosis through treatment and after discharge.
- On the CDU staff and patients told us staff got to know the patients and built rapport which helped to ensure care was person-centred as most patients came to the unit every fortnight for their treatment.
- We saw that staff went out of their way to give compassionate care to patients on the oncology ward and CDU. For example, one of the health care assistants did the eyebrows of a patient that had lost their eyebrow hair due to chemotherapy treatment. Staff gave specific examples where patients had been really touched by this gesture and moved to tears. We noted that the HCA had approached their managers to enrol on a makeup course to help support and teach patients.
- A patient commented that following their first chemotherapy treatment they were nervous and anxious to go home and staff were helpful, compassionate and supported them to stay on the wards till they felt confident to be discharged home.
- In the CDU, there was a display case with wigs and leaflets to discuss possible options if patients lost their hair. We noted that nurses were passionate about finding ways to make cancer patients feel they had dignity and value through all stages of their journey.
- Nursing staff showed an awareness of the impact that a patient's care, treatment or condition could have on their well-being and those close to them. Patients confirmed that all MDT staff had an awareness of their treatment on their well-being and they were very caring and supportive.
- The hospital provided in-house psychological support services, including psychiatrist support and counselling. The oncology and chemotherapy day unit had a qualified Macmillan cancer counsellor. Patients could call staff on the on-call service on the oncology ward seven days a week for support. Leaflets were available in the public areas in the oncology ward to direct patients to this service. The leaflet detailed some feelings patients and families might have, how counselling could help and what the counselling offered.
- Patients consistently said that they had been offered emotional support and that it was available if they needed it. One patient shared with us that they had used the counselling services following a new cancer diagnosis and had found the service to be very helpful, caring and therapeutic.
- Patient commented staff had allowed relatives to bring their dogs for visit during stay which helped their recovery.

- There were prayer rooms and a reflection room available to patients and their families or carers. In the reflection room, there were a wide range of books of religious text and spiritual support. The room was quiet, calming, and had several comfortable chairs. There were books in which patients or their families could draw or write a message in that others would also be able to read and reflect upon. This allowed patients to share their journeys with others going through similar experiences. This was positive as this was implemented despite the challenge of limited space in the hospital.
- Though they did not have an in-house chaplain, staff said they had would be able to contact spiritual support for multi-faith needs if requested by a patient or their relative.
- There were clinical nurse specialists (CNS) across the medical service with specific knowledge in different areas. The service had two palliative and cancer care CNS and they spent time with patients and their loved ones to help them manage their conditions and provide care and treatment including during end of life.
- There was a nurse navigator who supported patients on the oncology ward or chemotherapy day unit during their hospital stay. The nurse navigator worked with the consultant during the new diagnosis of patient from pre-chemotherapy assessment and supported the patient during their treatment pathways. The nurse also followed patient up when they are discharged home in between their chemotherapy treatment.
- Patient information leaflets on bereavement were available which detailed support for end of life and bereavement, funeral directors including those who supported Muslim patients who needed a more immediate funeral process following death. The leaflet detailed information of the palliative care nurse and counsellor, and external national and local contacts for
- bereavement support such as such as the Jewish Bereavement, London Friend (LGBT bereavement), The Terrence Higgins Trust (AIDS) and Cancer Black Care (BME).
- We saw example of where the service had signposted patients and their loved ones to charities and voluntary organisation for support. The oncology service signposted patients to other agencies and charities such as Macmillan, Age Concern, RSPSYCH, CLLSA (Chronic Lymphocytic Leukaemia Support Association). We saw leaflets of the CLLSA which detailed facts on engagement and support patients and relatives could benefit from. The service also had link to a local charity for patients in need of financial support and benefits for UK residents.

Understanding and involvement of patients and those close to them

Staff took extra care to involve patients and those close to them in decisions about their care and treatment.

- Patients and their relatives were treated as active partners in the planning and delivering of their care and treatment. We saw that staff were committed to working with patients and their relatives, gave them appropriate information and encouraged them to make joint decisions about their care.
- Patients told us that staff were very thorough and answered all patients' questions patiently and in a considerate manner even when they were busy. We spoke to a patient who was just been discharged during inspection. The patient told us that the discharge process was thoroughly explained by staff and that they were given precautions following their inpatient medical procedure. Another patient told us that the doctor explained their endoscopy procedure and discharge plan in detail right from admission.
- Specific comments received from patients included, "Staff involve me in decisions and I am able to ask questions", "Staff discuss my blood result with me", "Staff always obtain my consent, explain care and change of plans and the rationale behind it", "I felt well informed before giving consent."
- We observed patient consultations during clinic and handover and noted the consultant had clear communication with patients, showed them their scans or test results and explained their findings and treatment plans in detail in a way they understood. Staff took their time to explain information to patients and involved them in their treatment plans. Evidence of patients and their relative's involvement in their care were seen in patients note and do not attempt cardio pulmonary resuscitation (DNACPR) forms were reviewed.

- We saw various examples of where staff had involved patients and their relatives in their care through best interest decision meetings and family meetings. We saw specific examples where the dietitian had worked with nurses and patients to improve their care around feeding. Staff worked with a patient with a brain injury to change their eating habit by eating healthier food. Staff developed a plan for the patient and used finger foods to empower patient to pick up their own food as they were unable to use cutlery due to coordination issues. Staff used a reward chart to encourage patients during the intervention. Staff worked with the patients' relatives and were able to identify that one patient loved drinking water in a wine glass and implemented this for them. Staff were able to encourage the patient to drink more water and wean them off intravenous fluid.
- The chemotherapy CNS educated patients on their treatment through consultation on medicines, scheduling of medicines and side effects such as fatigue, and fertility issues. The chemotherapy CNS also carried out holistic care consultations with patients' relatives to support and educate them on their relatives care and treatment and how to support them. This is an improvement from the last inspection.
- On the oncology ward patients were given a neutropenic sepsis instructional video developed by one of the consultants to support the verbal information and teaching given to them during consultation about their care and treatment. Patients we spoke to told us this video have helped their understanding about their care and treatment. We observed that staff gave patients detailed discharge letters about their care and explained its content in a caring and supportive way with the patients. The discharge letter and information given to patient also included specific instruction to take should specific events happen including attending A&E.
- Patients and relatives told us they had a named consultant and knew who they were and when they were off or annual leave they knew who the cover consultant was.
- In cases where patients were responsible for full or partial cost of care or treatment, staff provided appropriate and sensitive discussions about the cost of patients care. Staff also gave examples of where the service had worked with patients receiving specialist care such as dialysis and chemotherapy to reduce their concerns and worries about finances (hospital bills) by providing care and treatment tailored to their budget (including discounted price on exceptional circumstances) without compromising safe and effective care.

Are medical care services responsive?

Outstanding ☆

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of people using the service.

- The medical service planned and delivered care in a way that met the diverse needs of the population of patients who accessed the service. Patients' needs and preferences were considered and acted on to ensure services were delivered to meet those needs.
- Due to the large demographic of international patients, the hospital had a dedicated international patient centre (IPC) that coordinated patient admissions and supported the patient and their family throughout their stay. Data received from the hospital showed 50% of patients who accessed the service were from overseas. The relations department helped patients to select the most appropriate medical treatments, arrange appointments and urgent admissions, organising payments and offered reassurance to those who travelled from abroad as well as liaised with stakeholders. We noted that the International patient co-ordinators and interpreters could speak and write fluently in French, Arabic and Greek.
- The service also worked with their stakeholders such as the embassies, government and insurance companies in the planning and development of the service. The hospital also held regular local community engagement events to provide an opportunity for the local population to discuss the provider's services and strategies.
- We saw that the service made provisions to meet patient needs through access to digital radio, national and foreign magazines and newspapers, Freeview and satellite television channels.

Medical care

- At the last inspection, we had concerns around the lack of space and waiting rooms in some areas of the service. During this inspection we saw that the dialysis room now had a waiting room, the cardiology room now had a reflection room and improvements had been made in the waiting and recovery area in the endoscopy suite.
- The hospital website contained vital information such as: visiting the hospital, how to get there, visiting times, brochures of services, accessing records, meals, infection control, counselling and therapist services. There was detailed information for support for overseas patients from the airport, the luxury suites and how to access the VIP suites through a separate entrance. The website advised that patients could leave their details for the contact centre to call or email them back.
- Some basic information on the hospital website could be translated to four different language apart from English which include Arabic, French, Greek and Russian.
- Patients and their relatives told us that there was good access to food and drink provisions in the hospital. Since our last inspection, there was a café installed in the reception area that was accessible to patients, relatives and staff. During out of hours when the café was closed, patients and relatives had access to free water and hot drinks on the wards through the self-service coffee machines and water dispensers.

Meeting people's individual needs

The service made extensive provision to take account of patients' individual needs.

- The needs and preferences of patients were taken into account when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Care and treatment was coordinated with other services and stakeholders, to ensure the needs of patients and their families were met.
- The medical ward environment was spacious and patients felt it had a relaxed and homely feel.There was wheelchair access to the wards and the patient rooms were ensuite with accessible toilets and showers which were suitable for people with reduced mobility.
- The hospital had set up a quiet room in radiotherapy for consultations with newly diagnosed cancer patients which included information leaflets from Macmillan cancer support. This was an improvement from the last inspection.
- The patient led assessments of the care environment (PLACE) 2018 audit result for the medical ward was 56% on disability provision against a hospital average of 53%. The medical wards also scored 49% for dementia provision against the hospital average of 47%. As a result, dementia and disability were included in the quality improvement plan as areas for improvement and the hospital created a working group to oversee this change.
- We saw that the serviced also engaged with patient following the audit on how to improve the service provision for people with disability. The hospital recently developed a 'Map for All' with support from the Royal National Institute of Blind People (RNIB) for patients with visual impairment to improve their hospital experience. The Map for All is a map that can be read by sight or touch and combines visual and tactile elements.
- The service rolled at new dementia awareness training in June 2018 as part of their dementia 2018-19 strategy. The data provided by the hospital showed an average 50% compliance for the medical service as at September 2018. The service had appointed a neurology CNS to support patients with dementia across the medical service. Majority of patients with dementia were treated on the neurology ward. The service introduced a passport for patients with learning disability or lacked capacity called, "this is me" to improve their hospital experience. Patients relative or carer with learning disability could stay overnight or during patient admission for free to provide on-going support and minimise distress.
- Staff we spoke with had a good understanding of meeting the needs of patients living with dementia and the hospital had a dementia strategy in place to improve quality of care of patients living with dementia and for their relatives and carers. Staff told us that there were regular dementia awareness workshops and they were able to tell us what they would do specifically for patients with dementia.

Medical care

- The hospital was meeting their strategy for patients living with dementia by creating dementia friendly rooms. There were two dedicated rooms for patients with dementia. The mirrors in these rooms now had blinds to cover the mirrors, as evidence had shown mirrors could be disturbing to people with dementia. The rooms were marked by flower posters so that patients could recognise their rooms. They also had items, such as a tooth brush holder, to make it look more like a private home, a calming, simple environment and used contrasting colours appropriately to aide navigation in the room.
- Interpreter services were available for patients for whom English was not their first language if required. These were provided face-to-face or via a dedicated telephone interpreter service and staff were able to access interpreters at all times. A significant number of patients admitted spoke Arabic. Signs on patients' doors, such as NIL by mouth, thank you for visiting the ward sign or contact precautions were written in English and in Arabic.
- There were automated coffee machines and water dispensers on each ward with adequate cups that was available complimentary at any time to patients and their families.
- Patient had a choice of meals, which took account of their individual preferences, respecting cultural, medical, nutritional and personal choice such as halal, diabetic and kosher meals. outside of set meal times. Patients could order from the menu list and were they wanted something different staff placed order to the catering staff. We saw specific example where patients did not want hot food but requested for specific fruits and the staff ordered a mixed berries fruit platter for the patient. Most patients we spoke with were generally very happy with the timeliness, quality and selection of food. Some patients said that it was as nice as restaurant quality and better than any food they had received in hospital before.
- The service had a nutrition group that met monthly to review the needs of patient with dysphasia (language disorder due to brain disease or damage) to ensure the service nutrition provision met the global international dysphasia diet standardisation initiative (IDDSI).The nutrition group had introduced nutrition champions on the wards and creating dysphasia awareness posters.
- Patients told us that staff responded to their call bell promptly and they were given adequate pain medication in a timely manner.
- There was an outdoor rooftop garden terrace on the medical wards for patients and their relatives to use. We observed staff taking a patient to the terrace to escape the potential boredom and isolation of staying in a hospital room.
- Patients had good access to palliative care. Following issues found on our last inspection, the service now had two full-time palliative care clinical nurse specialists (CNS) who were knowledgeable in their field.
- On the oncology ward, there were three partitioned rooms for family members to stay in an adjacent room for patients who chose to die in hospital.
- The service had three end of life rooms on the oncology floor which were double rooms with a partitioning door which allowed families to be together at the end of life in a more peaceful intimate environment.
- The wards had relevant medical information leaflets available. These included leaflets from Macmillan cancer support, the Stroke Association and the British Heart Foundation. Though most were in English, staff said that they could have the leaflets translated to another language if needed.
- On the oncology ward and chemotherapy day unit (CDU) there were leaflets available for patients that included information and contact details of organisations and charities that could support them on their treatment journey. For example, patients were given leaflets on their sexual health and wellbeing and lubricants to help address the vaginal dryness which was a side effect from their treatment. Staff also referred and provided information on two services that offered support on managing and coping with hair loss, skin and make up solutions, eyebrows and lashes, wigs and hair pieces, bra service, head shaving and conditioning, head wear and wellbeing therapies. During inspection we saw wig examples displayed on the wards for patients.

- There was a scalp cooling facility for both male and female patients on the CDU and oncology ward. The cooling machine helped cool the scalp of patients undergoing chemotherapy so they don't lose their hair and were used before and during treatment.
- Staff used curtains on the dialysis unit to ensure that Muslim women's hair and bodies were not seen by other patients while receiving treatment in the open bay.
- Follow up appointments were given to patients in timely manner during clinic consultation and we saw that staff accommodated patient preferences and commitments.
- Patients relative could stay overnight or during patient's admission if requests were made prior to admission. The hospital also had arrangement in place at nearby hotel and accommodation for patients that would be admitted for long on the wards.

Access and flow

People could access the service when they needed it.
Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- We saw that patients could be seen and admitted in less than four hours for treatment particularly around diagnostic, dialysis and oncology treatment.
- Patients could also access the chemotherapy day unit and dialysis unit for treatment on the day and time to meet their needs and fit around their lives.
- Following referrals to the therapists such as dietitian, patients were seen the same day or within 24 hours.
- Patients repeatedly told us that they had good access to the hospital and did not experience prolonged delays to be seen.
- Patients could book an imaging appointment in a day and time that suited their work and social commitment. Staff told us that there were no 'wait times' for treatment for patients such as MRI or ultrasound or admission to the hospital. Staff told us patient admissions were dependent on patients' preference and confirmation from embassies and insurance company for treatment and billing.
- From June 2017 to May 2018, there were 8,600 adult inpatient and day case episodes of care recorded. Of these, 1% were NHS funded and 99% were privately funded or funded by other means. Eleven percent of the NHS patient stayed overnight on the inpatient wards during this period.
- For the period of 1 April 2017 to 31 March 2018, the service delivered 134 treatment sessions to 129 patients in the Gamma Knife services.
- For the period of July 2017 to July 2018, the service delivered 3,034 dialysis treatment sessions to 154 patients in the dialysis unit and wards.
- There were daily bed management meetings, which were attended by senior staff, to plan patient admissions, transfers and discharges. The service had nurse navigators who helped to facilitate patient flow throughout the oncology department.
- The service had a hospital admission policy in place that outlined the admission criteria and out of hours admission. For example, the service did not admit patients with suspected heart attack or cerebral haemorrhage (acute stroke).
- There was a cardiac pathway and one stop shop service for cardiac patients where they were seen and given their results the same day. We saw that patients had access to their result following their endoscopy procedure.
- Staff told us that they started working on discharge planning at time of admission. The therapies team liaised with embassies and a consultant to discharge patients into rehabilitation therapy. Patients undergoing cardiac rehabilitation would be flagged up to their GP within the NHS and other patients would receive a therapies discharge summary that they could bring to their GP to explore continuing care in the NHS.
- Staff told us the discharge process was effective and they had few cases of delayed discharge. During inspection there were two patients with delayed discharge on the neurology and general medical wards due to complex needs. For the period of June 2017 to May 2018 the average length of stay was two nights.
- The service used technology to support timely access to treatment. This included the introduction of the sleep video telemetry for complex patients such as those with brain injury. The remote video telemetry monitoring

could be used on the ward or in the patient's home. The service also had a counselling helpline service and a 24-hour oncology triage line to offer support to patients in a timely manner.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- There were processes in place to ensure complaints were dealt with effectively. Information was displayed and provided to patients on how to report concerns and make a complaint. Patients and relatives could make a complaint verbally or written, by face to face contact, telephone calls or through the hospital website.
- We saw there were leaflets and posters on the wards with information on how to make complaints; these were available in English and Arabic. The leaflets detailed the complaint process and how to contact other agencies such as ombudsman, CQC, Independent Healthcare Advisory Service (IHAS) and Independent Sector Complaints Adjudication Service (ISCAS) if patients were not pleased with the hospital response.
- Patients we spoke with knew that they could make a complaint if they wanted and said they were comfortable bringing up issues to staff. Patients and relative told us staff had asked for their feedback and acted quickly on negative feedback or complaints.
- Staff understood how to handle complaints, including out of hours. Through the international patient centre, interpreter service and patient relations manager, staff were able to support non-English patients to make complaints.
- From June 2017 to May 2018, the medical service received 19 complaints, of which 15 were treated as formal complaint and the rest resolved at the resolutions meeting. No complaints were referred to the parliamentary and Health Service Ombudsman. The complaints were closed within the hospital target. This was an improvement (33% reduction) from the last inspection. Staff told us that managers followed up with individual complaints through a "closed-loop calling" system, which had helped analysed trends, improve patient satisfaction and reduce complaints. Managers called patients to follow up on good or bad feedback. The hospital aimed to respond to formal complaints within 20 working days. For the period of July 2018, the medical care wards and oncology wards closed complaints on average in 6.1 and 5.2 days, respectively. We noted that the complaints investigation process was robust and the feedback letter to patients detailed the investigation, lesson learnt and improvement made to the service.
- The hospital published a monthly 'You Said, We Did' bulletin which outlined steps they had taken to address concerns from patients and staff. We saw that staff uniforms were changed as a result of complaints received by the service around confusion on staff roles.

Are medical care services well-led?

Outstanding ☆

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- There was a clear management structure within the hospital and service with defined lines of responsibility and accountability, and clear lines of communication with the executives. The leaders were passionate about the service provided and knowledgeable about their risks, quality issues and priorities, understood what the challenges were and took action to address them.
- The leaders at every level prioritised safe, high quality, compassionate care and promoted equality and diversity. The leadership model of the service encourages cooperative and supportive relationship among staff and patients so that they felt respected, valued and supported.
- The medical service was under the interventional medicine division with the exception of endoscopy which was under the surgical division. The medical services were led by the operation director, divisional manager and lead nurse. Consultants, resident medical officers, senior nurses, and clinical nurse specialists supported the senior management team.
- At the last inspection we found some areas for improvement regarding local leadership on the ward

and the support they received from the organisation as a whole. At this inspection we saw there had been an improvement in the organisational and local leadership, and the support received.

- There had been a change in the leadership structure in January 2018 to ensure wards were within the right division in order to receive appropriate support. The nursing structure was also changed and senior managers told us this had helped increase the focus on delivering high quality effective, compassionate care through clinical governance. Senior managers we spoke with told us this change was a collaborative decision and they were involved in this change through the keeping 'in touch' session and open forums. The service now had dedicated non-clinical directors such as IT directors and marketing directors with the aim to reduce the responsibilities from the clinical directors in order to have oversight and support on clinical staff and patient outcome.
- The hospital created leadership tools with the aim of encouraging the executive team and local senior management to take overall responsibility for leading the hospital and feel involved in services. Some of the tools implemented to support staff on a local level included the head of department briefing, and implementing the 'look first' (contained relevant updates and learning) folder. There were also tools which focused on improving patient safety including the self-assessment tool, 15 steps challenge, monthly review of the integrated quality report (IQR) and local quality improvement plans (QIPs).
- The service had invested in the development of the organisational and service leaders to ensure they had the right skills and knowledge to lead the service. Staff told us there were various leadership courses they could attend which was helpful and different from their previous employers. Training for leaders included the clinical and lead excellence development programme, courageous conversation programme, BUPA leadership course, how to lead individual's course, coaching courses and other practical in-house training.
- Senior nurses on the ward felt their leadership skills had improved and their leadership role had changed in the last year to ensure they now participated in audits and manage complaints. They were positive about this change and told us it gave them a sense of local ownership of their ward area.
- Staff including the charge nurses and ward managers told us the executives were visible, accessible and supportive, and encouraged their career progression. The service introduced the 'well-led' walkabout in April 2018 and 'bosses the basics' campaign. Staff told us this had helped improved the visibility and accessibility of their leaders. The 'boss the basics' campaign had covered topics such as putting customers first and ensuring teams were compliant. Data provided by the hospital from a recent staff survey showed that 84% of staff reported good visibility of executives including the director of nursing is visible on their wards or department.
- Senior staff such as lead nurses and ward managers told us they had access to board and executives and had their direct lines. Senior staff gave examples of where the board had supported their ideas, innovation and suggestions for change in practice.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

- The hospital vision was to be the outstanding hospital of choice for quality and experience in London for their patients, people and partners, and be known for their excellence in oncology and complex medicine.
- We noted that some of the specialist areas in the medical care service such as the dialysis unit had their own vision and strategy which was reflective of the overall hospital vision and strategy.
- The dialysis unit vision was to be the largest UK haemodialysis unit within an acute private hospital, caring for international visitors and the local community, delivered by highly experience and qualified professionals achieving excellent patient outcomes and experience through bespoke VIP services, following global dialysis standards of practice and using of state of the art technology.

- The hospital values were being open, passionate, caring, authentic, accountable, courageous and extraordinary. Staff we spoke to were aware of the staff values. The hospital introduced the care programme (teaching and learning programme) in 2017 and created dedicated time for staff to reflect and shape their values. As at 18 September 2017, 73% of staff had attended this programme.
- The hospital's top priorities were to provide outstanding quality of care for their patients and continuous quality improvement.
- Bupa's corporate purpose was helping people live longer, healthier, happier lives. This purpose was to be delivered through three strategic pillars: loved as a true customer champion, people love working at Bupa, and love our customers through strong and sustainable performance.
- The hospital strategies were fostering patient engagement, development of staff and operational excellence and efficiency. The hospital aimed at improving patients and customer engagement through various means such as outstanding care, quality improvement, and innovation in areas like oncology. The strategy for staff and performance focused on governance and risk management through robust processes, clear accountabilities, improving and investing in the environment and digital development to improve staff and patients experience.
- The dialysis unit strategy was embedded by core pillars and enablers which included

Culture

- Staff we spoke with had a strong commitment to their job and were proud of the team working, continuity of care, positive impact to patient care and experience, and improvements they had made to the service since the last inspection.
- Some staff had been working at the hospital for several years, for example a consultant had been working in the service for over 30 years. Also we spoke to health care assistants who had been working on the oncology services for 16 years.
- All staff we spoke with described good teamwork and respect within the medical service and across disciplines and gave examples of good team working on the wards between staff of different disciplines and grades. Staff felt respected and they could approach any member of staff and challenge practice or behaviour if necessary.
- Staff told us they felt supported and valued by colleagues and senior managers. They said the senior management facilitated an environment of learning and progression, where staff could be innovative and make or drive improvements of the service such as putting in a business case for new equipment. Examples of specific comments received from staff included, "Hospital is able to recognise people talents and what you know", "Happy with job, feel supported", "Lots of support which is incredible and team respond so well to change". Staff on the oncology ward spoke highly of their team, senior managers and particularly their clinical nurse specialist who they said listened and advocated on their behalf.
- Staff told us the service was cohesive which helped promote a good work environment that was supportive. Staff from different disciplines told us they had good relationships with each other and good team working. We saw some staff who had left the hospital previously had come back to work in the service due to support and culture.
- Staff felt it was easy to progress and be promoted. We saw examples of medical, nursing and non-clinical staff who had progressed into leadership roles. For example, we saw a staff member who was employed as a catering staff and had been trained and promoted over the years and was now a patient co-ordinator.
- The hospital celebrated staff and team success through the 'fun at Bupa' (FAB) team, star awards and displaying of innovation, best practice and team success on the staff restaurant wall. During inspection, some staff we spoke with had received or been nominated for the star awards more than once. Staff told us this made them feel valued and recognised for their efforts and contribution to the service.
- The culture encouraged openness, honesty, learning and improvement. Senior managers told us the service focused on culture and building on people's pride in the hospital through opportunities for learning and

celebrating success. The service also implemented a new equality and diversity group to promote an open and fair culture and improve staff experience as part of their hospital strategy.

- Staff told us there was a no blame culture when incidents happened and the team supported each other through debriefs and reflective practice forums. These forums are evidence-based structured forums where all staff come together regularly to discuss the emotional and social challenges of caring for patients. Staff were able to raise concerns when needed. The duty of candour was implemented in the service and we saw that cases that met the duty of candour were reviewed and monitored at the governance.
- The hospital had a freedom to speak up policy and champion. Senior managers told us the service was committed to continuously improving patient safety and staff experience by ensuring that all staff could speak openly about things that went wrong or the things that worried them. Staff told us a result of the speak up process the service had identified some concerns raised by staff on discrimination and some cultural issues they experienced from some patients. This issue related to mostly nurses from a particular ethnicity where nursing were poorly viewed and treated badly in their country. Staff told us that as a result when they had patients from that ethnicity the patients tended to treat the nurses poorly. This concern had been raised to senior staff and the safeguarding team. Senior staff told us they had stepped in during an incident and ensured patients were aware the service had a zero tolerance of abuse, bullying and harassment.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- At the last inspection governance and risk management were not fully embedded in the service. During this inspection we found that the service had a clear systematic governance process to continually improve the quality of service provided to patients. The arrangements for governance and processes were clear and operated effectively. Staff understood their roles and accountabilities.
- We observed that the hospital has invested in the governance team and changed its structure since the last inspection. There were more robust governance processes in place, and clearer oversight of risks and performance in each division using the integrated quality report.
- The governance lead had been in post for a year and the hospital had employed more staff within the governance team to create a new governance department in September 2017. There were seven staff in the governance team with roles including: complaints lead, clinical audit lead, risk manager, information governance manager and clinical governance administrator.
- The service gained assurance through various governance meetings such as the executive board risk and compliance meeting, clinical governance committee (CGC) meetings, and incident, complaints and risk committee (ICRC). Other governance meetings included: monthly departmental meetings, head of department meetings, quality key performance indicator (KPIs) meetings and daily incident review meetings. The subcommittees and quality improvement (QI) groups reported to the monthly CGC. The sub committees included infection control, safeguarding, medical devices, drugs and therapeutics, resuscitation, medication safety, end of life care, mortality and morbidity and blood transfusion committee.
- The hospital had various QI working groups which included VTE, pain, acute kidney injury (AKI), national early warning score (NEWS), pre-assessment, intravenous (IV) quality standard and sepsis.
- Daily incident review meetings were held to review all incidents, near misses and complaints, which ensured that all incidents and complaints were logged and reviewed within 24 hours, helping the service respond and manage any concerns in a timely manner.
- We reviewed minutes of leadership team meetings for the last six months and noted meetings were well attended by appropriate staff. Leaders discussed issues and performance around projects updates, QI plans, staffing, mandatory training, IT, engagement, strategy, hospital priorities, performance around finance and patient survey satisfaction.

- The medical advisory board (MAB) oversaw the renewing of consultants' practicing privileges, clinical governance issues, key policies and guidance and monitored patient outcomes. The MAB reviewed each application relating to practicing privileges of consultants and advised the hospital. Their advisory function covered the granting, renewal, restriction, suspension and withdrawal of practicing privileges. The practice privilege process in the hospital included consultant interview, references, DBS clearance, scope of practice and approval of the MAB chair before privileges were granted. The MAB recently reviewed consultants' scope of practice to ensure they were practicing within their normal practice.
- During inspection staff told us there was now better governance processes for reviewing consultants practice privilege and their scope of practice. The multidisciplinary team meeting was also used to monitor and ensure doctors practiced within their scope of practice.
- We reviewed the MAB meetings for the last six months. We noted that the new medical director introduced themself to colleagues following their appointment and outlined their priorities. Other topics that had been discussed in the meeting included mortality and morbidity meeting, governance, practice privilege update, and plan for a consultant summer drinks reception.
- The CGC met monthly and fed into the risk and compliance meeting, and the performance and priorities meeting. The executives, chief pharmacist, department managers, CNS, consultant nurse IPC and lead nurses were part of this committee. We reviewed some CGC minutes for the period of March to June 2018. We saw that the committee discussed performance on integrated quality report (IQR), audits, patient survey, research and innovation, governance newsletters, external conferences, guidelines, review of critical incidents, complaints, safeguarding training compliance, subcommittee or working group update. We noted that an average of five incidents was reviewed at this meeting.
- At the ICRC meetings, each division presented their data and performance from their integrated quality report (IQR) which detailed the quality performance and determine risk rating. Any risks rated 12 and above were reviewed at the ICRC and the risk and compliance meeting. In the ICRC meeting, complaints and compliments were reviewed more closely. Complaints were also discussed in the Executive Board Risk and Compliance meeting held every month.
- The monthly IQR detailed lessons learnt from complaints and incidents, with clear outcomes and changes. The IQR enabled the leaders to monitor results and trends monthly, escalate key changes or trends, which enabled mitigation and controls to be implemented.
- The Quality KPIs meetings reviewed the safety process and outcome metrics on safety, experience and effectiveness of care were reviewed and actioned. Where risks were identified as part of the governance processes, these were fully risk assessed and added to the local service or hospital risk register.
- The performance and priorities meeting looked at finance, incident governance, patient experience survey and general hospital updates.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The service had clear risk processes and systems in place for managing performance and identifying and mitigating risks. The hospital had introduced an online risk register which enabled staff to report, discuss and review the risks in their service and at a hospital level. Staff told us the new process of managing risk on the risk register was effective as the system prompt them when risks were due for review the risks.
- Incidents were reviewed at various governance meeting and minutes of governance meetings and feedback Friday minutes we reviewed showed that serious incidents, complaints and quality audit updates were discussed and shared with staff. Actions taken to reduce recurrence and improve service provision were detailed and we noted that any potential serious incidents were escalated appropriately.
- The service had arrangements in place for identifying, recording and managing risks. The divisional and hospital risk register included a description of each risk,

with mitigating actions and assurances in place. An assessment of the likelihood of the risk recurring, possible impact and those responsible for review and monitoring were highlighted on the risk register.

- We reviewed the hospital wide risk register which contained risks that had been rated above 12 in each service. The risk register contained risks that related to the medical service which included direct exposure to cytotoxic or cytostatic drugs, safeguarding training, paediatric endoscopy, IT, records and information governance. We observed that the risks were reviewed regularly with update of each review documented on the risk register. Staff were aware of the risks on the register.
- During inspection we saw that 61 risks were reported in the medical care departmental risk registers for five of the medical care wards; these included dialysis (20), cardiac ward (13), oncology ward (11), chemotherapy day centre (10) and neurology ward (7). We also reviewed the Gamma Knife risk register and saw the risk were regularly reviewed and up to date.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The service had plans in place to obtain additional IT and digital resources to ensure effective management of information.
  The service had various digital health facilities used to access patients records and provide on-going health assessment. This include their online portal and an electronic healthcare management portal for accessing documents GPs chose to share with their patients such as radiology reports and blood results.
- The hospital was the first private hospital in the UK to gain certification of quality management systems at the ISO 9001:2015 level, and successfully achieved reaccreditation in September 2018. This accreditation meant that the service had effective quality information management and an ongoing commitment in place to deliver high quality care.
- During inspection we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR).

Engagement

The service engaged well with patients, staff, stakeholders and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- The service obtained and acted on people's views and experiences to shape and improve the services and patient experience. We saw evidence during inspection that patient feedback was sought to inform changes and improvements to service provision.
- The service engaged well with staff through various initiatives such as feedback Friday, reflective practice forums, FAB and fun at work. Staff told us they had a beach trip, Easter activities and Pancake Day.
- The service gave feedback to staff through the "you report it, we fixed it", "keeping in touch sessions", brief update for consultants, newsletter and staff meetings. We reviewed staff meeting minutes for the last six months and saw leaders gave and received feedback on clinical and non-clinical issues such as the staff survey to help improve the service.
- Staff gave several examples of where the service had engaged with them to get their feedback and make changes or improvements to the service. The service introduced virtual dementia training for all staff to take both at induction and in teaching updates as a result of staff feedback on their knowledge on dementia. Staff wanted better awareness of patients nearing end of life, as a result managers introduced the use of candles on wards to represent a patient receiving end of life care to increase awareness and sensitivity. The service also introduced new uniforms across the hospital based on staff and patients feedback received on confusion around staff roles. The service commenced the fortnightly divisional manager walk arounds based on staff feedback around visibility of their leaders.
- The hospital engaged with and received feedback from the local community. The hospital recently launched the 'Cromwell conversation', which is a public event to showcase the hospital services and reach out to the community to help understand their needs to shape the service future provision. We saw that the hospital had worked with patients and their family in their hospital

redevelopment programme and the designing of the reflection room located on the medical ward. The hospital had worked with a charity in painting the hospital.

- The oncology service engaged with various charities and organisation such as Macmillan. The service organised annual Macmillan coffee morning to engage with patients and the public. This was also used as an opportunity for health promotion and networking. The service also organised a breast cancer awareness day in 2017 for staff, patients and the community.
- The hospital engaged and worked with the (RNIB) to develop a map for people with visual impairment.
- The hospital engaged with patients through various ways such as patient surveys, patient forums, compliments and complaints feedback. Senior staff told us they also followed up on negative feedback received following patient surveys to understand why some patients would not recommend the service to help improve the service. As a result, the service had identified patients concerns around signage, which resulted in new signage in the hospital to help visitors navigate around the hospital. This had improved the patient feedback survey scores.
- We reviewed the hospital patient forum minutes for the last four months. We noted that patients had the opportunity to give their positive and negative feedback about their experience to senior staff. There were few negative feedback areas for the medical service and mostly related to the hot room temperature and the need for air conditioning and call bells. During inspection, we saw that a portable air conditioner had been placed on the wards and telephones were in place in the rooms where call bells were faulty. There was a lot of positive feedback about the medical service which included compassionate care received from MDT staff, and improvements in food and patient safety.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

- There was a strong culture of, and focus on, continuous learning, innovation and improvement in the service to improve patient outcomes. Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, peer reviews, promoting training and innovation.
- The hospital developed the '15 step challenge' which is a quality tool with a series of questions and prompts that guided staff to work together to identify improvement to help enhance patient experience. This covered areas such as the feel of the environment and ward atmosphere, safety, caring and involving patients and loved ones in their care.
- The service had implemented a digital map system for people with visual impairment to navigate their way round the hospital and installed 23 new hearing loops around the hospital to improve patient experience.
- The hospital was one of the only private hospitals delivering the home video telemetry which monitored the brain activity.
- Staff gave several examples of where they have been encouraged and supported to make positive changes and implement initiatives to improve the service such as the amendment to World Health Organisation checklist used during endoscopy procedure.
- The hospital launched the innovation hub where staff could present their ideas and innovations in their service or other areas in the hospital. For example, a team introduced the monthly Schwartz rounds which are confidential meetings that allowed staff to share their views and experiences.
- Data provided by the hospital during inspection showed the introduction of Schwartz rounds had reduced staff psychological poor health from 25% to 12% for staff that had attended.
- Staff felt that things had improved significantly since previous inspection in end of life care provision as there were more options available to patients since the introduction of the gold standard framework.
- The hospital was awarded an international safety award in 2018 by the British Safety Council for their commitment to good health, safety and well-being management of staff.

Outstanding ☆

Medical care

- We saw that the MAB had plans to introduce tele-medicine style clinics for overseas patients' consultations so that patients would not need to travel to UK to have their first assessment with the consultant.

Good

Surgery

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

Are surgery services safe?

Requires improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff informed us that their mandatory training was useful. Mandatory training was a mixture of online and classroom sessions. Throughout the year the service offered additional training in sepsis and competency based sessions. Staff informed us that due to the amount of work it was difficult to attend these sessions and often they did not get the protected time required to attend.
- The hospital mandatory training programme included clinical induction, fire safety training, Immediate life support (ILS), infection management, managing conflict, safeguarding and other topics which related to working safely at work. In theatres we saw that safeguarding children level 3 had been added to the mandatory training list.
- Staff could track their own mandatory training compliance through an electronic mandatory training system. We asked four members of staff to log onto their own training records, which demonstrated 100% compliance in all training. Staff told us that the system was a useful tool in tracking compliance and that it would flag any training which was soon due to expire. The system also allowed for staff members to book onto training which was required for their role.
- Mandatory training information we received from the hospital, documented varied mandatory training compliance rates for staff within surgery services. For ward staff there were 19 different mandatory training topics and for theatre staff there were 20. The hospital set a target for 95% of staff to have completed all topics relevant to their job role. For ward staff we saw that 11 out of the 19 mandatory training topics had a compliance rate of 95% or above and in theatres we saw nine out of the 20 topics had a compliance rate of more than 95%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- Since our last inspection the service had appointed a new safeguarding adult's named nurse. There were clear processes and procedures in place for safeguarding adults and children. There were policies in place available to staff accessible through the hospitals intranet system.
- All staff we spoke with on the wards were aware of who the safeguarding lead was and spoke highly of the additional training sessions that they received.
- Safeguarding knowledge amongst staff we spoke with outside of the ward area varied and not all nurses had a clear understanding of what was meant by the term safeguarding or what their role was. Staff on the ward were aware of who to escalate safeguarding concerns to and could provide examples of needing to escalate specific concerns.

- Safeguarding policies were available in both paper form and online on the hospital intranet. All staff had access to the online policy folder.
- The hospital had adopted the NHS England 'Safeguarding Adults' reference guide and we saw posters in theatres and on the ward which reminded staff what safeguarding looked like.
- All staff that we spoke to on the ward had an awareness of female genital mutilation (FGM). Staff informed us that their safeguarding lead provided ad-hoc sessions on FGM and staff were aware of who to escalate FGM concerns to.
- Safeguarding training rates demonstrated good compliance rates across the surgical services. 96% of ward staff had completed training and in theatres 100% of staff had completed adult safeguarding and 90% of staff had completed safeguarding children level three.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

- We asked the hospital to provide surgical site infection (SSI) data. The hospital information documented there were seven surgical site infections from August 2017 to July 2018.
- We saw incident reports for two SSI's which were reported in February and July 2018 respectively. Both reports included detailed investigations and details of the root cause analysis. We did not see learning documented for either of the SSI incidents, one of which details opportunities for learning where a swab could have been taken and was not.
- At our previous inspection we noted that the theatre scrub area was open to the main corridor. Since then, the theatre team has added a glass panel to shield the scrub area from the main corridor.
- The hospital had an infection prevention control (IPC) policy and an infection control link nurse. The IPC link nurse conducted the hand hygiene audits, provided training and ensured that every nurse had a monthly hand hygiene observation carried out. The link nurse fed into the infection prevention and control team (IPCT) and met regularly with the microbiologist, who was frequently on the wards. Staff could direct all IPC concerns to the link nurse. The IPC link nurse reported IPC issues to the IPC nurse consultant. The IPC nurse consultant was made fully aware of IPC issues such as patients who were MRSA positive.
- The ward consisted of 19 beds. There were no hand washing facilities for staff in the patient rooms. There were however sinks located outside the patient room. There was one sink per three patient rooms for staff to utilise once they left the patient room. There were hand gels easily accessible just outside each patient room and immediately inside each patient room. Staff informed us that they would use the hand gel once they entered each patient room and then wash their hands once complete.
- Personal Protective Equipment (PPE) was available throughout the ward and we observed staff utilising these at adequate times. Staff, including surgeons, anaesthetists, pharmacists and therapies staff were always bare below the elbows (BBE). We observed posters on the ward stating the importance of being BBE always throughout clinical areas.
- On the ward, sluice rooms were clean and well organised. We observed green 'I am clean' stickers being used by cleaning staff and we saw these stickers were up to date.
- At the time of our inspection there was a patient on the ward who presented with MRSA. We observed staff responding to this by following the hospital policy. We saw the theatre list adjusted and the patient managed with appropriate infection prevention control procedures followed.
- We saw the hand hygiene audits in the recovery area of theatres were fully completed. Audit results for the months of June, July and August were 100%. In main theatres staff were unable to locate the hand hygiene audits which had been completed and submitted and therefore we were not able to validate the results we saw on display.
- We saw the hand hygiene audit completed on the surgical ward in August 2018 was 50% complete. The hospital wide audit review was set up to look at the hand hygiene practices of 20 members of staff whereas the August 2018 audit had looked at ten.

- Hand hygiene compliance rates provided by the hospital for the ward area demonstrated varied compliance. In May 2018 we saw a compliance rate of 85%, 95% in June 2018 and 100% for July 2018.
- Patient led assessments of the environment were carried out although there was no specific date on this data collection. Data provided for the 2018 year demonstrated that 100% of patients who completed the audit were satisfied with the cleanliness of the general surgical and orthopaedic ward.
- Cleaning audits were in place within the recovery department which detailed daily cleaning duties and standards. In May and June 2018 there were no omissions to this audit and the compliance rate was 100%.
- In theatres the decontamination of equipment was outsourced to an external company. There were two members of support staff who managed the equipment pathway. Equipment was tracked on an online system and could be fast tracked when needed.
- In Surgery there were no incidents of hospital acquired Meticillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection. There were also zero cases of Meticillin sensitive staphylococcus aureus (MSSA) Bacteraemia and Clostridium Difficile (C.Diff) between January and August 2018.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- Patients were protected from the risks associated with an unsafe environment because all clinical areas were clean and free from clutter. At our previous inspection the surgical directorate was split across two wards. There was one orthopaedic ward and one surgical ward. The service has since been reorganised. The surgical directorate consisted of one ward made up of 19 beds and four suites. The patient base could consist of both orthopaedic and general surgery patients. Orthopaedic patients were prioritised to be accommodated in patient rooms with showers and not baths.
- The surgical ward area was clean and clutter free. We viewed three patient rooms which were spacious and were clean except for the oxygen and suction equipment at the head end of the patient's bed. We noticed that the packaging of one piece of equipment was covered in a layer of dust.
- The arrangements for the management of waste products and clinical specimens were appropriate for keeping patients and staff safe from harm. Sharps bins were used correctly and sluice areas included bins that were adequately labelled and classified to ensure segregation of waste.
- The clinical areas were free from clutter and well maintained. Due to the merger of the general and orthopaedic ward there was less space in staff areas e.g. staff office. There were various staff groups working together in small non-clinical spaces.
- Difficult airways trollies in theatres were not checked regularly. In main theatres we saw that the adult's difficult airway trolley checks were performed sporadically and one of the ventilators had not been serviced since 2016. Attached to the trolley was the paediatric difficult airway algorithm. The jet ventilator had no servicing information. We made theatre staff aware of these issues and they rectified the it.
- Resuscitation equipment was stored on secure trolleys and was checked daily by recovery staff in theatres and ward nurses on the ward environment. We saw that checks were performed with no omissions throughout August and September 2018 up to the date of our inspection.
- We saw audit information displayed which demonstrated a 97% completion of anaesthetic machine checks in August 2018, however this did not correlate with what we had seen in the log books for checking the machines. In theatres we saw a surgical log book used for checking the anaesthetic machine. We saw this was not completed and there were several omissions. Over a two-week period, we noted 19 omissions where the checklist had not been signed to confirm that the machine had been checked and saw 47 omissions where the lot number of the breathing system was not added. There was an omission from the previous day where we had seen that a theatre list was running. On the ward and in theatres we saw equipment checklists for the months of August and September 2018 which were fully completed with no omissions. We were

told that the checking of the resus trolley on the ward was confirmed at the end of each shift by the shift leader, however, the confirmation checklist had not been completed for either August or September.

- Monthly environmental audits were completed in all areas of the surgery services. The audit included checks of the storage areas and cupboards, cleanliness of commodes, a review of waste management and whether gloves and aprons were available. Results demonstrated good compliance and included an action log where the audit had noted areas for improvement.
- Arrangements for the management of waste products and dirty linen were appropriate for keeping patients and staff safe from harm and preventing infection. Sharps bins were used correctly and the sluice areas were kept clean and tidy. We saw 'I am clean' stickers used throughout the service to indicate when equipment had been cleaned.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- The service had a pre-operative assessment room that was maintained by a nurse from the ward. Here, the nurse would use the pre-operative tests recommended by National Institute for Health and Care Excellence (NICE) guidelines. The nurse would also screen high-risk patients for MRSA. In order to avoid do not attends (DNAs) for surgery, the nurse would also carry out phone-based pre-operative assessments instead of assessments in person if necessary.
- All surgical patients were seen in the pre- assessment clinic prior to their operation. Pre- assessment patients were met at the reception area of the hospital before being taken to the pre- assessment nurse. During the pre-assessment appointment all pre- operation tests were performed. We saw a patient attending pre-assessment for vein treatment who had an ECG, blood tests, MRSA swab, height, weight and clinical observations performed.
- A hospital-wide admission and exclusion process was in place. The admission process included an admission checklist that verified patient details, checked patient labels and ensured that the patient's registration information was correct. The admission policy also contained clear exclusion criteria. Patients past 16 weeks of pregnancy, along with those requiring emergency care (for example, those with a heart attack) were excluded. Patients with known mental health conditions required a risk assessment by the site lead and consultant prior to admission.
- We discussed admission and exclusion of patients with three anaesthetists who told us they received information about the patient prior to the day of their lists and could perform additional screening if needed. For example, due to there not being a paediatric intensive care unit on site one anaesthetist ensured he phoned every patient prior to their list to further access the patient's suitability.
- We spoke with the lead nurse about admission and exclusion criteria and how she ensured the nurses had the skills and competencies required to care for patients admitted. We were told that all surgeons worked within an agreed scope of practice. We were told about a new surgeon due to start operating at the hospital. Meetings had been set up prior to their start to access and discuss the needs of the new patient base. This was also scrutinised during the bed management meetings where both ward nursing and theatre staff would flag any concerns with the practice required to care for patients that day.
- At our previous inspection the service used two separate forms to measure venous-thromboembolism (VTE) risk. Since our last inspection, the service had adapted their assessment of VTE's and formed a new document that was produced in line with NICE guidelines. The new VTE assessment was now performed at three key times: on admission, 24 hours after admission and one week after (if applicable). We saw the assessment completed in all 13 sets of notes we reviewed, however we saw the old VTE assessment still in the surgical pathway document which was sometimes also completed and the new VTE assessment was loose and therefore at risk of falling out or being miss placed. In the patient notes we looked at and in the patients, notes we reviewed in the pre-assessment clinic there were still two VTE forms which were used.
- Over the course of our inspection we looked at 13 medical records. All the patient records we looked at showed evidence of being reviewed by a consultant

within 12 hours of admission. All the patients we spoke with informed us that they spoke with informed us that they spoke with their surgeon both pre- and post-operatively.

- The Early Warning Score (EWS) is a scoring system that identifies patients at risk of deteriorating and who require urgent review based on their clinical observations. We saw nurses in recovery and on the wards recording EWS on the patient observation charts.
- Compliance against National Institute for Health and Care Excellence (NICE) guidance for the recording of EWS were completed monthly. Audit information provided demonstrated a compliance rate of 85% in May and June 97% in July and 100% in August 2018. EWS compliance was monitored in detail through the monthly Quality Report along with other high-risk audits.
- Patients at risk of falls were provided with anti-slip socks and staff were made aware of these patients via the daily handover.
- There were several sepsis leads available throughout the service. On the ward there was one sepsis lead who provided ongoing training on sepsis. All ward staff we spoke with were aware of sepsis 6 and who to escalate a suspected sepsis case to. We observed sepsis guides on the ward. Sepsis escalation and recognition had been a priority at the hospital and nurses told us about training they had received. Nurses we spoke with could explain clearly how they would respond and what would trigger patient escalation. Nurses were clear about the screening and action tool used to detect sepsis and when to initiate the sepsis 6 pathway.
- There was a clear sepsis policy and pathway, based on NICE quality standards. We saw detailed information relating to recognition, diagnosis and early management of sepsis. There was an adapted sepsis screening tool available both in hard copy on the wards and on the hospital intranet. This would be used if the EWS was four or more, or if infection was suspected.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of The World Health Organisation (WHO) five steps to safer surgery checklist, which was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. The WHO checklist was audited monthly. The audit documented only three out of the five steps to safer surgery. Audit data from April 18 to June 18 demonstrated a 96% - 100% compliance rate with these steps. The hospital did not complete observational audits of the WHO safety checklist in use.
- Work to improve the use of the WHO surgical safety checklist was ongoing. The theatre department had introduced a formal team brief step of the process and we saw this in use. Staff members told us this was a new step and that the use and effectiveness was still being monitored. We saw the process completed for both adult and paediatric theatre patients, which included team introductions, discussions on expected surgery outcomes, equipment needed, patient co morbidity, infection status and allergies. We saw the team brief step taking place in the middle of the morning when the surgeon and anaesthetist had changed over.
- Staff told us that the de-brief segment of the checklist still required attention. We were told that once the team brief section was fully imbedded work would be done to facilitate this. We did not observe the de-brief segment of the audit performed.
- We saw the time out process completed and this was led by the anaesthetist. The time out process in all three cases we observed was concise and staff appeared confident and engaged in this stage of the process.

Nursing and support staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- At the time of our inspection, we found no significant concerns regarding staffing in the surgical departments. All areas we visited followed national guidelines in terms of nursing numbers. Throughout out visit we saw the Association for Perioperative Pathway (AfPP) guidelines for staffing followed in theatres and on the ward, there was one nurse to every 3-4 patients with one nurse in charge. The trust took appropriate action to cover any shortfalls using agency and bank staff.
- Nursing rotas we reviewed demonstrated staffing levels were consistent and we did not find any concerns with staffing numbers on the wards for either night or day shifts.

- We saw a systemic approach to nurse staffing at ward level to ensure that patients receive the nursing care needed. We saw examples on the rota where nurse staffing numbers had been adjusted to accommodate for the numbers of patients admitted or increased due to patient complexity.
- We saw examples on the rota where staff had been deployed to other areas of the hospital due to over staffing. We were told that this was to increase the skill set of the nursing team and was used as a learning opportunity.
- In theatres, AfPP guidelines were followed. In the recovery area of the theatre there were six whole time equivalent (WTE) members of staff and two long term agency members of staff. During inspection we noted that there was no recovery nurse on the on-call rota. Staff we spoke to told us there was not enough staff to cover the rota. The impact of this meant, often recovery staff were staying late after their shift to ensure cover was available.
- Staff vacancy rates on the ward were managed by the lead nurse. Data provided demonstrated there were 3.8 WTE staff vacancy for orthopaedic nurses and 1.39 WTE vacancy for general surgery nurses. Vacancy rates were not causing a problem at the time of our inspection as two ward areas had combined and therefore, there were less patient beds available.
- Sickness rates within the surgical services were generally above the national average of 4%. We measure sickness rates as they often have a direct link to staff satisfaction. The sickness rate for ward nurses in the three months prior to our inspection was between 4% and 13%. In theatres the sickness rates in the same reporting period were between 1% and 5%. Staff sickness was monitored and the higher rates accounted for. We were advised that there were staff members on long term sick leave for many reasons and saw details of this documented.
- Staff turnover rates were also documented as higher than the national average. The overall staff turnover for the surgical services was at the time of our inspection 15%. This was monitored by senior staff, who were aware that some staff wanted to specialise solely in orthopaedics and the opportunity to do so had arisen at a nearby hospital.

Surgical staffing

The service had enough surgical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Surgeons worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The hospital had procedures in place to monitor the scope of practice of the medical workforce. For example, on application to the hospital a full scope of practice document was required with supporting references. Two doctors we spoke with confirmed this process and confirmed that this was reviewed annually.The Medical Advisory Board (MAB) had oversight of the hiring of surgeons. Members of the MAB were aware of the processes required to provide practising privileges to a surgeon.
- At the time of our inspection there were 205 surgeons with practising privileges.
- Resident Medical Officers (RMOs) in the surgical directorate could work over 24 hours with prior permission from the medical director. At the time of our inspection there were six general RMOs who worked at the service under a contract from a local trust. The RMOs worked from 6pm to 6am. RMOs that we spoke with informed us that they had protected time in order to rest during their shift.
- At the time of our last inspection there was no on-call anaesthetist rota. This has since changed and we found that anaesthetists waited with patients post-operatively to ensure they were not in too much pain and out of hours, there was an on-call rota that staff could access.

Records

Staff kept detailed records of patients' care and treatment

- Paper records were used throughout the surgical directorate. Medical records were stored in lockable cupboards in the staff office. Clinical observations including early warning scores were stored in patient rooms.

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- Staff could explain with clarity incidents that resulted in directorate wide learning. Staff provided an example of a patient who was found to have a sore on his sacrum post procedure that wasn't present prior to procedure. Staff performed a root cause analysis (RCA) and since that incident staff on both the wards and in theatres check pressure areas both pre- and post-procedure.
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- Incident meetings occurred daily Monday to Friday where all incidents which occurred over the previous 24 hours were discussed and shared hospital wide. Each service was represented at the meeting and a range of staff attended. In surgery a nurse from both the ward area and the theatre department attended.
- We saw evidence of a serious incident report which included a detailed Root Cause Analysis (RCA). We saw detailed information and evidence, including chronology of events, contributory factors, lessons learned and arrangements for hospital wide shared learning. We saw details of training that had occurred due to the incident which included re-training in the management of the deteriorating patient and use of the National Early Warning Scores.
- Morbidity & Mortality (M&Ms) were carried out when necessary and therefore, were not frequent. We saw details of and M&M which had occurred during an unexpected death.

Safety Thermometer (or equivalent)

The service used safety monitoring results well.

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes

of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 years old and venous thromboembolism (VTE) incidence.

- The hospital did not use the NHS safety Thermometer as it was a private healthcare provider.
- Staff were aware of their responsibility to reduce and report incidents such as falls, pressure ulcers and UTIs relating to the use of catheters.

Are surgery services effective?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff informed us that their mandatory training was useful. Mandatory training was a mixture of online and classroom sessions. Throughout the year the service offered additional training in sepsis and competency based sessions. Staff informed us that due to the amount of work it was difficult to attend these sessions and often they did not get the protected time required to attend.
- The hospital mandatory training programme included clinical induction, fire safety training, Immediate life support (ILS), infection management, managing conflict, safeguarding and other topics which related to working safely at work. In theatres we saw that safeguarding children level 3 had been added to the mandatory training list.
- Staff could track their own mandatory training compliance through an electronic mandatory training system. We asked four members of staff to log onto their own training records, which demonstrated 100% compliance in all training. Staff told us that the system was a useful tool in tracking compliance and that it would flag any training which was soon due to expire. The system also allowed for staff members to book onto training which was required for their role.
- Mandatory training information we received from the hospital, documented varied mandatory training compliance rates for staff within surgery services. For ward staff there were 19 different mandatory training topics and for theatre staff there were 20. The hospital set a target for 95% of staff to have completed all topics relevant to their job role. For ward staff we saw that 11 out of the 19 mandatory training topics had a compliance rate of 95% or above and in theatres we saw nine out of the 20 topics had a compliance rate of more than 95%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- Since our last inspection the service had appointed a new safeguarding adult's named nurse. There were clear processes and procedures in place for safeguarding adults and children. There were policies in place available to staff accessible through the hospitals intranet system.
- All staff we spoke with on the wards were aware of who the safeguarding lead was and spoke highly of the additional training sessions that they received.
- Safeguarding knowledge amongst staff we spoke with outside of the ward area varied and not all nurses had a clear understanding of what was meant by the term safeguarding or what their role was. Staff on the ward were aware of who to escalate safeguarding concerns to and could provide examples of needing to escalate specific concerns.
- Safeguarding policies were available in both paper form and online on the hospital intranet. All staff had access to the online policy folder.
- The hospital had adopted the NHS England 'Safeguarding Adults' reference guide and we saw posters in theatres and on the ward which reminded staff what safeguarding looked like.
- All staff that we spoke to on the ward had an awareness of female genital mutilation (FGM). Staff informed us that their safeguarding lead provided ad-hoc sessions on FGM and staff were aware of who to escalate FGM concerns to.

- Safeguarding training rates demonstrated good compliance rates across the surgical services. 96% of ward staff had completed training and in theatres 100% of staff had completed adult safeguarding and 90% of staff had completed safeguarding children level three.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

- We asked the hospital to provide surgical site infection (SSI) data. The hospital information documented there were seven surgical site infections from August 2017 to July 2018.
- We saw incident reports for two SSI's which were reported in February and July 2018 respectively. Both reports included detailed investigations and details of the root cause analysis. We did not see learning documented for either of the SSI incidents, one of which details opportunities for learning where a swab could have been taken and was not.
- At our previous inspection we noted that the theatre scrub area was open to the main corridor. Since then, the theatre team has added a glass panel to shield the scrub area from the main corridor.
- The hospital had an infection prevention control (IPC) policy and an infection control link nurse. The IPC link nurse conducted the hand hygiene audits, provided training and ensured that every nurse had a monthly hand hygiene observation carried out. The link nurse fed into the infection prevention and control team (IPCT) and met regularly with the microbiologist, who was frequently on the wards. Staff could direct all IPC concerns to the link nurse. The IPC link nurse reported IPC issues to the IPC nurse consultant. The IPC nurse consultant was made fully aware of IPC issues such as patients who were MRSA positive.
- The ward consisted of 19 beds. There were no hand washing facilities for staff in the patient rooms. There were however sinks located outside the patient room. There was one sink per three patient rooms for staff to utilise once they left the patient room. There were hand gels easily accessible just outside each patient room and immediately inside each patient room. Staff informed us that they would use the hand gel once they entered each patient room and then wash their hands once complete.
- Personal Protective Equipment (PPE) was available throughout the ward and we observed staff utilising these at adequate times. Staff, including surgeons, anaesthetists, pharmacists and therapies staff were always bare below the elbows (BBE). We observed posters on the ward stating the importance of being BBE always throughout clinical areas.
- On the ward, sluice rooms were clean and well organised. We observed green 'I am clean' stickers being used by cleaning staff and we saw these stickers were up to date.
- At the time of our inspection there was a patient on the ward who presented with MRSA. We observed staff responding to this by following the hospital policy. We saw the theatre list adjusted and the patient managed with appropriate infection prevention control procedures followed.
- We saw the hand hygiene audits in the recovery area of theatres were fully completed. Audit results for the months of June, July and August were 100%. In main theatres staff were unable to locate the hand hygiene audits which had been completed and submitted and therefore we were not able to validate the results we saw on display.
- We saw the hand hygiene audit completed on the surgical ward in August 2018 was 50% complete. The hospital wide audit review was set up to look at the hand hygiene practices of 20 members of staff whereas the August 2018 audit had looked at ten.
- Hand hygiene compliance rates provided by the hospital for the ward area demonstrated varied compliance. In May 2018 we saw a compliance rate of 85%, 95% in June 2018 and 100% for July 2018.
- Patient led assessments of the environment were carried out although there was no specific date on this data collection. Data provided for the 2018 year demonstrated that 100% of patients who completed the audit were satisfied with the cleanliness of the general surgical and orthopaedic ward.
- Cleaning audits were in place within the recovery department which detailed daily cleaning duties and standards. In May and June 2018 there were no omissions to this audit and the compliance rate was 100%.

- In theatres the decontamination of equipment was outsourced to an external company. There were two members of support staff who managed the equipment pathway. Equipment was tracked on an online system and could be fast tracked when needed.
- In Surgery there were no incidents of hospital acquired Meticillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection. There were also zero cases of Meticillin sensitive staphylococcus aureus (MSSA) Bacteraemia and Clostridium Difficile (C.Diff) between January and August 2018.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- Patients were protected from the risks associated with an unsafe environment because all clinical areas were clean and free from clutter. At our previous inspection the surgical directorate was split across two wards. There was one orthopaedic ward and one surgical ward. The service has since been reorganised. The surgical directorate consisted of one ward made up of 19 beds and four suites. The patient base could consist of both orthopaedic and general surgery patients. Orthopaedic patients were prioritised to be accommodated in patient rooms with showers and not baths.
- The surgical ward area was clean and clutter free. We viewed three patient rooms which were spacious and were clean except for the oxygen and suction equipment at the head end of the patient's bed. We noticed that the packaging of one piece of equipment was covered in a layer of dust.
- The arrangements for the management of waste products and clinical specimens were appropriate for keeping patients and staff safe from harm. Sharps bins were used correctly and sluice areas included bins that were adequately labelled and classified to ensure segregation of waste.
- The clinical areas were free from clutter and well maintained. Due to the merger of the general and orthopaedic ward there was less space in staff areas e.g. staff office. There were various staff groups working together in small non-clinical spaces.
- Difficult airways trollies in theatres were not checked regularly. In main theatres we saw that the adult's difficult airway trolley checks were performed sporadically and one of the ventilators had not been serviced since 2016. Attached to the trolley was the paediatric difficult airway algorithm. The jet ventilator had no servicing information. We made theatre staff aware of these issues and they rectified the it.
- Resuscitation equipment was stored on secure trolleys and was checked daily by recovery staff in theatres and ward nurses on the ward environment. We saw that checks were performed with no omissions throughout August and September 2018 up to the date of our inspection.
- We saw audit information displayed which demonstrated a 97% completion of anaesthetic machine checks in August 2018, however this did not correlate with what we had seen in the log books for checking the machines. In theatres we saw a surgical log book used for checking the anaesthetic machine. We saw this was not completed and there were several omissions. Over a two-week period, we noted 19 omissions where the checklist had not been signed to confirm that the machine had been checked and saw 47 omissions where the lot number of the breathing system was not added. There was an omission from the previous day where we had seen that a theatre list was running. On the ward and in theatres we saw equipment checklists for the months of August and September 2018 which were fully completed with no omissions. We were told that the checking of the resus trolley on the ward was confirmed at the end of each shift by the shift leader, however, the confirmation checklist had not been completed for either August or September.
- Monthly environmental audits were completed in all areas of the surgery services. The audit included checks of the storage areas and cupboards, cleanliness of commodes, a review of waste management and whether gloves and aprons were available. Results demonstrated good compliance and included an action log where the audit had noted areas for improvement.
- Arrangements for the management of waste products and dirty linen were appropriate for keeping patients and staff safe from harm and preventing infection.

Sharps bins were used correctly and the sluice areas were kept clean and tidy. We saw 'I am clean' stickers used throughout the service to indicate when equipment had been cleaned.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- The service had a pre-operative assessment room that was maintained by a nurse from the ward. Here, the nurse would use the pre-operative tests recommended by National Institute for Health and Care Excellence (NICE) guidelines. The nurse would also screen high-risk patients for MRSA. In order to avoid do not attends (DNAs) for surgery, the nurse would also carry out phone-based pre-operative assessments instead of assessments in person if necessary.
- All surgical patients were seen in the pre- assessment clinic prior to their operation. Pre- assessment patients were met at the reception area of the hospital before being taken to the pre- assessment nurse. During the pre-assessment appointment all pre- operation tests were performed. We saw a patient attending pre-assessment for vein treatment who had an ECG, blood tests, MRSA swab, height, weight and clinical observations performed.
- A hospital-wide admission and exclusion process was in place. The admission process included an admission checklist that verified patient details, checked patient labels and ensured that the patient's registration information was correct. The admission policy also contained clear exclusion criteria. Patients past 16 weeks of pregnancy, along with those requiring emergency care (for example, those with a heart attack) were excluded. Patients with known mental health conditions required a risk assessment by the site lead and consultant prior to admission.
- We discussed admission and exclusion of patients with three anaesthetists who told us they received information about the patient prior to the day of their lists and could perform additional screening if needed. For example, due to there not being a paediatric intensive care unit on site one anaesthetist ensured he phoned every patient prior to their list to further access the patient's suitability.
- We spoke with the lead nurse about admission and exclusion criteria and how she ensured the nurses had the skills and competencies required to care for patients admitted. We were told that all surgeons worked within an agreed scope of practice. We were told about a new surgeon due to start operating at the hospital. Meetings had been set up prior to their start to access and discuss the needs of the new patient base. This was also scrutinised during the bed management meetings where both ward nursing and theatre staff would flag any concerns with the practice required to care for patients that day.
- At our previous inspection the service used two separate forms to measure venous-thromboembolism (VTE) risk. Since our last inspection, the service had adapted their assessment of VTE's and formed a new document that was produced in line with NICE guidelines. The new VTE assessment was now performed at three key times: on admission, 24 hours after admission and one week after (if applicable). We saw the assessment completed in all 13 sets of notes we reviewed, however we saw the old VTE assessment still in the surgical pathway document which was sometimes also completed and the new VTE assessment was loose and therefore at risk of falling out or being miss placed. In the patient notes we looked at and in the patients, notes we reviewed in the pre-assessment clinic there were still two VTE forms which were used.
- Over the course of our inspection we looked at 13 medical records. All the patient records we looked at showed evidence of being reviewed by a consultant within 12 hours of admission. All the patients we spoke with informed us that they spoke with informed us that they spoke with their surgeon both pre- and post-operatively.
- The Early Warning Score (EWS) is a scoring system that identifies patients at risk of deteriorating and who require urgent review based on their clinical observations. We saw nurses in recovery and on the wards recording EWS on the patient observation charts.
- Compliance against National Institute for Health and Care Excellence (NICE) guidance for the recording of EWS were completed monthly. Audit information provided demonstrated a compliance rate of 85% in

May and June 97% in July and 100% in August 2018. EWS compliance was monitored in detail through the monthly Quality Report along with other high-risk audits.

- Patients at risk of falls were provided with anti-slip socks and staff were made aware of these patients via the daily handover.
- There were several sepsis leads available throughout the service. On the ward there was one sepsis lead who provided ongoing training on sepsis. All ward staff we spoke with were aware of sepsis 6 and who to escalate a suspected sepsis case to. We observed sepsis guides on the ward. Sepsis escalation and recognition had been a priority at the hospital and nurses told us about training they had received. Nurses we spoke with could explain clearly how they would respond and what would trigger patient escalation. Nurses were clear about the screening and action tool used to detect sepsis and when to initiate the sepsis 6 pathway.
- There was a clear sepsis policy and pathway, based on NICE quality standards. We saw detailed information relating to recognition, diagnosis and early management of sepsis. There was an adapted sepsis screening tool available both in hard copy on the wards and on the hospital intranet. This would be used if the EWS was four or more, or if infection was suspected.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of The World Health Organisation (WHO) five steps to safer surgery checklist, which was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. The WHO checklist was audited monthly. The audit documented only three out of the five steps to safer surgery. Audit data from April 18 to June 18 demonstrated a 96% - 100% compliance rate with these steps. The hospital did not complete observational audits of the WHO safety checklist in use.
- Work to improve the use of the WHO surgical safety checklist was ongoing. The theatre department had introduced a formal team brief step of the process and we saw this in use. Staff members told us this was a new step and that the use and effectiveness was still being monitored. We saw the process completed for both adult and paediatric theatre patients, which included team introductions, discussions on expected surgery outcomes, equipment needed, patient co morbidity, infection status and allergies. We saw the team brief step taking place in the middle of the morning when the surgeon and anaesthetist had changed over.
- Staff told us that the de-brief segment of the checklist still required attention. We were told that once the team brief section was fully imbedded work would be done to facilitate this. We did not observe the de-brief segment of the audit performed.
- We saw the time out process completed and this was led by the anaesthetist. The time out process in all three cases we observed was concise and staff appeared confident and engaged in this stage of the process.

Nursing and support staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- At the time of our inspection, we found no significant concerns regarding staffing in the surgical departments. All areas we visited followed national guidelines in terms of nursing numbers. Throughout out visit we saw the Association for Perioperative Pathway (AfPP) guidelines for staffing followed in theatres and on the ward, there was one nurse to every 3-4 patients with one nurse in charge. The trust took appropriate action to cover any shortfalls using agency and bank staff.
- Nursing rotas we reviewed demonstrated staffing levels were consistent and we did not find any concerns with staffing numbers on the wards for either night or day shifts.
- We saw a systemic approach to nurse staffing at ward level to ensure that patients receive the nursing care needed. We saw examples on the rota where nurse staffing numbers had been adjusted to accommodate for the numbers of patients admitted or increased due to patient complexity.
- We saw examples on the rota where staff had been deployed to other areas of the hospital due to over staffing. We were told that this was to increase the skill set of the nursing team and was used as a learning opportunity.

- In theatres, AfPP guidelines were followed. In the recovery area of the theatre there were six whole time equivalent (WTE) members of staff and two long term agency members of staff. During inspection we noted that there was no recovery nurse on the on-call rota. Staff we spoke to told us there was not enough staff to cover the rota. The impact of this meant, often recovery staff were staying late after their shift to ensure cover was available.
- Staff vacancy rates on the ward were managed by the lead nurse. Data provided demonstrated there were 3.8 WTE staff vacancy for orthopaedic nurses and 1.39 WTE vacancy for general surgery nurses. Vacancy rates were not causing a problem at the time of our inspection as two ward areas had combined and therefore, there were less patient beds available.
- Sickness rates within the surgical services were generally above the national average of 4%. We measure sickness rates as they often have a direct link to staff satisfaction. The sickness rate for ward nurses in the three months prior to our inspection was between 4% and 13%. In theatres the sickness rates in the same reporting period were between 1% and 5%. Staff sickness was monitored and the higher rates accounted for. We were advised that there were staff members on long term sick leave for many reasons and saw details of this documented.
- Staff turnover rates were also documented as higher than the national average. The overall staff turnover for the surgical services was at the time of our inspection 15%. This was monitored by senior staff, who were aware that some staff wanted to specialise solely in orthopaedics and the opportunity to do so had arisen at a nearby hospital.

Surgical staffing

The service had enough surgical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Surgeons worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The hospital had procedures in place to monitor the scope of practice of the medical workforce. For example, on application to the hospital a full scope of practice document was required with supporting references. Two doctors we spoke with confirmed this process and confirmed that this was reviewed annually.The Medical Advisory Board (MAB) had oversight of the hiring of surgeons. Members of the MAB were aware of the processes required to provide practising privileges to a surgeon.
- At the time of our inspection there were 205 surgeons with practising privileges.
- Resident Medical Officers (RMOs) in the surgical directorate could work over 24 hours with prior permission from the medical director. At the time of our inspection there were six general RMOs who worked at the service under a contract from a local trust. The RMOs worked from 6pm to 6am. RMOs that we spoke with informed us that they had protected time in order to rest during their shift.
- At the time of our last inspection there was no on-call anaesthetist rota. This has since changed and we found that anaesthetists waited with patients post-operatively to ensure they were not in too much pain and out of hours, there was an on-call rota that staff could access.

Records

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- The hospital incident policy included clear timeframes for incidents to be reported and reviewed. We saw that low/moderate incidents should be investigated and an outcome reported within ten working days. Hospital quality performance data showed that incident closure fell below the hospitals expected targets. Closure rates of incidents within ten days for May, June and July were 53%, 42% and 38%.
- Incident meetings occurred daily Monday to Friday where all incidents which occurred over the previous 24 hours were discussed and shared hospital wide. Each service was represented at the meeting and a range of staff attended. In surgery a nurse from both the ward area and the theatre department attended.
- We saw evidence of a serious incident report which included a detailed Root Cause Analysis (RCA). We saw detailed information and evidence, including chronology of events, contributory factors, lessons learned and arrangements for hospital wide shared learning. We saw details of training that had occurred due to the incident which included re-training in the management of the deteriorating patient and use of the National Early Warning Scores.
- Morbidity & Mortality (M&Ms) were carried out when necessary and therefore, were not frequent. We saw details of and M&M which had occurred during an unexpected death.

Safety Thermometer (or equivalent)

The service used safety monitoring results well

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 years old and venous thromboembolism (VTE) incidence.
- The hospital did not use the NHS safety Thermometer as it was a private healthcare provider.
- Staff were aware of their responsibility to reduce and report incidents such as falls, pressure ulcers and UTIs relating to the use of catheters.

Are surgery services caring?

Good

Compassionate care

Good

Surgery

Staff cared for patients with compassion

- Over the course of the inspection we spoke with eight patients on the ward. All patients spoke highly of the care and compassion of staff. All patients stated that the nursing care was compassionate.
- We saw that patients were treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. We saw examples of staff reassuring patients, respecting their wishes regarding their care choices and taking time to explain procedures.
- We followed many patients through theatres and heard and saw staff interact with patients in a calm, clear and polite manner.
- We saw patients were introduced to all healthcare professionals involved in their care, and were made aware of the roles and responsibilities of the members of the healthcare team. In theatres we saw staff introducing themselves to the patient on arrival in the department and saw staff explaining their roles and what this meant.
- Patient dignity was considered throughout each stage of the patient's journey. Patients were provided with dressing gowns to cover over their theatre gowns and in theatres we continually saw patient's dignity being protected using curtains.
- All patients spoke positively about the care and support they had received. For example, one patient we spoke us told us how professional all the staff were and told us the nurses had been particularly helpful.
- Patients on the ward spoke very highly of the care they received and particularly of the nursing care. One patient informed us that they "want for nothing, the staff do everything they can for me".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Patients could have support from family members and friends at any time as there were no restrictions to visiting times.
- Throughout out inspection we saw doctors, nurses and support staff giving reassurance to patients and providing additional support when needed.
- We were given examples of patients being contacted after discharge to ensure support arrangements were adequate. Patients could access care when needed and re admission rates were demonstrated to be higher than expected as patients would re attend for reassurance when needed.
- Due to the elective nature of the procedures performed and the patient base, counselling was not routinely used. Staff could access psychological support for patients if they had any concerns.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- We saw patients in the pre- assessment clinic and during anaesthetic consultation had opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. We saw an anaesthetist adjust the patients care to accommodate their wishes.
- Patients on the ward stated that staff kept them informed at all stages of their admission, treatment and discharge. One patient on the ward informed us that "my surgeon has explained everything very thoroughly".
- We saw in the pre- admission clinic patients were encouraged to be involved in their care decisions.
- Patients were supported by the healthcare team to understand relevant treatment options, including benefits, risks and potential consequences. We saw examples where staff had discussed alternative options to surgery.
- We observed staff discussing care pathways with patients and their relatives to ensure family were aware what to expect. Nurses were available to update relatives and in the paediatric theatre, staff ensured the parents of patients were called at the earliest possible opportunity after surgery.
- Of all the patients we spoke with, only one was self-pay. This patient informed us that they were made aware of the pricing structure at every stage of care. All other patients were covered by insurance and were provided with information on pricing on request.

Good

Surgery

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The service had been adapted to meet the needs of its population. As the hospital offered private care most of surgeries were elective. This meant that admissions to the surgical inpatient wards were planned with the patient in mind.
- Since our last inspection, the hospital had refurbished the entrance and reception to the main hospital. This provided more access to patients with disabilities.
- Throughout our inspection we found that facilities and the premises were appropriate for the services that were being delivered.

Meeting people's individual needs

The service took account of patients' individual needs.

- We saw the patient's cultural social and religious beliefs were identified during the pre-assessment stage of the patient's journey. During a pre-assessment clinic we saw the nurse asking patients questions about their religious and cultural background and the nurse told us they would try and accommodate patient's wishes whenever possible.
- Translation services were available throughout the hospital however we were told by nursing staff that they would use relatives to translate for patients if they accompanied the patient to appointments. This is not in line with safeguarding guidelines and can also pose a risk if the family member does not correctly understand the medical terminology themselves and misinterprets the information.
- In theatres staff could give examples of situations where a patient's cultural wishes were identified and care was adjusted accordingly. For example, a patient felt uncomfortable being taken down to theatre in their gown and dressing gown and therefore time in the anaesthetic room was given for the patient to change.
- On the wards there were 19 en suite rooms and four VIP suites. Of the 19 en suite rooms, only eight had walk in showers. Staff informed us that orthopaedic patients were prioritised when rooms were being allocated to patients. Staff informed us that since the merger of the two specialities it was increasingly difficult to accommodate orthopaedic patients in rooms with showers.
- The service did not actively admit patients with learning difficulties or dementia but did have measures in place to ensure those patients were catered for.
- Leaflets were available on the ward and throughout the reception on a variety of topics. All leaflets were provided in Arabic and could be translated into any required language.
- The service had access to quarterly dementia awareness drop-ins. Staff were encouraged to attend and ask questions to a specialist panel.
- Patients had access to a trained, accredited healthcare chaplain who could provide support to patients. The chaplains provided pastoral, spiritual and religious care. All the 13 patients we spoke with informed us that they did not require support from a chaplain.
- The catering team insured that patients with specific dietary requirements had specialised menus with a variety of food.

Access and flow

People could access the service when they needed it.

- Bed management meetings took place every day at 10.30 and representatives from each clinical area were present. The meeting not only took sight of all vacant beds in the service but also went through NEWS score DNACPR status and any safeguarding concerns. This ensured that heads from all clinical areas were aware of the issues around the hospital and could offer further assistance by way of additional staff if need be.
- The top three surgical procedures that took place in the year prior to inspection were as follows: orthopaedic (22%), general surgery (16%) and ear, nose & throat (11%).

Good

Surgery

- Over 75% of patients received their procedure within 2 weeks of consultation. Patients that we spoke with informed us that they were "very happy" with their waiting time. One patient informed us that they had their procedure within 48 hours of their consultation.
- Between June 2017 and May 2018 theatre utilisation ranged from between 10% and 60%.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Staff were provided with a complaint leaflet pre-surgery. This leaflet was available in other languages and outlined the processes if a patient chose to complain. Representatives from the Medical Advisory Board informed us that if a patient had a complaint after they left the service, they would receive call in the first instance and staff would attempt to resolve the complaint informally.
- Junior staff that we spoke with both in theatres and on the wards informed us that complaints were managed informally in the first instance. Staff escalated all complaints to their managers. Managers informed us that if a complaint could not be dealt with informally then they would launch the formal complaint procedure.
- The hospital had a policy to acknowledge receipt of complaints within two working days. The expectation was that complaints were then responded to within 20 working days.
- In the reporting period the service received 21 complaints. 14% (3) of the complaints related to standard of clinical care as a whole. Ten per cent (2) related to poor nursing care and 10% (2) related to cancellation of appointment. We observed letters from the service to the complainants and found them to be thorough. All the complaints were dealt with within timescale. Feedback from complaints was fed back to staff on the wards and in theatres via daily safety huddles.

Are surgery services well-led?

Good

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- Surgical services possessed a clear management structure both in the wards and theatres. The Theatre Manager reported to the Divisional Manager, who reports to the Director of Operations. The wards were managed by a surgical lead nurse who reported to the Director of Nursing. The chief nurse reported to the executive team.
- In theatres there was a theatre manager who had been in post for two and a half years. There were 6 senior staff members who had defined roles and responsibilities within the department. The lead nurse for the surgery division did not manage theatres. Instead the deputy director of nursing had oversight responsibility of the theatres and had line management responsibility for the theatre manager. We found the theatre risk and safety management less defined than the wards. For example, there were clear audit results displayed but we could not access the physical audits which had led to these results and our own audit activity during inspection did not match the audit result information displayed.
- Theatre staff we spoke with were clear who their line manager was. For example, we spoke with two members of the theatre support staff team who could tell us who their line manager was and told us they were supportive and approachable.
- Theatre staff were keen to tell us that the theatre manager was approachable, supportive and visible to staff. Theatre staff gave examples where the theatre manager supported them with embedding the team brief stage of the WHO safer surgery checklist.
- Staff on the ward informed us that whilst their direct managers were highly supportive and visible, their divisional managers were "noticeably absent". Staff informed us that they did "not feel like the executive team were very supportive or communicative about big decisions."

Good

Surgery

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

- Whilst the surgical directorate did not have a strategy, the theatres department did have an undated vision and strategy. The theatres vision was "delivering excellent clinical outcomes, in an efficient and safe environment by highly qualified surgical staff using cutting edge technology, supported by efficient processes and engaged across hospital teams". Staff we spoke with in theatres could tell us that the vision for the future was to continue to improve on patient safety through processes which included the WHO surgical safety checklist. The MSK team also had their own strategy.
- Staff throughout the surgery departments could tell us about future visions to specialise and become the specialist provider for specific conditions. This included for example, work in liver procedures.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Junior nursing staff across the ward informed us that they did not feel adequately supported by their divisional leads or executive team. They informed us that they felt unappreciated in their role. Whilst the staff did not feel supported by senior managers they did inform is that they were very supported by their managers on the ward.
- Senior staff were members of the recently formed equality and diversity team. The team met monthly and included members of the executive team. Staff informed us that the initiative was a good idea and launched events for various minority groups.
- All staff were aware of the hospital expectation to speak up when things went wrong and staff of all levels were aware of the principles behind the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The surgical governance structure contained the lead nurse for surgery, the theatre manager and the surgical ward sisters. These roles also sit on the surgical improvement plan (QIP) meetings.
- There were several sepsis leads available throughout the service. On the ward there was one sepsis lead who provided ongoing training on sepsis. All ward staff we spoke with were aware of sepsis 6 and who to escalate a suspected sepsis case to.
- A surgical representative from the Medical Advisory Board (MAB), informed us that the medical director had oversight of surgeons practising privileges documents. We observed the HR files for surgeons and found that they contained evidence of indemnity insurance, this was in accordance with the Health Care and Associated Professions (Indemnity Arrangements) Order 2014.
- On the occasions that surgeons brought in their own first assistants, it was medical directors responsibility to ensure that these assistants had their scope of practice checked. We observed HR files and found that they were reviewed appropriately in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) regulations 2014.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- There were six risks on the surgery risk register and 48 on the theatre risk register. The registers were maintained by their respective managers. Overall, we found that the risks on the risk register matched the risks that we observed whilst on inspection. Senior staff could explain what was on the risk register and who took oversight.

- Senior staff in theatres had knowledge of what was on the departments risk register. We looked at the risk register during inspection and saw relevant risks were documented with action plans which were reviewed regularly.
- Performance data was displayed clearly within monthly KPI information. In theatres we saw performance data for the months of June, July and august 2018 and saw relevant performance data displayed in the staff coffee room.
- There were tested back-up generators in the event of a power outage. The service provided generator testing documentation which we found to be thorough and within date.
- The hospital defined a major incident as any event whose impact could not be handled within routine service arrangements and required the implementation of special arrangements.
- There was a major incident policy and a hospital business continuity plan in the case of an emergency. The surgical division also had a contingency plan in place. The service manager would take the lead in the event of an emergency. Staff we spoke with were aware of this.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Consultants informed us that they always had access to all the information required to treat patients. The senior nurses informed us that the international team played a big role in ensuring that all the necessary records arrived with the patient and this was corroborated by senior members of the international team.
- As well as having access to the hospital intranet for all up-to-date policies, staff were aware that policies and pathway information was kept in paper format on the wards.
- On the wards, patient records were kept in two different places. Nursing observations were kept in the patients' rooms and the reception team handled discharge notes.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- In theatres there was no time set aside for team governance meetings or staff engagement. The theatre manager informed us that during the team brief every morning necessary information would be communicated to staff. The coffee room television was also used to project key information via presentations.
- Patient forums were held every month. We observed minutes of nine patient forum meetings and found them to be well attended by patients due to be discharged and staff alike. The general format was senior staff asking patients what they could do to improve. The feedback was generally very positive.
- The physiotherapist team started a 'joint school' for hip and knee patients requiring surgery. The joint school was available for patients undergoing total hip and knee replacement. If a patient was on this pathway they were pre-assessed and had the opportunity to meet the multidisciplinary team, physio, nursing and pharmacy team in a one stop shop. During the inspection, we spoke with two patients who had taken part in the 'joint school' and spoke very positively about the experience. One patient informed us that they "were able to ask any questions and had all [their] pre-operative tests done two weeks before surgery'.
- Over 50% of staff had attended 'In-Touch' sessions with members of the executive teams. Since our last inspection the executive team had launched 'New starters' breakfast for staff that had worked at the hospital for up to 12 weeks. This provided an insight into the culture of the workplace for new starters.
- Since our last inspection, the service had introduced reflective practice forum using a recognised approach. These forums are evidence-based forums where staff can come together and discuss different clinical issues in a supportive environment. The forums occurred every month and lunch was provided to encourage staff to attend and not miss their lunch break. There were always different topics and different staff groups could provide learning sessions.

Learning, continuous improvement and innovation

Good

Surgery

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- We saw robotic replacements performed in theatres and were told that 52 robotic replacements had been performed at the hospital from December 2017 to May 2018. Surgeons we spoke with told us about the improved accuracy of surgery while using the robot. There was no audit data to highlight improved outcomes available at the time of our inspection.

Requires improvement

Critical care

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

Are critical care services safe?

Requires improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Mandatory training for adult intensive care unit (AICU) staff included induction, fire safety, patient handling, fighting financial crime, staying safe, safeguarding, medical gases, conflict management, information management, display screen equipment or working at height. Data provided showed compliance rates above hospital target of 90% at the time of inspection, except for patient handling (77%) and fighting financial crime (87%).
- The training was delivered via e-learning or face to face. Each member of staff had their individual training records and staff told us they would receive email alerts when training was due. Staff told us they were given time off to complete mandatory training modules. Senior staff kept oversight and were notified when a member of staff was overdue for a mandatory training module.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- The service had systems in place for the identification and management of vulnerable adults and children at risk of abuse.
- All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Staff understood safeguarding procedures and knew how to report concerns. Safeguarding policies were up to date and readily available for staff. There was a named safeguarding lead within the hospital. Staff knew who the safeguarding lead was and were aware of the escalation process.
- Safeguarding vulnerable adults and children training level one and two was part of mandatory training and data provided showed an overall 90% compliance rate for AICU staff at the time of inspection. This was in line with the hospital target of 90% training compliance.

Cleanliness, infection control and hygiene

The service did not control infection risk consistently well

- We observed staff were not consistently compliant with infection control standards; for example, a nurse undertook multiple different tasks wearing the same apron or staff took personal items into an area of isolation.
- We found labelling of cleaned equipment did not always correspond with completed cleaning checklists. We found that not all equipment was appropriately cleaned and labelled, for example, a commode had residual stains.
- Inappropriate isolation facilities on the AICU had been highlighted at the last inspection. Since then, the hospital had developed plans to build a new intensive care unit including adequate isolation rooms. Staff showed us building plans of the new AICU to be finished by June 2019. Currently, the team used two separated

single rooms to isolate infectious patients. These were cubicles located at either end of the unit, with sliding doors. Those rooms did not fulfil requirements for an isolation facility as outlined in HBN 00-09. The rooms did not have gowning lobbies, special ventilation or local temperature controls. The sliding doors were not tight fitting or sealed. This was against the code of practice, published in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.

- Patients from critical care units overseas had a high risk of carrying multi drug resistant pathogens and required initial isolation. These patients were admitted to one of the separate cubicles, which did not fulfil criteria for isolation facilities.
- Hand wash basins at bed spaces were not easy to access. They were located behind the beds and partly obscured by equipment. This did not encourage hand washing after patient contact. However, the hospital audited hand hygiene monthly and the AICU had an average compliance rate of 97% in 2017.
- There were hand sanitisers situated in appropriate places before and within the unit. During our inspection, we observed staff used hand sanitisers adequately. Staff adhered to the bare below the elbows policy.
- The unit overall looked clean and well maintained. The corridors leading to the entrance were well lit and uncluttered.
- Adequate supplies of personal protective equipment, including gloves and aprons were available for staff. Aprons at each bed area had a different colour, which helped discourage inappropriate movement between bed spaces.
- Disposable curtains around bed spaces were visibly clean and dated.
- The infection prevention and control nurse performed a monthly quality audit of the unit, checking 35 items against cleanliness and appropriateness.
- The management of healthcare waste audit 2017 showed 91% compliance for AICU. The management of linen audit 2017 showed 94% compliance for AICU. Both audits resulted in recommendations and actions for improvement.
- Infection management was part of mandatory training and data provided showed a 94% compliance rate for AICU staff at the time of inspection.
- An antimicrobial stewardship team undertook weekly reviews of all inpatients on intravenous antibiotic treatment. A microbiologist was available for advice between those days, if required.
- There were no reported cases of Meticillin resistant staphylococcus aureus (MRSA) or Meticillin sensitive staphylococcus aureus (MSSA) bacteraemia or Clostridium difficile from January to August 2018. There were three reported cases of E.coli bacteraemia during the same period.

Environment and equipment

The service did not have suitable premises, although plans were in place to build a new department.

- The environment did not comply with recommendations of Guidelines for the Provision of Intensive Care Services and Core Standards for Intensive Care Units, published by the Faculty of Intensive Care Medicine and the Intensive Care Society. The hospital and AICU management was aware of this and it had been highlighted at the last inspection. Managers showed us the time line for planned building works of a new unit on the first floor. The unit refurbishment plan, unit would be compliant with Guidelines for the provision of intensive care services (GPICS). According to plans we saw, the newly built AICU would be finished by June 2019.
- The AICU contained seven beds in total, two beds were separated by sliding doors each and five beds were located in an open bay area. There was a general lack of space throughout the unit and around bed spaces. Medical equipment filled up limited space around beds. However, the unit was rarely fully occupied allowing staff to use extra room around empty bed spaces.
- The unit appeared cluttered with various medical equipment, trolleys and storage units. There was no separate clinical treatment room. All medicine and storage cupboards were placed behind the nurses' desk and there was limited space for movement.

- Not all equipment was appropriately checked and labelled. We saw two ventilator machines and the electronic medicine dispenser were out of date for servicing. Staff informed clinical engineering subsequently.
- We found gaps in daily equipment checklists at the bed spaces.
- Access to the AICU was swipe card secured; visitors were required to ring the bell. Patients and visitors shared the same entrance. This was against recommendation of GPICS, Core Standards of Intensive Care Units and HBN 04-02 to prevent visitors from observing patients coming in and out of the unit.
- Staff completed various specialised equipment training and we were shown evidence of it.
- The resuscitation and difficult intubation trolleys were clean, secure and fully stocked. We saw evidence of documented daily checks dating back two months.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- A daily safety meeting was held on the AICU to give an overview of critically unwell patients within the hospital. All hospital RMOs, the site lead and AICU nurse in charge attended this meeting.
- The hospital had a resuscitation team for emergencies. Team members were assigned specific roles in the daily safety meeting, The AICU RMO was usually part of the resuscitation team.
- There was a dedicated critical care outreach service 24 hours and seven days a week. This had been implemented after the last inspection. The outreach nurse identified patients that might need intensive care treatment and monitored them on the wards. RMOs and AICU consultants would discuss or review referred patients if required.
- Hospital staff used an early warning score system to monitor patients for signs of deterioration Patients triggering a review were seen by the critical care outreach nurse or the AICU RMO. Where required, cases were escalated to the consultant. We saw evidence of early warning scores in use in medical records.
- Staff used a standardised sepsis screening tool and sepsis care pathway. There was a sepsis policy for staff to access as well as AICU guidelines for sepsis management. Sepsis training was offered to staff and data provided showed 79% compliance rate in September 2018. Further numerous training sessions had been organised for staff to attend until end of the year.
- Immediate life support training was mandatory for clinical AICU staff and data provided showed 96% compliance rate at the time of inspection. Advanced life support (ALS) training was mandatory for AICU shift leaders with compliance rate of 77% at the time of inspection. The clinical educator informed us that all staff without current ALS certificate had been booked for a course this year. All RMOs working on AICU had completed ALS training.
- In case of an emergency transfer to another hospital, the consultant on call would come in to support the unit or the transfer.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- We found the AICU to be well staffed. Staffing levels were based on a set staff to patient ratio of one registered nurse to one level two or level three patient. We observed all patients receiving 1:1 nursing care during inspection. There was an additional nurse on duty to support break times as well as a health care assistant during daytime. There was a supernumerary nurse in charge for every shift in line with standards for intensive care services, published by the Joint Standards Committee of the Faculty of Intensive Care and the Intensive Care Society (2013).
- The unit had an establishment of 29.4 whole time equivalent nursing posts. There were 31 staff in post, including one clinical nurse manager, one clinical educator, four sisters, eight senior staff nurses, 15 staff nurses and two health care assistants. A ward clerk worked Mondays to Fridays.
- The rate of use of bank and agency staff ranged from 7% to 33% between September 2017 and August 2018.

Recommendations of Core Standards of Intensive Care Units suggest a maximum of 20% of bank or agency nurses on any one shift. The higher rate of use of bank and agency nurses was due to an unexpectedly busy summer period with increased medical admissions. As annual leave had already been granted to permanent staff, bank and agency staff had to be used to cover shifts.

- The AICU reported 1.7 whole time equivalent vacancy at the time of inspection. There was an ongoing recruitment campaign and senior staff regularly attended recruitment fairs.
- Data provided showed a staff turnover rate of 13.6% for the last 12 months.
- The sickness rate for September 2017 to August 2018 was 4.5%. This was comparable to national average.
- Physiotherapy staffing consisted of experienced senior cardiothoracic physiotherapists, two whole time equivalent posts Monday to Friday and one whole time equivalent Saturday, Sunday and bank holidays. Other physiotherapy staff in the inpatient therapy team included another three whole time equivalent posts and provided intervention based on clinical presentation. The occupational therapy team consisted of two dedicated whole time equivalent posts.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The AICU fulfilled all medical staffing requirements of Core Standards for Intensive Care. There were four intensive care consultants working a one week in four rota to provide 24 hours a day and seven days per week cover. The consultants we spoke with confirmed they and their colleagues had no other clinical commitments whilst on call. They performed ward rounds twice daily and were able to come into the hospital within 30 minutes, meeting the Intensive Care Society Standards.
- Consultants worked under a practicing privileges arrangement. The granting of practicing privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory board reviewed each application for practicing privileges and advised the hospital.
- Resident medical officers (RMO) provided 24 hours, seven days a week cover on the AICU. The RMOs worked 24 hour shifts, extended work time beyond 24 hours would have to be authorised by the medical director. RMOs we spoke with confirmed they did not work longer than 24 hours.
- All RMOs were recruited via bank or agency and had previous experience in anaesthesia and intensive care. This met the Intensive Care Society guideline for ensuring there was immediate access to a practitioner with skills in advanced airway techniques.
- Staff we spoke with confirmed that sufficient medical staff were available to care for patients.

Records

Staff kept detailed records of patients' care and treatment

- All documentation was paper based. We found patient records to be detailed and fit for purpose. They included multidisciplinary input and evidence of personalised care.
- We looked at seven medical records and found daily documentation from nursing and medical staff about ward rounds, results, patients' progress and family discussions. All records included details of allergies, daily treatment plan and evidence of daily consultant reviews.
- Doctors and nurses could view patients' monitors with vital signs at the nurses' desk and staff escalated concerns as appropriate.
- Paper records were stored safely in trolleys at patients' bed spaces.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines

- Medicines were stored securely in locked electronic dispenser cupboards and were available for patients

when needed, including controlled drugs. However, we found that the cupboard containing intravenous fluids was kept unlocked. Staff told us the lock had broken. The cupboard was secured with a chain lock later.

- A specialist critical care pharmacist spent time on the AICU daily to review medication plans and prescriptions. Pharmacists took part in daily ward rounds, regular departmental meetings and provided clinical input and advice to staff and patients.
- Controlled drugs (CD) were stored in a separate locked electronic dispenser cupboard. Two nurses' logins were required to access CDs. We looked at the CD register, which was managed accurately.
- Paper based prescriptions we saw were written clearly and administrations were signed for or coded and recorded to why they were not given.
- We reviewed nine prescription charts, which contained appropriate documentation of medicines prescription and administration.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

The service managed patient safety incidents well

- There were 27 incidents reported on AICU between January and August 2018. Of these incidents, 25 (93%) resulted in no harm or minor harm, one resulted in moderate harm and one in serious harm/death. The service reported all unexpected deaths as incidents. That case was investigated with a root cause analysis and the patient underwent a post mortem examination, the death was classified as unexpected and unavoidable. We saw an action plan with recommendations including shared learning from the case.
- Since August 2017, one death had been reported to the coroner who declined to open an inquest.
- There was no never event reported since 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious harm or death, but neither need have happened for an incident to be a never event.
- Staff we spoke with understood how to raise concerns and report incidents on an electronic incident reporting system. Lessons learned from incidents were shared during daily team briefings, handovers, via emails and hospital newsletters.
- Staff were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support, truthful information and a written apology to that person.
- We observed a daily hospital wide incident meeting where all incidents of the past 24 hours were reviewed. Requirement for further investigations were discussed and identified in this multidisciplinary meeting. We noted a friendly atmosphere without blame culture.
- We saw a comprehensive root cause analysis of a pressure ulcer incident that had occurred on the unit. The report contained clinical information, lessons learned and an action plan.
- We saw evidence of staff attending mortality and morbidity meetings every five weeks where all deaths were reviewed and discussed. Learning and recommendation were shared among the team in emails, team briefs and team meetings.

Safety Thermometer (or equivalent)

The service used safety monitoring results well.

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 years old and venous thromboembolism (VTE) incidence. The hospital did not use the NHS safety Thermometer as it was a private healthcare provider. The hospital monitored harm to patients but this information was not openly displayed.
- Staff were aware of their responsibility to reduce and report incidents such as falls, pressure ulcers and UTIs relating to the use of catheters.

Are critical care services effective?

Requires improvement

Critical care

Requires improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness

- Lack of critical care specific policies was highlighted during last inspection. The service had since corrected this. In date service policies, guidelines and standard operating procedures were available on the hospital's intranet. Policies and procedures we reviewed were aligned with recognised national standards and guidance.
- Lack of critical care audits was highlighted during last inspection. The service had since implemented a comprehensive local audit programme. This included care bundle audits, audits for pain/sedation/delirium, audit of enteral nutrition and nasogastric tubes, quality rounding audits or mouth care audit.
- Lack of delirium assessments was highlighted during last inspection. The service had since made improvements. Patients were assessed daily for their level of delirium as recommended by the Intensive Care Society Standards and NICE guidelines. We saw documentation of this in patient charts. Staff utilised an adapted version of the Confusion Assessment Method (CAM) score for use in intensive care patients (CAM-ICU). Audit data of July 2018 showed 50% compliance rate. As consequence, recommendations and actions were shared among the team and a re-audit planned after three months.
- Staff assessed patients' level of sedation using the Richmond Agitation and Sedation Scale (RASS), which is a validated and reliable method in intensive care units. Audit data from July 2018 showed 87% compliance rate.
- The hospital used a sepsis screening and action tool and sepsis care pathways based on the national sepsis trust. There were in date AICU guidelines for sepsis management available for staff.
- In line with national guidance and best practice, patients had a rehabilitation assessment completed within 24 hours of admission to the unit. We saw evidence in medical records of patients receiving daily physiotherapy as required by the Intensive Care Society Standards. Assessment of rehabilitation needs of patients were initially completed by the physiotherapy team who would refer to occupational therapy team.
- The unit was member of the North-West London critical care network. The network worked with members to provide specialist services and manage critical care provision over a defined area.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

- Patients were enabled to eat or drink independently if possible. We observed that drinks were placed within patient reach.
- We saw evidence of completed nutrition and fluid charts in patient records.
- A specialist dietitian visited the unit daily and attended regular multidisciplinary meetings. Dietitians reviewed patients who required oral, enteral (via nasogastric tube) or parenteral (via central venous catheter) nutrition. They played an essential part in the prescription of parenteral nutrition and would organise it.
- Staff used an AICU nutrition scoring tool as part of the risk assessment. The dietitian told us they started using it a month ago and planned to audit it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain

- Staff assessed pain using a 0-3 pain score. We saw evidence of staff assessing and recording patients' pain in medical records.
- Staff utilised a critical care pain observation tool (CPOT) for patients unable to report pain themselves. Audit result of July 2018 showed 67% compliance rate. Recommendations had been formulated and shared as consequence and a re-audit was planned after three months.
- Pain was managed by the RMO and the consultant on the AICU. We observed a postoperative patient looking comfortable and pain free.

Requires improvement

Critical care

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- The AICU contributed to the Intensive Care National Audit Research Centre (ICNARC), meaning the outcomes of care delivered and patient mortality were benchmarked against similar critical care units nationwide. The latest ICNARC report at the time of inspection was for the period April 2017 to March 2018.
- ICNARC data for April 2017 to March 2018 showed that more than half of all admissions (58.8%) were patients following elective surgeries. About a third of all admissions (38.2%) were non-surgical cases, 3% of admissions were due to emergency or urgent surgeries.
- According to the ICNARC report, there were 7.5% high-risk admissions from the ward, this was higher compared to similar units (2.0%). There were more high-risk sepsis admissions from the ward (6.5%) compared to similar units (3.2%).
- There were 3.1% unit acquired infections in blood (rate per 1000 patient days). This was higher compared to similar units (2.0%).
- The risk adjusted acute hospital mortality (Exponentially Weighted Moving Average Plot) was above calculated expected acute hospital mortality within two standard deviations. One of the consultant explained this was related to the increased number of high-risk admissions to the AICU.

Competent staff

The service made sure staff were competent for their roles

- Absence of a clinical educator was highlighted during last inspection. The hospital had since then recruited a clinical educator for intensive care available for staff, in line with Core Standards for Intensive Care Units.
- Staff underwent an induction programme that ensured they were competent to carry out their roles. Data provided showed a compliance rate of 97%.
- Bank and agency staff underwent an induction programme to ensure they were competent to care for patients. We saw evidence of completed induction forms. All newly appointed bank staff worked a supernumerary shift for induction. Relevant critical care competencies and skills were checked before employing agency staff and they were allocated appropriate to their skill set.
- Data provided showed 80% of the nurses held a post-registration award in critical care nursing. This was above the recommended minimum requirement (50%) of the Royal College of Nursing. However, permanent staffing provided cover for bed occupancy of up to four beds. Remaining shifts were filled with bank or agency staff. Agency staff were required to be critical care trained.
- The AICU nursing team was split into four teams, each led by a charge nurse or sister who provided clinical supervision for their team as one to one meetings within the group or with supervisors outside the clinical field, managerial supervision or group supervision in the form of MDTs or education sessions. The clinical nurse manager and clinical educator provided additional support for clinical supervision for the teams.
- Staff had completed addition training in specialist equipment, for example ventilators or invasive cardiac monitoring.
- The education team had developed a centralised data collection system where the competencies related data from all clinical staff was inputted and analysed. This system was reviewed and updated on a monthly basis by the education team. Colour coding was used to RAG (red for high, amber for moderate or green for low) rate the data and highlight the members of staff that required update depending on the device and job role enabling pre-planning to ensure training and support was provided as timely as possible.
- Data provided showed the appraisal rate for staff was 100%. We saw examples of performance conversations describing goals, development and conversations with actions.
- Consultants with practising privileges and RMOs had their appraisals and revalidation undertaken by the NHS trust they had contracts with.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

Requires improvement

Critical care

- There were daily consultant led ward rounds in the morning and in the afternoon, in line with Core Standards for Intensive Care Units.
- There was a daily multidisciplinary team (MDT) ward round, led by the AICU consultant or RMO. We observed one MDT ward round, which was attended by a nurse, pharmacist, dietitian and physiotherapist. A friendly and relaxed atmosphere allowed everyone to speak. The MDT team would include a speech and language therapist, occupational therapist or microbiologist, if required.
- A weekly MDT meeting for long stay patients was led by the AICU consultant. The team discussed all patients receiving treatment on AICU for longer than five days.
- There was a safety meeting every morning after handover, organised by the outreach nurse and attended by all hospital RMOs. The team was made aware of critical patients in the hospital.
- The RMO we spoke with did not experience inappropriate ward referrals and told us about a good working relationship with other hospital RMOs. As per admission policy, all referrals to AICU went through the RMO on call and the AICU consultant had to be advised and involved in the decision to admit to the unit.
- Physiotherapists were available every day and we saw evidence of physiotherapy assessments and therapy sessions in the seven patient records we reviewed.
- When patients were discharged to the ward, the AICU RMO would write a discharge summary and leave a print out in the notes. We saw evidence of this in patient records we reviewed. Nurses would accompany the patient to the ward and provide a verbal handover at the bedside. The outreach nurse reviewed all recently discharged patients on the wards as part of a routine follow-up.

Seven-day services

- There was a 24 hours, seven days a week RMO cover for the AICU.
- On call consultant cover for the unit was provided 24 hours and seven days a week.
- Physiotherapists were available seven days a week.
- Dietitians were available Mondays to Fridays from 8am to 5pm.
- Pharmacists were available Mondays to Fridays from 8am to 8pm with on call service out of hours. The site manager and RMO could access to the pharmacy out of hours.
- Radiology services were available 24 hours and seven days a week.

Health promotion

- The hospital had leaflets on smoking cessation, alcohol cessation and keeping fit that could be made available in various languages if a patient required. We saw posters that encouraged staff and visitors to use the stairs to promote exercise. Hospital staff had access to discounted gym memberships at various sites.
- Hospital staff were offered free flu vaccination.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

- Staff adhered to the system in place to protect people from the risks associated with providing care and treatment without appropriate consent. Our review of patient notes found that in all cases consent to treatment had been obtained.
- We reviewed consent forms in seven patient notes and all were completed correctly.
- Staff knew how to obtain consent. Where consent could not be obtained, staff delivered care in the patient's best interest. We saw evidence of this in one of the medical records we reviewed.
- There was a hospital-wide policy on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) and staff knew how to access it. However, not all staff we spoke with knew about the principles of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) and how they would be applied in a critical care setting.

Are critical care services caring?

Requires improvement

Critical care

Good

Compassionate care

Staff cared for patients with compassion

- Care was provided in a caring and compassionate way. We observed staff speaking with patients in a polite and professional manner.
- We observed staff treating patients and visitors with dignity and respect. For example, staff would draw the curtains around beds when providing personal care.
- We spoke with one relative who was very happy with the care on the unit and had no criticism.
- The AICU collected feedback from patients and relatives. Data provided showed comments from 2018 were mostly positive. One of the comments was: "I was really impressed with the service in intensive care. All the nurses and doctors were brilliant and caring, even during the night.". Another patient wrote: "All the staff were magnificent. Kind, caring, funny and professional.".

Emotional support

Staff provided emotional support to patients to minimise their distress.

- The AICU nurse manager visited all patients individually on the unit before the ward round to assess whether they had any concerns.
- We observed staff explaining tasks before performing them on the patient to reduce anxiety. Staff would give reassurance to patients and relatives and offer their support.
- Patients had access to a psychologist if required.
- There was a 24/7 multi-faith chaplaincy service available for patients and relatives and staff knew how to access it.
- Prayer and reflection rooms were available in the hospital for patients, relatives and staff.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Staff introduced themselves and their role to patients and relatives. This was relevant because most staff wore the same colour and type of uniform.
- Discussions with patients and relatives were evident in medical records we looked at, including discharge planning, obtaining consent and planned treatments.
- Patients could have support from family members and friends and staff helped making them feel comfortable at the bed space.

Are critical care services responsive?

Requires improvement

Service delivery to meet the needs of local people

The service had improvement plans in place to meet the needs of people using the service.

- The AICU provided care to complex elective surgical patients whose admissions were planned in advance to ensure bed capacity. The AICU also admitted deteriorating patients from the wards and patients from other critical care units overseas.
- Inappropriate facilities for relatives was highlighted at the last inspection. There was one small windowless room available for relatives. The room could accommodate two to three people, which was not sufficient for a seven-bedded unit. The room was furnished with a sofa and a water dispenser. The hospital had agreed to plan to build a new intensive care unit with a more spacious relatives' room as well as a quiet room for private family discussions. Building works were planned to begin in October 2018 and to finish in June 2019.
- There was no follow-up service available for discharged patients or for relatives of deceased patients. The consultant clinical lead explained that it would be difficult to follow-up on overseas patients or families. However, there were plans to initiate a follow-up service for local people.
- The International Patient Centre (IPC) helped facilitate admission, treatment and discharge of patients from

overseas. They provided translation services and liaisons with embassies and insurance companies. Staff told us that the IPC was very efficient and helpful in their role. We observed staff calling the IPC to ask for translation service and an interpreter was present on the unit within minutes.

Meeting people's individual needs

The service did not always take account of patients' individual needs.

- Dementia training was available but not mandatory for staff. Staff told us about dementia days, facilitated by BUPA that staff could attend. Staff we spoke with said they rarely had patients living with dementia or with learning disability, but they would liaise closely with the patient's carers or family and the safeguarding team. Staff were aware of 'forget me not' stickers to make nurses aware of the condition of patients living with dementia and knew where they were kept. Patients living with dementia often lose ability to care for themselves, the stickers were designed to help staff recognise patients living with dementia.
- Staff did not use a formalised end of life care pathway for all patients. Staff explained that the application of end of life care pathways was limited due to different cultural backgrounds of their predominantly overseas patients. However, the service had developed a quality improvement project to introduce a tailored approach for palliative patients with different beliefs and expectations.
- We did not see any information leaflets for patients or visitors in the relatives' room or on the unit.
- Staff told us that a significant number of patients came from overseas and did not speak English. In-house interpreters were readily available during the day and via telephone at night. Staff knew how to access the service.
- Staff were aware of cultural differences and needs of patients and did their best to accommodate this, for example female patients would be seen by a female physiotherapist if requested.
- Bariatric equipment was available if required.

Access and flow

People could access the service when they needed it.

- The unit cared for 264 patients between April 2017 and March 2018.
- Occupancy rates between September 2017 and August 2018 ranged from 46% to 70% with an average of 57%. There had been no identified instances of delayed admission to AICU in the same period.
- ICNARC data for April 2017 to March 2018 showed there had been zero bed days of care post eight hour delayed discharges. This was lower than similar units (0.1%).
- During the same period, there had been zero bed days of care post 24-hour delayed discharges. This was in line with similar units.
- In the same reporting period, there were more unplanned readmissions (1.5%) within 48 hours from discharge compared to similar units (1.3%).
- There were 0.8% out of hours discharges to the ward, this was higher compared to similar units (0.5%).
- There was no occurrence of non-clinical transfer to another unit in the same period. This was better than similar units (0.1%).
- Patients were reviewed in person by a consultant in intensive care within 12 hours of admission to the unit. We reviewed six patients' notes and all patients had been reviewed by an AICU consultant within 12 hours of admission to intensive care. This was in line with Guidelines for the Provision of Intensive Care Services, 2015. Data provided by the hospital showed 100% compliance rate for the last 12 months.
- There were no cases of AICU patients being cared for in recovery over night with the last 12 months. An additional critical care bed was available for any unplanned patient requiring level two or three support. The AICU always had an additional nurse on the rota, floating within the unit to support care and unplanned admissions.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Staff told us that most concerns were dealt with informally by nursing or medical staff and the clinical nurse manager.

- There had been four formal complaints relating to AICU between October 2017 and September 2018. All had been responded to within 20 days as per hospital policy.
- Complaints were recorded on the electronic incident reporting system and reviewed in daily incident meetings. Learning was shared in team meetings or in hospital wide weekly feedback meetings.

Are critical care services well-led?

Good

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The leadership structure consisted of a designated consultant clinical lead and a nurse lead (the clinical nurse manager of the AICU) this complied with the guidance for the provision of intensive care services (GPICS) 2015 standards.
- The clinical nurse manager oversaw the unit and reported to the surgical lead nurse. Sisters and charge nurses supported the clinical nurse manager in her duties.
- The consultant clinical lead of the AICU worked closely with the clinical nurse manager. They held daily conversations and at least monthly meetings. Nurses and RMOs we spoke with felt very well supported by the consultant clinical lead and other consultants working in the unit.
- All the staff we spoke with: nursing, medical and AHP felt their leaders were approachable and visible and supportive. The clinical nurse manager had her office within the unit and practised an open-door policy.
- We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and to give advice in a friendly and professional way.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

- The lack of a strategy to improve or adjust to the environment for the AICU was highlighted during last inspection. Since then, the hospital had agreed building plans for a new adult intensive care unit, to be finished by June 2019, to improve the working environment and facilities and achieve compliance with recommendations of the Core Standards for Intensive Care Units.
- The hospital presented an AICU strategy, which was based on the goals of quality and safety processes, a highly experienced and trained clinical team and best available equipment. To enable this, focus had been set on communication, staff training, safety, governance, environment and modern IT systems.
- The AICU's vision was to deliver excellent quality care for patients by highly qualified clinicians using state of the art technology.
- Staff knew how their work contributed to the vision of the unit and were aware of the plans for the AICU. Nursing staff and consultants told us how they were involved in the planning of the new unit.
- Staff on AICU worked in accordance with seven hospital values: caring, passionate, authentic, accountable, open, courageous, extraordinary. All staff underwent training sessions where values were introduced and related back to different work areas.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- We observed the AICU team working well together in a friendly professional climate. RMOs and consultants were available for nursing staff to discuss patients or other issues. There was a collaborative working between critical care staff and allied health professionals, for example physiotherapists, dietitians or pharmacists.

- Staff in different areas we spoke with praised teamwork in the unit and the positive working atmosphere. They were committed to provide empathetic high-quality care and felt proud to work in the AICU.
- Consultants we spoke with praised the supportive and close working relationship with their colleagues.
- Staff we spoke with felt encouraged to develop and improve their skills. For example, they felt supported by the hospital to undertake training courses.
- The hospital had a whistleblowing policy in place and freedom to speak up guardians were available for all staff to voice concerns.
- Staff we spoke with were aware of the requirements of duty of candour and we found that it was embedded into practice in the service. We saw examples of duty of candour being applied.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The hospital had clear governance structures with clear reporting lines.
- The AICU leadership team was part of the hospital wide clinical governance committee and presented departmental issues to monthly meetings. The clinical governance committee reviewed audit results, learning from incidents, recommendations to improve clinical practice and ensured that information was shared across the hospital. There was a clinical governance strategy and plan, which had been developed in September 2017, providing a strategic direction for the following three years. We saw the hospital wide clinical governance quality improvement plan, which included general governance topics, each RAG rated and with progress updates.
- The AICU consultant clinical lead was member of the medical advisory board, which reviewed applications for practising privileges and advised the general manager of the hospital.
- The AICU had a named consultant governance lead and the whole AICU team discussed governance issues regularly as additional agenda item of five weekly mortality and morbidity meetings. Information was shared via emails and in monthly team meetings and daily team briefs.
- The AICU team held daily team briefs after handover where information was shared and current topics were discussed. Meeting minutes were shared among the team via email and kept in a shared folder. We saw examples of meeting minutes and found incidents, audits, training or feedback discussed. We observed one team brief, which covered current risks, audits results and training opportunities.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The management of the risk register was highlighted after the last inspection. Managers had since then made amendments to the content and changes to the management of the local risk register for the AICU. All risk register items were given a RAG (red for high, amber for moderate or green for low) status dependent upon levels of risk. The risk register was reviewed monthly at team meetings by the nurse manager and clinical lead and we saw mitigating actions and updates were documented. Senior staff knew about risks in their department, which corresponded to items on the risk register. The hospital wide risk register, including local risk registers were reviewed monthly by the incident, complaint and risk committee and risk and compliance committee, as well as during full executive meeting and health services board meetings.
- The absence of critical care specific policies or protocols was highlighted during last inspection. Since then, managers had provided staff with current policies, protocols and standard operating procedures to ensure best practice. Staff knew where and how to access them and those we reviewed were found to be comprehensive and within date.
- The lack of performance monitoring was identified as an area of concern during last inspection. Since then, a comprehensive clinical audit programme had been implemented, which was used to monitor services and

compliance against national and local standards. Nursing staff participated in local audits, with the resulting information shared amongst teams to promote improvement.

- Managers audited unit compliance against Faculty of Intensive Care Medicine Core Standards. We saw an action plan in response to guidelines for the provision of intensive care services. Each topic was rated in red, amber or green and was assigned to named individuals. The document contained progress notes and updates. The goal was to fully achieve compliance with Core Standards for Intensive Care Units formulated by the Faculty of Intensive Care Medicine and Intensive Care Society.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained within.
- Staff we spoke with told us they could access the information they needed to provide safe and effective care. There were systems in place to manage and monitor care records.
- All staff had access to their work email and we were shown that they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.
- Information governance training compliance for AICU at the time of the inspection was 90%. Information security and privacy matters training was part of mandatory 'Staying safe at BUPA' training. This module was implemented into the training in October 2018 with the expectation of all staff completing by the end of January 2019. The compliance rate for this module was 68% at the time of inspection. Remaining staff had been booked for training sessions.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- The limited approach to obtain patient feedback was highlighted during last inspection. Since then, the AICU had started collecting ward specific feedback from patients and relatives. We saw comments from 2018, which were overall mostly positive.
- The hospital conducted regular staff surveys, asking two questions: how likely they would recommend BUPA as place to work and how likely they would recommend the products and services. Results were presented using the net promoter system, with an index ranging from -100 to 100 and with a European employee average of -10. The AICU had a response rate of 52% in 2017 and positive results of 20 and 40 for the two questions.
- The hospital organised 'Feedback Fridays' for staff from all wards to attend and learn about hospital wide incidents and learning.
- There was an annual Star award with different categories based on hospital values. Staff could nominate any colleague and the hospital hosted a festive award ceremony.
- Staff had the opportunity to attend monthly peer forums to constructively discuss the emotional and social challenges of caring for patients. These were confidential meetings that allowed staff to share and reflect on challenges and rewards of working in healthcare.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The service undertook a quality improvement project for end of life care that took into account different expectations of overseas patients. The plan proposed to introduce a 'wellbeing support team' for palliative patients and tailor the end of life care service for the unit's patient cohort with different beliefs.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- There was a statutory and mandatory training programme, which all staff completed annually and attendance was monitored. Sessions were a mixture of e-learning programmes and face-to-face training, with formal attendance monitored.
- The mandatory training target set by the hospital was 90% and the mandatory training programme included the following: health and safety, fire safety, conflict of interest, information matters, safeguarding children levels one, two, and three, safeguarding vulnerable adults level three and basic and paediatric intermediate life support. Between June 2017 and May 2018, all paediatric staff compliance with mandatory training ranged between 88% and 100%.
- Staff told us they were given time to complete their mandatory training and received reminders when training was due. However, a few nurses informed us that they had not been able to attend face to face mandatory training due to commitments on the ward; they told us they had rebooked to attend at a future date.
- At the time of the inspection 95% of paediatric staff had received sepsis training.
- Staff did not receive any specific training on potential needs of people with learning disability and autism. This was not in line with best practice.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- The department had made improvement since the last inspection in 2016. A full time safeguarding lead for adults and children was appointed in February 2018, who developed clear and effective processes to ensure that potential safeguarding concerns were escalated appropriately.
- There was now a safeguarding children policy which reflected national guidance available to staff. Domestic violence and child abduction policies were also available.
- Both junior and senior nurses were aware of their roles and responsibilities to safeguard children and young people. Staff were able to explain potential signs of abuse and could identify the processes for raising a concern. All staff we spoke with informed us that the safeguarding policy was available on the hospital intranet. Staff showed us how to access the safeguarding guidance and explained the process to raise concerns.
- Safeguarding was part of the mandatory training programme and different levels of training were provided for different roles. Within paediatric services

between 95% and 100% of staff had attended level one, 100% had attended safeguarding level two training in the year before our inspection against the hospital target of 90%.

- National guidance specifies that all clinical staff working closely with children and young people should receive training in level three safeguarding. Data provided demonstrated that between 72% and 100% of all staff had taken part in safeguarding children level three training.
- Staff had a good understanding of female genital mutilation (FGM) and FGM was included in the safeguarding policy. All staff told us there was always ready access to a senior member of staff for a second opinion on any potential safeguarding issues.
- The hospital safeguarding lead linked with the tri-borough local safeguarding children board (LSCB), which ensured links with other services.
- In 2017, there were 29 incidents where staff had recognised safeguarding risk and concerns. Out of these seven were referred to external agencies. The safeguarding lead told us of examples when safeguarding concerns had been identified and that appropriate steps were taken to liaise with other health workers and social services to ensure the child was safeguarded from abuse.
- Access and exit from the Starfish ward and the paediatric outpatient department (POPD) was via a locked door with an intercom. This ensured that children could not leave the unit unescorted and that access to the department was restricted to authorised staff and visitors. We noticed however that some staff not working in the POPD had access to the department and walked through the POPD to access the adjoining administration offices on the same floor. We informed the senior leadership team, who were aware of this and informed us that this was on the risk register and they will ensure that access was only limited to the relevant staff working within POPD.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

- All areas that we inspected were visibly clean and dust free. There was an infection prevention and control (IPC) link nurse and all staff were provided with annual training in IPC.
- We observed staff used personal protective equipment (PPE) such as gloves and aprons appropriately where indicated.
- Most staff adhered to the bare below elbow (BBE) dress code and we observed staff cleaning their hands regularly. We found however, one clinical staff and few non clinical staff visiting the Starfish ward were not bare below the elbow and wearing long selves, wrist bangles and watch. One staff had long nails and another staff was wearing nail varnish. We also observed non-clinical staff using the PODP waiting area to access the administration block were not bare below the elbow.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit. Hand washbasins were equipped with soap, disposable towels and sanitiser were available within the corridor and hand gels were available in the inpatient rooms. Guidance for effective hand washing was displayed at the hand wash basins. Hand hygiene audit results showed compliance range between 92% and 100%, in January 2018 to August 2018. We observed staff handwashing practice during the inspection.
- Equipment was labelled after cleaning with the green 'I am clean' label with the time and date. Domestic staff had access to appropriate cleaning equipment and cleaning schedules were available for every area.
- Toys were cleaned in line with the hospital policy and a cleaning schedule was displayed in the playroom.
- We observed safe systems for managing waste and clinical specimens during the course of inspection. Staff used sharps appropriately; most of the containers were dated and signed when full to ensure timely disposal and most were not overfilled and temporarily closed when not in use.
- Between January 2018 and August 2018, the paediatric department had no reported cases of Meticillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection. The department also reported no cases of MSSA (Meticillin susceptible staphylococcus aureus - a

type of bacterium that can live on the skin and develop into an infection, or even blood poisoning) and Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics).

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- The POPD waiting area was child friendly and provided a range of toys, books and games for children and young people to play with whilst waiting. Furniture was clean and water dispensers were available. There were plans for a new POPD to open in November 2018; which included separate areas for younger children, adolescents, breast feeding room and a space for buggy parking. Though, there were no separate waiting areas for children in the waiting areas for x-ray, CT, PETCT, MRI and ultrasound. These were all recognised risks on the hospital risk register and there were controls and mitigation plans for those risks.
- Starfish ward was bright, well-lit and a spacious environment. All children cared for on Starfish ward were cared for in single rooms with en-suite facilities.
- There was a playroom available, which had a variety of toys, games, craftwork and books for children and young people. The playroom was open seven days a week and parents were encouraged to visit the playroom frequently with their child.
- There was a buzzer system at the entrances to the children's department so staff could monitor and control who entered the ward.
- Paediatric resuscitation trolleys were available on Starfish ward, paediatric and adult theatre and in the outpatient department. The trolleys were clean and secure, fully stocked and had been checked and logged on a daily basis.
- We checked various equipment during the inspection and found it all to be safety tested and within date.
- Children had access to up to date diagnostic and imaging equipment on site, in the main hospital including MRI and CT scanning, digital x-ray and ultrasound.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- Since the last inspection, the children's services had made significant improvement in relation to managing a deteriorating child. There was now a clear policy for the transfer of the deteriorating child.
- There was a formal service level agreement now with children's acute transport service (CATS) and all staff were clear of the escalation plan. Any deteriorating child was assessed and stabilised by a resident medical officer (RMO) trained in paediatric intensive care, supported by an on-call Paediatric Intensive Care Consultant, before being transferred to the most appropriate paediatric intensive care provider by the Children's Acute Transport Service (CATS).
- At the last inspection, we found that the admission criteria were not reviewed since the closure of the four-bedded paediatric intensive care unit (PICU) and certain procedures that might require PICU support were still included. There were now stringent admission criteria in pace. Senior clinical staff informed us that all admitting consultants were clear about the type of patients that could be admitted to the ward.
- Staff gave us an example of management of a deteriorating child who attended the POPD with acute asthma. The child's asthma worsened while in the outpatient clinic, staff took appropriate actions and the child was stabilised within the Starfish ward and was transferred to a London private PICU within three hours.
- All children under 18 were the responsibility of the paediatric team. However, there were agreements that if a 17 to 18 year old was to be treated on an adult ward, the specialist clinical team would provide care with support from the paediatric team.
- In addition to the RMO on duty, an onsite PICU RMO was available to manage any deteriorating child. In addition to this there was paediatric anaesthetic on call cover. The paediatric clinical director informed us that there were plans to have an onsite paediatric consultant intensivist in future.
- Children and young people were monitored for signs of deterioration using a paediatric early warning score (PEWS) to monitor patients, with different parameters set out for different age groups. This structured method

for communicating critical information contributed to effective escalation and increased child safety. Nurses we spoke with understood all the observations that made up the PEWS and the escalation processes. A PEWS score above three would be escalated to the paediatric RMO.

- We reviewed eight patients records and found that PEWS scores were recorded in all cases. The department audited the use of PEWS, data for June 2018 showed that staff were correctly scoring patient triggers in 100% of cases.
- Risk assessment in relation to the risk of falls or pressure ulcers and the use of bed rails or cots were undertaken for all children.When risks were identified appropriate action was taken and included in the patient notes. The department audited the completion of falls risk assessment, data for August 2018 showed that risk assessment was completed in 100% of cases.
- At the last inspection, we found that the department's operational policy said shifts should be co-ordinated to ensure there was always a European Paediatric Advanced Life Support Training (EPLS) nurse on duty on the paediatric unit and the service was not always meeting this guideline. At this inspection, senior staff informed us that there was always an EPLS trained nurse on shift.
- There were twice daily safety huddles to review expected admissions for the day and reminders of daily checks to be undertaken.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- The hospital had introduced 'SafeCare' into the wards and used the Royal College of Nursing guidelines for paediatric care in Starfish ward. The levels to pick within 'SafeCare' were based on the ratio of patients to nurses the patient needs, dependent on their age/level of care needed. When a shift was short of staff, gaps were filled either by permanent staff changing their rota or by the corporate provider's bank staff.
- There were 18.8 whole time equivalent (WTE) nurses working in children's services. There were 6.2 whole time equivalent nursing vacancies in the department. The corporate provider's bank staff covered these vacancies. We were informed that the current vacancies in the Starfish ward were based on the ward being open seven days a week.Senior staff told us that as the bed occupancy had been low since the closure of PICU and they had reduced inpatient activity to 5.5 days, the full complement of staff was not currently needed.
- Staff turnover rates were also documented as higher than the national average. The overall staff turnover for the children's services at the time of our inspection was 45%. This was monitored by senior staff, who informed that this was due to uncertainty among staff since closure of the PICU and the reduced inpatient service.
- All inpatient activity was elective and nurses told us there were enough staff to meet the needs of children, on the ward.Parents confirmed this, and said any requests for help or care were responded to promptly.
- At least one nurse per shift in each clinical area should be trained in advanced paediatric life support APLS/ EPLS depending on the service need. The service was not always meeting this national guidance at the time of the last inspection. At this inspection, we found improvement in this regard and nursing coverage on Starfish ward was sufficient. Between June 2017 and May 2018, the percentage of shifts with EPLS trained nurse on Starfish ward varied between 69.5% and 91.9%. Senior staff informed us that they have also introduced a safety check within the electronic rostering system, if a shift was not filled with an EPLS nurse, the electronic rostering system will flag a warning and it was reviewed before a shift was approved. In addition to this two of the four senior staff nurses were EPLS trained, all RMOs were APLS trained and all nurses on Starfish ward and POPD were PILS trained.
- There should be a minimum of two registered children's nurses at all times in all inpatient areas. The service had made improvement since the last inspection. Between June 2017 and May 2018, the service had progressively increased the percentage of shifts compliant with the royal college of nursing (RCN) guideline from 36% to 88%.

- Between June 2017 and May 2018, there had been a consistent improvement trend and maintenance of 100% since December 2017 of shifts with at least one registered children's nurse on duty.
- All registered nurses (RNs) in the children's services held children's nursing qualification. Senior nursing staff informed us that going forward the recruitment of RNs had been limited to those with RN children qualifications to achieve 100% compliance for all shifts with a view to open 24/7 inpatient service.
- Nurse handovers took place at each shift change, the nurse in charge handed over was followed by a bedside 1:1 handover. There were twice daily safety huddles to review expected admissions that day and reminders of checks to be undertaken that day.
- Managers were aware of the possible impact of reduced activity on staff competencies, to address this we were told that training updates were being arranged during the quiet period. Staff told us about recent training they had attended on sepsis.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Care of patients within paediatric services was consultant led. Records we viewed confirmed that consultants reviewed all patients on a daily basis. There were 81 paediatric consultants with practising privileges at the time of our inspection.
- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.
- To ensure adequate cover paediatric bank RMOs from the corporate provider's bank were used. Access to resident medical officers (RMOs) were available 24 hours a day. The RMOs had paediatric experiences and supported the accountable consultants and provided onsite medical care. The accountable consultants were responsible for their patient's care. The RMO were able to contact the accountable consultant out of hours if required.
- At the last inspection, we found that there were a number of occasions where RMOs were working 48-hour shifts. At this inspection, the hospital had made improvement in this regard and RMOs confirmed that they only worked 24 hours shift. An RMO stated that this was a positive change, all senior staff monitor this closely. The medical director approval was required for any shift longer than 24 hours and only in exceptional circumstances.
- In addition to the ward RMO, a paediatric intensive care RMO was also available onsite 24 hours a day. We were informed that there were plans to have a paediatric consultant intensivist onsite when the inpatient service would be available seven days a week.
- An on call paediatric consultant was available 24 hours seven days a week and was able to attend within 30 minutes. A paediatric anaesthetist on call consultant was available out of hours for emergency cases.

Records

Staff kept detailed records of patients' care and treatment

- The children's department used paper records. We found inpatient records to be detailed, with evidence of personalised care plans and multidisciplinary input that adhered to guidance from the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). Patient records and clinical notes were created and stored securely in line with GMC Confidentiality (2009) guidance.
- We reviewed eight inpatients and five outpatient records. All inpatient records we looked at included details of allergies, a daily treatment plan and evidence of pre- and post-operation consultant reviews. All entries were legible, dated and signed. Care pathways contained relevant risk assessments that were completed at pre-operative assessments or on admission.
- We found however inconsistent practice in four out of five outpatient records; some entries were not legible with no date and time, there was limited information of the consultation and observations for example; height, weight and temperature were not always recorded.
- On discharge from the unit, a discharge summary was incorporated into the inpatient medical records. We saw

evidence of clear and comprehensive discharge summaries completed for patients leaving the department. Discharge letters were sent to GPs to allow ongoing care and monitoring. A copy was also shared with the health visitors or school nurses where appropriate.

- Staff demonstrated a good understanding of the need for confidentiality and used electronic password protection systems effectively to access blood test and imaging results.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

- The provider carried out a range of medicines related audits to assess how they were performing, and to identify areas for improvement. These included audits of controlled drugs, missed doses, medicines reconciliation, and safe and secure handling of medicines.
- Staff told us that thepharmacyteam were a valuable resource in identifying issues with medicines and encouraging improvement. In all of the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety.
- A paediatric pharmacist visited the ward throughout the day to review all prescription charts and speak to staff regarding any issues or concerns.
- We reviewed eight prescription charts and saw they were fully completed. All prescriptions were dated and signed and allergies were clearly documented. We saw antibiotics were prescribed as per guidelines.
- Arrangements for the supply of medicines were good. There were effective arrangements for medicines supplies and advice out of hours.
- Medicines stocked in the wards were managed safely. A centralised medicine fridge temperature monitoring system had been implemented in all pharmacy department refrigerators and this was due to rolled out to all refrigerators across the site in the next three months.
- There were arrangements to ensure that medicines' incidents were reported, recorded and investigated and staff we spoke with knew how to report incidents involving medicines. The provider had a medicines safety officer who linked into the national network who fed back any learning every month.
- Controlled drugs were managed appropriately, the provider had a controlled drug accountable officer and quarterly reports were submitted to the local intelligence network.

Incidents

The service managed patient safety incidents well.

- The children's services reported no incidents classified as never events between June 2017 and May 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff we spoke with had a good understanding of what would constitute an incident, including near misses, and how they would report one. The hospital used an electronic incident reporting system and staff were able to show us how they would access it. Staff told us they were encouraged to report incidents and managers confirmed that they tried to encourage a "low threshold" for incidents. Staff told us they received feedback about incidents within the department.
- Between June 2017 and May 2018, the children's services reported 86 incidents. Out of 86, 44 incidents were in the paediatric outpatient department and 42 were in the inpatient ward.Top two categories of incidents were care and clinical treatment (17) and access, admission and discharge (16).
- In accordance with the Serious Incident Framework 2015, the hospital reported no serious incident (SI) in children's services which met the reporting criteria set by NHS England from June 2017 to May 2018.
- Daily incidents meeting was held hospital wide to discuss incidents. Learning was shared in a variety of ways including email and during unit meetings. We looked at minutes from unit meeting and saw incidents and learning a regular agenda item.

Good

Services for children and young people

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of the duty of candour (DoC) regulation and evidenced through discussion the appropriate application of the duty when required.
- Monthly morbidity and mortality (M&Ms) meetings were carried out at hospital level to review all deaths. We saw notes of August 2018 meeting where expected and unexpected deaths that occurred at the hospital were reviewed and learning was shared. There were no deaths reported within children's services in last two years.

Safety Thermometer (or equivalent)

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- The hospital did not use the NHS safety Thermometer as it was a private healthcare provider. The hospital monitored harm to patients using KPI's (key performance indicators). This information was visible in the nurse's office.
- Staff were aware of their responsibility to reduce and report incidents such as falls and pressure ulcers. Staff reported these incidents via electronic reporting system.

Are services for children and young people effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- We reviewed a range of clinical care pathways which reflected national evidence based guidelines. Clinicians told us that they used the same protocols at the hospital as they used in their NHS practices.
- Staff said that care and treatment plans occasionally varied dependent on the individual consultant as not all consultants used the same protocol or treatment plan in the same situation.
- All policies and procedures were now available on the hospital's computer system. We found however, the process to search clinical policies was still cumbersome. We asked some staff to show us how to access guidelines for a particular condition and staff were unable to do this, for example, staff were unable to find the antibiotic policy. We found out of date and different versions of some policies available on the database. For example, diabetic care standards for nursing policy was out of date and paediatric consent policy had two versions available. Senior staff informed us that the central governance team was working to update all clinical guidelines and over 90% of up-to-date hospital policies were available on the hospital intranet.

  At the last inspection, we found a lack of clinical audits. During this inspection, we found that the children's services had a clinical audit programme and there were scheduled audits for care and treatment. This included the World Health Organisations (WHO) 5 steps to safer surgery checklist, falls risk assessment completion, documentation audit, paediatric early warning score compliance, patient discharges and pain audit. However, we found that the programme was limited to mainly nurse led audits and did not included consent audit. The clinical director told us that the department focus was to first embed the newly established governance structure and then build on the current local clinical audit programme.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

- There were processes to ensure that patients' nutrition and hydration needs were met on the wards. The hospital paediatric dietitians attended paediatrics to support feeding and nutritional planning for children and young people.

- The children's services used an adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risks. Data submitted showed a snapshot audit in
- Children and young people were offered a choice of meals that were appropriate to their age group. There were special menus available for different patient groups including those who had specific dietary requirements such as allergies or intolerances.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Pain scores were assessed using a variety of methods including Face, Legs, Activity, Cry, Consolability scale (FLACC). This is a tool used to assess pain in children from two months to seven years. For younger children staff used the 'Wong-Baker smiley FACES' where children were asked which face best described their pain. We observed the use of a numerical rating scale for older children, who were asked to describe their pain on a scale of one to 10.
- All eight inpatient records we reviewed had detailed information about the type of tool being used and the pain score.
- Pain management was audited on a monthly basis. Between May 2017 and July2017, 55 % of patient's records showed evidence of the pain scoring tool being consistently used. Noncompliance was mainly related to the use of wrong pain assessment tool. There were recommendations to improve compliance, for example educational strategies for staff, audit outcomes to be shared with teams and to create pain management competency assessment tool for staff.
- Since the last inspection, a full time play specialist had been appointed who would help children in preparing for procedures. Distraction and relaxation techniques were used to help children manage their pain prior to receiving an injection.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- The service complied with national key performance indicator (KPI) monitoring, which included recording numbers of unplanned readmissions, unplanned returns to theatre and unplanned transfers.
- There were no deaths reported within the children's services over the last two years.
- Between January 2018 and August 2018, the children's services reported no surgical site infection (SSI).
- Between June 2017 and May 2018, there were five unplanned readmission cases with 28 days of discharge. For example, patient choice to be readmitted for procedure rather than stay in hospital, abdominal pain after surgery and paint and stiffness after ENT procedure.
- The service monitored patient outcomes using the net promoter system (NPS). NPS is an index ranging from -100 to 100 that measures the willingness of customers to recommend a company's products or services to others.The service audited for trends primarily using patient feedback questionnaires which staff sent electronically. The last overall NPS score for the children's services was 91 which showed high levels of patient satisfaction.
- We found however that the service made limited progressing in relation to monitoring specific clinical outcomes. The clinical director told us that the planned next phase for the department was to expand the clinical audit programme and focus on monitoring specific patient outcomes, for example auditing post ENT procedure bleeding rate.

Competent staff

The service made sure staff were competent for their roles.

- To assess whether staff had the necessary skills, all RMOs and nursing staff worked a three months' probation period before they were provided with a permanent contract. New staff shadowed another staff member for a week and undertook initial mandatory training to familiarise themselves with the hospital's policies.
- There was support through supervision and mentoring for staff moving into new roles. Several staff spoke positively about career progression within the hospital.

- Permanent staff could access a range of training opportunities internally and externally. Staff said that they were supported to attend training for professional development. The service was funding training for general nurses to do a conversion course to become registered children's nurses.
- The Medical Advisory Board (MAB) was a representative body of consultants that met on a regular basis. The MAB involved the CEO, medical director and the head of clinical governance. The MAB was defined as advising management on clinical issues, reviewing practicing privileges and receiving reports from the CEO, Director of nursing and medical director.
- The MAB and specifically, the medical director had clinical oversight of the paediatric consultants who held practising privileges. The medical director's office would ensure that consultants filled out a scope of practice form every quarter. This ensured that paediatric surgeons would only carry out surgery that they were skilled and competent to perform.
- The service took appropriate measures to ensure that the staff it employed via practising privileges were adequately skilled. The service ensured that each consultant filled out a scope of practice form that ensured that the consultants did not deviate from their skill base. The clinical director informed us that they were reviewing all practising privileges as part of their paediatric strategy, a database of competencies of paediatric consultants was being developed to ensure that the hospital had concrete evidence of basic competencies of all clinical staff in line with the Royal Colleges' standards.
- There were processes to ensure staff employed by the hospital had access to regular appraisals and opportunities for professional development. Managers were prompted by an email when appraisals of clinical and non-clinical staff were due. Between June 2017 and May 2018, 95.45% of staff had received an appraisal.
- Consultants with practising privileges had their appraisals carried out at their respective NHS trust and had to provide a copy to the hospital each year. Doctors also usually revalidate with the organisation where they carry out most of their clinical work.
- Those paediatricians who did not hold NHS contracts, had their appraisal and revalidation undertaken by the hospital at corporate level on procedures and ways of working.
- The hospital had adopted the Royal College of Anaesthetists guideline for the provision of service of anaesthetic services (GPAS) 2018. These form part of the Anaesthesia Clinical Services Accreditation (ACSA) standards for provision of service for paediatrics. The standard states that all anaesthetists must demonstrate advanced life support training on an annual basis in a simulated multidisciplinary environment. The clinical director informed us that the hospital was engaged with the anaesthetic consultants who have practising privileges at the hospital to undertake a gap analysis of how many of their consultants meet these standards, and how best to support clinicians to meet these standards over a reasonable timeframe. The senior leadership team were clear that not meeting these standards was not an option for the hospital from either a safety or a commercial perspective.
- Since the last inspection, the service had appointed a paediatric nurse educator who was responsible for all elements of training and education for the nurses as well as supporting student placements.
- All paediatric nurses were trained in paediatric immediate life support (PILS). Senior/charge nurses in Starfish ward had European Paediatric Advanced Life Support (EPALS). All resident medical officers (RMOs) had completed advance paediatric life support (APLS) training and were available to support the resuscitation team if required.All theatre and recovery staff had PILS qualification. There were ongoing simulation scenarios and training to ensure that staff were confident in using their skills.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- Throughout the inspection we observed a high level of integrated collaborative working between specialities.
- Multidisciplinary team (MDT) working at the hospital was good. All disciplines worked closely with each other and no specialty was excluded. We spoke with

physiotherapists, occupational therapist, health care assistants and all levels of nurses and doctors. Everyone we spoke with was committed to delivering the best possible outcomes and care.

- Patient records we looked at showed that while it was clear who had overall responsibility for a patient's care, there was input from a variety of disciplines. Dieticians, physiotherapists, pharmacists, pathologists and other health professions were involved in multidisciplinary discussions as appropriate. These discussions were recorded in the patient's record.
- The service had an array of diagnostic imaging services including MRI & CT, X-ray, interventional radiology, scanning and cardio-physiology.
- On inpatient wards, the RMO conducted a daily ward round accompanied by the nurse looking after the child but not routinely accompanied by other professionals. There was also a daily bed management meeting attended by senior nurses and managers.

Seven-day services

- Since the last inspection the department had reduced the inpatient services to five and a half days a week.
- The rota of RMOs provided inpatient cover 24 hours a day, five and a half days a week.
- Consultants visited the children they were responsible for daily. We were told that there were arrangements for when a consultant was working in an NHS trust or on leave. Consultants made their cover arrangements themselves with a colleague. This was part of their practising privileges contract. Consultants told us the hospital was informed about who was providing cover at any time, and that cover was always available for children. Nurses and RMOs said the system worked effectively and the elective nature of the service meant that consultants ensured they were available for the length of their patient's stay.
- There was seven-day service for pharmacy, radiology and physiotherapy teams out of hours were available through on call rotas.
- Diagnostic imaging including ultrasound, CT scans and magnetic resonance imaging (MRI) was available seven days a week with on-call support for out of hours.
- Outpatient appointments were available six days per week between 8am and 8pm on weekdays and 8am to 2pm on Saturdays.
- Interpreters were available every weekday from 7.30am to 8.30pm. Thereafter, there was an on-call rota.
- The 'international patients centre' worked between 8am and 8pm and were also available on call 24 hours a day.

Health promotion

- Printed health promotion material and posters on notice boards were readily available for patients in the children's' outpatient waiting area. This included information leaflets on healthy eating, 'Start 4 Life', sugar in breakfast cereals and immunisations.
- Various health promotion services were available for children and young people. For example, paediatric immunisation clinics, dietetics support to support healthy eating and paediatric therapies to encourage active lifestyles.
- Parents that we spoke with informed us that they were empowered and supported to manage their child's health and care. They were provided with opportunities to meet with occupational health, physiotherapists if applicable.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 for those aged 16 and over and the Children's Acts 1989 and 2004. The hospital had a consent policy and specific consent form for children and young people were used.
- We were told parents provided informed, written consent for the treatment their child received and that older children were encouraged to participate in decision- making. We saw signed surgical consent forms in patients' records.
- Parents told us they had been given enough information to understand the expected benefits and possible complications of treatment to enable them to make an informed decision.
- The children's services did not audit the use of consent form and this was not part of the hospital wide consent

audit. Senior staff informed that they were already reviewing to extend the hospital wide audit to include children's services, however no definite date was provided.

- All staff we spoke with were aware of the organisation's consent procedure and could describe the legislative requirements regarding consent in young people. Staff were able to describe Gillick competencies and the requirements for seeking consent from children and young people. The Gillick competence is a test in medical law to decide whether a child of 16 or younger was competent to consent to medical examination or treatment without the need for parental permission and knowledge.
- Clinical staff informed us that verbal consent was obtained from the child or parent before some nursing or medical interventions such as blood sampling took place.

Are services for children and young people caring?

Good

Compassionate care

Staff cared for patients with compassion

- We observed staff treat patients and their parents with dignity and respect. Nurses and doctors introduced themselves to patients and their parents. Where appropriate, staff asked older children if they would like to speak in the presence of their parent or not.
- Interactions between staff and patients were positive across the service. Nursing staff reassured children and their parents and answered questions about their care. They made sure that children and parents were informed about procedures they were about to undertake and listened to children's points of view. Between March 2018 and August 2018, 92.5% of parents felt they were involved in the decision about the care and treatment.
- Staff had a caring, compassionate and sensitive manner. We saw staff playing and laughing with children and talking to the children in the paediatric outpatient department (PODP) whilst providing care.
- We observed staff maintaining patient's privacy and dignity at all times by keeping the room door closed during assessments.
- The children's service collected monthly patient satisfaction data called 'exceeding patient expectation'. Between October 2017 and August 2018, 100% of patents and relatives said they would recommend the service to friends and family, except in March 2018 when it dropped to 92%.
- The 'exceeding patient expectation' survey results between March 2018 and August 2018 were largely positive 96% of parents said they were treated with respect and dignity and 100% of parents agreed that they were given enough privacy when discussing the condition or treatment.
- All the parents that we spoke with had largely positive comments about the service. Parents comments included: "Very good experience", "Everyone is good with children and way better experience than expected". Children were given 'bravery teddy bear certificates' and 'bravery stickers' after their surgery.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- There was no permanent psychologist available within children and young people's services. However, staff told us they could make a referral to a psychologist who had practising privileges if required.
- Since the last inspection, the hospital had appointed a play specialist. Play specialists support children by preparing them for treatment and teaching them coping strategies. This can help reduce the anxiety of the child and increase treatment compliance. At the time of our inspection the play specialist was on leave, staff informed us that they used hand held computer devices with children and young people to help distract them during painful procedures, such as taking blood. Staff also told us that since the appointment of the play specialist, they have learned additional distraction skills and the specialist has been a valuable addition to the team.
- Starfish ward provided a 48-hour follow up phone call following discharge from a member of the nursing team.

Good

Services for children and young people

This offered an opportunity for staff to provide any additional information or support as required. The service audited this monthly, in August 2018, 100% of patient received the follow up call.

- At the last inspection, we found that there was no bereavement support service available within the children and young people's services. At this inspection, although there was still no dedicated support service specific to children's service, at hospital level patient information leaflets on bereavement were available which detailed support for end of life and bereavement, funeral directors including those who supported Muslim patients who needed a more immediate funeral process following death. Within children's services staff had developed bereavement boxes which stored all the relevant information all in one place for easy access. There have been no paediatric deaths in the hospital in the previous two years.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- The Starfish ward had introduced 'pants and tops' as a tool to encourage feedback from children and young people. Children and young people feedback on what's 'pants' (bad) and what's 'tops' (good) about their healthcare experience by writing or drawing their ideas blank papers cut out in the shape of pants and tops. The paediatric outpatient department (POPD) had a 'You said, we did' board which gave feedback on changes that had been made because of patient and relative feedback.
- Staff were described as having a high level of expertise and helped to involve parents in the care of their children and babies. Parents we spoke with commented that staff took their point of view on board and always kept them informed of clinical decisions.
- All the parents we spoke with told us they were always kept informed of any treatment plans and staff explained any test that their child was due. Children reported being well-informed about their care and able to take an active part in their treatment decisions. All parents we spoke with said that parents and children both were involved in making decision and explanation about care was provided. We observed doctors and nurses offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of.
- Discussions with patients and families were evident in all of the notes that we examined, including in care plans, discharge planning and gaining of consent. Family involvement and education was also discussed in the handover that we attended on the Starfish ward.
- There was involvement of young people in the development and naming the new PODP via survey and involving the local school to send in art work to be placed with in the new department.
- There was a reflection room and a prayer room. A multi-faith chaplain was available 24 hours a day, seven days a week.

Are services for children and young people responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- We observed that the environments of both the inpatient Starfish ward and the outpatient's department were fit to meet the needs of young children.
- The hospital's international office managed all aspects of care for international patients. The team was designed to meet the needs of the large number of international patients that used the service. The team assisted international patients every step of the way throughout their pathway.
- Services were planned around the needs of the patients and parents. Evening clinics were held in outpatient departments in order to facilitate children coming from school. Outpatient services were planned by consultants and appointment times were staggered to ensure that patients didn't have to wait long for their

appointment slots. One parent we spoke with said they had "No problem in getting an appointment and in fact the service was very quick and responsive to their needs."

- The waiting areas, clinical areas and therapy areas were all suitable for both children and young people. The play rooms had toys and games suitable for both young children and adolescents. Senior staff were aware that the current layout of the POPD did not separated children and adolescent and this would be rectified in the new outpatient department. We saw the plan for the new outpatient department which was fit to meet the needs of both children and young people.There was a play room on the inpatient wards and there were a wide variety of toys and games and books for older children.
- Patients over the age of 16 could choose whether they wanted to stay in the paediatric ward or move to an adult ward. The service worked closely with adult services when children chose to move to adult wards to ensure that there was access to a paediatric nurse from the paediatric ward at all times.
- The paediatric charge nurse had oversight of the service which children received in adult areas of the hospital and told us that there was good engagement throughout adult services in providing effective care for children.

Meeting people's individual needs

The service took account of patients' individual needs.

- The service took account of the individual needs of children and young people. The entrances leading to the children's ward and children's outpatient unit were decorated with cartoon characters and animal pictures to make the environment child friendly.
- Starfish ward was bright and welcoming and had been designed with children and young people in mind. The play room on the ward was bright with suitable toys and books for different age groups. Children had access to the internet and laptops and mobile devices were allowed on the ward. One parent however said that 'it will be useful to have more toys to distract children then just mobile devices.'
- All children cared for on Starfish ward were cared for in single rooms with en-suite facilities. There were built in wardrobes with pull down beds available for parents to use if they wished to stay with the patient.
- Interpreting services were available in house. Staff were aware how to arrange interpreting services to support patients and their families whose first language was not English when needed. Staff confirmed that it was easy to book interpreting service, which could be arranged face to face, or by telephone. Information leaflets on the ward could also be requested in large print, staff informed us that these can be translated if required.
- Children's food menus were child friendly and had options to meet religious and personal preferences. Menu was also available in Arabic. A patient's parent said their child felt the food was good.
- Since the last inspection, the ward had introduced a passport for children with learning disabilities and we saw a copy of that. Staff were able to describe how they would support children with learning disabilities; however no formal training was provided. Staff informed us that there was no learning disability link nurse available and they would normally seek advice from the play specialist.
- There was a dedicated paediatric theatre and child friendly anaesthetic room attached to Starfish ward. Paediatric patients were recovered in a child friendly recovery area. Parents were able to accompany their child in the anaesthetic room and in recovery area.
- At the last inspection, we found that some children were treated in the adult theatres and recovery room which were not child friendly. At this inspection, staff informed us that no children under 16 were treated in the adult theatre unless the child needed an orthopaedic operation, due to the adult theatre being equipped with a laminar flow (laminar flow theatre work to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments, surgeons and the patient's own skin). We saw the new separate paediatric recovery room which had been built next to the adult theatres. The theatre manager informed us that the

recovery room would be staffed separately and would be functioning once fully staffed. Between June 2017 and May 2018, 273 paediatric patients were operated in the adult theatres.

- Senior nursing staff informed us that there were no regular transition clinics as there were low volumes of patients who would fall into this category, patients with long term care were generally facilitated within NHS services.However, shared care between specialties and physicians was used where required. Senior clinical staff were aware that to strengthen and improve the quality and safety of paediatric services there was a need to improve the transition service and had applied to an NHS trust to use their 'Ready, Steady, Go' Transition Programme.
- The service admission criteria stated Starfish ward did not accept patients requiring child and adolescent mental health services (CAMHS). There was no psychiatric provision with the hospital and a psychologist was only available on request. We were told if a patient required this type of support a referral would be made to an external organisation, such as a local NHS trust.
- There was one play specialist on the ward providing support to patients. Play specialist supported children undergoing procedures on the ward by providing therapeutic play, distraction therapy and emotional support for older children. All staff we spoke with told us that the play specialist had been really helpful and reflected that their input enhanced the children's hospital experience.
- All staff we spoke with described how they would always make sure to record the patient's choice and to talk to the patient and not just their parents.
- There were dedicated paediatric physiotherapists and occupational therapists who attended the ward daily to review patients.

Access and flow

People could access the service when they needed it.

- Children and young people were assessed, diagnosed and treated promptly. Due to low bed occupancy rates, beds were readily available on the paediatric ward, therefore consultants could arrange surgery without delay.
- Parents in the inpatient and outpatient departments confirmed they had been able to arrange treatment at a convenient time for the family. Parents could arrange general paediatric consultations with consultants' secretaries, and appointments were made to fit in with the family's needs. Follow up appointments for children who had been inpatients could also be arranged in this way. Parents we spoke with told us that it was "Very easy to book an appointment" and they "Did not had to wait at all in the waiting area".
- There was clear guidance within the care of children policy to indicate which groups of children and young people could be admitted to the hospital and what types of procedures would be excluded.
- The imaging service was used by both children and adults. The facilities were not specifically designed to be child-friendly, but we were told children rarely had to wait in the department. All children who required an intravenous dye injection before the scan would wait within the Starfish ward would be accompanied by a paediatric nurse to the imaging department.
- The median time for first appointments between creation of a booking and attendance in outpatients was five days with an average of nine days.
- Between the same time period there was one case that required unplanned return to theatre.
- Between the same time period there was only one case cancelled due to non-surgical reason as the hospital did not operated on children under five-kilogram weight.
- Bed management meetings took place every day at 10.30am and representatives from each clinical area were present. The meeting covered all vacant beds in the service and patients' national early warning sign (NEWS) scores, 'Do Not Attempt Cardiopulmonary resuscitation' (DNACPR) status and any safeguarding concerns. This ensured that heads from all clinical areas were aware of the issues around the hospital and could offer further assistance by way of additional staff if need be.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Good

Services for children and young people

- Information was available for patients and relatives on how to make a complaint. The procedures followed the Code of Practice set out by the independent sector complaints adjudication service.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results. The first point of call was to make contact with a member of the immediate team. Nursing staff told us they aimed to resolve concerns in the first instance in a timely way to improve the patient experience and prevent a formal complaint. Formal complaints were managed through the Director of nursing with support from the children's services senior nurse and clinical director.Feedback was given to staff at the ward meetings. We saw an example of a complaint response letter where duty of candour had been applied.
- The children's services had 31 formal complaints made between June 2017 and May 2018. Out of 31 complaints, 13 were upheld and 12 were partially upheld. There were no specific themes that could be identified from the data provided.

Are services for children and young people well-led?

Good

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- Since the last inspection, the hospital had made improvement to strengthen the leadership of the children's services. There was a newly established leadership team and staff felt supported by the local leaders. The children's services were led by a clinical director with support from lead nurses for inpatient and outpatient services.
- Staff told us that they thought the leadership of the department were visible, approachable and supportive and that the department was well led. Staff told us that managers had a good understanding of what was happening at ward level. Staff told us and we corroborated from our interviews with managers that they had an understanding of the challenges facing the department and plans to meet these challenges.
- Staff we spoke with told us that senior managers of the hospital sometimes visited the wards. Staff told us they felt confident raising issues and concerns both with their immediate managers and senior leadership.
- Leaders of the paediatric service felt that they had a voice at board level and that the hospital as a whole was committed to services for children and engaged with them in areas such as development of the new outpatient department and extending the services to seven days a week.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

- There was a paediatric strategy and vision which aligned with the overall hospital strategy. The senior leadership team told us there was a strategic aim to expand the paediatric services and in anticipation of the increasing inpatient service to seven days, a recruitment plan was developed to support that.
- Staff were aware of the corporate provider's values of open, passionate, caring, authentic, accountable, courageous and extraordinary and we saw that these values were reflected in the way staff responded to children and their families.
- Ward staff knew how their work contributed to the wider vision of the hospital and were aware of the hospital values. They saw their objective as providing excellent care and they understood the focus on high quality care and the importance of family satisfaction with the service.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- We found a positive and inclusive working culture within the children's services at the hospital, all clinical and

administrative staff we spoke to were passionate about achieving the best for patients. Staff we spoke with described a supportive and patient orientated environment and said they felt valued by their colleagues. Staff told us that they were encouraged to 'speak up'.

- Leaders of the service were proud of their staff and highlighted their efforts and contribution to the department and high standard of care for patients.
- Nurses we spoke with told us there was a supportive, respectful and positive working atmosphere and that there were good relationships with colleagues from different disciplines and levels of seniority.
- All staff we spoke with told us that since the last inspection, the team had really come together, 'The environment was not toxic anymore and they all work as a team now'. Staff told us that they saw that the senior managers were serious about investing in the children's services and that had boosted staff morale.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The children's service had clear operational structures and there were clear reporting lines up to the board level. However, they were at an early stage of formalising their clinical governance structure. The clinical director was leading on monthly departmental quality improvement programme (QIP) meetings within the children's service where information was shared as a team including governance updates, complaints, incidents and risks. Senior leaders informed that terms of reference for the clinical governance meeting were planned to be approved next month. We saw the terms of reference of the new clinical governance committee and QIP information sharing document. Though we were assured that the current arrangements were effective, it was too early to comment on the formal governance process as it needed to be embedded well.
- All staff felt connected with the governance system as information was shared in departmental meetings and key messages were shared in the daily safety huddles, but staff found it difficult to attend the QIP meetings due to clinical commitments. Some junior nursing staff had not attended any QIP meeting and informed that charge nurses would share the information.
- The hospital central governance team facilitated a daily incident and complaint meeting which looked at all complaints logged within the previous 24-hour period.This ensured the hospital could respond to all complaints and incidents in a timely manner.
- Staff were clear about their roles, what managers expected of them and for what and to whom they were accountable.
- The medical director and medical advisory board (MAB) followed a process to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The clinical director represented the children's service on medical advisory board (MAB) which ensured children and young people's services were on the hospital's agenda.
- There were arrangements to ensure all consultants working under practising privileges held appropriate indemnity insurance in accordance with the health care and associated professions (indemnity arrangements) order 2014. Senior managers monitored this annually as part of the consultant's quality performance KPIs. All consultant data was submitted to private healthcare information network (PHIN) and the hospital was currently ranked as second best in the country for maturity of data submissions to the network.
- At the time of last inspection, we found there was no clear audit plan for national and local clinical audits. At this inspection, we saw that though there was a formal audit programme, it was very limited and all audits were nurse led audits. The clinical director was aware of this and informed that this would be the next area to focus on once the department was operating a seven day service. Senior leaders told us that there was a need to embed a clinical driven audit plan in all the directorates.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The children's service had a quality improvement plan (QIP). This was a working document, which meant items were being completed or added simultaneously to the spreadsheet. This document rated all items as red, amber or green (RAG rated), dependent if the item was still outstanding, on its way to completion or completed. Items on the document ranged from the risk register, through to signage and inductions within the department. There were no items rated as red within this document. It named an individual responsible for the task or item set out, as well as the initial date raised, completion date, status (RAG), comments and evidence. This was a working document hence some items were not complete and some boxes were left without information due to the status of the action.
- The children's service risk register fed into the hospital risk register. Each risk was given a score. Anything over 12 points was sent to the executive team to review and identify any actions that could be taken to reduce the risk. We saw minutes of the meetings where these risks were discussed and reviewed which enabled mitigation and controls to be implemented. There were 13 risks on the children's services risk register. At the last inspection we identified that not all risks were on the divisional risk register and some were not reviewed regularly. At this inspection, we found that there were effective systems to ensure all identified risks were on the risk register. Senior staff could explain what was on the risk register and who took oversight.
- Performance data was displayed clearly within monthly KPI information. In Starfish ward we saw performance data for the months of July and August 2018 and saw relevant performance data displayed in the nurse's station.
- The hospital defined a major incident as any event whose impact could not be handled within routine service arrangements and required the implementation of special arrangements. There was a major incident policy and a hospital business continuity plan in the case of an emergency.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- There was good access to patients' medical records. Staff said they had access to information required to treat children and young people.
- Outpatient records were held by the consultant in the outpatient department and therefore were available for paediatric clinics. Records included the initial referral letter from the GP and detailed letters sent from the paediatric consultant to both the parent and GP. This demonstrated information had been shared appropriately with other healthcare professionals.
- Staff accessed results of diagnostic investigations via digital services. If required hard copies could be printed off and added to the patient's medical records.
- All policies and procedures were now available on the hospital's computer system. We found however, the process to search clinical policies was still cumbersome, there were out of date versions of policies available on the database. We asked some staff to show us how to access guidelines for particular conditions and staff were unable to do this.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- From speaking with staff, reviewing the minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback. All of the staff we spoke with told us that communication was not good initially when the PICU was closed in 2016 but now the department had made progress and they felt listened to and could tell us who they would approach when they had concerns.
- The service engaged well with staff through various initiatives such as 'Feedback Friday' and 'FAB' (Fun at Bupa). Since our last inspection, the service had introduced reflective practice forum using a recognised approach. These forums are evidence-based forums where staff can come together and discuss different clinical issues in a supportive environment. The reflective practice forums occurred every month and

lunch was provided to encourage staff to attend and not miss their lunch break. There were always different topics and different staff groups could provide learning sessions.

- Managers and staff told us they thought that children's service was well represented throughout the hospital and there was good communication from senior managers. The service gave feedback to staff through the "you report it, we fixed it", 'keeping in touch sessions', 'The Brief' update newsletter for consultant, newsletter and staff meetings.
- The hospital held an awards night called 'star awards' once a year where staff were recognized for their contributions and awarded with prizes for good work. Staff informed us that the paediatric lead nurse from the children's department had been nominated for the 'star award' for 'people manager of the year' category.
- There were examples where the services had been designed with input from patients. For instance, the department contacted the local primary school children to suggest ideas and name for the new POPD.
- Staff surveys were undertaken yearly by the hospital. The hospital used a system called net promotor system (NPS)to gain feedback from staff. The last staff survey took place during 2017 and the new survey was due to take place through October 2018. The most recent results from the survey indicated a worse than average score than the European and Australian companies, where the average was -10. With a response rate of 32%, the hospital children's nurses generated a score of -25 for recommending Bupa as a place to work, and -38 for recommendations of Bupa's services and products.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The hospital was working in partnership with a local NHS trust to develop a working model between the nursing and medical staff at Bupa Cromwell hospital and the paediatric critical care department at the local NHS trust. A service level agreement was awaiting final approval which would provide a high dependency nurse (HDU) from the NHS trust to work at Bupa Cromwell hospital 24/7 to provide expertise to assist with children with complex needs and a child that deteriorates. Senior staff informed us that the timeframe was up to 12 months to achieve this.
- There were plans for Bupa Cromwell resident PICU consultant to provide support via tele-links to the local NHS paediatric critical care unit as part of the partnership working but timeframes for implementation were yet to be agreed.

Good

Outpatients

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

Are outpatients services safe?

Requires improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Within the outpatients department (OPD), we were able to see evidence that all mandatory training had been completed for most nursing staff. Staff returning from a period of absence were supported to complete their mandatory training." These staff members were in the process of completing their training. The target for mandatory training and appraisals for medical staff, nursing staff and health care assistants (HCAs) within OPD was 95%. The hospital was unable to separate training compliance figures, as during 2018, the OPD had been restructured. This data therefore, may not be accurate.
- OPD staff mandatory training and compliance rates were, induction 100%, display screen equipment 92.86%, fighting financial crime in Bupa 92.86%, fire marshal training 100%, fire safety awareness 100%, first aid at work 100%, immediate life support (ILS) 85.71%, induction welcome to Bupa Cromwell Hospital 100%, infection management 100%, information matters in Bupa UK 100%, managing conflicts of interest 100%, medical gas cryogenic 100%, patient handling 85.71%, risk management essentials 100%, risking it 100%, safe use of medical gases 81.82%, safeguarding children level 3 100%, safeguarding vulnerable people 100%, staying safe at Bupa 100% and working at height 100%. This generated an average compliance of 96.49% which was above the hospital's target. The hospital did not provide PREVENT training for its staff. This is specific training to recognise individuals that have been or in the process of being radicalised of terrorism purposes.
- All nursing staff and HCAs were given time during normal working hours to complete their mandatory training. Bupa provided this training via internal educational courses. All bank and agency staff were up to date with their mandatory training. There were processes in place to check their competencies had been completed and were up to date prior to working within the department.
- Consultants completed their mandatory training within their NHS Trust and provided evidence of completion to the medical director's office, where their practising privileges were reviewed and agreed, alongside the medical advisory board (MAB). Consultants were only able to practice if their training, appraisals, insurance and competencies were up to date. This was overseen by the medical director's office.
- Bank staff completed mandatory training in fire safety awareness, infection management, information matters, managing conflict of interest, staying safe at Bupa and working at height. The overall compliance for bank staff was at 83.33%, however, the reporting period for this data was not specified.
- The hospital employed patient coordinators as part of their front of house team. Patient coordinators were the patients' point of contact from check in at OPD and throughout their visit within the department. All patient coordinators had completed their mandatory

training, including basic life support, to enable them to assist a patient in cardiac arrest until the crash team arrived. One of the patient coordinators was always based within the OPD pharmacy as part of their team on a rotational basis.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- We saw evidence that all nurses, doctors and allied healthcare professionals were trained to level two safeguarding for adults, and level 3 safeguarding for children. Children were welcomed into the hospital for treatment, as well as visiting with their families who were undergoing consultation or treatment. Staff were trained for these eventualities. The OPD lead nurse was booked to attend the level 4 safeguarding training just after our inspection. There were other nurses and leads throughout the hospital that were also level 4 safeguarding trained. Administrative staff were all trained to level 2 safeguarding.
- The hospital had appointed a safeguarding lead that had been in post approximately four months at the time of our inspection. The new lead had made many changes to the training and structure of safeguarding processes within the hospital. All staff that we spoke with were aware of the name and expectations of the safeguarding lead, how to make contact and what should be referred. The site lead and director of nursing were also informed of any safeguarding concerns within the hospital, especially if the team were concerned with a patient being discharged, or post appointment in OPD. They also had links with the local social services for safeguarding concerns. There was a strong culture of understanding with safeguarding issues. The hospital had clear processes in place to identify and escalate any cases that needed to be referred to the safeguarding lead, or where advice needed to be sought. Staff were able to give examples of cases referred as potential safeguarding concerns. All safeguarding cases were logged on the electronic reporting system.
- The safeguarding lead was working closely with staff to deliver training on the modern day slavery act and domestic violence. These were two topics of particular interest to the hospital due to their international clientele. They wanted to ensure all patients, from all cultures and backgrounds visiting or using the hospital felt it was a safe place to be able to raise any concerns. A 'Z' card was provided to all staff as a resource to act as an aide memoire for referring safeguarding cases.
- Children were seen occasionally within some adult clinics; the hospital mitigated this risk by informing the site lead, the lead nurse and requesting a paediatric nurse to attend whilst the child was in the department. The hospital were aware of the issues surrounding children within adult waiting areas. The refurbishment of the OPD was still underway during our inspection; this included the provision of new children's only waiting areas for some clinics, but not all. None of these areas were complete at the time of our inspection. If children were to be seen within an adult's clinic, advanced warning was given to the department to give them time to carry out a risk assessment and to make necessary arrangements for safeguarding the child.
- Female genital mutilation (FGM) was understood amongst staff that we spoke with. All staff completed online training in this topic, and the OPD sister had attended a conference on FGM. We did not see any posters within the hospital to raise awareness of FGM amongst staff or patients.
- Some patients attending the hospital were victims of domestic violence; this also affected the international patients and relatives. Posters were placed on toilet walls to alert those using the hospital as to how to get help and assistance with this issue, however, the poster was only available in English.

  If a patient was frail or becoming unwell, the staff or consultant would notice this and refer the patient to the nurse in charge for the department. If the concern was regarding how the patient was cared for at home or their living environment, the team would refer the patient to the safeguarding lead.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

- The service controlled infection risk well. Staff kept themselves and the premises clean. They used control measures to prevent the spread of infection.

Good

Outpatients

- We visited all of the areas within the hospital that provided outpatient services. We saw there were cleaning schedules in each of the consulting rooms that were completed by housekeeping on a daily basis, once the clinic had finished for the day. However, we found that in some consulting rooms, there were gaps in the checking of cleaning schedules; this also included some of the disposable curtains not being checked daily. We saw these had been completed everyday within the main OPD consultation rooms and the radiology department. In some consulting rooms, we found a thin layer of dust on some equipment. The daily cleaning schedules within each consulting room did not include equipment.
- The changing rooms and toilet facilities with the radiology department were clean and had their daily cleaning schedule completed.
- All areas were inspected were visibly clean and free from clutter. All clinical areas contained domestic waste and clinical waste bins. Clinical waste was contained in yellow bins and the lids closed when not in use. The bins were changed regularly and were not overfilled.
- All clinical areas contained sharps boxes affixed to the wall on brackets. These were correctly labelled and dated as required, not overfilled, and all had their temporary lids closed when not in use.
- All consulting rooms had a sink with elbow taps in line with HBN 009 regulations, hand washing soap, hand gel and paper towels. The exception to sink provision was seen on the third floor temporary OPD unit. Due to refurbishment works, the third floor was being used to assist with capacity and demand. This floor was not designed with outpatients in mind, and was an older ward style unit. There were no sink provisions inside the consulting rooms. Instead, there was a sink placed outside the room, which was shared with the consulting room next door. These were easily accessible to the consultant and nurse/HCA and therefore mitigated this situation.
- Hand gel was available in all consulting rooms, including those temporarily based on the third floor. These were affixed to the walls. Throughout the hospital, hand gel dispensers were available in all areas for staff and patients to utilise. We observed staff using hand gel as they travelled through the hospital.
- The OPD pharmacy area was awaiting refurbishment in 2019. There was a waiting area consisting of a small number of seats. It was accessible to all.
- We visited the therapies department within the hospital and found the treatment rooms to be visibly clean and bright. They contained a sink with hand wash and gel. They also contained appropriate waste bins. Within the main therapies areas such as the gym and kitchen rehabilitation area, there were sinks with elbow taps, hand wash and hand gels available. There were also sharps boxes fully labelled and dated correctly.
- We observed antibacterial wet wipes in each of the consultation rooms ready for use, as well as the examination/treatment couches covered with disposable couch roll as an infection control measure, changed between each patient usage.
- An audit was carried out by the hospital for Decontamination of Shared Medical Devices and Standards of Environmental Cleanliness 2017. This audit was carried out in January 2018 for all hospital areas. Within OPD, it was found that compliance was over 95%. The audit looked at decontamination and cleaning of equipment, through to storage of items and use by dates.
- A monthly infection prevention and control (IPC) 15 steps monthly audit was carried out, to identify any areas where the hospital was compliant and areas that needed to improve. In May 2018, the compliance level within OPD was 55%. Actions were placed against the audit, however, the action plan attached to the audit had not been created or set. A further 15 steps audit was carried out at the Well Woman Clinic which falls under the remit of OPD. This audit took place in August 2018 and showed 82% compliance. Again, the action plan log had not been filled out or completed. The 15 steps audit for the main OPD also documented themes and rationale for recommendations for improvements. The audit outlined gaps in knowledge of staff and made recommendations of actions for improving knowledge and training.

- An annual audit for Healthcare Waste and Linen was carried out. The last audit (February 2018) showed OPD had 100% compliance for waste management, however, linen management was 88%. This audit also documented themes and rationale for recommendations for improvements. The audit also outlined gaps in knowledge of staff and made recommendations of actions for improving knowledge and training. It was unclear how often this audit was carried out, therefore we cannot comment on the frequency of this audit.
- During the course of our inspection, we found all clinical staff within clinical areas were bare below the elbows. This is evident in the IPC Stats 2018 Hand Hygiene and Bare Below the Elbows Compliance Audit conducted each month between January and August 2018. Each month showed 100% compliance except June 2018 which gained 95% compliance. Between January and December 2017, the hospital was 100% compliant in all but three random months. There was no further information as to lack of compliance in those months identified.
- An audit was carried out during August 2017 or IPC Safe Use and Disposal of Sharps. This recorded 100% compliance within OPD, however, it was not clear how often these audits were carried out. This audit also documented themes and rationale for recommendations for improvements. The audit outlined gaps in know ledge of staff and made recommendations of actions for improving knowledge and training. The department had an IPC link nurse that attended IPC meetings on behalf of the department, to keep them up to date with any new developments. These meetings took place every two months.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- The hospital was undergoing a programme of refurbishment in several areas during the time of our inspection. The main OPD on the ground floor by the reception area had completed its refurbishment. There were plans in place to refurbish the OPD pharmacy area, and the outpatients area attached to this, during 2019.
- Staff within the radiology department were provided with dosimeters to measure their exposure levels to radiation. Rooms that contained radiotherapy equipment were clearly marked 'no entry', and contained warning signs on the doors for when the room was in use.
- The radiotherapy department housed a class 2 laser. We saw this was set up correctly to provide treatment and aligned correctly. Class 3 and 4 lasers were also in use within theatres. The laser therapy treatment rooms contained appropriate signage outside of the room to ensure no one entered the room whilst treatment was in progress, as well as the door being locked during treatment. Tomotherapy was also available within the department. We saw evidence that the radiology department had revalidated their ISO 9001:2015 (7.5.1) accreditation during April 2018. The report was available, and showed areas of improvement suggested, although no serious matters of concern were raised.
- There was a CCTV screen that was visible to staff and the public within radiotherapy, that had been fitted the week prior to our inspection. The hospital were aware that this was a risk, and had sought to mitigate this by changing the angle of the screen, and ordering a privacy guard to attach to the CCTV monitor to ensure unauthorised viewing did not take place.
- The therapies department was spacious, however, the waiting area was fairly small. The main gym contained curtained cubicles, gym equipment, two treatment rooms and an occupational therapy and cognitive assessment room. The therapies rooms were visibly clean and tidy, contained clean towels ready for use, piped oxygen and entonox and cleaning equipment for treatment couches, such as antibacterial wipes.
- Medication fridges within the phlebotomy department had their temperatures checked and recorded daily. The room temperatures were also checked and recorded daily. The fridges contained medication such as eye drops and diabetic medications. Disposable tourniquets were available for use to take blood samples from patients. We found items and consumables stored in boxes on the floor within the department; this is an infection risk and was also identified at our previous inspection. The reason given

for storage of items on the floor was due to bulk ordering. Personal protective equipment (PPE) was available within the department for all staff; this included gloves and hand gel.

- The flooring in all OPD areas was wipe clean. All chairs were made of a material that was able to be wiped clean after patient use.Chairs and wheelchairs for bariatric patients were available within the area that served the bariatric clinic. Access to all OPD areas was clear and had enough room for a wheelchair to pass through. There was no clutter or obstruction.
- Lifts and stairs were available for patients and staff to use, to access different levels of the hospital. There were many banks of lifts throughout the building and these were easily accessible.
- Resuscitation trolleys were checked by staff on a weekly basis. The audit provided by the hospital did not contain quantitative data, however, it rated the risk if it was found to be non-compliant. Between January and August 2018, there was one month (February 2018) that was not audited, and three months where the audit concluded the audit as 'low risk'; four months were noted as compliant. Within the main OPD area, which was situated at the front of the hospital by the reception desk, there was an adult and paediatric grab bag, as well as a resuscitation trolley based within the pharmacy area.
- Within the hospital, they had a clinical engineering department. If items of equipment had broken down or stopped working, they were called. They attended immediately and would be onsite with the equipment within 10-15 minutes. The equipment would either be repaired by the team, or a call to the manufacturer to arrange repair within 48 hours. If the item was unable to be repaired within that time, the hospital sought to loan the equipment from a third party. This was to reduce disruption to service as much as possible.

  The clinical engineering department had their own system where all equipment was logged, although they did not have a tagging system in place. Instead of a tagging system, the department used colour coded stickers, which changed each year, to identify equipment that had been tested and serviced. All the details regarding servicing and repairs were recorded within the system.They also carried out portable appliance testing (PAT) in-house. All pieces of equipment had a device report available to view. The team were also responsible for organising movement of equipment throughout the hospital.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- The hospital staff were aware of patients' needs and medical conditions. If a patient checked in at the reception desk and looked unwell, the front of house team and patient coordinators alerted the senior sister to deal with the situation.
- Patients were escorted to the waiting area from the reception desk by patient coordinators. They were the patient's point of contact throughout their visit to the OPD. If a patient felt unwell, they knew to contact this person. Nursing staff were available within the OPD and the senior sister was within the department at all times. The senior sister was there to oversee the running of the clinics and for patient welfare. This included watching patients for any signs of deterioration whilst they waited for their appointment. If a patient was identified as deteriorating, the senior staff nurse would use the national early warning score (NEWS) chart to monitor the patient and record their observations. They would then inform the patient's consultant of the patient's condition, and make a decision as to whether the patient needed to be sent to an NHS hospital via ambulance, or needed to be seen for their appointment and stabilised at the hospital. Consideration was given as to whether the patient's insurance would cover any further treatment. All nurses within OPD were intermediate life support (ILS) trained. If a patient went into cardiac or respiratory arrest, the hospital would stabilise the patient and then call an ambulance to take the patient to the nearest NHS hospital. The patient's consultant would also be informed of the situation.
- The hospital provided an example of a situation involving a patient and identifying risk. A patient attended the OPD and had a cough. At that stage the OPD team became concerned that the patient may have a respiratory disease that could be passed on to others close to the patient. The concern was raised with a consultant microbiologist to gauge the level of

risk, and they were able to reassure staff and take appropriate action to mitigate the risk. A root cause analysis (RCA) was carried out; actions were identified and given a time scale for completion with an appropriate person to follow the action through.

- For specific invasive treatments, procedures and specialities, the hospital had developed a folder containing safety standards for nursing and consultant staff. Staff had input in developing these; the governance team notified the department if there were any changes or updates to national and NICE guidance.
- In some adult clinic areas, children were seen by the OPD team. At the time of our inspection, not all clinics had separate paediatric waiting areas. To mitigate this risk, a paediatric nurse was asked to attend the department whilst the child was present.
- If a patient went into cardiac arrest, the crash team would attend to the patient and attempt to stabilise them, and if required, would call for an ambulance to take the patient to an NHS hospital for further treatment. The hospital were aware of their duty of care, regardless of insured status of the patient.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- Within OPD, there is no national guidance as to how nursing staffing should be planned or utilised. The hospital used an electronic system to plan staffing levels based on information including, the clinics running each day, knowledge of the consultant and their clinical speciality, the requirements of the specialty and any further needs to plan their nursing staffing levels. Between September 2017 and August 2018, no bank or agency staff were used to cover the OPD reception. During the same time period, bank and agency nursing staff usage for OPD varied between 9% and 22.81% for bank staff and 2.39% and 12.97% for agency staff. The month with the highest bank usage was September 2017, and November 2017 for agency nursing staff. Ad hoc clinics were staffed by flexi staff; the staffing for these clinics was reviewed at 3pm everyday by the nurse in charge.
- The hospital had employed nursing staff within OPD. If they needed to fill a shift due to holidays, sickness or flexible clinic demands, they would ask nursing staff if they wished to cover the outstanding shifts. If they were unable to oblige, bank nursing staff were contacted and offered the shifts. Agency nursing staff were used if substantive and bank staff were unable to fill the shifts. All bank and agency staff were known to the hospital and were consistently used where needed.
- All nursing staff had been through the hospital vetting procedures, security checks and professional validation checks prior to being accepted by the hospital. All bank and agency staff had attended the hospital induction and training programme before treating any patients.If a nursing member of staff required suspension, the lead nurse had a conversation with the member of staff and documented this, and informed HR. The lead nurse would issue a letter of concern to the employee and place this in their HR file whilst notifying HR. If required, the hospital would contact the nursing and midwifery council to report the matter. We were informed this situation had not arisen within the hospital.
- If a consultant requested a specific nurse to work alongside them within their clinics, they had to go through the hospitals practising privileges procedure and be accepted prior to working at the hospital.
- At the time of our inspection, there were two nursing vacancies in OPD. Until these posts were filled, bank and agency staff were being used to ensure all clinics were adequately staffed. Once the vacancies were closed, the hospital intended to keep using bank and agency staff to cover holidays and other shifts as required, to ensure they kept up to date with the hospitals standards and requirements. The hospital did not have an issue recruiting or retaining staff. A new senior staff nurse was joining the team in November 2018.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

- There is no national standard to describe the level of medical staffing required within the OPD setting.
- Consultants worked on a system of booking rooms/ clinics within the hospital. They normally ran clinics at set times each week, however, ad hoc clinics did take place to cope with patient demand. Consultants booked their clinics six weeks in advance, therefore holidays and planned absences were able to be factored into this. If a clinic was cancelled due to unforeseen circumstances, the hospital would offer the patient an alternative list of consultants under the same speciality that could be utilised. Patients that were funded by insurance were asked to check authorisation for change of consultant prior to agreeing to see an alternative.
- All medical staff worked on practising privileges with the exception of the resident medical officers (RMOs). In order to hold a clinic within the hospital, consultants and doctors had to go through the hospitals practising privileges process, which included being accepted by the MAB.

Records

Staff kept detailed records of patients' care and treatment

- Patient medical records for clinics running on that day were stored in a large cupboard behind the consultant reception desk. These were brought to the department daily and removed every evening. The cupboard was always attended whilst records were present; however, the cupboard was not locked.
- As part of our inspection, we reviewed 10 paper medical records. The hospital did not use electronic patient records within OPD. Diagnostic results were stored and accessed via an electronic record system; this was available to all consultants within OPD. We found that four out of ten records did not have the patient contact episode recorded in the hospital patient record. This is conclusive with the hospital's own medical records audit findings. This did not comply with best practice or records management code of practice for health and social care. GP letters did not always correspond with the patient records, as in some cases nothing had been recorded of the patient's visit. The divisional lead was aware of this situation, and had introduced a care plan for every patient seen; this had to be completed by nursing staff and consultants. There was a plan to audit these records to see if there was an improvement on the medical records audit results.
- Within patient records, there was no evidence that patients were involved in their treatment, care or decision making. There was no information to suggest patients were provided with information leaflets to take away to read in their own time. There was also no evidence to show patients were told when their test results would be available. Medical records were not permitted to be removed from the hospital unless express permission was sought from the medical director.
- We were provided with audits of OPD medical records. The hospital based their audits on the general medical council (GMC) guidelines. A total of 30 patient records were reviewed between April 2018 and June 2018. A total of 10 records were selected randomly each month. The hospital found overall compliance was 61.81%, the target was between 80-90% compliance. The variations reported were 6.67%-76.6% for compliance across all questions; 6.67% was the number of patient records with their unique number recorded on both sides of the sheet. It was noted within the audit that 23% of patient records did not have any patient documentation regarding their visit within the hospital notes. They also found in 13.3% of cases, medication prescribed was recorded. The audit identified 20% of cases where a chaperone was required, however, it showed a 60% compliance with the chaperone being accepted or declined when offered. The compliance rate for obtaining consent was 100%.
- A further audit was carried out for medical records during July 2018-September 2018. Overall compliance remained at 61.81%. Some of the areas of the records reviewed were the same, allowing the results to produce a comparison, and one had improved. This was medication that was prescribed and recorded and had increased to 36.37%. Chaperoning and consent were inconclusive, as one record required these interventions, therefore it was recorded as not being a true reflection of the records. Within this audit, it did

however audit the legibility of the notes written. This scored 66.67%, although the commentary provided with this figure considered it may not be useful or conclusive.

- Auditing of nursing notes had started just before our inspection. This was due to feedback from staff, as nurses and HCA's had nowhere to write their notes from the patient visit. There were no audit results available at this time. At the time of our inspection, waiting times, time to consultant and time to check out were not audited, however plans were in place to begin this process.
- If a patient's medical record was not available, the patient was still seen by the consultant, and the front of house was informed of the situation. Temporary records were produced and sent to the medical records storage unit once completed. The incident would then be recorded on the electronic reporting system.
- Within the therapies department, paper records were used and scanned onto the computer. They were transferred from a word document to a PDF and stored on the hospital records system. This situation was on the hospital's risk register.
- GPs were not always sent discharge or follow up letters regarding their patients. Some patients were international and did not have a GP; some patients attended a private hospital because they did not want their GP to be informed. The hospital were unable to audit the number of letters sent to GPs and their timescales; this was due to the fact that each consultants secretary was responsible for the production and sending of the letter, and they were not based within the hospital, therefore obtaining this data was not possible. The hospital accepted the patient's wishes and act accordingly, however, the patient always received a copy of the letter for their records. Some patients were sponsored by a third party or an embassy. For these patients, consent was sought before details of their medical conditions and records were passed on to their sponsor.
- If a patient living with dementia was to attend the hospital for care or treatment, if the hospital was aware of this situation, they would email the OPD team and ask them to read the patient notes. There was no current way of flagging a patient living with dementia to alert staff. This was also the same for patients with learning difficulties and mental health conditions.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

- Prescription pads were stored in a locked cupboard when an individual consulting room was not in use. These were logged in and out when required. Patient group directives (PGDs) were used to administer a limited range of medicines to patients. The PGDs we saw complied with all legal requirements and there was a list of all staff that had been trained to use them.
- This system had very recently been implemented after a risk assessment identified a possible risk of diversion (August 2018).
- We spoke with the pharmacy department and were told there was always a minimum of one pharmacist within the department. The pharmacists were very proactive and would contact other departments and/or consultants for advice or guidance on medications to be dispensed if there were any queries. The inpatient pharmacists were able to cover the OPD pharmacist if required, so that consultants could be spoken to face to face.
- If a medication was out of stock, or had to be specially ordered, most medications could be delivered to the hospital within a few hours or the next day. They had good relationships with suppliers and were able to provide a fast service for their patients.
- The hospital housed an OPD pharmacy, which was based on the ground floor within the main OPD. This remained open throughout clinic hours to enable patients to obtain their medications. The pharmacy team kept in touch with the OPD team, so that in cases where clinics ran late, patients were still able to have their prescription filled. They received twice daily deliveries of ordered medications to ensure they were able to fulfil patient demand. There were certain medications that consultants used that had to be ordered from abroad. These could take up to a week to arrive, however, if this was a medication routinely used at the hospital, the pharmacy ensured they

monitored stock levels to cope with demand and timescales. At times, consultants utilised unlicensed medications to treat their patients. If the pharmacy received a request for this from the consultant, the medications would be verified with the drugs and therapeutics committee before approval was granted. This committee looked at research and references before approval was given or rejected. The pharmacy were able to dispense all medications and prescriptions except for NHS prescriptions. Waiting times for prescriptions to be filled were audited. The last audit was conducted between April and May 2018; the findings were an average waiting time of 22 minutes. They had set their target time of 10-15 minutes, however, they realised this was unrealistic. The reasons identified for the larger waiting times were; the pharmacist needed to contact the prescriber to clarify the prescription, certain medications being used off licence had to be recorded separately and this took extra time, some medications needed to be reconstituted before dispensing could take place, controlled drugs (CD) had to be written in the CD register to ensure an audit trail could be followed, as well as other factors. An action plan was created to try to reduce waiting times where this was safe and possible. The action plan was not yet in use or allocated to individuals for action.

- For our detailed findings on medicines please see the Safe section in the Surgery report.

Incidents

The service managed patient safety incidents well.

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- There were no never events or serious incidents (SIs) within OPD during September 2017 until September 2018. We were aware of two incidents that occurred within OPD between January and August 2018. Learning from incidents had been taken on board by the hospital management team, and shared down through to all staff. This was evident in the staff communications that were produced; this was not just with the incidents that we were aware of, but included other departments.
- We saw the final response letter sent to a patient involved in an incident at the hospital. The letter set out the concern, what had gone wrong, the outcome of the investigation, an apology and a final outcome. The hospital showed how they had used the duty of candour with this incident, and were able to explain the process fully. Learning was disseminated down through the management team to the staff within the department, to ensure the issues did not happen again.
- Within OPD, they had started a new system for incidents and complaints. The team was encouraged as a whole, to conduct the root cause analysis (RCA) together, establish any issues that led to the incident occurring, and to establish learning for the team. The hospital felt this was a way to ensure the team were involved with the process, as well as learning how to conduct an RCA.

Are outpatients services effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- The radiotherapy department carried out a number of audits throughout the year. These ranged from handwashing audits, crash trolley audits, patient care pathway audits to radiation and dosimetry. We saw evidence of the audit calendar, audits which had been completed by the time of the inspection, as well as those planned for later in the year. The audits provided observations and recommendations, however, there was no scoring used. This meant that no direct comparison was able to be made or reported upon as there was no quantitative data.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

- Staff gave patients enough food and drink to meet their needs.

- Patients had access to water fountains at all times in waiting areas. There was also a coffee shop in the main OPD reception, as well as a restaurant in the basement of the hospital. Patients were able to utilise these services as required during their opening hours.
- Patients within the department were provided with a voucher for a hot drink and a sandwich if they had been waiting 10-15 minutes for their appointment. These vouchers were for use in the coffee shop within the main OPD reception area. This was so that patients were able to obtain refreshments without leaving the area, and risk missing their appointment.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Staff assessed and monitored patients to see if they were in pain and supported those unable to communicate using suitable assessment tools.
- If a patient arrived at the hospital and was in pain, the nurses would speak to the patient's consultant and see if they could prescribe some pain relief for them. The patient would have to pay for the medication given unless their insurance covered the cost. Pain was assessed by asking a patient to rate their pain on a scale of 1-10. If patients were unable to understand this or had dementia or learning difficulties, the nurse would use a paediatric pain scale that used a series of faces with different facial expressions to describe their pain. The lead nurse for OPD sat on the pain group and fed back to the OPD team with any new information.
- There was a minor procedures room that was used within the OPD. Local anaesthetics were available for use for patients undergoing procedures that were required. All of the medications were stored correctly and safely within the department for these procedures.
- There was an onsite pharmacy that also sold over the counter medications that could be taken for pain relief. There were no controlled drugs kept within the OPD.

Patient outcomes

- The hospital did not benchmark against other organisations or NHS trusts, or monitor patient outcomes for outpatients specifically. Audits were conducted by each speciality within inpatient areas for example, surgery or medicine, and outcomes were reported towards national audits.
- As the hospital was not able to benchmark within OPD, they commissioned a peer review of the department from another provider with an 'outstanding' CQC rating. They attended the hospital and carried out a 15 steps challenge on specific and specified criteria. A report was then produced with the findings. The report RAG (red, amber, green) rated the findings; the hospital took the findings that resulted in a 'red' within the RAG rating system, and produced an action plan to cover those points raised, to improve their standards.
- At the time of our inspection, the hospital had a working copy of their quality improvement plan (QIP) for OPD. This had 48 items logged, and had each item rated as red, amber or green (RAG) depending on its completion status.
- Another system in place was with insurance companies and Bupa UK. They monitored and benchmarked the service against other independent providers, so that terms of business could be negotiated every year.

Competent staff

The service made sure staff were competent for their roles.

- Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- All staff were on an electronic system that logs dates of revalidations, training and appraisals. The system notified the nurses 90 days before their revalidations were due, to ensure they were provided with enough time to complete all relevant forms and training prior to this date.
- The hospital provided multiple in-house training courses, in both clinical and leadership skills, where nursing staff were able to gain continuing professional development (CPD) points and use these towards their revalidation. All training and CPD that was agreed, was

paid for by the hospital; this included external courses. Courses were booked through an electronic system, which sent the request through to the staff members manager, where it was either agreed or declined. Staff told us they felt supported to attend training courses, and were given paid time off to attend these. Career opportunities were also discussed and offered at staff appraisals. There were no clinical nurse specialists (CNSs) that worked under OPD.

- Consultants worked at the hospital under practising privileges. All consultants practising privileges had to be agreed at the medical advisory board (MAB), and through the medical director's office. This process checked their suitability for acceptance via interviews, checking of credentials and references. Only once they had satisfied all of the terms and conditions were they allowed to practice at the hospital. The OPD lead nurse and sister were notified via the divisional lead once a consultant had been accepted. If a consultant was suspended or practising privileges were removed, HR informed the divisional lead, OPD lead nurse and sister; the security department were also informed, so that the consultant was unable to enter the hospital, and computer logins were suspended. The process was dealt with via the medical director's office, in conjunction with HR.
- All radiology staff were registered with the Health and Care Professions Council, and their registrations were up to date. They belonged to a journal club that also included medical physics. They invited a wide variety of presenters from different specialities to give talks to continue their learning and keep their knowledge up to date. Radiology staff were entitled to study leave, and encouraged to attend training and courses to develop their expertise. Funding was available for training, however this had to be applied for and agreed as required.
- Therapies staff all completed mandatory training, including basic and intermediate life support. Training was via internal and external courses, some of which were provided by Bupa UK. The hospital paid for essential and revalidation courses. CPD was completed via internal courses. All staff within the department had appraisals as well as one to ones with managers on a four to six week basis. These were all recorded.
- Pharmacy staff were up to date on mandatory training. They had to complete CPD to remain registered. A new revalidation system was being brought in at the time of our inspection, and at this stage, was voluntary. The chief pharmacist was currently going through the process, to gain an understanding and ensure the correct processes were in place. This also allowed for mentoring other pharmacy staff through the process. There were no specific pharmacy in-house training events; all were external courses. Staff were encouraged to attend courses and develop their expertise and broaden their scope of practice; an example was for prescribing courses. Training courses had to be applied for and approved before they were booked. Funding was provided on approval by management. The chief pharmacist had attended accountable officer training for this hospital.
- All bank and agency nurses had attended an induction at a local level at the hospital, before they were allowed to begin working. For agency workers, the practice development nurse liaised with the agency prior to accepting any new members of staff, to ensure mandatory training and revalidations are up to date. For bank staff, they attended an induction and mandatory training at the hospital, before being accepted to work. The HR department within the hospital ensures all training and revalidations are correct and up to date. Once they are satisfied the nurse is competent, they email the lead nurse and sister for OPD. For bank staff, appraisals take place twice per year; once in the middle and once at the end of the year. They also take part in 'ongoing conversations', which occur monthly, and allow both the staff member and the manager to give feedback to each other, and discuss any concerns.
- The sister in charge of OPD carried out appraisals for all senior staff nurses. Senior staff nurses carried out appraisals for staff nurses and HCAs.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- Multidisciplinary meetings (MDMs) occurred within the hospital for a variety of specialities. Not all of these were within OPD. Within OPD, there was an

established breast MDM which was also classed as a one stop shop. A meeting was held to discuss a patient's medical case and the investigations or treatments that may be required. For example, the MDM consisted of a breast nurse, oncology consultant, radiologist, radiographer, radiology nurse and an administrative team member. The patient was then booked to go to the hospital for a day and attend a number of appointments, rather than returning for separate visits. This included scans, biopsies and consultation with the oncologist, all as required. This was coordinated by a lead clinician, so that the day ran smoothly and effectively for the patient, with as little stress as possible.

- The hospital were in the process of starting their prostate MDM one stop shop within outpatients, and this followed a very similar path to the breast one stop shop. It was to spend a day within the hospital, attending various clinics and theatre if required, to avoid multiple visits for the patient.

We were shown the plans of new MDM's and one stop shops that the hospital were in the process of beginning. Some of these were set to go live during October 2018, and included a pelvic floor pathway to deal with urinary incontinence.

Seven-day services

- The hospital provided OPD clinics Monday to Friday 8am until 8pm and Saturday 9am until 2pm. There were no Sunday clinics.

Health promotion

- Patients were encouraged to look after their health in a number of ways. Leaflets were available to patients in waiting areas on health conditions such as high cholesterol, breast awareness, men's health and diabetes type 2. The hospital also provided health assessments for their patients; there were a variety of different levels of health assessment the patient was able to choose from, depending on their concerns or level of insurance cover.

Consent and Mental Capacity Act

- The hospital did not treat mental health conditions within the hospital as one of their speciality service. If a patient with a mental health condition were to attend the hospital, primarily for this purpose, the hospital assisted the patient by either contacting the local NHS Trust for advice and guidance, or, if the patient had health insurance that covered mental health conditions, the hospital would contact a well-known local private mental health hospital to ask if they were able to take the patient and assist. There was no other mental health provision within the hospital.
- The hospital did have a Mental Capacity & Deprivation of Liberty Safeguards (DoLS) Policy. This was written in September 2016 and due for review in September 2018. At the time of our inspection, this review had not yet taken place. Following the inspection we were informed the review was delayed for a short period.
- We saw the hospitals consent policy. This was in its seventh version and had been reviewed during July 2018. It was next due for review in July 2020. We saw evidence that patients had consented to examination and treatment in the patient notes. This was also part of the hospital audit, where 100% of notes reviewed showed consent was obtained and recorded.

Are outpatients services caring?

Good

Compassionate care

Staff cared for patients with compassion

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff at the hospital treated all patients and other members of staff with care, kindness and compassion. We noted several examples of where staff went above and beyond their role so that patients felt cared for and looked after during their visit. Patents said they had had a great experience, felt well looked after and that staff were genuinely friendly. One patient commented, "felt like me, felt like a person, always called me by name".
- Patients were met at the reception desk by the front of house team; they were immediately allocated a patient care coordinator who became their single point of contact for their visit to OPD. They escorted

the patient to the nearby waiting area and seated them. When a desk became available, they were invited to attend a check in desk with their coordinator. The role of the coordinator at this point was to check all the patient details, answer any questions and take payment. Once this process had been completed, the patient was re-seated in the waiting area. The desks used were private and confidential and separated from the main waiting area. The patient coordinators then proceeded to check the patient in with the consultant's desk, where the patient's medical records were stored. The patient remained seated during this time.

- A quiet room had been created during the refurbishment works within the radiology department. This room was for patients or relatives that were breast feeding or for having confidential conversations with patients as required.
- Posters were seen placed within the OPD areas reminding patients that they were entitled to ask for a chaperone if required.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- A counsellor was available to patients at the hospital, especially after they had been given some bad news. The counsellor was a palliative care nurse based within oncology. They were on hand to attend the OPD as required. The hospital provided eight complimentary counselling sessions to their patients that had been given a cancer diagnosis, or were undergoing treatment. This also extended to the patient's relatives. If the patient required further sessions, they either had to refer back to their insurance company, or pay for these privately.
- Staff had been trained to provide emotional support for their patients. In the event bad news was to be broken, the consultant would provide the information to the patient, supported by a nurse or HCA. Specially trained nurses within inpatients were also asked to provide support to patients that had been given bad news; they were more than happy to come down from the wards to support patients and staff within OPD.
- For patients with conditions not relating to cancer, counselling was available to patients on paid service or via insurance if their insurance company authorised the service.

Costs were discussed with all patients prior to any care or treatment being provided. The discussion took place at the confidential patient coordinator desks, where forms were signed, and payment taken, if required.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- The hospital understood that international patients often travelled with a large number of family members. At times, many relatives would attend with the patient for their consultations. The hospital accommodated as many relatives as possible; however, there were times it was explained there was not enough space in the consulting room to accommodate all. These conversations were handled sensitively and with care and explanation.

Are outpatients services responsive?

Outstanding ☆

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

- The hospital provided services to the local community, as well as international and national patients. They had identified the areas and cultures predominantly utilising the hospital, and had ensured all patients were catered for. The International patient centre (IPC) arranged translators for patients in advance of their visit to the hospital once the appointment had been booked.
- The newly refurbished OPD area on the ground floor near the reception desk was bright, spacious, visibly clean and had good access for all patients. There was complimentary tea and coffee available to patients in certain OPD areas including radiology, except in the

main reception area where there was a coffee shop situated. Water fountains were in all waiting areas around the hospital, and bottled water was available if requested by a patient.

- Within the main OPD area, there were individual desks situated along a wall with privacy dividers in between. These desks were to enable each patient to be checked in and discuss any questions or financial information required. Payment was also taken at this location. The dividers were modern and transparent, with a pattern throughout for privacy and aesthetics. At all desks where computers were displayed, privacy screens were present on the monitor to stop confidential information being visible to anyone walking past or sitting at the desk.
- Documentation was available in English, Arabic and Russian. The hospital was looking into producing leaflets and information in alternative languages via their website in the future, as it was not possible to cater for all languages in a paper format. At the time of our inspection, the hospital mitigated this risk by providing a translator for the patient to understand their leaflet or document. Some staff spoke alternative languages. These were clearly marked on their name badges by displaying the flag of the country applicable. Staff were used to translate where possible and if appropriate.
- Patients attending from abroad were inducted into the hospital on arrival. Part of their induction was a cultural lesson. Similarly, staff were taught about different cultures and behaviours and what to expect from international patients; this included how they preferred to be treated and what would be classed as respectful.
- There was no car parking available at the hospital. There were good links via train and taxi's to the hospital. The hospital had a service level agreement with a taxi company, to provide transport services as required.
- Every month, the hospital held the 'Cromwell Conversation'. This was a talk by a consultant at the hospital on a specific topic. The local community were invited to attend and ask any questions they may have. The hospital used these meetings to engage with the local community and to provide services that they required.
- Very few NHS patients were treated at the hospital. If they were seen or treated, this was under contract via the NHS, however, these patients were not treated any differently to private patients.
- If a clinic was running late, a complimentary taxi was offered to the patient, to reduce their inconvenience.

Meeting people's individual needs

The service took account of patients' individual needs.

- Clinics were run Monday to Friday, 8am until 8pm and on Saturdays from 9am until 2pm. This was to meet patient demand, for those working or travelling. If clinics were overrunning, or running late (classed as 10-15 minutes wait), the patient was offered a refreshments voucher, and the consultant had a red card placed on top of their files. This was so that they had a visual cue that they were running late. If the consultant was running late and had not yet come out of their consulting room, the staff were able to call through to the room on the intercom telephone, making it ring a couple of times to alert the consultant. Rapid access clinics were available for breast and prostate. These were 'one stop shops' for a patient to attend, to reduce the number of visits to the hospital for a diagnosis.
- Understanding different cultures was important to the hospital. They provided cultural lessons for both staff and patients to reduce any issues due to cultural differences and misunderstanding. This was provided by the international patient centre. An example was provided by the international lead. In certain international cultures, it is acceptable to raise your voice and demand certain items or services. Patients were provided with information to explain how this behaviour differs within the UK to other countries and cultures.
- Deaf or hard of hearing patients were catered for with 25 hearing loops throughout the hospital. Interpreters were also available and accessible for face to face communication. Translators were readily available

within the hospital. The main languages spoken and required were Arabic and Russian. Many of the staff within the hospital were international. Each member of staff fluent in a language other than English, wore a small flag on their name badge to identify them as able to translate and assist patients. If face to face translation was not available, or there was an emergency situation requiring an alternative language, a telephone translation service was available.

- At the entrance to the hospital, there was a map of the layout. This was accessible for all patients as it contained braille for patients with sight problems. The map provided helpful information to those patients with mobility issues where departments were located, where stairs were situated, and where pillars were located, for ease of movement and safety.
- Visitors and patients attending the hospital came from a wide variety of faiths and cultures. The hospital was able to cater for each dietary requirement. Pre-made sandwiches and beverages clearly displayed any allergens, and catering staff were on hand to assist with requests. Alternative milks were also available within the coffee shop situated in the main reception OPD, for those with allergies and dietary preferences.
- All areas were signposted clearly in English and Arabic. The hospital received a large number of Arabic patients, therefore they endeavoured to cater for their needs.
- Patients attending radiotherapy appointments were provided with information and leaflets that helped them understand each part of their treatment, from the first day through to the end of their treatment. This included what to expect emotionally and physically from the treatment received and advice. These had been provided as part of patient feedback. Patients had many questions about their treatment, these leaflets aimed to provide as much detail as possible.
- If the clinic was delayed by 10 to 15 minutes, the patient was informed and an explanation was provided. A voucher was also provided for tea, coffee and a sandwich from the coffee shop based within the OPD. Options were also offered to the patient, such as an alternative consultant if they preferred.
- Within the main OPD waiting area, there were two dementia friendly clocks displayed, one at each end of the waiting room. There was also a dementia friendly room based on the first floor of the hospital.
- Patients attending the well woman clinic were asked prior to their appointment if they required a chaperone. They were then asked again by the consultant, if applicable.
- Wheelchairs and seating were available to accommodate bariatric patients' needs. The wheelchair was available via porters, and appropriate seating was based within the area of bariatric clinics. Within the clinics, equipment for bariatric patients, such a blood pressure cuffs and weight scales were available.
- Leaflets were available to patients throughout the hospital. These were predominantly in English, but were also available in Arabic. Other languages were not always available. The hospital mitigated this by providing a translator for the patient, should an alternative language be required. At the time of the inspection, the hospital was working towards putting their leaflets online within their website, where they would be able to be translated into a variety of languages without the need for a translator. If an international patient was attending for an appointment, the IPC arranged a translator in advance.
- The radiology department contained leaflets on procedures, cancer and fatigue. There were also newspapers, magazines and cookery books available and accessible to all patients. Posters were displayed with 'You said, we did' results displayed; there was also a feedback box for patients to post their suggestions and comments regarding their experiences. Refreshments were complimentary and available for all patients within this waiting area.
- Part of the OPD had moved temporarily to the third floor of the hospital. This was due to the refurbishment works that were ongoing. In the waiting area, there were newspapers and magazines available, and a water fountain was accessible to patients. There were leaflets on vaccinations and immunisations for young people and information leaflets for patient information, on a variety of topics and subjects.

Signage was in English, with some signs also translated in to Arabic. There was adequate waste and recycling provision and a plug socket to enable patients to charge their mobile phones or tablet devices. The area did get busy at times, as it was the waiting location for the third-floor pharmacy, phlebotomy and three clinical rooms.

- The occupational and cognitive room was set out as a kitchen environment, to allow assessment and therapies of everyday living skills. This room also contained equipment to create a personalised splint for a patient on request from a physiotherapist or consultant.
- The hospital held several one hour drop in sessions to raise dementia awareness amongst staff. These took place throughout the year, and were provided through a number of morning and afternoon sessions. This was to give staff many opportunities to attend. The hospital had a document called 'This is ME' for dementia patients. This document recorded details about the patient, their preferences, their likes and dislikes, specific memories, and other personal details. This was to help staff care for, and treat the patient in a way that they would wish, as the patient may not always be able to make this known to staff.
- Staff were given a 'Z' card. This was a pocket guide to dementia that was issued to all staff. They were able to keep this with them for reference and assistance. If the hospital was alerted to patients attending with dementia, they would ensure a member of staff accompanied them throughout their visit, to each of their appointments.
- There was a dementia strategy in place for 2018 until 2021. This had been issued in January 2018 and reviewed in August 2018. It was next due for review in January 2019. It outlined aims and objectives and how the hospital hope to integrate dementia awareness and assistance to its patients.

- Posters were seen in all OPD areas offering a chaperoning service to patients. We heard patients asked if they required this service prior to seeing their consultant. There were also posters reminding clinical staff to be bare below the elbows in clinical areas and when dealing with patients.

Access and flow

People could access the service when they needed it.

- Patients calling the hospital or contact centre had the phone answered within three rings, which equated to under 10 seconds. Call answer times were reviewed daily and weekly, however, this information was not available. Other options were also available to patients; they could leave a message for a call back, or were able to redial the call centre at another time.If the hospital or organisation had a marketing campaign running, the call centre had dedicated telephone lines for this, to ensure business as usual was not interrupted. There was a bookings reception desk based within the main OPD reception. At the time of our inspection, this was manned between 5pm and 8pm daily. The hospital hoped this would increase to 8am until 8pm once staff had been recruited to fill this position. Until this time, a telephone was placed on the bookings desk to enable patients to contact the call centre to book their next appointment outside of these hours.
- Patients were offered appointment times to suit their needs. Clinics ran from 8am until 8pm Monday to Friday and 9am until 2pm on Saturdays, so that patients had a variety of times to choose from.
- Next day appointments were available for patients, and there were no current waiting times. Patients that had arrived for appointments were kept up to date with any delays by their personal patient coordinator.
- Patients were generally seen within a few days after booking their appointment or sooner. There were no waiting times for appointments, however, patients could postpone or choose appointments further into the future to suit their schedules if needed.
- The hospital did not monitor referral to treatment times. For NHS patients, no data was collected as this was collated by the referring trust.
- There were times that clinics were cancelled. The hospital was unable to give us specific figures for cancellations for the OPD alone; their figures included the GP service and other clinics that were not within the scope of this inspection. Between June 2017 and May 2018, the number of clinics cancelled, including

those not within the scope of this inspection was between approximately 110 and 140. The number of patients rebooked within two weeks was 79%, two to 12 weeks was 17%, and more than 12 weeks was 4%.

- The call centre assisted patients to rebook at a convenient time, or patients were able to liaise with the consultant's secretary to rebook their appointment. If a clinic was cancelled and an international patient had begun their journey to the UK for this purpose, an alternative consultant was offered. If the patient had already arrived, the situation was explained to the patient and again, an alternative consultant was offered if there was space in their clinic; this was also dependent on whether the patient was covered by insurance. If they were, the patient had to have authorisation from their insurance company prior to agreeing any care or treatment. We were told this had not occurred, as consultants go above and beyond for their patients. We were given an example where a consultant had left an important family function in another UK city early, to ensure he was able to see the patient as booked.

- The hospital did not monitor their do not attend (DNA) rate. Patients were sent an email confirmation of their appointment at the time of booking, however, there was no reminder system in place nearer to the time of the appointment. There was no process to follow up patients that did not attend for their appointment. The consultants' secretaries were involved with making and cancelling appointments. Monitoring and recording DNA rates was not always possible as the secretaries did not work onsite.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- Complaints received were logged on an electronic reporting system. This process generated an email to the outpatient management team for review, investigation and root cause analysis (RCA) if required. The complaint or concern was acknowledged by the lead nurse via email reply. Once the complaint or concern had been investigated, a reply was sent to the complainant. This would include the resolution if it was not personal or something that was not able to be disclosed. Learning was also established, and disseminated throughout the team and other clinical areas. This was sent out via staff newsletters, emails, team communications and staff meetings. This was also relayed to the complainant via the electronic reporting system.

- Between January 2018 and August 2018, there had been 15 OPD nursing complaints recorded on the electronic reporting system. These recorded the initial complaint, the date the complaint was first received, initial actions, actions taken and lessons learned. We found that nine out of the 15 complaints recorded had their lessons learned recorded and one complaint did not record actions taken.

- Complaints were also reviewed by senior management and executives. An executive from the hospital responded to formal complaints raised by patients. We saw two letters sent in response to complaints from the Operations Director. The letter was open, honest and apologetic. It addressed the concerns of the patient and provided an apology, explanation, and lessons learned and how the hospital would take the information forwards to improve their service. The hospital had a complaints policy which was due for review in September 2018. The policy stated that all formal complaints should be acknowledged within three working days and logged on to the electronic reporting system. The hospital set themselves 20 days to respond to the complaint, which should provide time to carry out any investigations required. If this was not possible, a holding letter was sent to the patient. We were not provided with timescales for responding to complaints within OPD.

- Staff were actively encouraged to use the electronic reporting system to document any issues or concerns, to create an audit trail, as well as to help establish any trends. This extended to clinics delayed by 10-15 minutes, to monitor clinic delays to help improve the service patients received.

Good

Outpatients

Are outpatients services well-led?

Good

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The leadership team within OPD comprised four senior staff nurses that reported to the OPD sister. The sister in turn reported to the lead nurse. The lead nurse reported to the divisional manager and the director of nursing. The directorate lead reported to the operations director. Both the operations director and the director of nursing reported directly to the hospital director.

- The leadership team were visible within the OPD. Staff knew the names of the board and their roles. The lead nurses for all departments (three lead nurses), listened to feedback from previous staff surveys and suggestions. Each nurse either worked the late shift, or stayed after 5pm on a rotational basis; during which time, they conducted a walk around different departments, and asked staff how they were, if they needed any help, and any challenges that they were facing and any changes they thought needed to happen within the hospital. Staff found this helpful, as the lead nurses were able to offer suggestions and advice, or help if required, after other management had left for the day. Staff and management felt that this increased their visibility throughout the hospital. The divisional manager conducted a weekly walkabout, and the divisional manager and lead nurse conducted a bi-weekly walkabout together. The lead nurse was able to give an example of how they were able to offer help and advice during their walkabout within a different department.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff.

- The hospital had a very clear vision and strategy. All staff were very aware of these and worked towards achieving it throughout their work. We were given examples demonstrating how they incorporated this into their work.

- The hospital vision was to 'be a hospital of choice dedicated to caring for you'. The values were caring, passionate, open, and extraordinary. Each department was responsible for creating their own strategy, however, OPD were waiting for further details from the hospital strategy before they were able to create their own; they hoped this would be completed by October 2018.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The culture within the hospital was positive, and patient and staff-centred. Staff were kind and caring towards each other and happy to help and assist where necessary. They were open and honest and felt this was reflected as they were encouraged to report incidents and concerns freely on the electronic reporting system, as they believed that safety and patients came first. Staff were also encouraged to log positive feedback and compliments on the electronic reporting system, and they had started to see an increase in this.

- The hospital had a speak-up policy to allow staff to speak openly and freely about any concerns they may have had. The policy was reviewed annually and was due for review in October 2018. It set out the remit of the policy, contained contact details of those that may be able to help staff, and information on topics that were subject to the policy. The hospital also provided a staff helpline that they were able to call, to get advice and guidance as required. Managers had an open door policy so that staff felt comfortable and able to raise concerns as required.

- Health promotion was also available to staff as part of their contract and work package. All staff were entitled to a number of health promotional treatments, activities and health checks either on a complimentary basis or at a reduced rate. This included free flu jabs every year, being able to arrange

time with the in-house masseuse, discounted gym membership, reduced rate health checks and advice lines. Once staff had been in post for six months, they were entitled to a comprehensive health assessment by the provider.

- On national sepsis day, the hospital ran quizzes and provided educational material to all staff that attended the staff restaurant during certain hours. They also had a theme to the day and provided cakes and pastries to staff who took part.
- Some nursing staff felt unable to challenge certain consultants on behaviours that were shown to them. This had been reported back to the OPD management team. To act on this feedback, the divisional and medical director had created an escalation process, to assist staff and enable them to report and deal with behaviours they felt uncomfortable with. At the time of our inspection, the draft escalation process was out for consultation with staff. It was also encouraged for staff to report challenging behaviour on the electronic reporting system, so that trends could be identified with consultants. Management reviewed the reports and challenged consultants through conversation. Once consultants had been spoken with, they were asked to apologise to the staff involved, where appropriate.
- Staff were invited to attend the monthly reflective practice forums using a recognised approach. These forums are evidence-based forums where staff can come together and discuss different clinical issues in a supportive environment. The feedback from staff that attended was positive.
- There was an equality and diversity group based within the hospital; staff described the CEO as a “trail blazer” for equality and diversity and “valued different backgrounds” The group were running an event for black history month the week after our inspection.

- During the summer in 2018, the hospital provided an ice cream station for staff to be able to go and have a free ice cream. The communication sent out to staff stated this was provided due to their commitment and hard work throughout a busy time.
- All staff were asked to attend a new starters' breakfast three months after joining the hospital. This time was used to see how they had settled into hospital life, their experiences to date, and to give management a fresh look and insight into current practices and procedures within the hospital. They took ideas and feedback from staff, and where appropriate, looked to implement change to better the service provided.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- Staff within outpatients and diagnostics services worked side by side within the hospital. They attended a monthly governance and heads of department meeting, to discuss patient safety, including any incidents and any investigations attached to this; patient experience, including patient complaints; clinical effectiveness, including reviewing policies and patient experience data; clinical effectiveness, including audits that the hospital were carrying out; risk management including review of the risk register; quality improvement plans updates and any learning taken from the department or across the hospital that was to be fed back to the team. They also discussed the hospital performance.
- We saw evidence that meeting minutes had taken place for governance meetings. Action plans were made during these meetings and each action was assigned to a member of staff that was responsible for taking the agreed action. The action plan from the previous meeting was also reviewed and further actions created as required. If new national guidance was issued, a gap analysis was undertaken, and where applicable, an action plan was created. An example was provided by the hospital as they were looking to introduce a new service. As part of the preparation for registering the service, a gap analysis was created to ensure all standards and requirements were met. This was managed by the governance team.
- Risk and compliance meetings took place monthly and included the board members. These meetings were minuted. The meetings had a set agenda incorporating minutes and actions from the previous meeting, the hospitals risk register, the well-led framework, integrated quality report, the hospitals quality improvement plan and reporting data to

external bodies, andcustomer outcomes framework. The minutes showed actions recorded and who was responsible for overseeing the task, and a date set to complete.

- To ensure the hospital complied with the competition and market authority (CMA), all costs were discussed with the patient prior to seeing a consultant or undergoing any care or treatment at the hospital. All costs were set out in full, so that there was no misunderstanding as to liabilities.
- The governance team met and reviewed the QIP with the medical director and heads of department. Other grades of staff were welcome to attend the meeting if they wished. The QIP was RAG rated and comments were recorded on the QIP as to what was discussed and agreed.
- Each area within OPD contained a folder for staff, with a risk assessment of the area and treatment being given. There were specific safety standards for lithotripsy and for the well woman clinic only. Radiology contained their own safety standard folders and guidance. The radiographers kept this up to date themselves, using the latest evidence-based treatment guidance. They fed this information back into the governance team; they also shared the information with the rest of OPD. The manuals within radiotherapy had been revised prior to our inspection, to incorporate newly published regulations.
- Within radiotherapy, there were three radiation protection supervisors (RPS) and external radiation protection advisor (RPA) in post. The week before our inspection, the radiology department had revalidated its ISO accreditation and been successful with minor recommendations. Tomotherapy followed radiation protection legislation and national guidance. RPS's received training yearly as per legislative requirements. The RPA carried out a laser protection audit annually. All documentation we saw for radiotherapy was up to date and complete. We also saw evidence of a risk assessment in place under the laser protection policy. IEC-60825 guidance and 60825 Part 8 were verified. A radiological committee met every six months and discussed any issues that had arisen, and any resolutions necessary.
- The clinical effectiveness group met monthly. They discussed updates from national and NICE guidance. They then disseminated the information down to the relevant speciality including within OPD; this included cardiology, dermatology, endocrinology and elderly care. This was sent to the departments as an alert. This group had subscriptions to various journals and societies that were involved with publishing the latest guidance.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- A risk management policy was in place at the time of our inspection. This had been reviewed during June 2018 and was due for review in June 2020. The policy set out how the hospital was to manage risk; it included the purpose, objectives, scope and responsibilities of those within the hospital.
- A quality improvement plan (QIP) was in place for OPD. This was a working document, which meant items were being completed or added simultaneously to the spreadsheet. Therefore the document was kept up to date with existing items and their progress, as well as new items being added for action or monitoring. The hospital were aware that improvement and change was constant. They utilised this document to ensure all points were addressed and that nothing was forgotten, due to it being placed on a different spreadsheet elsewhere. This document rated all items as red, amber or green (RAG rated), dependent if the item was still outstanding, on its way to completion or completed. Items on the document ranged from the risk register, through to signage and inductions within the department. There were no items rated as red within this document. It named an individual responsible for the task or item set out, as well as the initial date raised, completion date, status (RAG), comments and evidence. This was a working document hence some items were not complete and some boxes were left without information due to the status of the action.

- Each department had ownership of their risk register. Each risk was given a score. Anything over 12 points was sent to the executive team to review and identify any actions that could be taken to reduce the risk. Every morning, the divisional lead attended a meeting run by the governance team on incidents and complaints that had occurred, or were ongoing, and discussed their management and how these could be closed. All complaints and incidents were closed within 10 working days, unless an investigation or RCA needed to be completed.
- Within OPD, the plaster room was placed on the risk register. Particles from the dust produced by the plaster had the potential to enter the environment. This had been risk assessed. Another risk on the register from the OPD was queueing times; since the refurbishment, this had altered the feedback received and the NPS score had improved by 12 points.

- The divisional manager and lead nurse had a meeting every Thursday morning for collaborative working, and to support each other in the running of the department.The divisional manager also had monthly meetings with the operations manager (line manager); the operations manager took part in the weekly meeting the divisional and lead nurse attended, once per month. He attended to give feedback from the executive meeting, so that the information could be shared amongst the team.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The hospital reported data to Private Healthcare Information Network (PHIN). This was specifically for inpatient data and did not include OPD.
- Consultants were respectful of patient wishes. If the patient agreed, a copy of the summary or discharge letter was sent to the patients GP. If they were from abroad or refused GP details, a copy of the letter was given to the patient instead. Patients were copied into all correspondence.
- For patients being sponsored by a third party, for example an embassy, the hospital received a referral via secure email to the IPC. Only with the patients permission were details and results of the consultations or treatment shared with the sponsor.

- The hospital had an intranet page for staff to use, to access all policies and details required to carry out their role. As well as information being available on the intranet, staff received an number of emails containing relevant information to their role, staff engagement, team building activities and communications.

Engagement

The service engaged well with patients, staff, the public to plan and manage appropriate services.

- Staff at the hospital were asked to contribute to the development of safety standards developed by the organisation. They felt involved, listened to, and part of the team. This information was stored in a folder in the department. The folder contained information such as patient information discussions that would be expected, what to look for, and national guidance.
- Staff surveys were undertaken yearly by the hospital. They also used the NPS system to gain feedback from staff. The last staff survey took place during 2017 and the new survey is due to take place through October 2018. The most recent results from the survey indicate a worse than average score than the European and Australian companies, where the average was -10. With a response rate of 61%, the hospital OPD nurses generated a score of -43 for recommending Bupa as a place to work, and -21 for recommendations of Bupa's services and products.
- If new changes or procedures were being brought in by the hospital, staff were informed via email and face to face conversations. Management asked staff for their input on what support and equipment they might need to carry out their role. During meetings staff were also asked for their contribution on new clinics and ideas.
- Therapies staff were invited to attend a number of MDTs throughout the hospital. They helped to set up the musculoskeletal MDM at the beginning of 2018. A number of consultants attend this meeting, and it is also used to give talks on topics that are of interest to

the department. The team felt integrated into the hospital, and had input into the quality assurance group. They were also part of the outcome measure committee, the medical committee, thoracic committee and the intensive care committee.

- The hospital communicated with staff through a variety of means, this included the sharing of learning, and information about the services ongoing. Staff were invited to feedback Friday, which was a weekly meeting where lessons were shared from incidents that had occurred. There was also a presentation given by a member of staff on a specific topic. The CEO also produced a monthly blog where he touched on various issues and thanked and praised staff for involvement in projects or any achievements they had attained. A newsletter was sent out to staff. This was called The Buzz. This was a brief bulletin style mailing to give short details of information to staff as required.
- A bulletin was sent out to staff detailing any job vacancies that were available within Bupa, both in the UK and internationally. The bulletin explained to staff how to look and apply for new roles, and how to refer a professional to the business.
- Videos were produced on small tablet devices for staff to see short updates about the hospital.Each department and area had a tablet delivered with a short video uploaded. At regular intervals, these were re-collected and new videos uploaded.
- A self-assessment booklet and questionnaire was used by the hospital to receive feedback from staff. For staff whom completed the questionnaire and retuned this to the relevant department, they were rewarded with a voucher to receive a free hot drink from the hospitals coffee shop to encourage participation.
- Another scheme the hospital actively encouraged was 'Boss the Basics'. Staff were able to meet with the CEO and tell him what they had identified as being required within the hospital. The CEO reviewed this and would then decide if the item of equipment or change was feasible, and then look to put the change in place. This fed into the QIP for the department. They also ran the 'You said, we did' initiative. This was where the hospital management team were able to feed back to the rest of the staff, the changes that they had made, based on staff contributions and ideas.
- A committee had been formed by some of the staff based at the hospital called FAB. This stood for Fun At Bupa. It was a group of staff that arranged fun and different events for staff to attend. This brought staff together outside of the work environment and was supported by the management team. Some of the events were karaoke, quiz nights and a beach day outing.
- The hospital used a system called net promotor score (NPS) to gauge patients reaction to the care and treatment they received whilst at the hospital. This system produced a score based on patient responses to certain questions, which was fed back to the hospital. The system allowed patients to state if they would return for treatment and recommend the service, or equally if the patient was unhappy and would not recommend the service. There was space for patients to free text comments about their visit, and this was fed back to the hospital for their consideration. If a patient scored six or below on the scoring system, with their consent, a manager would call the patient to discuss their experiences, and to gain an understanding of the patient's journey at that visit. We saw patient comments had been taken and reviewed, and changes made where possible and appropriate, to the service affected. Equally, those that scored over six on the NPS were given the opportunity to request a call back and speak to a manager to give verbal feedback.
- Between August 2017 and August 2018, the NPS score for OPD was between 59 and 70. In August 2018, the hospital reached its highest score of 74 for the year. Within the results, reasons to recommend the hospital for care and treatment were higher scores on excellent/good service, quick efficient service and kind/understanding/friendly staff. Amongst the negative was service "feels rushed", "unhelpful clinician" and "disorganised".
- The hospital used feedback from patient and staff surveys to improve the patient experience. Data was continually collected to capture different viewpoints and experiences. The management team listened to ideas and suggestions from patients, and implemented change as feasible and appropriate. We saw evidence of changes and improvements based on

results of questionnaires, NPS closed loop telephone calls and patient and staff conversations. This included the refurbishment of the OPD and queueing within the main reception.

- The hospital engaged with the local community via the Cromwell Conversation. This was a monthly meeting, where members of the community, local GPs and other professionals were invited to hear a talk on a specific topic by one of the hospitals consultants. Invites were also sent out to embassy staff to attend evenings with a number of consultants, where talks and refreshments were available.
- Patients were asked to complete a survey via email, post treatment or consultation within OPD. An email was sent to the patient, and once completed, this generated a net promoter score (NPS). This survey was used to capture patient experience and the likelihood that they would recommend the hospital to others for care and treatment. All the scores were collated and an audit generated. All patients had the option within the survey, to request a call back. If a call back was requested, this was actioned by a manager. When a score of 6 or below was recorded, the patient was asked if a call back could be arranged to understand their experience and concerns.

- The hospital was very patient orientated and proactive. They listened to feedback from both patients and staff, as to what would improve patient experience and efficiency. The hospital was able to provide examples of changes made to services and processes based on patient and staff feedback.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The hospital conducted monthly reflective practice forums, where every month, a different topic and presenter was chosen for presentation and discussion. All staff regardless of job title or grade from every department were welcome to attend this meeting, to share their experiences and gain knowledge from one another. An audit was conducted for the previous six months (October 2017- March 2018), and found physiotherapists, nurses and midwives were the highest attending staff group members during this time. There were a variety of staff groups that had not attended any of the meetings; these ranged from ward clerks and junior doctors through to board level staff. Some quotes from staff that were received about the sessions included, “Large focus on Arabic culture and impact of this on relationships between family, patient and medical staff. Issues of expectations, honesty, consent and ethics. Made me reflect on my stance on this.”
- There was an ideas hub where staff were able to contribute and give ideas to the hospital. Staff were encouraged to lead on their ideas if they were taken forwards, and if appropriate.
- The hospital was the first in the UK to introduce a braille map to guide patients to the departments they needed to attend. This allowed blind or partially sighted patients and their relatives' independence in navigating the hospital. The map was created in conjunction with asight loss charity. It showed the different departments, stairs, lifts, reception desk, toilets and pillars within the departments, so patients were able to be as safe as possible.
- Therapies staff brought the initiative of clinical excellence to the hospital. They did this centrally at Bupa UK. They brought staff from all different specialities, for example, dental and care homes, to train at these events in alternative areas to their expertise. This was to expand their knowledge base and incorporate other experiences into other areas of the business.

- Every year, the hospital held the STAR awards. Staff were able to nominate colleagues that have shown services or behaviour that go above and beyond their role for an award. There are set categories for nominations. The STAR awards are an evening celebration to celebrate success within the team. The next award ceremony is scheduled for October 2018.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are diagnostic imaging services safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- All staff we spoke with had completed mandatory training.One member out of 27 staff commented they did not have time to complete mandatory training. All other staff we spoke with said their mandatory training was easily accessible and staff could track their own mandatory training compliance through an electronic mandatory training system.
- Mandatory training included the Mental Capacity Act and dementia learning along with other subjects.This ensured all staff were equipped with information to care for patients with a diverse range of needs.
- Data submitted to us showed a 94.65% compliance with the mandatory training curriculum both face to face and e-learning.This was just below Bupa Cromwell hospital's target of 95%. We saw that five out of the 20 mandatory training topics had a compliance rate of 95% and below but basic life support (BLS) training only achieved 65.52% compliance (10 staff out of 29 being overdue). The service told us six of the overdue BLS courses were radiology administrative staff and two were medical physics staff in non-clinical roles. Immediate life support training had been completed by 23 staff with a completion rate of 100%. This ensured at least one member of staff per department were able to manage a situation if a patient suffered a cardiac arrest'.
- The service ensured staff administering radiation were appropriately trained to do so. Those staff without training received adequate supervision in accordance with legislation set out under Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) to work in the radiation field. We saw records which confirmed this. This ensured staff could safely perform examinations involving radiation to keep patients safe. We also saw evidence to indicate all staff had confirmed they had read the local rules.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- Staff understood how to protect patients from abuse. The service recently appointed a new safeguarding adult and children's named nurse and there were clear processes and procedures in place for safeguarding adults and children. There were policies in place available in both paper form and online which staff could access through the hospital's intranet system.
- Staff were aware of their responsibilities if they identified a patient who had undergone female genital mutilation.Staff could describe the escalation process if they were to have safeguarding concerns and were aware of the policies and where to find them. Staff also received child sexual exploitation training as part of the children's safeguarding training.

- All staff we spoke with received training in levels two or three for children's safeguarding as appropriate. For example, diagnostics reception staff received level two and superintendents were trained at level three. Staff were aware of where to gain additional advice from for example Bupa Cromwell hospitals safeguarding lead. Staff reported non-accidental injuries identified to the department lead and escalated appropriately.
- To safeguard patients against experiencing the wrong investigations staff asked patients to confirm their identity by providing their full name, date of birth and first line of their address. This evidenced staff followed best practice and was in line with the legal requirements of IR(ME)R.
- The diagnostics service displayed posters within female toilets detailing where to get help if patients or their family or friends were victims of domestic violence.

Cleanliness, infection control and hygiene

The service controlled infection risk well. However, some areas did not have documentation to check they were cleaned effectively.

- An external company provided cleaners for the service.We saw daily cleaning schedules mostly completed and up-to-date, however during the inspection the cleaners had not completed the waiting area checklist in the nuclear medicines waiting area for one day and the MRI on the ground level waiting area checklist had not been completed during the week of the inspection.This did not assure us the monitoring of cleaning was robust
- From January 2018 to May 2018 the diagnostics service achieved 100% compliance for hand hygiene and bare below the elbows.During inspection we observed all staff to be compliant with uniform policies which included all staff to be bare below the elbows and long hair tied up. We observed posters throughout the departments stating the importance of being bare below elbows always in clinical areas.
- Staff said when treating patients who had a communicable infection such as TB, flu or scabies, staff ensured their investigation was prioritised to reduce time spent with other patients. Where possible, staff booked appointments for quieter times within the departments. Patient times in treatment rooms were minimised to reduce the risks of cross infection and after their investigation staff sought immediate support from an external cleaning team. The external cleaning team took responsibility to deep clean the environment and staff told us they were happy with their response times.
- Personal protective equipment such as gloves and aprons were available to staff. We saw appropriate use of gloves during a clinical intervention.
- We found clinical and patient waiting areas were visibly clean and free from dust and debris. There were cleaning schedules in place and we saw staff clean equipment at the start of each day and in-between patient use using sanitising wipes for surfaces and equipment.
- The radiology department had three infection control link practitioners who regularly audited the environment and staffs hand hygiene practices.
- Staff appropriately cleaned and stored equipment such as probes used for intimate investigations. This eliminated the risk of cross infection between patients.
- We saw all equipment had green labels which indicated the date the item had been cleaned.
- We saw hand sanitiser dispensers placed in prominent positions throughout the diagnostics service to encourage use by staff and patients. We observed staff use the hand sanitiser appropriately.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However, there were no separate waiting areas for children in the waiting areas for x-ray, CT, PETCT, MRI and ultrasound. This could result in exposure to inappropriate adult conversation.

- The department accommodated children and young people for general x-rays, ultrasound, PETCT, CT and MRI scans.There were no dedicated children's waiting area's except for within the clinical investigations clinic, posing a risk, children could potentially

overhear inappropriate adult conversation.However, plans were in place for a full refurbishment of the area next year and the issue raised as an incident and placed on the risk register.

- Patients arrived in the diagnostics reception area and the administration team greeted them.This area was open to the waiting area and staff had concerns regarding maintaining confidentiality.Plans were in place for a full revamp of the diagnostics service including a new confidential waiting area including a separate children's waiting area for early 2019.
- Waiting areas were clear of clutter with suitable numbers of chairs available to meet patients' needs.
- The nuclear medicine department had a 'hot' waiting room (where people, who had received their radionuclide injections and were radioactive, waited). These patients also had their own toilet which ensured there was no risk of unintended radioactive contamination. Children were always first on the list to ensure their radiation doses remained as low as reasonably practical. There was limited access to the department for just patients, patients' relatives and interpreters to ensure any risk of exposure to radioactive substances was minimised.
- Within the lower level MRI department, relatives waited in a waiting area directly opposite the MRI entrance.There was a barrier to stop unauthorised visitors from entering the MRI room but we observed at the time of inspection, it was broken. Additionally, the barrier was on the outside of the door which increased the risk of breakage when opening the door. The scanning staff only area was close to the main MRI door however, there was a risk of unauthorised entry of relatives in to the MRI area with an active magnet which was a high risk due to visitors not being de-metalled.
- The environment within the angiography unit appeared cluttered and posed a fire risk as there was a large amount of accessory equipment in the room and staff explained this was due to the wide range of examinations performed in this room. We saw limited storage outside of the room.At the time of inspection, the lead told us and showed us plans of a refit of the storage area due to commence that weekend, which would tidy consumables away and reduce the fire risk.
- The diagnostic imaging service had two magnetic reasoning imaging (MRI) machines, one computerised tomography (CT) and one positron emission tomography/computed tomography (PET/CT), three ultrasound rooms, three x-ray machines, one gamma camera and many various pieces of equipment in the clinical investigations unit.Staff commented on how well equipped the diagnostic imaging service was.
- There was a formal capital rolling replacement programme for equipment. This included details on the year the service purchased the equipment, expected date for replacement, details of the use and any recommendations according to the level of risk presented should an item fail. Equipment within the hospital was under a service level agreement for maintenance and replacement with an external provider. The radiation protection advisor (RPA) held the records for equipment maintenance.
- The management team had proposed a business case to replace the old (2012) Nuclear Medicine Spect CT.Replacement was planned for 2019.This would improve the diagnostic scope and yield of the unit, the reporting quality and increase the number of referrals the unit could receive.
- We saw staff labelled equipment with Portable appliance test (PAT) stickers, however in the angiography theatre we saw a worn extension lead which had not had a PAT test since 2011.We raised this at the time of inspection and staff told us it would be replaced.
- The radiology and radiotherapy departments had working radiation warning signs outside all rooms for safety and to prevent unauthorised access.
- The general signage to the different diagnostic departments was clearly signposted.
- Resuscitation trollies were readily available throughout the departments.We reviewed five resuscitation trollies and saw evidence staff had checked them daily, we saw fully charged equipment which had received a yearly service. We also saw audits which demonstrated staff audited the trollies monthly to ensure equipment was in date and fit for purpose.

- Each treatment room had details displayed of what activity took place in the room (radiation risk assessments/local rules). The service clearly labelled MRI equipment and devices, and this was in accordance with Medicines and Healthcare Products Regulatory Agency 2015 recommendations. Rooms were clearly identifiable and controlled areas highlighted. We saw staff escorted patients and their families to the x-ray room or adjacent waiting areas, prior to their investigation. This helped to reduce the risk of patients or visitors inadvertently accessing radiation restricted areas.
- Staff labelled all equipment in both MRI areas as MRI safe, in line with MHRA recommendations for example the resuscitation trolley outside the MRI area was labelled as MR unsafe and the wheelchair as MR Safe.
- Staff wore lead aprons where appropriate which staff screened annually to ensure they were not damaged. Staff also wore radiation exposure devices which the RPA analysed monthly to ensure staff were not over exposed. Staff working within nuclear medicine were subject to daily review of radiation levels of their hands and shoes to ensure exposure levels were within safe ranges.
- The RPA was reviewing how to monitor cumulative operator (radiologists) doses across sites where they worked which was only an issue in angiography.The RPA was recording the doses annually which were low and showed compliance radiologists were wearing their radiation monitoring devices. The service proposed to regularly audit the doses of all angiography radiologists to have a good estimate of their external cumulative doses and compare these with the doses received at Bupa Cromwell hospitals for future assurance.
- A dose reference level chart was available on the wall across the departments which ensured when audited, staff provided dosages to patients during investigations that were within acceptable levels.
- The service mostly stored cleaning materials securely in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation which requires employers to control substances which are hazardous to health. However, on two occasions in the main diagnostics service we observed an unlocked cleaning cupboard.This posed a risk for children or adults of unauthorised access to cleaning products and we raised this concern at the time of inspection.
- The service had support for their Picture Archiving and Communication System (PACS) which was the system used to store patient images. In the event of a PACS failure it would significantly impact on service availability. Staff told us the radiologist could view images but would be unable to report on them. The PACS manager explained the contingency plan for getting the service back up and running within a window of approximately four hours.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

- Staff told us what action they would take if a patient became unwell or distressed while waiting for, or during, investigation. The action taken depended on the specific situation and staff provided examples which showed they would take appropriate action.All rooms were fitted with emergency bells to alert other staff of concerns.
- All inpatients were risk assessed before staff brought them down to the CT or MRI scans to ensure they were stable enough to attend the scan. Radiographers or the radiology nurses completed the risk assessment.
- The department had a full set of Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2017 (2018). IR(ME)R procedures and standard operating procedures as required under the Regulations. The Health and Safety Executive (HSE) regulate the Ionising Radiations Regulations 2017 (IRR99). Local rules as required under IRR99 were evidenced throughout the department. All areas which utilised medical radiation in hospitals were required to have written and displayed local rules which set out a framework of work instructions for staff.
- Bupa Cromwell Hospital had an agreement with another independent provider to use each other's PETCT scans if theirs was to fail.

Good

Diagnostic imaging

- The service had designated and clearly identifiable radiation protection supervisors (RPS) available to provide guidance and support to staff in each area. Their details were publicised on treatment room doors.
- Bupa Cromwell Hospital's radiation protection advisor (RPA) worked within the hospital and was available to provide guidance and support. Staff, reported all these staff members were accessible and responsive to their needs.
- The patient's own GP or Bupa Cromwell hospital's GP and consultants referred into the service. The radiology administration team screened the referral for appropriateness to ensure the right investigation matched with the patients presenting complaint. If there were any concerns about the requested treatment, the administrator would contact a radiographer who would discuss alternatives with the referrer.
- Two radiographers expressed their concern regarding not being involved in the screening process and reported on numerous occasions the administrators booked the wrong scan type resulting in a delay to the list. The radiographers raised incidents reports for each occasion.At the time of inspection, we observed administrators had booked the wrong type of MRI scan which resulted in a delay to the list.This did not assure us the administration team were screening the referrals appropriately additionally, this issue was not on the diagnostic services risk register.
- Staff we spoke with demonstrated how they would appropriately deal with an aggressive or violent patient. Staff would remove the patient from the waiting area and would talk with the patient to calm them down.Staff could also call on security for assistance.Staff we spoke with said it was a rare occurrence for patients to be violent or aggressive.
- There was a robust process for the assessment of patients who may be pregnant. Posters, in all waiting areas, asked patients to talk to staff if they suspected they may be pregnant detailed in English and Arabic. Staff used a checklist to assess any potentially pregnant patient prior to any investigation and patients verbally confirmed, signed and dated they were not pregnant.
- A screening process performed by the radiology nurses was in place which enabled radiographers to identify any pre-existing clinical conditions which may impact on the ability to perform an investigation. For example, patients with an impaired kidney function required a reduced dose of contrast media. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. In the PET/CT department a machine could give an instant creatinine level (an indication of kidney function status) following a blood test. Staff checked patients, who required a contrast media were not allergic to any substance prior to administration. This was in keeping with the National Institute of Health and Care Excellence (NICE) Acute kidney injury guidelines and the Royal College of Radiologists standards for intravascular contrast agent administration.
- The new clinical nurse specialist in interventional radiology had introduced the use of the World Health Organisations (WHO) 5 steps to safer surgery checklist for biopsy procedures. The checklist was new and therefore there were no audit's available to see.
- Staff reported the procedures for the collapse of a patient in MRI was to call the crash team and to remove the patient from the MRI scanning room as quickly as possible.Staff reported in MRI they did not practice 'crash' scenarios however in nuclear medicine staff reported there was a scheduled 'crash' scenario specifically in PET/CT next month. All radiology nurses were qualified in paediatric intensive life support (PILS) and intensive life support (ILS). For children, the service ensured advanced life support trained registered medical officers (RMO)'s was on site during paediatric opening hours.

Nurse/Radiographer staffing

The service had enough nursing and radiographer staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- The diagnostics department had seven Whole time equivalent (WTE) radiographers in radiology (general and CT), eight WTE radiographers in MRI, three WTE radiology nurses, four WTE radiographers in nuclear

medicine, Four WTE physiologists in cardiology, 2.92 WTE physiologists in lung and sleep and three WTE physiologists in neurophysiology. There were nine WTE Administration staff.

- The service used an electronic rota to plan staffing.At the time of inspection, the x-ray and CT department were four radiographers short with two vacancies filled starting in October and two vacancies out to advert. Vacancies were included on the department's risk register which was regularly reviewed.The service used agency staff who were familiar to the department.Agency staff who had not worked in the service before underwent the providers induction and mandatory training programme. Nuclear medicine had put a business case together in support of a further radiographer due to the increase in the workload.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

- The hospital had a team of registered medical officers (RMO) some of whom worked on a 24-hour rotational basis to cover all aspects of the hospital and its services out of hours. The diagnostic service had access to the RMO's 24 hours a day if required.
- Within the diagnostic imaging department there were 30 radiologists with practicing privileges each with set sessions across the week. Each radiologist only worked within their specific scope of practice and expertise, thus ensuring the service had specialist radiologist cover seven days per week.
- Eight specialist interventional radiologists took part in an on-call rota every day of the year and supervised by two contracted specialists. All staff we spoke with told us radiologists on call were readily available and easy to contact.

Records

Staff kept detailed records of patients' care and treatment.

- The service provided electronic access to diagnostic results.Scans were available for the patients on a downloaded compact disk (CD) and developments were underway for radiologists in other hospitals to be able to access x-rays remotely. This ensured radiologists reported on all diagnostic investigations in a timely way and ideally within 24 hours of the investigation. For out of hours CT scans an on-call radiologist would discuss requirements over the telephone with a radiographer and the scan saved to the 'cloud' where the radiologist could access the scan results externally.
- The service used two electronic record systems. PACS was the system for storing completed images and the associated reports. This system was password protected. The service maintained comprehensive written patient records, with details of all investigations and their findings electronically on PACS; accessible only to radiology staff for reporting and clinicians who had requested the image.
- Staff across the department scanned in referral forms and checklists on to the system which was useful to refer to for future investigations. Radiographers rarely required the full patients notes as they would review previous investigation scans for information.
- All computers observed were password protected and locked when not in use. We saw computers were generally out of view of patients, but those which were in view, had a privacy screen so patients could not see the information.
- The service provided porters with detailed collection slips which stated the inpatients name, ward, infection risks, was the patient mobile, was the patient on oxygen for example. It also had a check box to ensure the porter collected the correct patient for the correct investigation signed by the nurse on the ward.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

- Within the CT and MRI areas staff stored contrast medium and all medicines in locked cupboards with keys which the lead radiographer held.We reviewed documentation which evidenced all medicines given in the department were correctly documented and audited.

- Staff monitored fridges containing medicines daily and were aware of the procedure if the fridge temperatures went outside the acceptable range. We saw evidence of these records.
- The service stored radioisotopes in accordance with local policy and legislator requirements.The service stored radioisotopes key lock safes, in secure rooms which staff accessed with a keypad code and fingerprint recognition. If staff attempted to access the store out of hours, an alarm alerted the security team who attended the area immediately.The same rules applied for the disposal area of radioisotopes.
- Nuclear medicine used the administration of radioactive substances advisory committees (ARSAC) diagnostic reference level charts which we observed the ARSAC holder had signed.Staff calculated the dose radiopharmaceuticals (medicines used) according to the patients' procedure.
- We observed the staff completed administration records for the radioisotopes accurately evidencing correct documentation of the information required.The nuclear medicines department had clearly identified rooms for the preparation, administration, storage and disposal of nuclear medicines.
- The administration of contrast media and specific medicines in MRI and CT was via patient group directives (PGD).A PGD is a written instruction for the supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs allow specific health care professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. The health care professional working within the PGD is responsible for assessing the patient fits the criteria as identified in the PGD. This meant radiographers could administer identified medicines, such as contrast medium, for specific investigations. PGDs we viewed were in date and approved according to the area they covered. Staff had signed these which evidenced they had received relevant training and were competent to meet the conditions identified in the PGD.
- We observed staff checking patients for their name, date of birth and address before they administered the medicine.We observed upon cannulation of a patient the radiographer double checked the saline solution with a colleague.This assured us staff were following their medicines administration policy.

Incidents

The service managed patient safety incidents well.

- The nuclear medicines team carried out six monthly scenarios of a radioactive spillage.This ensured staff were aware of current practices to maintain a safe department in the event of a spillage.
- Never events are serious patient safety incidents which should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From January 2017 to January 2018, the service did not report any incidents classified as a never event taking place in their diagnostics services.
- There were 16 incidents involving ionising radiation in the last year. The service reported two IR(ME)R reportable incidents to the CQC and none to the health and safety executive. We reviewed the investigation into one incident which detailed all care provided to the patient with lessons learned and actions taken, which minimised the risk of reoccurrence. It was clear the duty of candour regulations had been adhered to as the patient was fully informed.
- In a further reportable incident, the patient was very keen to help staff with learning from their specific incident and has offered to return to the hospital to present at the 'Feedback Friday' learning sessions.
- Staff were aware of their roles and responsibilities for reporting safety incidents and near misses internally and externally. Managers encouraged staff to report incidents who did this by using Bupa Cromwell hospital's electronic reporting system.
- Staff told us incident reports and discussed the resulting actions across the teams in team meetings.The divisional manager attended a daily incident meeting where the meeting discussed

incidents and allocated to the appropriate lead to investigate further. Messages regarding learning from incidents were cascaded from the executive board via email.

- Staff shared 100% of root cause analysis reports and discussed the reports at local or departmental meetings which showed a culture of learning from incidents. Staff we spoke with confirmed this.

Are diagnostic imaging services effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- The service worked to the IR(ME)R and guidelines from the National Institute for Health and Care Excellence (NICE), the Royal College of Radiologists (RCR), the College of Radiographers and other national bodies. This included all specialities within the diagnostics.
- We reviewed five policies and procedures which the service stored on the intranet, and all reflected current national guidance. The clinical governance team were involved in ensuring all policies and procedures were up to date and in line with current national guidance.If a policy was discovered to be out of date, the team escalated it to the relevant department and the policy would be reviewed by the superintendent who completed a gap analysis and feedback changes required to the clinical governance team.
- The service's medical physics team provided scientific support, advice and guidance on IR(ME)R regulations concerning the use of imaging equipment and monitored the radiology equipment and staff radiation dosages. The main legal requirements enforced by the Health and Safety Executive (HSE) are the Ionising Radiations Regulations 2017 (IRR99). In line with IRR99, the diagnostics service appointed Radiation protection supervisors (RPS's) whose role was to ensure staff followed the services standard operating procedures and adhered to the radiation protection procedures. IRR99 requires employers to keep exposure to ionising radiations as low as reasonably practicable.
- There were policies to ensure staff did not discriminate against patients. Staff were aware of the policies and gave examples of how they followed guidance when completing care and treatment. Staff told us they would escalate any concerns, and seek further guidance if necessary.
- Radiographers followed evidence based protocols for scanning of individual areas or parts of the body. Radiographers we spoke with were confident to discuss protocols with consultants if they felt the consultant had chosen the incorrect protocol.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs

- The administration staff or referring consultants advised patients on whether they could eat or drink prior to their treatment when they made the initial booking with the diagnostics administration team.The team issued patients with patient information leaflets detailing preparation procedures for bowel scans.However, one patient we spoke with told us staff did not advise them if they could eat or drink before an MRI scan.This did not assure us the diagnostics administration team were always offering the correct information.
- The administration team booked patients who were diabetic, frail or children, first on the scanning lists to limit any adverse effects on their wellbeing.
- Coffee machines and water fountains were in the main waiting areas to help occupy patients whilst awaiting their appointments.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Radiology staff did not routinely use pain relief in diagnostic imaging except for when patients were

attending for invasive procedures or required to lay still for a prolonged period. Radiographers provided patients with pain control specific to their investigation.

- If patients required pain relief before or during an investigation the patient's consultant or resident medical officers on call would prescribe pain relief for the radiology nurses to administer.
- Staff ensured patients comfort prior to completing all investigations.We observed staff reassure patients during investigations to let them know if they became uncomfortable so that comfort could be alleviated.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- Managers monitored patient outcomes using the net promoter system (NPS). NPS is an index ranging from -100 to 100 that measures the willingness of customers to recommend a company's products or services to others.The service audited for trends primarily using patient feedback questionnaires which staff sent electronically.
- The radiology department launched patient satisfaction surveys for each modality in January 2018.The last overall NPS score was 91 which showed high levels of patient satisfaction.Managers shared these results with the department staff at the radiology departmental meetings.
- The diagnostics service has recently received their ISO 9001:2015 accreditation award which had limited recommendations for the service to improve. The accreditation ensured the diagnostics service followed a strict audit schedule for continual review and improvement of their internal processes.
- The diagnostic service had recently invested in a new PET CT scanner which had reduced the radiation exposure by 25% during diagnostic CT scans.The scanning times had also reduced from 23 - 30 minutes to 15 – 20 minutes, which made it a more efficient service.
- The service completed 53 annual local audits to ensure staff were working in line with best practice guidelines. We saw an example of a cannulation audit from April 2017 – April 2018 with one extravasation (where the fluid leaks out of the vein) incident.This indicated cannulation techniques were very good. Other example included image quality checks and the patient care path in nuclear medicine. The quality and detail of the audits reviewed were good, with appropriate actions taken and improvements made as a result.
- We saw evidence of annual audits on radiation safety conducted by the medical physics expert and the findings had robust action plans.
- The number of examinations had not risen as hoped which could provide some risk the radiology's teams skills were not maintained in this procedure. However, the angiogram audit showed 96% of percutaneous coronary interventions (PCI) procedures were free of complications during 2017. This indicated staff were performing effective and safe care in the angiogram department.
- The radiology department invited an external company to conduct a peer review in December 2017 in MRI, x-ray and CT. Following the peer review the MRI department developed an MRI risk policy. The nuclear medicine department also took part in a peer to peer review in August 2018.This helped to ensure patients' outcomes were met to a high standard.All actions from the peer reviews were added to the divisions quality improvement plan which we reviewed at the time of inspection.
- We noted not all x-rays had the markers placed (left or right) at the time of x-ray.This was not in line with best practice. Best practice would be to place the markers in situ at the time of the x-ray. Staff also reported the required exposure for knee x-rays was higher than the recommended limits to achieve a good image. The impact could be the patient having an overexposure of radiation. We mentioned this to the superintendent at the time of inspection who advised they would investigate further and the service was about to undertake regular x-ray image quality audit.

Competent staff

The service made sure staff were competent for their roles.

Good

Diagnostic imaging

- We saw evidence of 92% of qualified nursing staff receiving their appraisal and 100% of health care assistants in the last year.There were no figures for this year so far. Some staff had regular one to one meetings with their managers to discuss concerns and areas for development.All staff we spoke with reported their appraisal was up to date.
- The lead nurse in outpatients and the clinical nurse specialist in interventional radiology fully assessed the radiology nursing competencies. This ensured nurses were fully competent for their role.
- All consultant radiologists working at the hospital had practising privileges which gave them the authority to undertake private practice within the hospital.All consultant radiologists underwent an annual appraisal system performed by the medical director of radiology. This ensured Bupa Cromwell hospital had oversight of their ability to practice.
- We saw evidence the radiographers had in date health care professional registration (HCPC). This is in line with the society of radiographers' recommendation that radiology service managers ensure all staff are appropriately registered.
- The service monitored the radiographers' registrations in two electronic systems.It was the responsibility of the health roster team, managers and employers to renew registration information and ensure their human resources records are up to date.The employment compliance team monitored this data.
- There was an established development plan for newly qualified radiographers. New staff completed a generic Bupa Cromwell hospital's induction, competencies and worked towards gaining additional skills. We saw competencies were specific to the area worked, for example, staff working within nuclear medicine had specific competencies for working within the department.
- The RPA provided radiation protection training to all radiology nurses. Bupa Cromwell hospital provided evidence and we saw all nurses had completed IRMER training appropriate to their role.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients

- Remote access to radiology imaging services were available for clinicians as of July 2018, to enable clinicians in other hospitals access the services system.This would ensure reporting systems became streamlined.
- There was very good communication between all multidisciplinary teams (MDT) and the diagnostic department.Staff from radiology regularly attended 12 MDT meetings including lung, cardiac and neuroscience amongst others.
- To ensure a seamless experience for patients and a safe working environment for staff the radiology team were involved with the theatres daily briefing and weekly meetings, the safer surgery working group, annual radiologist's meetings and twice a year nuclear medicine meeting.
- The diagnostic service provided a breast pathway where patients could access a consultant, have the diagnostic investigation with the results and further treatment arranged for the same day.Plans were in place for the introduction of a prostate pathway in the future.
- Radiographers had access to patient's previous scans which enabled them to identify if patients have been subject to previous scanning which may still be appropriate for use.This removed the risk of patients receiving repeated short-term exposure.

Seven-day services

The service operated over a seven-day period with the availability of on call radiologists to perform emergency diagnostic scans.

- The diagnostics service was open 8 am till 8 pm Monday to Friday and 9 am to 2 pm on a Saturday.Medical physics was open 8 am – 4 pm Monday to Friday only.
- The service made sure patients had access to the main diagnostic services seven days per week.The CT and MRI service was provided from 8 am to 8 pm for outpatient's scans Monday to Saturday and there was a 24-hour service for inpatients and emergency requests.On call radiographers and radiologist were available to cover MRI scans out of hours.

Good

Diagnostic imaging

- There was a walk-in service for plain film imaging and the service offered open access for CT and MRI scans from all GP's.
- Appointments were flexible to meet the needs of patients and they were available at short notice.

Health promotion

There was a lack of health promotion material available across the diagnostic department.

- We noted within the diagnostic screening department there appeared to be a lack of health promotion materials for patients to access such as bone health or breast health. This was not in line with the national priorities of improving the population's health.
- We noted in the main x-ray and ultrasound waiting room there were patient advice leaflets available for example, having an MRI scan or CT scan. The main diagnostics waiting area also displayed an information board detailing the function and suitability of the different types of imaging available.
- Bupa Cromwell hospital's website clearly displayed information on how to access the hospital services.
- All leaflets were available in English and Arabic but if requested they were available in other languages.
- Where patients were living with dementia or learning disabilities staff discussed with their families about the most appropriate way forward to complete the investigations.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care and staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

- Staff asked children over the age of 16, accompanied by their parent and deemed competent to consent for their treatment if they were pregnant in private before investigations took place.
- Staff told us training they received focused on obtaining consent from adults prior to completing investigative work. When children presented for investigation, consent for treatment was sought from their parent, guardian or other appropriate adult over the age of 18 years.
- We saw consent to treatment forms across the diagnostic service used.We saw the service correctly used a magnetic resonance imaging safety consent form to record the patients' consent which also contained their answers to safety screening.Staff documented consent on the patient's electronic care record. Discussions included a description of the investigation, the possible side effects and the recovery period. Staff gave patients the opportunity to discuss concerns or queries prior to confirming consent.
- We saw all policies on deprivation of liberty, mental capacity was available on Bupa Cromwell hospital's intranet.Staff had received training on mental capacity and although they stated they would not be likely to see patients with mental capacity issues in their service, they were aware of what to do if they had concerns about a patient and their ability to consent to the scan. They were familiar with processes such as best interest decisions.
- The service promoted supportive practice that avoided the need for physical restraint.Some of the scans required staff to wrap the patient's arms or legs gently for their comfort and to ensure their arms or legs did not become loose.All securing's were loose enabling the patient to easily remove them and we observed staff give thorough explanations regarding their use.

Are diagnostic imaging services caring?

Good

Compassionate care

Staff cared for patients with compassion.

- Staff demonstrated a kind and caring attitude to patients. This was evident from the interactions we witnessed on inspection and the feedback provided by patients.

Good

Diagnostic imaging

- Staff introduced themselves and explained their role and went on to fully describe what would happen during the procedure.
- Staff ensured they maintained patients' privacy and dignity during their time in the department and the scanner, however as the main diagnostics reception area was located within the waiting area there was a risk patient information could be overheard.Bupa Cromwell hospital had recently installed a private room off the waiting area where staff could speak with patients or breast-feeding mothers could feed their babies.
- Radiology nurses chaperoned all patients undergoing an ultrasound scan.We saw an up to date chaperone policy on the Bupa Cromwell hospital intranet.
- Staff said they took the time wherever possible to interact with patients and their relatives. We observed staff taking time to speak with patients in a respectful and considerate way.
- Patients reported: "I was seen straight away, very nice professional staff who explained everything in a very clear way. It was a very good CT scan" and "A wonderful experience, on time and organised"

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Staff supported patients through their investigations, ensuring they were well informed and knew what to expect.
- Staff provided reassurance and support for nervous and anxious patients. They demonstrated a calming and reassuring demeanour so as not to increase anxiety in nervous patients.
- We observed staff providing ongoing reassurance throughout the scan, they updated the patient on how long they had been in the scanner and how long was left.
- The service had access to play therapists to support children during treatment which minimised the distress the patient could experience. One MRI scanner had a projector that projected images on the wall which may help to distract and calm the patient.Unfortunately, at the time of the inspection this projector was broken.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- The service allowed for a parent or family member or carer to remain with the patient for their scan if this was necessary.
- Patients we spoke with told us they were involved with decisions about their care and treatment and were aware of what the next steps were.
- Patients received a CD of their images to forward on to their consultant leading their care.

Are diagnostic imaging services responsive?

Good

Service delivery to meet the needs of local people

The provider planned and provided services in a way that met the needs of local people.

- The environment was appropriate and patient centred with comfortable seating areas, adequate toilets and drinks machines and facilities for adults.However, there was no separate waiting areas for children except in the clinical investigations unit.Children had access to some toys and projector prints on the walls.
- There was no car parking onsite at Bupa Cromwell hospital for patients but many patients travelled by taxi or underground train due to Bupa Cromwell hospital being situated in central London.
- The service provided some evening appointments to accommodate the needs of patients who were unable to attend during the day.
- The diagnostic imaging department had clear signposting to each individual area which featured in English and Arabic.

Good

Diagnostic imaging

- Patients received an appointment letter which included preparation relevant for each scan.Some patients we spoke with advised they did not receive any information regarding their scan which they had booked at the main booking desk in the main reception.The administration staff showed us advice leaflets for scans involving fasting procedures they sent to patients upon booking appointments.
- Bupa Cromwell hospital did not support patients living with dementia or sensory loss to negotiate their way through the hospital and between imaging departments independently. Although at the entrance to the hospital there was a hospital map in braille on display but otherwise hospital signs directed patients to the correct departments.
- Within the main diagnostic waiting area, there was a single room which patients with learning disabilities or who found busy environments could wait.However, this room was used for breast feeding women and consultations with the administration staff if patients required to speak in confidence.
- We observed the administration staff giving clear waiting times for CD collections and suggested where the patient and their family could get a hot drink and snacks.
- The service used a 'wide bore' CT scanner, this was less enclosed than other scanners and so caused reduced symptoms of claustrophobia. The scanner could also accommodate larger patients and the table could accommodate patients up to 30 stone in weight.

Meeting people's individual needs

The service took account of patients' individual needs.

- Staff booked all appointments with the patient. Staff reported and we observed time spent with the patient to explain the procedures.Staff commented it was nice and valuable to be able to spend time with patients without feeling too rushed. All patients we spoke with commented they did not feel rushed through their procedure.
- If the service had to cancel a clinic such as ultrasound, staff informed patients immediately and offered the next available appointment that was suitable for their needs.
- The different departments invited nervous, anxious, phobic patients or patients living with dementia or learning disabilities to have a look around the scanners prior to their appointments, so they could familiarise themselves with the room and the scanner to decrease apprehension. Staff also encouraged patients to bring in their own music for relaxation and to bring someone with them as support, who could be present in the scan room if necessary whilst overseeing radiation safety constraints where appropriate.
- Bupa Cromwell hospital provided patients with information leaflets in multiple languages which explained their diagnostic investigation. Nuclear medicine gave clear advice to patients with regards to limiting dose exposure to others including pregnant women.
- Patients attending the diagnostics service were normally only there for a short time and did not require food.There was ample complimentary tea and coffee machines and drinking water.Close by to the department was a café area where patients could purchase a range of hot and cold drinks and snacks.
- Patients with mobility issues could enter the MRI scanning room on a MRI safe trolley or wheelchair.
- All waiting areas across the department were large enough to accommodate wheelchairs and patients with mobility issues.
- Staff fully assessed bariatric patients for the appropriateness of investigations before the procedure was organised.If Bupa Cromwell hospital were unable to accommodate the patient, radiographers referred the patient to a local NHS Trust.
- Staff reported there was access to a translation service via in house interpreters (the overseas patient team) and a telephone language line.
- Staff had received training in equality and diversity and Bupa Cromwell hospital expected staff to demonstrate these values throughout their work.

Access and flow

People could access the service when they needed it.

Good

Diagnostic imaging

- GP's inside and out of Bupa Cromwell hospital and consultants referred patients to the service. Administration staff made appointments in person or by telephone at a time and date agreed by the patient.
- Some patients came directly from a consultation with their physicians and had their scans undertaken there and then. Staff asked other patients to come back later in the day or the next day.The clinical investigations unit tried to accommodate same day investigations as far as possible.
- Bupa Cromwell hospital aimed to have radiology reports available to the referrer within 24 hours of the scan taking place.Specialist radiologists onsite reported scans and from January 2018 to June 2018 97.8% of mammograms, 99.5% of MRI scans, 99.3% of unassigned CT scans and 100% of PET CT scans were reported within 24 hours. Bupa Cromwell hospital considered these reporting times as very good and well within targets.
- Waiting times in the unit itself were short. Evidence showed there were very few delays and appointment times were closely adhered to. We saw this evidence during inspection and the feedback received from patients.
- The average waiting time for all patients (suspected cancer and non-urgent) from booking the appointment to the clinic date was 8.8 days, with the consultant seeing 17% of patients within 48 hours. Bupa Cromwell hospital told us the waiting times also took into account patients choice of appointments.This exceeded performance in relation to the NHS waiting time target of two weeks.
- One hundred percent of patients received an ultrasound appointment date on the same day of the referral received by the radiology department, the longest wait was two days which is a decrease from five days from the previous audit.Eighty six percent of patients had their CT scan within 6 days of request and scans longer than six days were due to patient preference.The MRI department accommodated 100% of MRI inpatient requests with either same day or next day appointments.Ninety percent of patients had their MRI scan within three days of request.
- The nuclear medicine department contacted patients the day before their procedure to ensure the patient was still attending due to the nature of the medicines used.This ensured the department rarely had patients who did not attend their appointments.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- The diagnostic service dealt with complaints immediately.If a patient complained using the electronic feedback form, the divisional manager would contact the complainant for further information, apologise if required and address the issue with the team involved.
- The divisional manager attended a daily complaints review meeting which the governance team led with an aim of closure of complaints by 10 days. This ensured that every complaint or incident had the correct clinical or heads of department assigned for investigation and any immediate action.
- There were 23 complaints received for the diagnostic imaging department from January 2018 – June 2018.On average the department took 10 days to investigate the complaint and closed 75% of the complaints. Complaints were a mixture of poor communication and human error.
- We saw evidence staff discussed complaints and compliments regularly within team meetings as well as at the incidents, complaints and risk committee.
- Bupa Cromwell hospital provided patients with information on how to make a complaint on their website.
- No complaints from the diagnostics service had been referred to the Independent Sector Complaints Adjudication Service (ISCAS).

Are diagnostic imaging services well-led?

Good

Leadership

Good

Diagnostic imaging

Managers at all levels in Bupa Cromwell hospital had the right skills and abilities to run a service providing high-quality sustainable care.

- The diagnostic imaging service was part of the Diagnostics, Outpatients and primary care division.
- The divisional manager led the team and oversaw the superintendents and team leads.The superintendents oversaw the radiographers.The lead nurse for outpatients was the overall manager for the radiography nurses. In medical physics the RPA oversaw the radiologists.
- The divisional manager was aware of challenges to sustainability and quality of the diagnostics service and the challenges different area's might face.Staff reported the divisional manager to be a good leader and approachable.
- The diagnostics service had an established management team across the department. The angiogram head of department was new in post but had made extensive positive changes to the department in the short time they had been in post. We observed all teams to be focused, enthusiastic and driven to make improvements to the services provided supported by the department leaders.
- All staff reported their managers to be approachable with strong leadership skills.Staff told us leaders had the skills and experience to appreciate the roles they completed and offered valuable support.
- Most staff reported the executive team were not visible and some staff we spoke with told us they did not feel listened to by the executive team especially when it came to the redesign of their department.
- The department had introduced a new structure to ensure a robust and supportive team for the department.This included an interventional radiology clinical nurse specialist, a lead CT radiographer and a lead mammographer.Staff we spoke with were positive about the changes.
- The executive team ran 'in touch' sessions which were smaller intimate meetings for staff with the executive team.

Vision and strategy

The provider had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

- Bupa Cromwell hospital's vision was to be the outstanding hospital of choice for quality and experience in London for their patients, people and partners. The hospital values were being open, passionate, caring, authentic, accountable, courageous and extraordinary.
- The diagnostics strategy was aligned with the hospitals and the wider Bupa strategic framework, focusing on patients, people and sustainability. The Outpatient department (OPD) strategy was linked to the primary care strategy, ensuring that Bupa Cromwell hospital worked in partnership with the primary care services, and the wider GP network within their community. Recent examples included the breast, prostate and cardiac pathways, with the strategic aim to include initiatives for further quick access pathways, and expanding the OPD department outside of the existing hospital setting.
- Most staff we spoke with could tell us the Bupa Cromwell hospital's visions and values but were unsure of the diagnostics service strategy or vision.
- The angiogram department had developed a strategy on a page. Their vision was "Delivering excellent clinical outcomes, in an efficient and safe environment by highly qualified clinical staff using cutting edge technology, supported by efficient processes and engaged across hospital teams". This included a quality improvement plan which fed into Bupa Cromwell hospital's quality plan.
- The radiology department had sufficient plans for the replacement of high cost equipment through managed services.

Culture

Managers across Bupa Cromwell hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Staff told us they had monthly team meetings and would participate in these fully. We saw many staff attended these and minutes were available to all staff on notice boards and on line.
- All staff spoke proudly about their work in their individual modality and as a part of the diagnostic imaging service. Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which senior staff encouraged. Staff told us they felt valued and supported by colleagues and senior managers.
- All staff placed the patient at the centre of their service and described the care they delivered was based around the patient's needs.
- Staff spoke positively about working for Bupa Cromwell hospital and felt their managers acknowledged their wellbeing needs.
- Staff undertook annual staff satisfaction surveys for Bupa Cromwell hospital to seek views of all employees within the organisation and Bupa Cromwell hospital implemented actions from the feedback received. The response rate for 2017 was 61% of staff with a NPS score of -43 recommending Bupa as a good place to work - 21 being likely to recommend their products and services.
- The service had an open no blame culture where managers actively promoted and encouraged incident reporting which they used for training to improve care. Satisfaction survey's sought staff and patient engagement.
- Staff were aware of the duty of candour (DoC) regulation and evidenced through discussion the appropriate application of the duty when required.The DoC is a regulatory duty which 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.
- Bupa Cromwell hospital had selected six staff from the department to attend the clinical excellence development programme which aimed to support clinical and clinical operational staff to lead change efficiently, drive forward quality and to encourage staff to realise their potential.
- Bupa Cromwell hospital shared information regarding learning from incidents and complaints with staff in their 'Feedback Friday' and reflective practice forums using a recognised approach. These forums are evidence-based forums where staff can come together and discuss different clinical issues in a supportive environment.
- Each year Bupa Cromwell hospital held STAR awards where managers and colleagues of the various teams nominated individual staff members to receive awards for various categories.All staff were invited to attend this yearly event.

Governance

Bupa Cromwell hospital systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish.

- The diagnostics service had a clear systematic governance process to continually improve the quality of service provided to patients. The arrangements for governance and processes were clear and operated effectively. Staff understood their roles and accountabilities.
- The radiation protection and medical exposures committee fed into the health and safety and wellbeing committee which fed up to the executive committee.
- There were monthly departmental meetings across the diagnostics service where information was shared as a team including governance updates, complaints, incidents and risks.We saw evidence of team meeting minutes displayed for all staff to read. However, within the clinical diagnostic centre staff reported there were no team meetings held.
- The governance team facilitated a daily incident and complaint meeting which looked at all complaints logged within the previous 24-hour period.This ensured the hospital could respond to all complaints and incidents in a timely manner.
- The ionising radiations group held monthly meetings and minutes we reviewed showed their agenda to include staff, incidents, IRMER manual and local rules review and departmental issues, general radiology (including all departments).

- Staff undertook internal quality audits and assisted in driving improvement and gave all staff ownership of things that go well and that needed improvement. This ensured staff from all disciplines were involved in quality improvement.
- Staff were clear about their roles, what managers expected of them and for what and to whom they were accountable.

Managing risks, issues and performance

The provider had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- Managers ensured risks were embedded in the quality system and added on to the registers and reviewed monthly by the senior managers.All staff we spoke with could identify risks in their local areas which matched those on the risk register.
- Each department had created risk assessments for all diagnostic equipment. Each risk had a risk matrix which detailed the level of risk and each risk was regularly reviewed in management meetings. This ensured the safety of patients and staff whilst undergoing diagnostic investigations.
- There was a risk assessment system in place locally with a process of escalation onto the corporate risk register.The risk register detailed risks, their effects, their risk score and when they were last reviewed.Management reviewed all medium risks within the last month.Where risks were identified managers took steps to identify how the risk originated, completed analysis to identify why the risks existed then took steps to minimise these risks.
- The service had a backup generator in the case of failure of essential services.There would be a delay of a few seconds for the generator to become effective.The only area this would effect was the angiography department where staff reported a power cut would force the computers to reboot which could take up to 10 minutes.This posed a risk to patient safety during angiography procedures. The service registered this as a high risk on the angiography departments risk register.

Managing information

The provider collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The service had access to Bupa Cromwell hospital's computer systems. They could access policies and resource material from the Bupa Cromwell hospital's intranet.
- There was sufficient information technology equipment for staff to work with across the diagnostics service.
- The service regularly reviewed quality performance which managers discussed at meetings across all modalities. Managers shared this information electronically with staff through minuted meetings to ensure their awareness of where improvements in performance could be made.
- Staff could access electronic patient records easily but records were kept securely to prevent unauthorised access to data.
- Information from scans was available to view remotely by referrers which gave timely advice and interpretation of results to determine appropriate patient care.

Engagement

The provider engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- There appeared to be good management engagement with staff.Most staff we spoke with told us the management was supportive accessible and visible
- The diagnostic service encouraged staff to voice their opinions and help drive the direction of the service provided and suggest improvements to the examinations provided.There was a 'shy' box for staff to anonymously raise concerns or compliments to the department.Staff discussed the feedback at the monthly team meetings. However, some staff had made suggestions on how to improve the MRI booking systems to reduce delays but felt they were not listened to.

Good

Diagnostic imaging

- Bupa Cromwell hospital engaged with embassies across the world and ran open evenings the 'Cromwell Conversation' promoting their services for example, the knee replacement processes for the public to attend.

Learning, continuous improvement and innovation

The provider was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- Plans for future sustainability of the hospital included for example, investing in a refurbishment plan for the diagnostic imaging department to improve the environment for patients and staff.However, we did not see the plans.
- The diagnostics service was aiming to re-invest in core assets on a demand driven basis which would ensure quick access to services for patients. Bupa Cromwell hospital ran an employee net promoter programme which drove initiatives to develop staff and supported improved leadership and development.
- The diagnostic service had just been reaccredited with the ISO 9001:2015. This audit demonstrated that the services had effective quality management and an ongoing commitment to delivering high quality care. The ISO standards promote on-time service delivery and great patient experience which reduces the need for complaints.

Outstanding practice and areas for improvement

Outstanding practice

Medical care:

- The hospital provided extensive emotional support and resources to patients and their families. The oncology and chemotherapy day unit had a qualified Macmillan cancer counsellor and patients really valued the service.
- We saw numerous examples of individualised care and progress made through the involvement of relatives, for example with patients who had suffered a brain injury.
- In medical care, staff provided compassionate individualised care. Staff provided extensive support to patients and their relatives and worked hard to meet the holistic needs of their patients through emotional and practical measures.

Outpatients:

- The hospital worked with a sight loss charity to provide a braille map for partially sighted and blind patients to enable them to navigate the hospital safely and independently.
- Patients were provided with a single point of contact via a patient care coordinator. This was their point of contact throughout their visit. They were responsible for looking after the patients' welfare, and checking them in with the consultants' reception desk. They also kept the patient up to date with any changes or delays.
- The hospital held cultural sessions for both international patients and staff prior to admission to the hospital. This was to ensure both patients and staff understood cultural expectations, enhanced the patient experience and so they did not offend each other.

Areas for improvement

Action the provider SHOULD take to improve

Medical care:

- The provider should improve the management and maintenance of clinical and portable equipment.
- The provider should review the consent process and documentation for administering chemotherapy medicine that are outside the terms of its product license.
- The provider should consider how to work with the catering suppliers to improve the menu provision for patients on dialysis.
- The provider should consider how to address the bullying and cultural issues staff experienced from patients

Surgery:

- The provider should ensure that patient rooms and equipment are free from dust.
- The service should ensure that anaesthetic machine log books are checked daily and completed in full.
- The service should ensure that all VTE risk assessments are affixed to the main records.
- The service should ensure that all pain scores are consistent throughout the surgical pathway.
- The service should continue to investigate to reduce the high number of unplanned readmissions 28 days after surgery.

Critical care:

- The provider should ensure that all equipment is safety tested and cleaned appropriately.
- The provider should ensure staff adherence to infection prevention and control standards
- The provider should improve compliance with recommendations of Core Standards for Intensive Care Units regarding the rate of bank or agency staff.
- The provider should investigate and reduce the rate of unplanned readmissions within 48 hours from discharge.

Outstanding practice and areas for improvement

- The provider should investigate and improve the number of unit acquired infections in blood.
- The provider should investigate and reduce the numbers of out of hours discharges to the ward.
- The provider should improve staff awareness about the principles of Deprivation of Liberty Safeguards in a critical care setting.
- The provider should continue to carry out plans for the environment to comply with recommendations Guidelines for the Provision of Intensive Care Services (GPICS) and Core Standards for Intensive Care Units, published by the Faculty of Intensive Care Medicine and the Intensive Care Society.
- The provider should continue to carry out plans for the provision of appropriate isolation facilities.
- The provider should continue to carry out plans for the provision of appropriate facilities for relatives.

Services for children and young people:

- The provider should improve the provisions around staff training to understand the needs of children with a learning disability. Including a defined role with in the hospital to lead on learning disability.
- The provider should improve the arrangements to allow staff to be relieved from their duties to attend face to face mandatory training.
- The provider should improve the adherence to the dress code for all staff in clinical areas to be bare below the elbow.
- The provider should ensure the consistent approach to documentation of outpatient consultation.
- The provider should improve the online database for policies and guidelines to make it more user-friendly.
- The provider should continue to improve the formal clinical governance structure for children's services is in place.
- The provider should continue to improve the comprehensive clinical audit programme including consent audit.
- The provider should continue to improve the monitoring of patient outcomes regularly.
- The provider should ensure it meets the RCN guidelines for safer staffing when the paediatric inpatient service is extended to operate seven days a week.

Outpatients:

- The provider should ensure all patient interactions and consultations are recorded in the patient medical records. This includes recording medications prescribed, and documenting conversations with patients to show involvement in decision making.
- The provider should ensure cleaning schedules are checked and completed daily.
- The provider should ensure action plans are written and actioned once audit results are available.
- The provider should ensure the therapies department are using correct patient record keeping facilities that are in line with hospital policy and data protection.
- The provider should audit their patient outcomes and interactions, an adherence to national guidance, to be able to benchmark against other providers.
- The hospital should ensure patients living with dementia, learning difficulties or mental health issues are flagged to staff to be able to assist the patient safely.
- The provider should ensure they have a mental health provision within the hospital for patients attending appointments or for treatment.

Diagnostic imaging:

- The service should provide a safe environment for children to wait within the adult waiting areas.
- The service should improve the cleaning of all areas of the diagnostic service regularly as per the services schedules.
- The service should address the MRI safety issue of unauthorised access to the -2 MRI area of relatives or carers who could be metal carriers.
- The service should undertake regular audits of the quality of plain film x-rays to ensure patients are not subjected to overexposure of radiation.