The Princess Grace Hospital

Quality Report

42-52 Nottingham Place
London
W1U 5NY
Tel: 020 7486 1234
Website: www.theprincessgracehospital.com

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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

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

The Princess Grace Hospital is operated by HCA International. The hospital has 126 beds. Facilities include eight operating theatres, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, urgent care, outpatients and diagnostic imaging. We inspected surgery, urgent care centre and outpatients and diagnostic imaging.

The CQC had received information raising concerns about the outpatients and diagnostic imaging service during the 12 months before this inspection, which led to the decision to plan this inspection. The concerns were around staffing issues, imaging request procedures and culture. The hospital has been inspected twice previously, and the most recent inspection took place in August 2016.

We inspected Urgent Care, Surgery and Outpatients and Diagnostic Imaging using our focussed inspection methodology. We carried an unannounced visit to the hospital on 6 and 7 February 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.

Services we rate

We rated Urgent Care, Surgery and Outpatients and Diagnostic Imaging as 'good' overall.

The ratings of the Urgent Care and Surgery core services improved from requires improvement to good since our last inspection.

The rating for Outpatients and Diagnostic Imaging core service was good, which was the same as the last inspection. Concerns raised with the CQC about this service were found to have been dealt with by the provider or could not be substantiated during inspection, except for a few individual staff members expressing worries about the culture in the hospital.

We found good practice in relation to urgent care, surgery and outpatients and diagnostic imaging:

- 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 controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- 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 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 and improve.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Summary of findings

- People could access the service when they needed it and there were no waiting lists. Waiting times for consultations, treatments and diagnostic services were minimal.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Leaders were committed to improving services and had implemented positive changes since the previous inspection.
- There was a realistic strategy for achieving the priorities and developing good quality and sustainable care. The hospital had effective structures, systems and processes in place to support the delivery of its strategy including a sound governance system.
- Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

We found areas of outstanding practice in outpatient care :

- A patient navigator role was implemented in the breast institute, the role is designed to ensure the patient pathway is fully completed and continued after the patient leaves the department. The navigator calls the patient at home to organise any further care if needed and this has ensured that patients are followed up appropriately and that no patient is missed.

We found areas of practice that require improvement in urgent care:

- The electronic systems did not always work well together in the urgent care centre to allow staff access to all necessary information at all times.
- Patients' privacy was not always ensured.

We found areas of practice that require improvement in surgery:

- Assessments for risk of venous thromboembolism were not always completed correctly.
- Possible risks of cross contamination in theatres were not always kept at a minimum.

We found areas of practice that require improvement in outpatient care:

- Out of the 24 staff we spoke with the majority of staff spoke positively regarding the working culture, however four members of staff told us they felt there was a culture of bullying.

Amanda Stanford

Deputy Chief Inspector of Hospitals (London)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Good	The urgent care centre provides urgent care for adult patients without appointment and is open daily. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients and diagnostic imaging	Good	Outpatients and diagnostic imaging services includes all areas where patients undergo diagnostic testing, receive diagnostic test results, are given advice or provided care and treatment without being admitted as an inpatient. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Background to The Princess Grace Hospital

The Princess Grace Hospital is operated by HCA International. The hospital opened in 1977. It is a private hospital in London. The hospital primarily serves private or self-funded patients.

The service is registered to provide the following regulated activities:

- Surgical procedures
- Diagnostic and screening
- Treatment of disease, disorder or injury
- Management of supply of blood and blood derived products
- Family planning
- Services in slimming clinics

The hospital undertakes a range of surgical procedures and provides medical and critical care for adults. The hospital also provides services for private patients through the outpatients department and the Urgent Care Centre.

The hospital has had a registered manager in post since 2012.

The Princess Grace Hospital had been inspected twice by the Care Quality Commission:

- January 2014 (focussed on oncology services). All standards assessed were found to be compliant. and
- August 2016 (comprehensive inspection). Rated as 'requires improvement' with requirement notices for regulation 12, 13 and 17 – all have been met by the provider since then.

Our inspection team

The team that inspected the service was led by CQC inspection manager and other CQC inspectors, specialist advisors of various backgrounds and an expert by experience. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

How we carried out this inspection

We inspected this service using our inspection methodology for independent health. We carried out an unannounced site visit on 6 and 7 February 2018.

Information about The Princess Grace Hospital

During the inspection, we visited the urgent care centre, three surgical wards, the surgical day case unit, theatres, outpatients areas and diagnostic imaging facilities. We spoke with 59 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 40 patients and relatives. During our inspection, we reviewed 39 sets of patient records.

The urgent care centre (UCC) at the Princess Grace Hospital (PGH) provides urgent care with no prior appointment and is open daily from 8am to 10pm. The last patient is registered to the centre at 9.30pm. The centre is open 365 days a year and offers urgent care for a variety of conditions, including acute medical conditions such as respiratory and chest complaints; ear, nose and throat conditions; fractures, sprains and strains; stomach,

Summary of this inspection

bowel and bladder problems; minor wounds, burns, or cuts and grazes and general aches and pains. The service does not treat London Ambulance Service (LAS) patients, patients under 18 years old, patients presenting with obstetric related problems and patients presenting with mental health issues. Patients can be admitted to the service by presenting at reception and completing a registration form before being seen.

Surgical services at the PGH provide day case surgery and inpatient care for private or international patients. The service offered a range of different surgical specialities, including orthopaedic, urology, gynaecology, breast or ear, nose, throat. There were eight operating theatres on two floors with a recovery area on each floor. The day case unit with 15 private rooms was on the first floor and the inpatient wards for surgical patients were located on the second, fourth and fifth floor. The wards provided 24 hour, seven days a week care.

The outpatient and diagnostic imaging department at PGH provide services to private UK patients and those from overseas. Outpatients and diagnostic imaging services includes all areas where patients undergo diagnostic testing, receive diagnostic test results, are given advice or provided care and treatment without being admitted as an inpatient.

PGH outpatient department holds clinics for a range of different specialities including but not limited to orthopaedics, gastroenterology, gynaecology, general surgery, neurosciences, breast care and oncology. The diagnostic and imaging services offer Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), X-Ray, Interventional radiology, Digital Mammography, Ultrasound and Nanoknife irreversible electroporation treatment to a range of different tumours.

The outpatient services were provided from three locations including the main hospital building, the 47 Nottingham Place outpatient building and the 30 Devonshire Street building. The diagnostic imaging department was split over the main hospital and the Devonshire Street building.

Activity (February 2017 to January 2018)

- In the reporting period, 7,250 patients visited the UCC.
- There were 5950 surgical patients treated at the hospital; of these 2.9% were NHS-funded and 97.1% other funded.
- There were 39,205 outpatient appointments for 26,098 patients in the reporting period.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good

Good

Urgent and emergency services

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

Are urgent and emergency services safe?

Good

Incidents

- There had been no 'never events' reported for the service in the 12 months prior to our inspection. 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 throughout the service were aware of how to report clinical incidents and near misses. Staff at all levels were able to show us their electronic reporting system and how to navigate this. Whilst staff felt confident with reporting incidents, the service had a low rate of clinical incidents so there were not many examples of learning that staff were able to provide.
- We saw evidence that incidents were robustly investigated and there were opportunities for learning that was shared amongst staff.
- Between February 2017 and January 2018 there were 40 incidents reported across the service. The majority of these incidents (35) resulted in no harm, four incidents related in low harm and one incident related in moderate harm. Of these incidents, the majority (13) related to delays in clinical assessment e.g. investigations, images and lab results. Staff were able to provide learning from incidents, for example, there was previously a delay with getting equipment in the service but staff ensured that there was sufficient stock of equipment available at all times. We saw evidence of this.
- There were no serious incidents (SIs) reported across the UCC between February 2017 and January 2018. Senior staff informed us that SIs would be fully investigated and action plans would be developed to assess areas of improvement. The learning from the SI would be shared amongst staff via email and monthly meetings.
- Doctors at the service informed us of the actions that were taken because of incidents that had occurred. For example, a trend in controlled drug (CDs) log book errors was recognised and as a result one of the doctors of the service started a regular audit programme. This audit checked the log book on a daily, weekly and monthly basis and ensured that CDs were checked thoroughly and efficiently.
- The service did not hold specific morbidity and mortality meetings as no deaths occurred in the centre. For more information on hospital wide M&Ms please see the surgery report.
- 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 at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan and all staff were aware of their

responsibilities under the duty of candour. The service had not employed the duty of candour within the reporting period as there were no incidents that met the duty of candour threshold.

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

- The hospital was not required to use the NHS Safety Thermometer as they are an independent healthcare provider. This is a tool which measures harm to patients which may be associated with their care. The hospital did however monitor incidents of patient falls, pressure ulcers, transfusion incidents and injuries. There was a 'hot board' in the service staff room that displayed data related to the unit and the hospital in general. This tool was also available on their online system which also indicated how many days had passed since the last incident. Please see the surgery report for more information.

Cleanliness, infection control and hygiene

- The UCC was visibly clean and tidy. There was one entrance which was clean and uncluttered. There were adequate supplies of personal protective equipment (PPE), for example gloves and aprons available in each bay and consultation room. Between January 2017 and February 2018 the use and management of PPE audit results were 100% throughout. There were antibacterial gel dispensers throughout the UCC and hand washing basins in each bay and consultation room. Green 'I am clean' stickers were used throughout the service to inform colleagues at a glance that equipment or furniture had been cleaned and was ready to use. Disposable curtains were in use in the bays and they were clean and fit for purpose.
- We observed posters in the medicines room and around the service displaying hand washing techniques and particularly the "World Health Organisation, 5 moments of hand hygiene". These were in line with infection control good practice standards.
- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training as part of an annual programme. The UCC had an IPC link nurse who acted as a link between the department and the hospital infection control team. The UCC infection control nurse was responsible for performing IPC audits such as hand washing and bare below the elbows (BBE). All staff we observed adhered to the BBE dress code. Between January 2017 and February 2018 hand hygiene audit results varied between 78% and 100%. 100% of staff, both medical and nursing had attended IPC training.
- There were three bays and two consultation rooms. The consultation rooms acted as single occupancy isolation rooms if required. Staff of all levels knew of measures they should take to reduce the risk of healthcare-associated infections.
- Between January 2017 and February 2018, the UCC did not report any cases of Meticillin-resistant Staphylococcus aureus (MRSA) or Meticillin Sensitive Staphylococcus Aureus (MSSA). MRSA is a bacterium that can be present on the skin and can cause serious infection and MSSA is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning. There were also no cases of E. Coli or Clostridium difficile infection (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics).
- There were safe systems for managing waste and clinical specimens. Sharps bins were used appropriately; the containers were dated and signed when full to ensure disposal. None of the bins were full during our inspection. Between January 2017 and February 2018 the disposal of sharps audit results were 100% throughout.
- The service systems for managing waste were in line with the corporate waste management policy. Between January 2017 and February 2018 the department waste audit results were between 99% and 100%.

Environment and equipment

- The service was clean and well-lit with natural light. There was enough space for patients and staff alike in clinical areas. The three bay areas were of equal size and could be closed off with a curtain. The two consultation rooms were well-lit and contained an adequate amount of space.
- Equipment used in the department was clean and labelled to indicate it was disinfected and ready to use.

All portable equipment we checked had been serviced and labelled to indicate the next review date. All disposable equipment was readily available, in date and stored appropriately.

- There was one resuscitation trolley in the department which contained equipment for both adults and children. Even though the service did not treat children they maintained equipment for children on the resuscitation trolley in case a child that was accompanying their parent to the department became ill. The trolley was checked on a daily basis and was fit for purpose. We checked all equipment and it was within date.
- The environment and equipment audit included clean and dirty utility, public and general areas and bed spaces. Between January 2017 and February 2018 the audit results were between 92% and 100%.

Medicines

- Nursing staff informed us that pharmacy services were easily available and we observed that the pharmacy was directly opposite the UCC front entrance. The pharmacy was open every weekday from 9am to 6pm, Saturdays and Sundays from 9am to 1pm. There was also a bleep pharmacy number that the staff could utilise out of hours.
- Medicines were managed and stored appropriately in the UCC. Staff kept medicines and intravenous (IV) fluids in the medicines room that was accessible via swipe card that only staff had. All drugs that we checked were within date. The pharmacy team would discard expired drugs.
- Controlled drugs (CDs) were securely stored in a cabinet that was accessible with a key that was held by the daily nurse in charge in the medicines room. The CDs were checked twice daily by staff. We reviewed the CD log and found it fully completed. This corroborated the audit that one of the doctors in the service carried out on a monthly basis to ensure compliance with CD guidance. The hospital had a controlled drugs policy that was up-to-date and readily available to staff.
- Nursing staff were aware of the hospital's policies on medicines management and the administration of controlled drugs in line with Nursing and Midwifery Council (NMC) guidelines. Staff also had access to copies of the British National Formulary (BNF), in addition to policies relating to medicines management (including the antimicrobial formulary), via the trust intranet. Staff understood and demonstrated how to report medicine safety incidents. Learning from these incidents was then fed back through various channels such as emails, nursing handovers and monthly meetings.
- The ambient room temperature of the medicine room was monitored daily to ensure temperatures did not exceed recommendations for the safe storage of medicines. The fridge temperatures were also monitored daily and were within range. Both these temperatures were noted down in daily log books.
- Nursing staff did not use Patient Group Directives (PGDs) for the administration of medicine, although the service had plans to introduce nursing staff prescribing of paracetamol in the weeks after the inspection.
- The pharmacy was located opposite the urgent care centre. Patients could get their prescriptions from the pharmacy. The pharmacy staff informed us that if patients of the UCC required medications that were not available, they would be ordered and delivered to the patients securely the next day.

Records

- Apart from the initial registration forms which were filled out by patients and later scanned into the system, the service used an electronic system to record patient records including their triage information, care plans, nursing and medical decisions and risk assessments. We looked at 15 sets of patient records. All were dated and showed detailed step-by-step accounts of the patients' time in the centre. All but one of the records showed patients pain scores. All patient records had been written in line with General Medical Council guidelines (GMC) and Nursing and Midwifery Council (NMC). All the records we looked at had taken a note of patient allergies. Pathology and imaging results were also stored electronically.
- Although the records were easily accessible to staff there was an issue with merging the two electronic databases that housed the patient records. There was a risk that the records could not be merged properly and so records had to be downloaded and copied onto one system. This risk was identified on the risk register.

- Information governance training was mandatory and 100% of staff in the UCC had completed this within the last year.

Safeguarding

- Both nursing and medical staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the up-to-date corporate safeguarding policy on the intranet and knew who to contact if they had any concerns. All staff knew who the hospital safeguarding lead was and how to contact her if need be.
- Both medical and nursing staff understood their responsibilities if a patient with female genital mutilation (FGM) presented at the service.
- Safeguarding was part of the hospital's mandatory training programme. Since our last inspection, the service had made strides towards training all staff in safeguarding adults and children. 100% of nursing and medical staff were compliant with level 2 safeguarding children and adults training. Additionally, 100% of nursing and medical staff were trained to level 3 in both adults and children safeguarding.
- Both medical and nursing staff knew that the chief nurse was the safeguarding lead and how to escalate any concerns or ask for support or guidance in safeguarding matters. During the reporting period the service did not report any safeguarding concerns to the CQC although they had made four safeguarding referrals to the local authority.
- In the year prior to our inspection the service had had made four safeguarding referrals to the local authorities. We reviewed all four referrals and found that they were appropriate and made at the appropriate time.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was mainly provided via e-learning. Topics for both medical and nursing staff included: Equality and Diversity, Ethics, fire safety, health and safety, infection control, information governance, manual handling, safeguarding adults and safeguarding children. Additionally, medical staff were all trained in Advanced Life Support (ALS) and nursing staff were all trained in Basic Life Support (BLS). Mandatory training completion rates for all staff was 100%.
- At our last inspection the doctors in the service were not trained in mental capacity act (MCA) and deprivation of liberty (DoLs). At this inspection both doctors and nurses had been trained in MCA and DoLs. All doctors maintained ALS training.
- The lead physician of the service managed the doctors training schedule and all doctors had an annual mandatory training schedule that they complied with.

Assessing and responding to patient risk

- On arrival at the UCC patients registered with the receptionist and completed a form including their personal details and their reason for attending the UCC. Patients were registered on the system and awaited triage by a trained triage nurse. The hospital policy for assessment of patients in the UCC stated that patients should be triaged within '15 minutes of arrival'.
- Between February 2017 and January 2018, 7,250 patients visited the UCC. In the same reporting period between 69% and 85% of patients were triaged by a nurse within 15 minutes of arriving at the UCC. This was apart from May 2017 when the figure was 37%.
- In the same reporting period, between 73% and 97% of patients were seen by a doctor within 30 minutes of arriving in the urgent care centre. This was apart from May 2017 when the figure was 48%.
- We asked the service for more information as to why the figures dipped in May 2017. They informed us that they introduced the electronic system in May 2017 and this system change influenced the figures for that month.
- At our previous inspection we found that there was no formal system to prioritise patients by acuity or severity of their condition. We found that this had been rectified as patients clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-patients in hospital'. A scoring system based upon these observations known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The hospital had

an on-call outreach team available 24 hours a day and 100% of doctors and nurses that worked in the UCC were trained in basic life support (BLS) and advanced life support (ALS).

- The audit results for the completion of NEWS between April 2017 and December 2017 was 100%. In the same reporting period, a doctor reviewed 100% of patients and between 98% and 100% had their entire treatment plan documented.
- We reviewed the service standard operating procedure which included the UCC exclusion criteria. Patients under the age of 18, pregnant women greater than 20 weeks gestation, requiring psychiatric care, requiring an urgent CT scan post head injury, requiring interventional cardiac care and patients who required treatment related to renal dialysis were excluded.
- The service had a pathway in place for suspected sepsis and staff were able to clearly outline the steps taken in the event of suspected sepsis. The service also had pathways for chest pain and deep vein thrombosis (DVT).
- There were pathways in place for the referral of patient transfers to other provider facilities and NHS hospitals if required.
- If the GPs in the service required more expertise assistance they had access to an intensivist RMO and a resident medical officer (RMO) twenty-four hours a day, seven days a week. They also had access to other specialists for example, cardiology and orthopaedic.

Nursing staffing

- There were five whole time equivalent (WTE) nurses in post at the time of our inspection. In the reporting period the nursing turnover rate was 25%. There were three nurses on shift at any given time of the day.
- Between February 2017 and January 2018 sickness rates amongst nursing staff were between 0% and 8%. This was apart from September and October 2017 when the rate was 11% and 25% respectively. We were informed by the service that the reason for this spike was due to two members of staff requiring extended sickness leave.
- Usage of agency staff varied in the six months prior to inspection. Between 13% and 20% of staff shifts were filled by agency staff from August 2017 to January 2018. Regular agency staff were provided with login details for the computer system and the patient records. The agency staff were familiar with local protocols and procedures. All agency staff were assessed prior to being able to administer medication.

Medical staffing

- A provider which was a subsidiary company of the HCA brand employed the GPs in the service. This subsidiary was responsible for maintaining all the personnel files for the doctors. All the GPs in the service undertook a three week provider induction.
- The service was open from 8am to 10pm daily all year and was staffed by at least two doctors at any time in the day. In emergency circumstances, the service would call the HCA bank department and arrange for a locum doctor to come in. We were assured that this happened on rare occasions. Between February 2017 and January 2018 the use of locum staff varied from 4% to 10%.

Emergency awareness and training

- Staff were aware of the actions they would take in the event of an emergency, e.g. a fire or power outage. 100% of staff in the UCC had completed fire safety training as part of the service mandatory training programme. Fire alarms were tested every Tuesday.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Evidence-based care and treatment

- At the time of our last inspection the service did not have any guidance or pathways that were evidenced to be based on national guidelines. Since then, the service had produced several policies based on the National Institute for Health and Care Excellence (NICE) and other national guidelines. There were several guidelines directly from the resuscitation council UK related to Advanced Life Support anaphylaxis, and both adult and tachycardia and bradycardia. There were also several pathways the service had developed based on NICE guidance. This included a chest pain pathway, adult

sepsis management, head injury guidelines and a VTE risk assessment. The service used a Public Health England (PHE) pathway on sepsis identification and management.

- We observed examples of local audits that had been carried out in the UCC. These included controlled drugs and cleanliness audits. Results of these audits and any learning were shared on the notice board in the staff room.

Pain relief

- Patient pain was assessed both at rest and upon movement and formed part of the pain assessment on the electronic system. The service used a numerical rating scale to measure pain from zero to three. In this scale, zero meant no pain and three was extreme pain.
- Between July 2017 and December 2017 [except for November 2017 of which there was no audit] the audit results revealed that 100% of patients received an initial pain assessment, a documented pain score and was either offered or prescribed paracetamol or Nonsteroidal anti-inflammatory drugs (NSAIDs).
- We reviewed 15 patient records that showed that appropriate actions were taken in relation to pain triggers to make patients more comfortable in all but one case and in another case there was no pain score noted at all. We saw examples of pain control managed with PRN (pro re nata/ when necessary) pain relief. All patients we spoke with were satisfied that their pain was well controlled.

Nutrition and hydration

- The service did not use a nutritional risk assessment tool as patients were not likely to spend over two hours in the centre.

Patient outcomes

- Between February 2017 and January 2018 there were no unplanned re-attendances at the UCC.
- The service did not participate in any national audits related to emergency care as they did not qualify as an emergency department. However, the hospital aimed to review national audit reports for recommendations and incorporate best practice into their policies and procedures.
- The service did however; collate data on referrals for further treatment, admissions to inpatient, patients assessed, treated and discharged home and the average time in the department.

Competent staff

- Revalidation is the process that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. Staff were provided with clinical supervision and supported through revalidation to maintain their registration. Staff also informed us that they were offered coaching and mentorship opportunities to ensure development was continuous.
- The nurses on the unit took part in competency classes at the hospital throughout the year. Within the first quarter of the year the nurses had access to: nutrition study day, tracheostomy skills day, urology and brachytherapy study day, chemotherapy study day and tissue viability study day. All staff received training on sepsis.
- All doctors in the UCC had their GMC registration checked on an annual basis as part of the clinical governance process. Consultants were appraised via the subsidiary company that hired them. The service reported 100% completion rate of validation of professional registration for doctors and nurses. All the doctors at the service received a three day corporate induction as well as a local induction.
- Bank and agency staff received a thorough induction by the senior nurse. We observed the induction files and found that they covered all areas of the department.
- The service reported that 100% of nursing staff had received an appraisal in the year prior to inspection. Medical staff had their appraisal carried out by the provider and all had been appraised in the last year.
- Three patients that we spoke with informed us that they had been to the service several times before due to the effective nature of the service and competency of staff.

Multidisciplinary working

- The service had a wide scope of reference with other services in the surrounding geographical area. As the

service had a stringent exclusion policy it ensured that it had up-to-date contact numbers of specialists within the surrounding area that could assist if necessary. The service had good access to on-site imaging.

- We observed evidence of doctors and nurses working effectively together. A clinical director with an interest in urgent care led the service. Theatre, critical care and outreach teams when required also supported the department.
- Whilst there was no formal joint meeting between doctors and nurses, both doctors and nurses were complimentary about the support they received from one another.

Access to information

- There were two separate electronic based systems used in the urgent care centre. The first system was mainly used by nursing staff to take patient risk assessments and do the initial triage. The second system was mainly used by doctors to log all the clinical decisions. Whilst both groups of staff could access each system, the systems themselves did not merge effectively. This issue was noted on the risk register.
- The service had access to pathology and diagnostic imaging.
- All staff had access to the hospital intranet where all service policies were stored online.
- On discharge, patients received a print out of all treatment received which they could share with their GP if they wanted to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- The registration form that each patient filled out upon arrival at the UCC contained a consent element. All patients had to provide consent before any procedure or treatment was carried out. We observed evidence of this in all the records we observed. The hospital had an up-to-date consent to treatment policy which staff followed.
- At our previous inspection no doctors were trained in the Mental Capacity Act. Since then all clinical staff had been trained in Mental Capacity Act and deprivation of liberty safeguards. The lead physician of the clinical staff ensured that all clinicians were up to date with this training.

Are urgent and emergency services caring?

Good

Compassionate care

- The 12 patients we spoke with all provided positive feedback about the care and treatment they received from the staff in the centre. They were treated with compassion, kindness, dignity and respect including when receiving personal care. We observed clinicians and nursing staff alike introducing themselves to patients and patients responding positively to this.
- Patients felt listened to and informed us that the nursing staff were “brilliant”. Patients referred to the doctors as “very caring” and “kind”.
- Although we observed staff respecting patients and treating them with dignity we did note that you could overhear conversations being had between patients and clinical staff. Also if the curtains to the some of the bays were open you were able to see patients being treated from the waiting area in the reception. Senior staff were aware of this and had made plans to place doors on all the bays.
- At our previous inspection there were no patient feedback results collected by the service. Since then, the service had made more effort to hand out patient feedback forms. Results of the patient survey in the reporting period showed that between 94% and 100% of patients were satisfied with their experience in the UCC.

Understanding and involvement of patients and those close to them

- All patients we spoke with informed us that they felt involved with their care planning and in making informed decisions about their treatment. They informed us that doctors were “clear and easy to understand”.

Good

Urgent and emergency services

- We observed staff involving patients and those close to them during assessments and would give patients time to ask questions. Staff took the time to ensure that patients understood both the treatment plan and the payment options available to them. Written information leaflets featuring a price list were readily available to all patients who used the service.
- The receptionist team would ensure that patients understood everything they had to pay for and that payment was carried out.
- Patients were provided a full price list on arrival in the department and both reception staff and nursing staff went over pricing structure with patients

Emotional support

- We observed staff being sensitive to the needs of patients. One patient was feeling nauseated and we observed a doctor taking the patient to the consultation room and allowing her to lie down until her medication was ready.
- Even though the average length of stay was minimal, patients informed us that they felt supported by staff.
- The hospital provided a multi-faith room and chaplaincy support that the service could utilise if needed.

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

(for example, to feedback?)

Good

Service planning and delivery to meet the needs of local people

- The service was open from 8am to 10pm daily all year and was staffed by at least two doctors at any time in the day.
- The waiting area contained eight chairs and during the length of inspection the area was never full. We did not observe any patients having to stand while they were waiting.

Access and flow

- Over the reporting period zero patients were in the department more than four hours.
- The senior staff in the unit informed us that the main reasons for sending patients to the NHS were either due to patient funding or the patient not being within the inclusion criteria. Between February 2017 and January 2018 15% of patients were transferred from the UCC to the NHS. The majority of these transfers related to patients without funding.
- On discharge the patient was provided with a print-out of all the treatment received with explanations as to why. The patient could also request a copy to provide to their GP.

Meeting people's individual needs

- In the event that a patient had to be transferred out of the service, the UCC provided transport for patients post treatment or stabilisation.
- Patients who were flagged as having complex needs or learning difficulties during the triage process were provided with individualised care. Staff informed us that these patients were supported with 'this is me' passports and we saw evidence of this in the service policy folder. We were informed that the service rarely treated patients who did not have full capacity and all staff had been trained in managing patients with learning difficulties.
- Patients requiring translation services had access via the hospital translation team. The hospital had access to medical translation through language line and had Middle Eastern interpreters as required. The service also had access to translation services for other languages on request. Leaflets were available in other languages.
- The service had an induction loop for deaf patients or patients hard of hearing.
- We did follow one patient throughout their journey at the UCC. The patient treatment plan included getting a scan and waiting on blood results. This patient was offered a hot drink whilst waiting.

Learning from complaints and concerns

Good

Urgent and emergency services

- The service manager handled all informal complaints. There was an up-to-date complaints policy available to all staff on the intranet. The hospital target was to acknowledge all formal complaints within 48 hours. The aim of 20 working days was set for a full response.
- In the six months prior to our inspection the service received three complaints. These were all upheld.There were no themes in the complaints received. All of these complaints were dealt within the 20 day timeframe. All complaints were entered onto the hospital electronic system.
- A member of staff informed us of learning from a minor complaint. This complaint concerned a patient who was provided with a piece of orthopaedic equipment. The patient came back to the service the next day and was unhappy because the equipment seemed to be faulty. The staff at the service then took time to talk the patient through the equipment. This was noted as a complaint and as a learning point, the staff now set aside time to discuss all equipment with patients.

Are urgent and emergency services well-led?

Good

Leadership and culture of service

- There was a clear senior management structure within the hospital. The hospital had a Chief Nursing Officer (CNO) who oversaw all the nurses in the urgent care centre. A duty manager coordinated patients being admitted from the UCC to inpatient beds in the hospital. The Chief Executive Officer (CEO) managed the running of the hospital overall. The primary care lead of a HCA subsidiary company oversaw and managed the doctors that worked in the UCC.
- At our previous inspection there was no nurse manager of the UCC. Since our last inspection, the service had appointed a nurse manager who was employed after being a regular agency nurse. Staff spoke highly of this new appointment and were happy with the leadership structure of the service.
- During our inspection, we noticed senior staff were visible in the service and knew staff across the department. Staff of all levels confirmed that the senior staff were very 'hands on' and 'approachable'. Nursing staff spoke highly of their CNO and felt that they could go directly to her if they had any issues.
- We observed good team working amongst staff of all levels. The medical staff worked well with the nursing staff. Agency staff also informed us that they felt like a part of the team and felt comfortable sharing ideas and suggestions with doctors.
- Staff who were present during our last inspection informed us of the positive changes made since then. Medical staff informed us that the management of the department had been streamlined and 'worked a lot more effectively for both staff and patients'.
- All staff we spoke from doctors to nurses stated that one of the main reasons they liked working in the department was because they got "more time with patients". Nurses felt as though they had more time to care for and listen to their patients and doctors felt as though they could give "a high quality of care and treatment" to patients.

Vision and strategy for this core service

- The hospital vision was "to be the facility of choice for urgent care for consultants, staff, patients and referrers. To uphold a reputation for safe delivery of acute care".
- Although there was no distinct vision for the service, all staff we spoke with informed us of the provider vision which was "Exceptional Care, Exceptional staff".
- Staff were passionate about doing the best job for the patient and were proud of the work they did in the service.

Governance, risk management and quality measurement (medical care level only)

- Clinical governance meetings were held every month. The clinical governance committee discussed incidents, complaints and departmental changes. The service fed into the hospital wide clinical governance committee that met quarterly. We observed the minutes from the meeting in November 2017. The minutes revealed that the UCC pathway for transferring patients out of the service was discussed.
- There were two active risks on the service risk register. One of the risks related to the two electronic systems in

the service not being directly linked. This risk was rated as high and there were controls in place to mitigate against any potential negative effects. The second risk related to patient privacy. This risk was rated as moderate as patient confidential conversations may be over heard. The service planned to replace all curtains with doors.

Public and staff engagement

- The service kept a log of all patient survey results and measured patient satisfaction via this medium. The nursing staff were proud of their patient engagement measures.
- Due to the small nature of the service a departmental staff survey was not carried out. This was to ensure that confidentiality was secured. Instead, senior staff informed us that the executive team would talk with staff on a regular basis and ask for suggestions. This was corroborated by the staff within the department who informed us that their suggestions were taken on board and changes were implemented.

Innovation, improvement and sustainability

- The service had plans to roll out the use of patient group directives (PGDs) in the urgent care centre. The plans were to implement them by March 2018 and this would give nurses the ability to administer paracetamol and ibuprofen to patients in pain. We reviewed competency training that the nurses would go through and found them to be thorough.
- The service had plans to roll out a point of care testing system by June 2018. This system would work across the HCA sites and ensure that the patient health care record was fully integrated. The service would be the pilot for this new system.

Good

Surgery

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

Are surgery services safe?

Good

Incidents

- There were no never events reported for surgical services between February 2017 and January 2018. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents. Incident reporting training was included in the staff induction programme, which all staff attended when they commenced employment at the hospital and must complete to pass their probation period.
- Staff across surgical services were able to identify and describe situations requiring completion of an incident form. Staff told us there was a good reporting culture and that they were encouraged to report incidents. Staff told us they received feedback and learning from incidents through learning grids, via email and at nursing handovers.
- The hospital reported 294 clinical incidents for surgical services between February 2017 and January 2018. Out of these 186 resulted in no harm, 100 resulted in low harm, six resulted in moderate harm and two were in relation to unexpected deaths. Most common themes were around medication issues, clinical assessment and treatment or procedure.
- Serious incidents (SIs) are those that require investigation. Evidence submitted relating to the occurrence of three SIs in the hospital from February 2017 to January 2018 demonstrated that a root cause analysis (RCA) investigation was undertaken where these occurred. Recommendations were made following each investigation. We saw an example of RCA undertaken following SI, including learning and action plan, which related to the SI of a surgical drape catching fire in theatres in September 2017, a fire risk assessment and drying time were added to the theatre safety checklist.
- The service held monthly mortality and morbidity meetings, chaired by the medical director. We saw meeting minutes, which showed good attendance by medical and nursing staff, cases were discussed with findings, actions and resulting changes if applicable.
- 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 we spoke with were aware of the requirements and we found that it was embedded into practice in the service. We saw examples of duty of candour being applied and handled according to regulations with letters containing an explanation of the situation and apology.

Clinical Quality Dashboard or equivalent

- The hospital had developed a dashboard which monitored pressure ulcers, falls and VTE. Data provided for the period of February 2017 to January 2018 demonstrated two hospital acquired pressure ulcers, eight falls (three resulting in harm) and no VTE on the surgical wards. The dashboard for different wards was accessible on the hospital's intranet and included incident calendars, information about risk assessment compliance and patient satisfaction results.

Cleanliness, infection control and hygiene

- Infection prevention and control (IPC) issues were an area of concern during the previous inspection. Since then, the hospital had implemented a number of changes to address these: Cleaning routines and checks in theatres were intensified, monthly microbiologist walk arounds with the theatre manager and IPC lead were started and IPC training of all staff was reviewed. Additional hand hygiene signage and hand wash stations were placed on ward corridors to promote hand hygiene. Theatres were cleaned between cases and we observed this during inspection. The hospital provided completed cleaning checklists for ward and theatre areas.
- Staff demonstrated good hand hygiene practice. We saw staff washing and using antibacterial gel to clean their hands. There were hand wash basins in all patient rooms and hand gel was available throughout the surgical wards and theatre department. Hand hygiene audit results from 2017 demonstrated 86% compliance for theatres, 95% for the second floor ward, 89% for the fourth floor and 84% for the fifth floor.
- We observed staff adhering to bare below the elbows (BBE) recommendations. Uniform and BBE audit results of 2017 showed 92% compliance rate for theatres, 97% for the second floor ward, 98% for the fourth floor and 100% for the fifth floor.
- Staff in all areas had access to personal protective equipment (PPE) such as gloves and aprons. We observed that theatre staff and ward staff wore the appropriate PPE during procedures.
- In 2017, there had been no incident of MRSA, one incident of E-Coli and two incidents of C.diff reported at the hospital. The provided information did not break the infection rates down by service.
- There were six (0.06%) surgical site infections (SSIs) in total in 2017. They occurred in three cases of breast surgery and one case each of urology, liver and elbow surgery.
- All patient rooms on surgical wards were single occupancy and therefore additional isolation areas were not required.
- Each theatre did not have its own anaesthetic room and staff had to use main theatre doors if the anaesthetic room was occupied. We observed staff exiting and entering the theatre through main theatre doors during an orthopaedic procedure. These main theatre doors opened onto the main theatre corridor. This caused a risk of cross contamination and interrupting the laminar flow. Managers told us this was due to the theatre sharing the anaesthetic rooms with the adjacent theatre and staff were instructed to use these doors only when absolutely necessary. The chief operating officer showed us plans to refurbish the theatre area, which included building separate anaesthetic rooms for each theatre. The refurbishments were planned to conclude by August 2018.
- Waste was transported out of theatres in the lower ground floor through corridors also used for transport of clean or sterile equipment. This caused a risk of cross contamination and was listed on the local risk register. Managers told us that waste was wrapped and covered in plastic bags before moving and planned theatres refurbishments would create a separate corridor for transport of waste.

Environment and equipment

- Resuscitation trolleys were located on corridors on each theatre floor and on all surgical wards. We saw they were checked daily and we found no omissions in the checklists.
- Difficult intubation trolleys were available for each of the theatre floors and were kept on theatre corridors for quick access.
- Equipment in theatres was clearly labelled on shelves with use of barcodes. Staff were aware of where equipment and consumables were kept.
- Implants utilised in theatres were recorded in the electronic patient record system, including serial

number and vendor. In addition, a sticker with the same information was placed in the paper documentation. We saw corresponding evidence in the patient records we reviewed.

- In CSSD (central sterile services department), we saw sterile equipment stored above shoulder height, this was possible manual handling risk. Managers told us that a different shelving system had been ordered. We saw packs without the weight printed on the label, this was not in line with best practice to prevent staff injury.
- We observed main theatre doors on the lower ground floor not closing tightly, but staying slightly ajar. This presented a possible risk of cross contamination. Replacement doors had been ordered in January 2018 and managers showed us evidence of this.

Medicines

- Medicines including intravenous fluids were stored safely in locked cupboards and refrigerators within a locked room which was accessed via keypad. The wards had a range of stock medicines to enable frequently used medicines to be available promptly when required. Patient's own medicines were stored separately. Results of the safe and secure storage of medicines audit October 2017 to December 2017 showed compliance rates between 90% and 100% for ward and theatre areas.
- The wards used a paper based prescription and medication administration record chart for patients which facilitated the safe administration of medicines. Allergies were recorded on the medication charts. We looked at 10 medication records of patients within the surgery services and saw appropriate recording of prescription and administration of medicines. However, we found that a separate intravenous heparin infusion chart for a patient was not completed and indicated blood clotting checks had not been done. This was not in line with the hospital's heparin protocol. When challenged, staff explained that this drug was rarely used and they would investigate this.
- Controlled drugs were checked twice daily, with a separate signing sheet seen. Controlled drugs were correctly documented in the controlled drug register, with access to them restricted to registered nurses who held the keys. The hospital conducted quarterly audits for all surgical areas. We saw audit results for October 2017 to December 2017 with compliance rates ranging from 75% to 100% and action plans for improvement.
- Results from the antimicrobial stewardship audit showed 100% compliance for the surgical wards in October 2017 to December 2017.
- The medicines reconciliation audit showed 100% compliance for the surgical wards in October 2017 to December 2017.
- Room and fridge temperatures were recorded on a daily basis, and were found to be within the recommended range. When asked what would happen if the normal fridge temperature of 2 to 8 degrees went out of range, the nurse stated that a member of clinical staff would be responsible for taking the appropriate action to rectify the anomaly, which included contacting the pharmacist and estates management.
- Staff understood and demonstrated how to report medicines safety incidents. Learning from these incidents was then fed back through various channels, such as emails, nursing handovers and monthly meetings.

Records

- The service used a combination of electronic and paper records. Nursing documentation and risk assessments were entered in an electronic patient records system. Staff recorded observations on a portable electronic device, which fed into the electronic patient record. Doctors and allied health professionals documented patients' updates in a paper record, which contained operation records, anaesthetic records, consent forms and letters. All paper records were scanned into the electronic record system after discharge.
- Patient information and records were stored securely on all the wards and in all departments we visited. Electronic records were not left on screens. Access to the computers with patient confidential information was password protected.
- Some agency staff did not have access to the electronic care planning system and documented on paper. At the beginning of the shift, the nurse in charge would provide relevant printouts and make a note in the electronic record.

- Risk assessments were completed and entered on the electronic care planning system. Staff were prompted to enter information by the system, and patients were given a specific care plans relevant to their condition and the procedure they were undergoing.
- Copies of perioperative treatment records were kept in patient notes. These included the five step surgical safety check list which were fully completed and details of any implants or prosthesis used.
- We viewed patient record documentation audit results of September to December 2017 for all surgical wards. Results demonstrated compliance rates of 92% to 100% for anaesthetist consultants and 94% to 97% for surgical consultants. Quarterly nursing documentation showed compliance rates of 93% for September 2017 and 87% for December 2017.

Safeguarding

- The hospital had a named safeguarding lead in post, responsible for safeguarding as dictated by statutory guidance. Processes were in place to provide appropriate safeguarding supervision for all staff and safeguarding information was displayed in all ward areas.
- Staff we spoke with were aware of how to access the safeguarding policies on the hospital's intranet. Most staff we spoke with were able to identify the different types of abuse and were aware of how to escalate concerns through senior nurses or the site manager.
- The hospital made one safeguarding referral to a local authority in 2017.
- Data provided by the hospital demonstrated that 93% of nursing staff had completed adult safeguarding training level one and two and 100% had completed safeguarding children training level one, two and three.

Mandatory training

- Mandatory training topics included: health and safety, manual handling, infection control, safeguarding, fire safety, code of conduct, information governance, equality and diversity and basic life support. The overall staff compliance rate was 93% against a hospital target of 85%.
- Basic life support training rate was 100%; this was an improvement since the previous inspection.
- An induction programme for all staff included all mandatory training for their individual roles. New staff were unable to pass their probationary period if mandatory training was outstanding. Ward managers showed us a folder with completed induction forms for agency staff.
- Senior staff monitored completion rates of mandatory training using an electronic learning system. They told us this was quick and easy to access. Clinical practice facilitators in each area ensured line managers updated staff training as part of their role. Staff had access to their own profiles and were able to see when mandatory training had expired and to book training courses.
- Managers were responsible for ensuring all staff were up to date with their mandatory training and completion was linked to salary increments. Nurse managers were able to see mandatory training figures for all staff in their area on the online system.

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

- The hospital had a pre- operative assessment team for high risk patients which provided advice and information to patients prior to their surgery, this included tests, screening and offered the patient an opportunity to clarify any details of their surgical journey. The hospital did not have exclusion criteria specifically for surgical patients.
- The majority of patients presented with low pre-operative risk with low ASA (American Society of Anaesthesiologists) scores. Data from February 2017 and January 2018 showed that 95.4% of surgical patients had ASA scores 1 or 2, meaning completely healthy fit or with mild systemic disease. Those patients were usually assessed by the anaesthetist on the day of surgery.
- Nursing staff told us patients were assessed for the risk of hospital acquired venous thromboembolism (VTE) at preadmission and on admission prior to surgery. Results for monthly VTE assessment audits for the surgical wards showed compliance rates between 80% and 100%, an average 96% in 2017.
- The electronic patient record included risk assessments for falls, malnutrition, acute kidney injury and skin integrity which were to be completed by the nursing

staff. Doctors would complete the VTE assessment in the patients' notes. However, we found during inspection that VTE forms were not always completed. In one set of notes, we found compression stockings were prescribed for a patient with contraindication. The stockings were not applied and the patient was not harmed, but it could suggest that the patient had not been examined for the VTE assessment. We raised this with staff and were assured that this would be investigated.

- Staff told us that if they had concerns relating to a patient's condition the on-site surgical resident medical officer (RMO), would be called to assess the patient and the patient's consultant would be informed if there were concerns. Staff on the wards told us the RMOs were accessible and responsive when called. If indicated, staff would call for additional support by the critical care outreach team.
- Patients' clinical observations were recorded and monitored in line with the National Institute for Clinical Excellence (NICE) guidance 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating. We saw staff on the surgical wards and in recovery recording patient observations such as heart rate, respirations, blood pressure, temperature and pain.
- Observations were recorded on an electronic system with the help of portable devices. The electronic system automatically calculated the early warning score, when a certain level was reached the on-call RMO was automatically informed and would review the patient. We looked at five observation charts on the wards and noted observations were fully completed with accurate NEWS documented and subsequent actions when NEWS was high.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist a checklist which was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. Results of the monthly WHO checklist audit in 2017 demonstrated 94% compliance on average. During two theatre cases that we observed, we saw that the mandatory steps of the WHO checklist were fully embedded in practice. We observed the whole theatre team were involved and staff stopped what they were doing to participate.
- A standard operating procedure was in place for management of major haemorrhage. The blood fridge in theatres always stored four units of O negative blood for emergencies.
- There were clear guidelines for the management of sepsis based on NICE guidance. Staff showed us sepsis screening and action tools based on the Sepsis UK Trust and a sepsis six pathway.

Nursing and support staffing

- We saw theatre staffing rotas confirming that the staffing levels in theatre during surgical procedures were compliant with recommendations from the Association for Perioperative Practice (AFPP) guidelines for patients in the perioperative setting. There was an on-call theatre team available for out of hour's emergencies. These staff were on-call from home and were expected to be on site within an hour.
- The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients; surgical services were compliant with this. We saw on the ward the nurse to patient ratios varied between 1:4 and 1:5, this was above the RCN recommendations. Senior staff told us staffing levels were flexible and bank staff were used when the acuity of patients was higher.
- Actual staffing numbers were above establishment for surgical wards. In theatres, staffing numbers (29.6) were below establishment (34.7) with ongoing recruitment.
- The hospital reported a vacancy rate of 4% in January 2018 for theatres and surgical wards.
- The turnover rate of nursing and medical staff in 2017 was 16.7%
- The average sickness rate for theatre and surgical wards from February 2017 to January 2018 was 4.6%.
- The rates of agency usage for theatres and wards varied from 2.6% to 13.4% in the reporting period of February 2017 to January 2018. Lowest agency and bank usage rates occurred during the summer months.

Good

Surgery

Medical staffing

- Patient care and treatment was consultant led. Records we viewed and staff we spoke with confirmed that consultants reviewed patients on a daily basis, including weekends. Surgical consultants reviewed their patients prior to discharge. The records we reviewed showed that consultants reviewed patients once or twice on weekends and were given updates on the phone by the RMO on call.
- The operating surgeon and anaesthetist were available for inpatients requiring unplanned surgery. There was an additional on-call surgical consultant rota for general surgery, trauma and orthopaedics.
- There was 24 hour, seven-day resident medical officer (RMO) surgical cover for the wards. The RMOs were employed by the hospital and had previous surgical training. During the day Monday to Friday there were two RMO's to cover the three surgical wards. At night there was one RMO that covered surgical wards.
- There were no vacancies for surgical RMOs at the time of inspection.
- Locum or agency rates for surgical RMOs have gradually decreased from 54.5% in February 2017 to 1.9% in January 2018.
- There was an on-call anaesthetic consultant rota which covered both the Princess Grace Hospital and another HCA hospital for emergency returns to theatre.

Emergency awareness and training

- The hospital had an up to date major incident and business continuity plan in place. Staff we spoke with and staff showed us that they were familiar with how to access the guidance online.

Are surgery services effective?

Good

Evidence-based care and treatment

- We viewed a selection of surgical and theatre clinical policies and procedures and saw they referenced the relevant NICE, Nursing and Midwifery Council (NMC) and Royal College guidelines. For example, the nasogastric and nasojejunal tube insertion policy had NICE references and was in date.
- Adherence to best practice, NICE, and Royal College guidelines was monitored and audited by the hospital's standards committee.
- Care was delivered in line with the relevant NICE and Royal College guidelines as well as taking account of individual consultants' preferences. There were patient pathways and protocols available and in use on the surgical wards. Different consultants had specific preferences or methods of care and nurses kept instructions in a folder on the wards for easy access.
- We observed patients receiving regular observations, for example, blood pressure and oxygen saturation, to monitor their health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic preparation.
- Nursing handovers within surgery were carried out at the beginning of each shift. Surgery handovers consisted of a full briefing of all patients on the ward that day. Handovers were also used as a communication tool to discuss incidents and learning. We observed a morning handover on the orthopaedic ward. Staff discussed patients using a handover sheet, listing current issues and plans for the day
- We saw the hospital's audit calendar, which included regular audits relevant to surgical services, for example, risk assessments, documentation, infection control or environmental audits.
- The hospital contributed data to the national joint registry (NJR). The NJR was set up by the Department of Health (DoH) to monitor performance of joint replacements in orthopaedic surgery.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS).[KS1]Patient

recorded outcome measures (PROMs) is mandatory for all NHS hospitals performing hip replacement, knee replacement, varicose vein and groin hernia surgery. PROMS uses patient questionnaires to assess the quality of care and outcome measures following surgery.

- The hospital started providing data to the British Spinal Registry since December 2017.

Pain relief

- We found that pain was generally managed well for surgical patients. Pain audits were undertaken monthly. Results from October 2017 to December 2017 reflected the level of pain management compliance. The audit looked at 10 patient records to assess aspects of pain management. Surgical areas demonstrated 97% compliance on the day case unit, 98% compliance for the second floor ward, 100% compliance on the fourth floor and 92% compliance on the fifth floor.
- As part of the patient satisfaction questionnaire patients were asked about the quality of the pain management they had received. Results from the questionnaire in 2017 ranged from 90% to 98% of participating patients (1442) being satisfied with how their pain was managed.
- Patients' records showed the level of pain was assessed regularly as part of their observation records. Staff used a 0-3 pain score and documented this in the electronic observation system.
- The ten sets of patient records we reviewed demonstrated that patients had been given regular pain relief medication post-operatively. Patients confirmed that they were asked by staff what their pain level was and were not kept waiting for analgesia when it was required.
- Staff told us that anaesthetists prescribed analgesia for day case patients and the five sets of patient records we reviewed on the day case unit confirmed this.
- Staff told us they would escalate to doctors if prescribed pain relief was not sufficient.

Nutrition and hydration

- The Malnutrition Universal Tool (MUST) was used to identify patients at risk of malnutrition. Audits of the use of this tool were completed to assess compliance against national standards. Results from September 2017 to December 2017 demonstrated compliance of 100% on the second floor, 93% on the fourth floor and 96% on the fifth floor. This showed an improvement since the last inspection.
- Patients received information about pre-operative fasting with their appointment letters and came fasted on their admission day. If there were delays, theatre staff would inform the wards and patients were given additional fluids in accordance with the anaesthetist.
- Records including fluid charts showed food and fluid intake on the wards was recorded to monitor patients post-operatively.
- Dieticians were available Monday to Friday and an out of hours on call team were available if required to provide support.

Patient outcomes

- Data provided showed there had been 4097 inpatient and 4143 inpatient and day cases attendances between February 2017 and January 2018.
- Data provided showed there had been 15 unplanned readmissions within 28 days of discharge for surgical patients in 2017. Of these, seven patients were readmitted to clarify possible infection, others had various reasons.
- There were no unplanned transfers of surgical patients to other hospitals in 2017.
- There were 23 cases of unplanned returns to the operating theatres in 2017.
- The hospital audited call bell response times on the inpatient wards on a six monthly basis. Results for 2017 showed average waiting times between a patient seeking assistance and the call bell being deactivated by staff varied between 2.5 minutes and 4 minutes. Senior staff told us that call bells were to be answered within five rings by any member of staff. This was implemented to improve patient satisfaction results for call bell response waiting times.

Competent staff

- Information provided by the hospital showed that across the hospital there were high levels of staff appraisal. Data provided by the hospital demonstrated

100% of staff working in the surgical department had received their annual appraisal. Staff told us annual pay increments were linked to training and appraisal and this ensured staff kept these up to date.

- Staff were generally positive about career development and training opportunities in the hospital. Clinical practice development nurses were available to support staff.
- Consultants who requested practising privileges were reviewed by the medical advisory committee (MAC). The MAC had executive powers and monitored the practice of consultants and other medical staff.
- Consultants holding practicing privileges were required to demonstrate their revalidation had been undertaken by their employing NHS trust. There was a nominated responsible officer in HCA for consultants who worked exclusively private practice who would ensure correct revalidation procedures were followed.
- Agency nurses completed an induction checklist at the beginning of their first shift. We saw two sets of completed documentation for two agency nurses in theatres.
- Corporate clinical assessment competency booklets were in use in theatre. We reviewed staff files, which included essential equipment skills and clinical skills assessments with completed competencies.

Multidisciplinary working

- Clinical nurse specialists were in post to support the ward nurses. For example there were orthopaedic, urology or breast nurse specialists available to review patients.
- Patient were given two copies of their discharge letter, one to be given to the GP, to ensure the GP was aware of the procedure and post-operative treatment recommended. The discharge letters also included contact details for the hospital should another health professional require further advice about patients care or treatment post discharge.
- Patient notes had regular input from members of the MDT. We saw that physiotherapists saw patients up to twice a day and occupational therapists were involved in patient care prior to discharge.
- Bi-weekly MDT meetings were held by the spinal service. We were told cases were chosen to discuss and that consultants, clinical nurse specialists and ward managers or sisters attended. These meetings provided opportunities to view patients care and recommend improvement when required.

Seven-day services

- There was a 24 hour, seven day a week rota of on-call RMO to cover surgical inpatient care.
- Consultant surgeons were available 24 hours a day, seven days a week if their patients required urgent review, or if they were not available they would arrange alternative consultant cover.
- An out of hours consultant anaesthetist and an on-call theatre team were available for emergency surgery and staff told us it was the role of the duty manager to call the team in when required.
- Physiotherapists were available seven days a week to assess and treat post-operative orthopaedic patients.
- A dietitian was available on call on weekends.
- There was an on-call pharmacist service out of hours when the hospital pharmacy service was not available.

Access to information

- There were sufficient computers available throughout ward areas to access information including test results, diagnostics and records systems. This ensured staff had easy access to patient information if required.
- A tele tracking system was available on each of the wards, which was regularly automatically updated with patient details. The tracking system informed staff of the location of patients, the named nurse and the admitting consultant.
- Patient notes and records were kept in a variety of places. We saw patient information on the electronic system, in medical notes and in folders. Nursing staff told us they would transcribe all necessary information onto the electronic system to ensure consistency and all paper documentation was scanned into the electronic record after discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

- The corporate policy relating to consent and capacity was updated in March 2017.
- Staff told us they rarely had patients who lacked capacity. Staff told us they had received e-learning on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had a good understanding of their roles and responsibilities in ensuring patients had sufficient capacity to consent.
- Senior staff told us there had been no DoLS applications submitted from their wards within the previous twelve months.
- Formal consent was obtained on the day of surgery by the consultant surgeon and patients received a copy of it. The 10 consent forms we reviewed were completed, dated and signed.
- There were checks that consent had been obtained on the ward, on arrival in theatre, and before the administration of anaesthesia in accordance with the world health organization (WHO) surgical safety check list and best practice guidance.

Are surgery services caring?

Good

Compassionate care

- We spoke with six patients on the wards who all provided positive feedback about the treatment and care they had received from staff. One patient told us the care and nurses were 'exceptional' and the staff were 'if anything, over attentive'.
- We observed staff being kind, respectful and polite when speaking to patients and their relatives. We saw staff knocking on patients' room doors prior to entering.
- Each patient on the ward had a named nurse looking after them and staff told us all nurses would introduce themselves at the beginning of each shift to ensure patients were aware of who they were.
- We saw multiple examples of positive patient feedback in thank you cards throughout the department. This meant that patients had taken the time to thank staff in writing.
- The results from the patient experience questionnaire were collated by an external company on a monthly basis and fed back to the hospital. Results for the surgical wards in 2017 showed an average of 96% of participating patients (1557) were satisfied with the nursing care and 97% of responding patients (1492) were satisfied with the overall quality of care.
- Friends and Family test (FFT) data was collected as part of these surveys. In 2017, 98% of participating patients (1518) from the surgical wards would recommend the service to a friend or family member.

Understanding and involvement of patients and those close to them

- Written information leaflets were available for patients about a range of treatments and procedures, including costs. We saw patients being offered written information to supplement verbal information about their treatment.
- Patient feedback was collected and monitored regularly by the ward managers. We were told that suggestions and comments were used to improve the service.
- We saw nursing and consultant staff explaining to patients and their relatives the care and treatment that was being provided. Patients told us they were given sufficient information before their procedure to prepare them for their surgery.

Emotional support

- Patients we spoke with told us they felt supported by both the clinical and non-clinical staff throughout their surgical pathways.
- Patients, relatives and staff had access to psychological support and counselling services.
- Patients had access to the corporate multi-faith spiritual support. We saw patient leaflets which advertised these services and explained how the team could be contacted. Staff we spoke with were aware of the service and how to contact them.

Good

Surgery

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital provided mainly private care and the majority of procedures were elective. This meant admissions to the surgical wards were planned in advance. Patients admitted to the surgical day case unit were discharged the same day.
- Some patients and their families were not local to the area and facilities were available for them to stay with the patient if the patient wished on a folding bed. We saw that they were able to access meals and drinks when required.
- There were service level agreements with local NHS hospitals to carry out different procedures. There were clear guidelines on which patients would be transferred from the NHS and this was based on clinical needs, patient risk and patient choice.

Access and flow

- Admissions for surgical procedures were elective and planned in advance by the admitting consultant. To access surgery the consultant first reviewed the patient during an outpatient clinic appointment and booked the patient for surgery. The booking form and the clinical letter were then sent to the reservations team and the pre-operative assessment clinic (POAC).
- The POAC followed a set of standard guidelines which were used to establish how the patient would be assessed depending on the patient's clinical and personal circumstances. Assessments included face to face, telephone and web based assessment. Data provided showed that 55% of patients had been pre-assessed in the reporting period February 2017 to January 2018. All patients were assessed by the anaesthetist on the day of surgery and had been seen and initially assessed by the admitting surgeon in clinics.
- Surgery dates were booked based on patient preference and the consultant's schedule. Private patients we spoke with told us they were able to choose from several dates available. There were no waiting lists and the hospital did not monitor patient waiting times.
- Data provided showed 13 procedures were cancelled for non-clinical reasons between February 2017 and January 2018. Of these cancellations, 100% of patients were offered another appointment within 28 days.
- Theatre utilisation was low when compared with other similar hospitals. Results showed 47% average theatre utilisation from August 2017 to January 2018.
- Bed meetings were held daily to ensure there were sufficient beds and staff for the expected admissions the following day and any current issues were discussed. This approach facilitated the identification of problems such as shortage of staff or delayed discharges.
- Patients were given a discharge letter for their GP on discharge. Patients were also given a card with a telephone number to use if they experienced any problems after discharge.
- Results from the patient satisfaction survey in 2017 demonstrated that 88% of responding patients (1442) were satisfied with their discharge arrangements. This was an improvement since the previous inspection.

Meeting people's individual needs

- Patients' individual needs were identified prior to surgery by the consultant responsible for the patients care or during the pre-assessment process.
- Dementia training was mandatory; most staff in theatres and on the wards had completed dementia awareness training to enable them to care for people living with dementia. The 'Forget-me-not flower' was used on the wards to alert staff to patients living with dementia.
- Staff told us there were no specific tools available to care for patients with learning disabilities (LD). Staff told us they would be made aware of a patient with LD prior to their admission and would ensure they came with a carer who could help support them.
- Translation services were available and were pre booked prior to a patient's admission. Staff also had access to translation services via telephone.

Good

Surgery

- Interpreters were employed by the hospital and they were accessible at any time. Staff told us there were rare occasions when an interpreter could not be booked and staff would therefore access telephone translation services.
- Information leaflets were provided to patients prior to their admission about their surgery and were available in a variety of different languages.
- A corporate multi-faith chaplaincy service providing spiritual, pastoral and religious care was available for patients, visitors and staff. Furthermore, patients and staff had access to a multi-faith prayer room in the hospital.
- Patients commented on the excellent quality and wide choice of food for different individual needs, for example vegetarian, vegan or religious preferences. Patients told us they could order food 24 hours a day directly from the kitchen. On the day case surgery unit, a member of the catering service ensured food and drinks were readily available for patients after surgery.

Learning from complaints and concerns

- Patients were aware of how to raise concerns and information on how to make a complaint and the process was provided as part of the patients information pack on admission and in leaflets we saw on the wards.
- All patients were encouraged to complete a patient satisfaction survey during or after their admission which allowed the hospital to evaluate the service provided to patients.
- Staff told us where possible they would resolve any issues with patients informally, and prior to a formal complaint being made. This was in line with the hospital expectation that any concerns raised by patients on the wards would be addressed immediately by the manager and if possible resolved immediately to the patients' satisfaction.
- Surgical services received 43 complaints in the last 12 months. Themes noted from these complaints were associated with suboptimal communication, frequency of observations and medication management. All complaints were responded to within the 20 day response time frame set by the hospital.
- All formal complaints were entered onto the complaints module of the incident reporting system where a unique reference number was assigned. Supporting information, such as staff reflections and documentation, and the final response were then attached on the system.
- The chief nursing officer and head of governance reviewed complaints before allocating to the relevant head of department for investigation. It was the responsibility of the lead investigator to review records and where necessary conduct staff interviews to establish a factual account of events. This was reported to the head of governance who would compose the response. The chief executive officer would review and sign-off the complaint response before sending it out.
- A weekly complaints review meeting was held with the chief executive officer the chief nursing officer and the head of governance to ensure adherence to timescales, review the integrity of investigations and identify lessons learnt to ensure responsiveness. Themes of complaints as well as learning were reviewed at the clinical governance committee meetings and fed back to staff during team meetings.

Are surgery services well-led?

Good

Leadership / culture of service related to this core service

- Since the last inspection, the theatre manager, a clinical nurse manager, the chief nursing officer and chief executive officer had been newly appointed. Leaders were committed to improve services and had been successful in implementing effective changes after the previous inspection, for example in infection prevention and control.
- Clinical nurse managers were responsible for the wards and reported to the deputy chief nurse and chief nursing officer. The theatre manager reported to the chief operating officer.
- The ward and unit managers were knowledgeable about their areas and demonstrated good leadership

skills. They were hands on and visible with their offices located on the wards. Staff told us they felt supported by their immediate line managers and the senior management team.

- Staffing structures on the wards included a clinical nurse manager, senior sisters/charge nurse, senior staff nurses and staff nurses. There was a supernumerary nurse in charge on all wards we visited during the day. However, at night the nurse in charge also looked after patients and therefore there was no supernumerary nurse at night.
- Senior nursing staff were positive about the hospital's leadership team. They told us the CEO and the chief nursing officer were accessible and visible within the department.
- Medical staff reported good working relationships with managers in the hospital and felt they were accessible and responsive.

Vision and strategy for this core service

- Staff could tell us about the service line vision to be the facility of choice for consultants, staff, patients and referrers and uphold a reputation for safe delivery of complex surgical care. The hospital had formulated value statements, which included treatment of people and one another with compassion, kindness, loyalty and respect. Staff were able to give examples of how their work contributed to these values.
- We saw the surgical care business plan, which aligned with the overarching business plan of the hospital. It listed areas for operational improvement, for example staffing or streamlining pathways and also contained areas of business development and growth.

Governance, risk management and quality measurement

- There were clear governance arrangements in place to ensure high standards of care were maintained through regular audits, reviews of incidents and complaint data and consideration of risk.
- The clinical governance committee had representatives of all departments and services and held monthly meetings with participation and input from localised committees, including: infection control, blood transfusion, medicines management, mortality group. Incidents, complaints and patient experience were regular agenda topics as well. Information was cascaded down via senior staff meetings and individual ward or team meetings. We reviewed minutes of clinical governance meetings and found that quality and governance issues were discussed.
  There were monthly sister meetings and ward meetings where information and learning was shared. Senior staff further attended monthly incident meetings, infection control meetings, medication meetings or audit meetings.
- The surgical risk register fed into the hospital wide risk register and was reviewed regularly. It contained description of the risks, ratings, controls in place, measures taken, targets and review dates. Managers and senior staff were aware of the risks in their service areas. Meeting minutes evidenced that the risk registers were regularly reviewed, discussed and updated.
- There were regular theatre user group meetings. We saw the theatre user group action plan which included topics from the risk register, incidents and audit results. Due to recent changes of theatre management, weekly theatre meetings were held to discuss theatre refurbishment plans for example.
- We saw the hospital's audit calendar, which included regular audits relevant to surgical inpatient or day case areas and theatres.

Public and staff engagement

- The hospital undertook an employee opinion survey, which was analysed by an external company. Latest results shown represented answers of 22 of 77 (29%) employees in theatres and surgical wards. Responses were mostly neutral to favourable, staff were positive about career development opportunities and the future of the hospital, for example and 100% of participants would want the quality of care offered at the hospital for a family member.
- The service had developed an employee engagement action plan in response to staff feedback. It identified actions to be taken by specified staff groups or individuals to improve staff engagement. To improve confidence in leadership for example, daily floor walks and ward meetings attended by the chief nursing officer were implemented and staff we spoke with confirmed increased visibility of senior managers.

Good

Surgery

- The chief executive officer sent a weekly newsletter to all staff with updates about the hospital and other topics, for example incidents and learning. Staff we spoke with were aware of this weekly email and knew the contents.
- We viewed the friends and family test (FFT) results for surgical wards in 2017. Results varied from 95% to 100% of respondents (1518) who said they would recommend the hospital to their friends and family.
- A patient experience forum had been implemented last year and was attended by all heads of departments to look at patient feedback forms and three examples of patient interviews from all wards. Senior staff told us that they took these discussions to ward meetings where staff would be involved in finding solutions. According to staff, patient feedback results had improved since starting the forum.

Innovation, improvement and sustainability

- The hospital utilised and invested in robotic surgery and recently acquired a robotic system for hip and knee surgery. This robotic system aimed to achieve a more accurate placement of implants compared to traditional methods, resulting in a more natural feeling knee post-partial knee replacement and smaller differences in leg length after a total hip replacement, for example.
- The hospital offered radical prostatectomy procedures using a surgical robot, for example robotically assisted prostatectomy.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There were no never events reported during February 2017 to January 2018. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no serious incidents reported during February 2017 to January 2018 specific to outpatients and diagnostics.
- There was one IR(ME)R incident during February 2017 to January 2018. This incident involved a patient having a CT scan instead of the requested x-ray, there was no harm to the patient and learnings were shared.
- There were 164 clinical incidents reported in the period of during February 2017 to January 2018. 106 of those incidents did not have any incident severity, 56 were of low harm and two were of moderate harm.
- Incidents were reported using an electronic reporting system. Staff could describe how to report incidents and told us the reporter always received feedback.
- Incidents were discussed at monthly governance meetings and information and lessons learnt were disseminated to staff via a learning grid discussed at staff meetings. Staff could describe examples of previous incidents that had occurred across the hospital.
- All staff we spoke to were aware of duty of candour and could describe circumstances when it would be exercised. We saw evidence of duty of candour being exercised as per the hospital process, a letter was sent to a patient detailing the findings of the incident investigation and offer for further discussion from the chief executive.

Cleanliness, infection control and hygiene

- All of the clinical and waiting areas we visited were visibly clean and tidy.
- During our previous inspection conducted in 2016 we observed that a portion of the outpatient consulting rooms had carpeted flooring. This flooring had since been removed in all outpatient clinical areas and replaced with flooring compliant with current national standards.
- Completed cleaning checklists for the period during November 2017 to January 2018 were observed in outpatients and radiology.
- Policies and protocols for the prevention and control of infection were in place and all staff attending clinical areas adhered to “bare below the elbow” guidelines. All staff we spoke with were aware of the procedure to decontaminate clinic areas after infectious patients.
- There were sufficient hand washing facilities including basins, hand wash, hand gels and moisturiser and we observed staff being compliant with the recommended hand hygiene practices.

Good

Outpatients and diagnostic imaging

- Green 'I am clean' stickers were placed on equipment to inform staff when equipment was last cleaned and we saw evidence of this being used across all departments we visited.
- Clinical equipment was sterilised and cleaned in-house the service was monitored via a quality assurance programme. Average turnaround times were 17 hours 42 minutes and any delays were reported to the CSSD manager. The service was accredited by the British Standards Institute for EC certificate in medical devices.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled and were disposed of immediately when full.
- The outpatient and diagnostic departments performed quarterly infection control audits. The audits checked hand hygiene, environment & equipment, sharps bins, uniforms, linen, personal protective equipment (PPE) and departmental waste. The target was 95% compliance.
- The outpatient department did not achieve the target for hand hygiene in quarter 1 and quarter 2 of 2017; achieving 94% and 93% respectively. The target was missed for linen in quarter 1; achieving 90%. The target was missed for PPE in quarter 1 and quarter 2; achieving 94% and 90% respectively. The department achieved the target or above for all other audits in quarter 1 to quarter 4 of 2017.
- The imaging department did not achieve the target for hand hygiene in quarter 1, quarter 2 and quarter 3 of 2017; achieving 82%, 89% and 92% respectively. The department achieved the target or above for all other audits in quarter 1 to quarter 4 of 2017.

Environment and equipment

- The outpatients and diagnostic imaging department were adequate for purpose and well maintained. Patient waiting areas were clean with sufficient seating for patients and relatives. All clinical areas seen in the outpatients and diagnostic imaging departments were visibly clean and tidy.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Portable appliance testing (PAT) for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the radiology departments to warn people about potential radiation exposure.
- Monthly quality assurance logs were provided for the X-ray units, MRI and CT scanners for the period of October 2017 to January 2018. We were assured that procedures were in place for the safety testing of all diagnostic imaging machines on a daily, monthly and annual basis.
- All clinical staff we observed in the radiology departments had valid in-date radiation monitoring badges.
- Personal protective equipment was available in all clinical areas we observed.
- Emergency resuscitation equipment was in place in all areas of the outpatients and imaging departments and followed national resuscitation council guidelines. Trolleys and crash bags we reviewed were checked on a daily and weekly schedule and had their seals intact; trolleys that were asked to be opened had all the required equipment and medication valid in-date.
- Due to the distance of the Devonshire Street building from the main hospital building, the use of basic life support bags was in place and two defibrillators were available for the entire building. There was no crash team available for this building and the policy stated to call '999' for emergencies. All staff we spoke with confirmed that they were aware of this policy.
- We observed that there were working emergency call bells in every clinic room, changing room and toilet.

Medicines

- Staff we spoke with were aware of medicine management policies and the systems in place to monitor stock control and report medication errors.
- We observed that all medicines in outpatients and diagnostic departments were found to be in date and stored securely in locked cupboards as appropriate, and in line with legislation. The keys were kept in a secure

area with a keypad lock. No controlled drugs (CD) were stored in the outpatients department. There were limited CD's and contrast media stored in the imaging department.

- We observed that drugs requiring temperature control were stored in fridges and temperatures were monitored regularly and remotely via a hospital wide electronic system. Contrast media stored in the imaging department were stored at an appropriate temperature.
- A record was maintained regarding administered drugs recording the relevant patient details.
- Prescription pads were stored securely and usage tracked.
- A monthly audit was undertaken by the pharmacy team to assess compliance with the medicine management policy of the hospital. Data provided to us for December 2017 showed that the outpatient areas in 30 Devonshire Street achieved 93% and 47 Nottingham Place achieved 87% against a hospital target of 90%. The audit concluded that there were some issues around treatment doors not being locked and staff not being aware of the correct ambient room or fridge temperatures. Findings and learnings were shared with departmental staff and the chief nurse.
- The turnaround time target for outpatient prescriptions was 30 minutes. Audit data showed that compliance ranged from 80% to 98% in the period of July to December 2017. Non-compliance was due to time taken to resolve queries with any prescriptions or time taken to source the medication.

Records

- The hospital used an electronic patient record (EPR) which ensured availability of medical records for outpatient's clinic. New patients arrived with all relevant records from their referring clinicians and these were scanned in to the EPR and a copy given to the consultant. If on occasion these were not available administrative staff would contact the referring clinicians to source the required details. We were assured patients were not seen without relevant records.
- Imaging records were held in their own system and were able to be accessed throughout the HCA hospitals. Diagnostic images were able to be shared with NHS hospitals via shared software. Patients were able to bring in external imaging records via CD's or memory devices and the hospital was also able to provide patients with these should they require them.
- The providers plan in case of disruption to the EPR was outlined in the corporate health record management policy. We were told that if the EPR was unavailable, paper forms were used to request diagnostics and that any notes taken were then inputted later on to the EPR.
- We reviewed 12 sets of patient records in the outpatients and imaging departments. All contained details of past medical history, allergies, infection control, medicines and discharge planning. Evidence of consent was also observed as appropriate.
- Records could be viewed off site in any HCA hospital due to the EPR. In such cases where physical records were required off site for continuity of patient care then copies were made and the notes were tracked.

Safeguarding

- Safeguarding policies and procedures were in place. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Managers for both outpatients and diagnostic departments told us that there were no safeguarding referrals made in the last 12 months.
- The hospital target for completion of safeguarding training was 95%. Hospital data showed that 90% of staff in both outpatients and radiology completed safeguarding training for adults' level one and two. 100% of staff had completed safeguarding level one, two and three for children.
- Safeguarding flow charts to help staff escalate concerns correctly were on display in the outpatients and radiology departments.
- There was a chaperone policy and we saw signs throughout the outpatient clinic and diagnostic imaging department advising patient how to access a chaperone should they wish to do so.

Mandatory training

- There was a mandatory training policy that detailed which training staff were required to attend. The training included; basic life support, diversity, ethics, fire safety,

health & safety, infection control, information governance, manual handling, safeguarding children and adults. The training records showed attendance was monitored and managers were required to take action to ensure that staff attended all mandatory training.

- Mandatory training completion was linked to staff annual appraisal system; failure to complete mandatory training would not allow staff to receive their pay award.
- Data showed that overall mandatory training compliance for nursing outpatient staff was 100% and therapies staff compliance was 97% as of January 2018.
- Data showed that overall mandatory training compliance for imaging nursing staff was 98%, for radiographers was 100% and for radiology assistant staff was 87% as of January 2018.
- We were told medical staff with practising privileges at the hospital completed mandatory training at the hospital they spent most of their time at. For example those working mainly at an NHS trust would complete this training at their respective trusts and were required to submit copies of their training record to the central HCA consultant management team. We were not provided with compliance data.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- The six point identification check was used in radiology as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2017). We observed staff check patients' name, date of birth, address, disease, area of interest and why they were attending.
- Staff told us they checked female patient's pregnancy status in the radiology department before initialising any imaging procedure. They gave recent examples of when patients were not permitted for a procedure due to lack of clarity regarding pregnancy status. We observed numerous pregnancy awareness posters in the imaging department on both sites.
- A radiation protection supervisor was appointed for both the main imaging department and the Devonshire street site. Further support was noted in the department's local rules.
- Staff were able to describe the procedure if a patient was suspected of suffering from a cardiac arrest or anaphylaxis. All staff knew the hospital internal crash team number.
- Concerns were raised by a whistle-blower that consultants were bulk signing radiology request forms. The concern was that these request forms were against safety standards and could allow for tampering and posed a risk to patient safety due to unauthorised staff completing the remainder of the forms. Managerial staff told us that they had identified this as an issue and undertook an investigation which did not find any evidence to substantiate the claims, however radiology staff told us that managers had identified particular consultants and it was agreed that this practice would stop. Radiology staff also told us that patients that may have been affected were retrospectively reviewed and it was determined that all procedures were carried out safely and no patients were harmed. Managerial staff told us that they conducted random audits to corroborate the findings of the investigation, these audits were not deemed to be part of the regular audit schedule; however we found that results were not recorded and that the sample size was small.

Nursing and allied health professional staffing

- Bank and agency staff usage for both the outpatient and radiology departments over the period of November 2017 to January 2018 ranged between 12% to 7%, the usage dropped over this period of time. Agency usage ranged between 4.5% and 2% during this period. Nursing staff explained to us that bank and agency usage usually rises during the Christmas period due to staff annual leave.
- Data showed that there were 17 full time equivalent (FTE) nurses, 7 FTE health care assistants, 22 FTE radiographer staff and 3 FTE therapist staff employed as of January 2018. The overall vacancy rate as of January 2018 was 6.8% this included one new post recently approved.
- The outpatient's lead nurse told us there were adequate staffing levels to enable the clinics to run effectively. Staff told us any staff shortage due to sickness and annual leave were covered by bank staff. The lead radiology nurse also shared this opinion.

- We had concerns raised to us by a whistle blower that radiographer staffing levels may not have been sufficient to the run the service in times of high pressure. Concerns were raised specifically around radiographer staff being held up in theatres and in turn leaving the main department without sufficient staff. We found that radiographer staffing levels were sufficient and new working arrangements had been initiated between the radiology department and theatres to address any historic issues. All radiographer staff we spoke with shared the opinion that the department had sufficient number of staff.

Medical staffing

- Data provided to us from the hospital showed that there were approximately 536 consultants with practising privileges attending the hospital, out of these 237 had outpatient activity in the previous three months prior to the inspection.
- There was a process in place for granting practising privileges, via the medical advisory committee (MAC). This process included interviewing, obtaining references and DBS checks on all applicants. A central HCA wide team checked consultant training and competencies.
- The hospital employed 15 Resident medical officers (RMOs) as of January 2018. RMO's are doctors of varying experience that are full time hospital employees. The RMO's provided medical cover in case of patients requiring to be seen urgently or in need of prescriptions if their consultant was unavailable. Out of these RMOs, four worked predominantly in outpatients. There were no RMO vacancies as of January 2018.
- Staff told us that clinics were rarely cancelled, but if consultants were on annual leave they would ask a colleague to see their patients.

Emergency awareness and training

- The hospital had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, loss of water supply and terrorist attack.
- We were told that staff members would be contacted by their line managers in regards to attending work following a major incident. Each department had their own major incident plan detailing actions to take. The policy outlined emergency numbers and action cards for managers to follow.
- Staff in the outpatients and imaging departments told us they could identify the designated fire marshals in their own departments.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- NICE guidelines were discussed at governance meetings and the medical advisory committee (MAC) and the disseminated to the various departmental leads, who implemented them if relevant to their service.
- Radiology dose reference level audit results were available for staff to read, the department's 2017 results complied with the national dose level. The department recently conducted an audit to determine if patients of varying body mass indexes (BMI) were receiving doses in line with the reference levels. The audit found that patients with higher BMI did receive a comparatively higher dose. The department was subsequently optimising their scanning protocols to adjust for patients of a higher BMI.
- The radiology department conducted regular audits as required by IR(ME)R (2017). We saw evidence of these audits and an active audit schedule.
- The deputy radiology manager explained that request forms were audited every three months. A random 20

request forms were audited from all areas of the department in any one session. Data from April 2017 to November 2017 showed that compliance improved 86% to 100%. Issues recognised were around referrers signing and dating the request forms.

- A monthly audit was conducted to measure compliance of correct patient group directive documentation in the radiology department. Data from January 2018 showed full compliance.
- A monthly image rejection analysis was conducted; this was done to help determine if there were any patterns in the data. The results for the period of October 2017 to December 2017 showed that 5% to 6% of radiological images were rejected. Upon analysis the main reason was determined to be the positioning of the patient to better demonstrate the area of interest. This number was determined to be low and clinically justifiable.
- Staff meetings were held in outpatients and radiology to share information and promote shared learning.
- A weekly departmental teaching session was held in physiotherapy and nursing staff told us of outpatient and inpatient nurses co-learning sessions.
- Safety alerts were received by the OPD manager and all relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings.

Pain relief

- RMOs were available to assess the patient and prescribe relevant medication in cases requiring urgent attention. If the patient's consultant was available then they would assess the patient.
- The outpatient and diagnostic (OPD) manager told us the outpatient department was in process to start recording patient pain scores at the start and end of their pathways. The goal of this endeavour will be to monitor if pain levels improved as a result of non-surgical intervention. After patient discharge admin staff would call to see how the patient was doing at set period of time. The service's long term goal was to use this collected data to create specialist pathways.

Patient outcomes

- During our previous inspection in 2016 we were told that the radiology department was aiming to start the Imaging Services Accreditation Scheme (ISAS) accreditation process in 2017. We were told that this was postponed due to managerial changes in the organisation and that it is now a departmental goal for 2018.
- All diagnostic images were reported within 24 hours unless the referrer requested earlier, this is compliant with the national guidelines for radiological reporting. This included all images being quality checked by radiographers before the patient left the department.
- The outpatient and diagnostic departments along with the London breast institute was accredited by Caspe Healthcare Knowledge Systems (CHKS) for ISO 9001:2015 quality management system.
- The outpatient and diagnostic services held regular audits as per the local audit schedule this included infection prevention and control audits, environment audits, local departmental audits and other quality management audits. The outpatient and diagnostic services did not participate in any national audits. Learnings from audits were fed back via local staff meetings. We saw evidence that learnings from regular audits were discussed at governance meetings.

Competent staff

- Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals.
- Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant to their role. This included completing competency frameworks for areas of development and they were also supported to undertake specialist courses.
- Evidence was provided to show all staff in the outpatients and radiology departments had CPD and competency records for their specific role. All staff we spoke with told us that they felt supported during revalidation process or audit from their respective governing bodies.
- Medical consultants with practising privileges had their appraisals and revalidation undertaken by the central

HCA consultant liaison team if they did not work at an NHS trust. For those working in a NHS trust a copy of their appraisal and revalidation undertaken at the trust was provided to the hospital. Consultant scope of practice and ongoing competencies were also checked annually by the central HCA team.

- Managers told us they had procedures in place for the induction of new staff and all staff completed hospital and departmental induction before commencing their role, apart from bank and agency staff who only attended the departmental induction. We saw evidence of attendance at these induction sessions.
- Equipment training records were in place for radiographic staff and consulting staff working with imaging equipment. New staff joining the department were required to complete workbooks and competencies under supervision in all areas of the imaging department before they were authorised to work independently. We saw evidence that all IR(ME)R protocols were read by all relevant staff.
- Data for 2017 showed that 100% of eligible staff in both the outpatient and diagnostic services had their annual appraisal at the appointed time in the year. Staff who were still within their probationary period would have a probationary review at various points in their tenure.
- The service did not have any nurses with post-graduate qualifications. There were a total of five radiographers, four pharmacists and one therapist with post-graduate qualifications.

Multidisciplinary working

- Multidisciplinary working was evident throughout the outpatients and imaging departments.
- Regular consultant led multidisciplinary team (MDT) meetings were held to discuss patients based on their treatment area. We were told by managers that nursing staff, allied health professionals and managers were encouraged to attend.
- We were told by managers that specialist nurses within the outpatient service would attend the hospital breast, oncology, spinal and gastrointestinal MDT meetings. All patients with the corresponding illness would be discussed at these MDT meetings and the outcomes would be recorded. We saw evidence to show that these outcomes were discussed at the clinical governance committee.
- We were told internal MDT meetings took place for differing core services and example of the breast institute was given where different allied health professionals, nursing staff and consultants would discuss on going patient issues.

Seven-day services

- The outpatient service was provided Monday to Friday 8am to 9pm.
- The imaging service was available Monday to Friday 8am to 10pm except MRI which finished at 6pm. The radiology department provided 24 hours on-call services except MRI which only provided a Saturday on-call service during 8am to 6pm. On-call services were for inpatients and urgent care centre patients only

Access to information

- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet.
- The radiology department used a nationally recognised system to report and store patient images. The system was used across the hospital and allowed local and regional access to images.
- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the EPR.
- Individual consultants wrote letters to the patients GP to update them regarding their care and treatment at discharge. Patients we spoke with confirmed this and they also received a copy of the letter.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2005 and its implications for their practice.
- Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any

procedure; however data from December 2017 consent audit only showed 78% compliance, learning from these audits were shared at staff meetings. Consent forms we observed were compliant with the standards and patients were provided with a copy of their consent forms. Consent forms for patients that lacked capacity were available.

- Consent forms for patients lacking capacity were available in outpatients and diagnostic imaging departments.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, asking them if they needed help and pointing people in the right direction.
- Patients' privacy was respected and they were addressed and treated respectfully by all staff. Staff were observed to knock on consulting room doors before entering. Curtains were drawn and doors closed when patients were having their consultation or treatment.
- The environment and the consulting rooms in the outpatients department allowed for confidential conversations.
- Patients consistently gave very positive accounts of their experiences with staff and the hospital. The majority of patients we spoke with felt staff genuinely cared for their well-being and nearly all repeat patients told us they felt very comfortable with the hospital staff.
- Overseas patients we spoke with told us that they felt the staff were very respectful of their cultural needs and understood their individual requirements. One patient we spoke told us the staff and service was 'perfect'.

Understanding and involvement of patients and those close to them

- We saw staff spent time with patients, explaining care pathways and treatment plans. All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- Patients told us they were given time to make decisions and staff made sure they understood the treatment options available to them.
- The outpatients and radiology department collected patient views using a patient satisfaction questionnaire. Data provided to us showed an increase in responses received by the departments from quarter 3 to quarter 4 of 2017. Patient satisfaction fluctuated between the quarters. In quarter 4 of 2017 satisfaction with the quality of care provided by nursing staff was 97%, by physiotherapy staff was 95%, imaging staff was 96% and mammography staff was 100%. We were not provided with a detailed breakdown of responses.
- The 20 patients we spoke with were satisfied with the overall experience of visiting the outpatients, breast institute and diagnostic departments. Patients had positive feedback to share with us regarding the all staff that they saw while in the hospital. A majority of patients we spoke with were repeat patients and all of them said they would recommend the hospital to family and friends.
- We were told by nursing staff that self-paying patients were provided with costing information before initiating any diagnostic procedures or treatments. This information was provided by reception staff and we were shown the leaflet. Self-paying patients were usually required to provide a pre-payment before any procedure was carried out, however this did not have to be the full sum and could range in any reasonable amount. There was a dedicated finance team that patients could speak with regarding any payments. Payments were usually sought after a discretionary period of two weeks and initial contact was done by telephone call. Consultation fees for individual consultants were sought by their private secretaries and this information was given to patients by individual consultants, the hospital made patients aware that hospital fees and consultant's fees were separate.

Emotional support

Good

Outpatients and diagnostic imaging

- Nursing staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.
- Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.
- Psychotherapy services were available for patients and their relatives, these services were provided for free for patients of the breast institute. All patients had access to a range of complimentary therapies including massage, aromatherapy, acupuncture and Pilates.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- We observed that there was adequate signposting in the outpatients and imaging departments.
- Patients told us they received instructions over the telephone when booking the appointments for outpatient or diagnostic appointments.
- Waiting areas were clean and had sufficient comfortable seating available with access to toilets and free refreshments.
- All waiting areas seen within the hospital had a selection of hot beverages, water dispenser, biscuits and selection of current newspapers and magazines.
- The radiology department provided out of hours service with a limited weekend service. Outpatient appointments were available till later hours dependent on the consultant patient arrangement.
- Nursing staff told us that patients do not usually wait long for appointments once they had arrived in the department, but in circumstances where the patient may want to leave the waiting area, reception staff would ring the patient to notify them.
- Due to the central London location of the hospital there were no car parking facilities, however the hospital was located near local public transport links.

Access and flow

- Patients were able to access the service by referral letter through their GP's or by contacting a particular consultant's secretary to set up an initial assessment consultation. Patients were not able to self-refer for diagnostic procedures this had to be done via a consultant with practising privileges or a letter from the patients GP.
- Consultant secretaries provided appointment times to the outpatient reception team. Consultants directly referred to diagnostic imaging and the booking team gave the patient appointment time choices.The service had slots available for same day referrals and radiology staff told us that they were usually successful in accommodating these patients.
- The radiology department conducted an audit to measure how long patients waited to be seen in the department. Only patients with appointments were included in the audit and patients arriving late were excluded. Results from January 2018 showed that 91% of patients were seen within 15 minutes of their appointment time, patients seen outside this target were usually due to consultant lateness. We were not provided the number of patients included in this audit.
- Patients we spoke with said they were informed of how to book an appointment at the clinic and they knew how to access to other services such as blood tests, physiotherapy and diagnostic imaging.
- We were told waiting time delays to see consultants once patients arrived were rare, and if there were any delays, these were minimal and that patients were always informed. This was confirmed by all the patients we spoke with. During the inspection we did not observe any patient waiting for excessive times. The service did not conduct any waiting time audits.
- Patients had access to same day diagnostics after consultation, appointment slots were allocated for same day referrals and results were available within 24-48 hours. We were told by managers that reporting on images was usually immediate if the radiologist was present in the department, unless a specific radiologist

was requested to conduct the report. There was an on-call rota for out of hours reporting and the referring consultant was provided with a verbal report and a written report was uploaded to the EPR during normal working hours.

- We were told consultants provided direct referral patients and post-operative follow up appointments within hours or days for most outpatient appointments and radiological diagnostics. All patients we spoke to confirmed this and also told us they had timely access to diagnostic investigations and minor treatment within a few days of their appointment at the hospital.
- The service had low did not attend (DNA) rates ranging from 0.3% to 0.8% in the period of quarter 1 to quarter 4 of 2017. Consultant secretaries would usually contact patients to discuss why they did not attend for an appointment and re-arrange if required.

Meeting people's individual needs

- Staff told us the provisions they would make for patients suffering with learning difficulties or dementia such as a special needs assessment and fast track service, however staff said that these types of patients are rare. All staff we spoke with confirmed they received dementia training.
- In house interpreters were available for Arabic only. We did not observe any posters or signs advertising this service to patients. A language line telephone number was available for all other languages.
- There was a multi-faith prayer room available on the ground floor of the main hospital. The room had a prayer mat, prayer beads and holy books from multiple faiths.
- There was no specific provision made for bariatric patients as they were a very rare type of patient for the service. Staff told us that arrangements could be made for patients with individual requirements, such as the consultant seeing the patients on the ground floor, being seen in a large consulting room and specialist equipment could be ordered.
- Within the outpatient, breast institute and diagnostic imaging waiting areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. The information we observed was only given in English, we were told by departmental leads that all information is able to be received in any print size, language, braille and audio loops.
- The majority of services the hospital provided were wheelchair accessible, however outpatient facilities in 47 Nottingham place were not. Outpatient nurses told us that consultants could see patients at either the main hospital or 30 Devonshire building if needed.
- The diagnostic imaging department has slots available to fit in patients that require imaging the same day in order to meet their individual needs.

Learning from complaints and concerns

- Complaints were responded to within 20 days as per the policy. In the period of February 2017 to January 2018 there were a total of 10 formal complaints for diagnostic services and five for outpatient services, most complaints received were regarding financial disputes this was a common trend within the independent sector. Two of these complaints were referred to the independent sector complaints adjudication service (ISCAS).
- Initial complaints were dealt with by staff in the outpatients and diagnostics departments in an attempt to resolve issues locally; however if this was unsuccessful staff escalate it to the department manager who then starts the complaints process.
- All patients we spoke with told us they knew how to make a complaint if needed.
- Details of complaints were discussed with staff in monthly team meetings. We saw minutes of meetings to demonstrate that learning from complaints had taken place; there was evidence to show that action had taken place to address the issues in a timely manner.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership and culture of service

- The service was structured so that radiographer staff would be supervised by superintendent radiographers

who in turn would be overseen by the deputy imaging manager. Outpatient nurses would be overseen by the deputy outpatient manager. The deputy mangers and usually the departmental area leads would all be jointly line managed by the overarching OPD and imaging manager. The OPD and imaging manager would be line managed by the chief nursing officer who would link to the chief executive officer.

- Since the previous inspection we conducted in 2016, the previous CEO and some executive staff had left and there was an interim CEO in place at the time of the inspection who had implemented some organisational changes in leadership structures. The outpatient department and diagnostic department had been reorganised to have central leadership and the new OPD and imaging manager role was created.
- Managers had a sound knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- It was evident from talking to staff and from our observations that managers in all departments we visited had a good working relationship with most their staff.
- It was clear from our conversations and the information we reviewed that the majority of staff felt supported and valued in their role. They told us they felt supported and valued by colleagues, line managers and the executive team.
- Out of 24 staff members we spoke with across the outpatient, diagnostic and breast institute departments' four staff members expressed views regarding a culture of bullying. Concerns were raised with us from a whistle blower citing similar issues. The staff in question felt that managers had a degree of favouritism when dealing with issues in their departments, they also felt that they were unable to escalate problems to the executive team or HR as it may become career detrimental.
- The majority of staff we spoke with told us that they were happy to escalate service related matters to the executive team and felt that they would be listened to.
- All staff we spoke with told us that the CEO and other executive members did walk rounds and staff felt they were approachable.
- We observed a working culture of openness and honesty in relation to patient care. Staff were provided adequate training in regards to duty of candour. All staff we spoke with praised the quality of care and expressed the willingness to go above and beyond.

Vision and strategy for this core service

- The hospital's mission was to be the hospital of choice for consultants, staff, patients and referrers and to uphold a reputation for safe delivery of complex care. The majority of staff we spoke with recalled this statement with ease and told us they felt this was a high priority for the organisation.
- The service managers explained to us that departmental goals and strategies were formed by the input of executive staff and local staff. Local managers would discuss issues and goals with frontline staff in team meetings and this would be fed back to the executive team.
- We were told by managerial staff that the immediate short term goals of the outpatient and diagnostic services were to create rapid access pathways for specialist areas, working closer with local GPs, working towards ISAS accreditation for the diagnostic department and including more staff in the local quality and audit programmes.
- The radiology and OPD business plan outlined more mid and long term goals for the department for 2018 and beyond. These goals included reviewing local processes, to improve staff engagement, reduce agency staff usage, support staff to participate in post graduate education, the introduction of new pathways and treatment modalities. The plan also outlined the goal of replacing aging imaging equipment in the department.
- The chief executive officer explained to us that the service will be hiring a new imaging lead who will oversee imaging services across three HCA sites.

Governance, risk management and quality measurement

- There were monthly clinical governance meetings attended by senior staff members, service leads and service managers. All hospital departments were represented at these meetings. Minutes of the clinical governance meeting confirmed incidents, mortality

reviews, complaints, patient experience, infection control, risks, safeguarding, MDT feedback, audit reports, consultant performance, safety alerts, NICE guidance and research were discussed.

- The clinical governance committee meeting was fed back to the medical advisory board and executive team. The executive team in turn fed back the hospital matters to the HCA corporate team.
- There were regular team meetings to discuss issues, concerns and complaints. Staff were given feedback at these meetings about incidents and lessons learnt by their line managers.
- Radiation Safety Committee meetings were held every 6 months to ensure that clinical radiation procedures and supporting activities in the outpatients and radiology departments were undertaken in compliance with IR(ME)R 2017 legislation. These were attended by the OPD imaging manager, the radiation protection advisor, the radiation protection supervisors and superintendent radiographers.
- We saw evidence of regular outpatients and diagnostic services meetings. The meeting minutes confirmed that these meetings were designed to facilitate open and frank discussion on how to implement best practice.
- The radiology, breast institute and outpatients department recorded risks on their departmental risk registers. We were shown the risk registers which did not contain any major risk apart from general hospital associated risks.
- The main risks associated with outpatients were the lack of wheelchair access at 47 Nottingham place, however the register did outline there was a ramp available if needed and security cameras to notify staff if a patient was waiting. An issue highlighted as extreme risk was changes in legislation due to come in to affect May 2018 regarding data breaches and disclosure of fees, the register showed the hospital updated their governance procedures and was ensuring it had sufficient data security measures in place.
- The main risks associated with the imaging department included the age of equipment across the hospital; however these were outlined to be replaced in the business plan for the upcoming year. Staff vacancies meant that existing staff may have to work extended hours, on-call or weekends. The department also highlighted the risk of data breach when sharing images or reports with GPs or referrers.
- We saw evidence to confirm that outpatients and radiology departments had active quality control measures and audit programmes that were regularly discussed and reviewed in meetings designed to incorporate all staff at differing seniority levels.

Public and staff engagement

- The views of patients were actively sought within outpatients and diagnostic imaging; patients were given a department specific feedback questionnaire. Data shown on the outpatients, imaging and breast institute dashboards from December 2017 demonstrated that 86% to 100% of patients from these services would recommend the hospital, we were not provided with response rates.
- We were not provided with detailed data regarding patient feedback or patient comments regarding the outpatients' services. We were provided with some basic data from the service dashboards that showed patient satisfaction ranged between 73% and 100%. The data also showed that the breast institute performed the best in relation to patient experience. We spoke with 20 patients and all them were positive regarding the service and care provided.
- We were told that the hospital manager, chief nursing officer and chief operations officer had an open door policy allowing any member of staff to approach them; this was confirmed by all staff we spoke with.
- Data provided from the outpatient staff survey conducted in May 2017 showed 50% of staff felt there was open and honest two way communication with their managers. 67% of staff agreed that the quality of care provided by HCA is what they would want for their own family. All staff felt part of the team. Data showed that 50% of staff felt valued at work, but all staff felt respected by their colleagues.
- Data provided from the imaging staff survey showed that 63% of staff felt there was open and honest two way communication with their managers, however 22% disagreed. Data showed that 79% of staff agreed the quality of care provided by HCA is what they would want

for their own family. Nearly all staff felt they were part of the team with 5% being unsure. 58% of staff felt valued at work and 89% of staff felt respected by their colleagues.

- There were employee of the quarter awards held hospital wide this gave the opportunity for staff to nominate other staff for recognition of their work, we were told by outpatient staff that they nominated people from their teams in the last awards. Staff would be given a monetary reward. Awards are also granted on a departmental basis. We were told by staff that profession recognition days are celebrated such as world radiographer day where the staff were provided with a voucher for free lunch. A long term service award is also held to recognise the service of staff that worked at the hospital for more than 5 years.
- We were told of the annual staff Christmas party and lunch held free of charge. Staff told us regarding the HCA wide thank you week which celebrated and recognised staff work, there were thank you cards and staff were encouraged to praise each other, free lunch or breakfast was also provided.
- Staff told us that they felt encouraged to introduce new ideas and new ways of working that it didn't take long for ideas to be adopted. We saw evidence of various staff forums where concerns could be raised or suggestions given.
- We saw evidence of a mentoring programme within the outpatients and imaging department with regular meetings between staff and mentors

Innovation, improvement and sustainability

- Staff told us they were encouraged to implement new ideas and working practices. Shared learning and researched was also facilitated.
- The radiology department conducted image guided tumour ablation and cryoablation treatment techniques.
- A patient navigator role was implemented in the breast institute, the role is designed to ensure the patient pathway is fully completed and continued after the patient leaves the department. The navigator calls the patient at home to organise any further care if needed and this has ensured that patients are followed up appropriately and that no patient is missed.

Outstanding practice and areas for improvement

Outstanding practice

- A patient navigator role was implemented in the breast institute, the role is designed to ensure the patient pathway is fully completed and continued after the patient leaves the department. The navigator calls the patient at home to organise any further care if needed and this has ensured that patients are followed up appropriately and that no patient is missed.
- The hospital actively sought to engage with the staff providing many forums where staff could raise concerns and suggestions. There were numerous events to recognise and celebrate staff achievements. Free lunch was provided at many occasions throughout the year.

Areas for improvement

Action the provider SHOULD take to improve

- The urgent care service should consider holding a joint MDT meeting with both nurses and doctors in attendance.
- The urgent care service should ensure that the pain score is adequately noted in patient records.
- The urgent care service should monitor safety issues that may take place in the department.
- The urgent care service should consider reviewing their electronic systems to ensure that staff have access to all necessary information at all times.
- The urgent care service should ensure that all confidential conversations cannot be overhead and passers-by cannot see into clinical bays.
- The urgent care service should ensure that it has a vision and a strategy.
- The urgent care service should consider finding a way to collate staff survey results whilst maintaining staff anonymity.
- The provider should ensure that VTE assessments are completed appropriately.
- The provider should ensure risks of cross contamination in theatres are kept at a minimum.
- The hospital should seek to alleviate any staff concerns regarding bullying.
- The request form audits to check compliance should be recorded and the data be analysed for service improvement.