Highgate Hospital

Quality Report

17-19 View Road
London, N6 4DJ
Tel: (020) 8341 4182
Website: www.highgatehospital.co.uk

Date of inspection visit: 6th, 7th and 8th December 2016
Date of publication: 31/05/2017

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

Ratings

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

Overall summary

This was the first comprehensive inspection of Highgate Hospital, which was part of the CQC's ongoing programme of comprehensive, independent healthcare acute hospital inspections.

Highgate Hospital is operated by Aspen Healthcare Group. The hospital provides surgery, medical care, and outpatients and diagnostic imaging. We also inspected the GP service that operates at this location and reported it as part of outpatients and diagnostic imaging service. Services are provided to insured, self-paying private patients and NHS patients via referrals from GPs, consultants and local contract systems.

The hospital has 43 en-suite single rooms mainly used for patients undergoing day case procedures. Facilities include four operating theatres, an endoscopy suite, seven bedded recovery bay, two-bed enhanced care unit, eleven consulting rooms and two treatment rooms. Other facilities include phlebotomy, pharmacy, X-ray, complex diagnostic investigations such as magnetic resonance imaging (MRI) and computerised tomography (CT) and other outpatient and diagnostic facilities.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6, 7, 8 and 12 December 2016.

Summary of findings

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.

Overall, we rated Highgate Hospital as good. We found surgery, medical care, outpatients and diagnostic imaging to be good, with well led rated as outstanding. We inspected but did not rate the key question of effective in outpatient and diagnostic imaging services.

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

We rated this hospital as good overall.

- The hospital put a strong emphasis on providing safe, effective and quality care for patients and launched a number of initiatives to support staff in providing safe care. There was a good incident reporting culture, with a robust investigation and learning from incidents process.
- The hospital monitored patient safety on a day-to-day basis. Patients were appropriately risk assessed and their condition was monitored throughout their stay. There were appropriate procedures and protocols for responding to any deteriorating condition.
- There were effective and well embedded infection control procedures in place.
- Staffing levels and skills mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patient received safe care.
- Medicines were stored and managed appropriately.
- Treatment was always consultant led and used evidence based best practice from the World Health Organisation (WHO), the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines. Most outcomes for patients were within the expected range.
- Staff were supported with opportunities for further professional development and underwent competency based assessment prior to working independently.
- Feedback from patients who use the service was consistently positive and people received care at the service without delay. The hospital understood the needs of the local population and services were planned to meet those needs.
- There was good multi-disciplinary working when managing patients with co-morbidities.
- Complaints were investigated within appropriate timescales, in line with the hospital policy and lessons were shared with staff.
- There was a clear statement of vision and values, driven by safety and quality. The hospital had a well defined strategy underpinned by the vision and values.
- The MAC was well represented and led on discussing and developing practice and ensuring patient safety.
- The hospital had a clear and robust governance structure. Governance focused on improving patient safety, learning from patients' experience, improving clinical effectiveness and patient experience.
- We found the culture within the hospital to be one of openness, transparency and willingness to learn and improve. Staff reported they were happy and proud to work for the hospital.

Professor Edward Baker

Deputy Chief Inspector of Hospitals (area of responsibility)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Medical care services were a small part of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and 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. Staffing was managed jointly with medical care. 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 was a significant activity of the hospital. We have also included the providers GP service in this section of the report. 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, caring, responsive and well-led. We did not rate the service for being effective.

Summary of findings

Contents

Good

Highgate Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Highgate Hospital

Highgate Hospital is operated by Aspen Healthcare Group. Aspen Healthcare acquired the Hospital in 2003. During Aspen's ownership significant investment has been made in the facility, the most recent in 2013/14 when an expansion and upgrade project was undertaken. Prior to 2013 the Hospital was primarily providing cosmetic surgery services however this strategic investment facilitated the re-launch of the hospital to deliver acute elective surgical services over a broader range of specialties. The hospital offers a range of surgical procedures, including orthopaedics, spinal surgery, plastic and reconstructive surgery including gender reassignment, urology and gynaecology amongst others.

It also offers GP service, endoscopy, diagnostic and imaging, pain management, and a physiotherapy service. Patients are admitted for elective surgery, day case or receive outpatient care. There are no urgent admissions.

Highgate Hospital provides privately funded and NHS treatments. Most of the hospital patients live in and around the North London.

The registered manager designate was Mark Nicholas Hawken registered in 2016. The provider's nominated individual for this service was Judith Ingram. The controlled Drug Accountable Officer was Christine Ann Etherington.

Our inspection team

The team that inspected the service was led by a CQC inspection manager, David Harris. The team included CQC inspectors and a variety of specialists:

- a radiographer
- a consultant surgeon
- three nurses, including an orthopaedic and trauma nurse, infection prevention and control nurse and one with experience in management and service improvement, governance and patient safety.

Why we carried out this inspection

We undertook a comprehensive inspection of the hospital as part of our planned programme of independent hospital inspections.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it 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. Before our inspection we reviewed a range of information provided to us about the hospital and the core services. We carried out the announced part of the inspection on 6, 7 and 8 December 2016.

Summary of this inspection

Information about Highgate Hospital

The hospital has one ward and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures
- Diagnostic and screening procedures

During the inspection, we visited the ward and the main outpatients and diagnostic imaging department. We observed care in the outpatient and imaging departments, in operating theatres and on the wards. We spoke with staff including; registered nurses of all grades, health care assistants, allied health professional, housekeepers, reception staff, a pharmacist, medical staff, operating department practitioners, and senior managers. We spoke with patients and relatives. We also received 36 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 21 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected before, and the most recent inspection took place in July 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 7,148 inpatient and day case episodes of care recorded at the hospital; of these 48% were NHS-funded and 52% other funded.
- 6% of all NHS funded patients and 45% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 31,729 outpatient total attendances in the reporting period (Jul 15 to Jun 16); of these 35% were NHS funded and 65% were other funded.

The five most common medical procedures between July 2015 and June 2016 were:

- Diagnostic colonoscopy, includes forceps biopsy of colon and ileum
- Diagnostic oesophago-gastro-duodenoscopy (OGD) includes forceps biopsy, biopsy urease test and dye spray
- Medial branch block or facet joint injection (under x-ray control)
- Diagnostic flexible sigmoidoscopy (including forceps biopsy and proctoscopy)
- Epidural injection (lumbar)

The five most commonly performed surgical procedures between July 2015 and June 2016 were:

- Breast augmentation
- Rhinoplasty
- Endovenous laser treatment (EVLT) of more than one venous trunk +/- phlebectomies – unilateral
- Mastopexy
- Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture)

Track record on safety

- Clinical incidents 247 no harm, 19 low harm, 19 moderate harm, 0 severe harm, 0 death
- 1 serious injury which was also classified as a never event
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Two complaints

Services accredited by a national body:

- Association for Peri-Operative Practice (AfPP) accreditation
- World Host Accreditation© - Principles of Customer Service

Services provided at the hospital under service level agreement:

- Cellular Pathology Services
- The Doctors Laboratory
- The London Clinic

Summary of this inspection

- Atlantis Medical
- Premiere Recruitment
- Your World
- Medics Pro
- Avensys Ltd
- The Whittington Hospital NHS Trust (Occupational Health)
- SRCL Limited
- NES Healthcare UK (Resident Medical Officer (RMO))
- The Holly House
- St George's Hospital NHS Trust (Radiation Protection)
- R.E.D.I Training
- A to E Training & Solutions

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There was a positive culture of incident reporting and there were established processes for investigating incidents. Incidents were discussed and lessons learnt.
- The hospital had launched a 'STEP-up to Safety' programme, an acronym which stands for 'spot', 'talk', 'examine' and 'prevent'.
- Medication and controlled drugs was stored securely and were checked on at least a daily basis by registered nurses or pharmacists.
- Ward staff used the National Early Warning Score (NEWS) to identify deteriorations in a patient's condition and we saw the NEWS was consistently recorded for all patients in records we reviewed.
- Staffing levels and skills mix were planned using an acuity tool and there were enough staff on duty on every shift to ensure patients received safe care.
- There were effective infection control procedures in place. We observed staff adhering to infection control procedures. Hand gel dispensers were available throughout the departments and staff used them. We also saw an adequate supply of personal protective equipment (PPE) such as aprons and gloves.
- There had been no incidents of hospital acquired infections such as MRSA or C Difficile and there had been just one case of surgical site infection during the reporting period.

Are services effective?

Good

We rated effective as good because:

- Care and treatment was provided in line with national guidelines and most outcomes for patients were within the expected range.
- Treatment was always consultant led and used evidence based best practice.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice.
- There was good multidisciplinary team (MDT) working.
- Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

Are services caring?

Good

Are services caring?

We rated caring as good because:

Summary of this inspection

- We observed staff being respectful at all times. Patients told us and we saw their privacy and dignity was respected at all times and care we saw supported this.
- The Friends and Family Test survey showed 95-99% of patients would recommend the hospital to their friends and family.
- All patients and relatives we spoke with told us they were fully involved in their care and were complimentary about the information they were provided to allow them to make an informed decision about their care.

Are services responsive?

Are services responsive?

Good

We rated responsive as good because:

- We saw complaints were investigated within appropriate timescales, in line with the hospital policy and lessons were shared with staff during team meetings.
- The hospital understood the needs of the local population and services were planned to meet those needs. There had been recent investment to develop the range of surgical services offered.
- There was a clear process for both NHS and private patients to book in for their surgery through the reservation and contracts team.
- Patients referred by their GP could book a convenient date and time for their appointment through the NHS 'choose and book' electronic booking system.
- Patients had single rooms that provided privacy and comfort with ensuite facilities and there was no restricted visiting times for patients.

Are services well-led?

Outstanding

We rated well-led as outstanding because:

- There was a clear statement of vision and values, driven by safety and quality. The hospital had a well defined strategy underpinned by the vision and values and focused on patient care. Staff understood and aimed to achieve the corporate and local visions and values in all aspects of their work.
- The hospital had effective governance and risk management systems. Service risks were well understood and mitigated effectively to promote the sustainability of high quality care. Meetings within the governance framework of the hospital were well attended and feedback was provided to clinical and non-clinical staff.

Summary of this inspection

- There was strong leadership at every level of the hospital and robust management processes in place for all staff including consultants.
- We found the culture within the hospital to be one of openness, transparency and willingness to learn and improve. Staff spoke highly of the senior management team and were confident to raise any concerns or suggestions.
- The hospital put a strong emphasis on providing safe, effective and quality care for patients and launched a number of initiatives to support staff in providing safe care.
- The MAC was well represented and led on discussing and developing practice and ensuring patient safety.
- Staff reported they were happy and proud to work for the service and found senior management to be supportive and approachable.
- Views of staff were regularly sought both formally and informally and they were incorporated into improvements to patient care.
- We saw the hospital welcomed and sought patients' feedback, including any concerns or complaints, and utilised it to improve the quality of care.

Good

Medical care

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

Information about the service

The medical services provided at Highgate Hospital were inpatient and endoscopy. There were a total of 1,645 endoscopy procedures in the reporting period of July 2015 to June. Inpatient medical care services were provided for both private and NHS patients. There were 1,887 inpatient and 5,261 day cases of which 48% were NHS funded while 52% had another source of funding between July 2015 and June 2016.

The inpatient medical service was situated on two wards; the ground floor with 19 beds used mainly for day cases and the first floor with 15 beds for patients who were elderly or with medical conditions. The inpatient medical service was provided by medical consultants with practising privileges, a resident medical officer (RMO), nurses, health care assistants, a pharmacist, allied health professionals and ward clerk administrators.

The endoscopy service was provided in the theatre department and utilised the ground floor ward for pre and post procedure for recovery. Procedures undertaken include oesophago-gastro duodenoscopy (OGD), colonoscopy, diagnostic endoscopy and flexible sigmoidoscopy.

During our inspection we spoke with members of staff: senior managers, nursing staff, allied health professionals, consultant physicians, resident medical officer, a pharmacist, housekeepers, health care assistants (HCAs), and ward clerk administrators. We also spoke with a number of patients and relatives on the inpatient ward. We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including six patient records. Before and during our inspection we also reviewed performance information about the service.

Are medical care services safe?

Good

We rated safe as good.

Incidents

- There were no never events reported in the reporting period of July 2015 to June 2016. 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.
- The hospital reported there were no patient deaths for the reporting period of July 2015 to June 2016.
- There were 285 clinical incidents reported across the hospital between July 2015 and June 2016, 87% (248 incidents) occurred in surgery or inpatients and 3% (9 incidents) occurred in other services.
- No incidents were reported as leading to “severe” harm in the reporting period of July 2015 to June 2016 in medicine. 266 (93.3%) were classed as either no harm or low harm across the hospital. This meant that the incident resulted in low or no harm to the patients.
- There were 169 non-clinical incidents reported across the hospital between July 2015 and June 2016; 44% (74)

of non-clinical incidents were reported by surgery or inpatients via the hospital incident reporting system. It was not possible to identify any inpatient incidents for medical or endoscopy patients in the data provided.

- The clinic had an online computer incident reporting system used to report incidents and staff told us it was easy to report incidents when they occurred. Staff members we spoke with described to us the process for reporting an incident. They gave us examples of incidents that were discussed during team meetings and lessons learned. For example, a colonoscopy incident where a patient forgot to collect their bowel preparation resulted in a colonoscopy preparation standing operating procedure (SOP) being drafted. At the time of the inspection the SOP had been circulated to the practice development group for comment.
- Investigations were undertaken into serious incidents and a root cause analysis (RCA) method was applied. The ward manager and ward sister had both undertaken RCA training.
- An incident policy (including serious incidents) was available on the hospital intranet site and staff knew how to access it.
- Incidents and safety matters were discussed and reviewed at the daily operational meeting attended by the senior management team.
- The hospital had launched a 'STEP-up to Safety' programme, an acronym which stands for 'spot', 'talk', 'examine' and 'prevent'. The campaign aimed to improve patients' safety by making staff appreciate the impact their work has on safety and better their understanding of the contributing factors to patient incidents.
- Minutes from clinical governance meeting showed that clinical incidents were reviewed and discussed.
- Staff advised that mortality and morbidity was not discussed at clinical governance quality meetings on a regular basis. However, mortality and morbidity was mainly discussed across the Aspen Healthcare group so learning was shared across the group.

Duty of candour

- From November 2014, NHS providers were required to comply with the duty of candour regulation 20 of the Care Quality Commission (Registration) Regulations 2014. 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.
- Nursing staff were aware of their responsibilities under duty of candour, which ensured patients and/or their relatives were informed of incidents that affected their care and treatment and they were given an apology.

Clinical Quality Dashboard or equivalent

- The hospital used a quality dashboard for measuring, monitoring and analysing harm. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- Patients had venous thromboembolism (VTE) assessments completed on admission. VTE screening rates for the period between July 2015 and June 2016 showed that between 95% and 100% of patients had an assessment on admission.
- There were one incident of a hospital acquired VTE, two incidents of slips, trips and falls and no cases of pressure ulcer or urinary tract infection reported in the period between July 2015 and June 2016.

Cleanliness, infection control and hygiene

- Patient led assessments of the care environment (PLACE) for the period from February 2016 to June 2016 showed that the hospital scored 100% for cleanliness; which was higher than the England average of 98% for independent hospitals.
- The hospital reported no incidents of Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus MSSA, E-Coli, Clostridium difficile in the reporting period between July 2015 and June 2016.
- We observed green 'I am clean' labels were in use to indicate when equipment was cleaned on for example drip stands.

Good

Medical care

- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- All the patient rooms we visited were visibly clean. Rooms had daily cleaning schedules in place. We saw the daily cleaning schedules were up to date and signed.
- Cleaning equipment followed the National Reporting and Learning Service's (NRLS) national colour coding system for cleaning equipment, to ensure that equipment was not used in multiple areas, therefore reducing the risk of cross-infection.
- Adequate supplies of personal protective equipment (PPE) such as gloves and aprons were readily available in all clinical areas we visited. We observed staff using this appropriately when delivering care. We noted all staff adhered to the 'bare below the elbows' protocol in clinical areas.
- Hand wash basins and alcohol hand sanitising gel were available in each patient's room. Hand gels were also available at the entrance and in common areas on the wards.
- The hospital had an infection prevention and control audit programme for 2016 in place. Hand hygiene audits were undertaken quarterly. The hand hygiene audit undertaken in January 2016 on the ward showed that nursing staff were 95% compliant.
- The hospital had quarterly infection prevention and control committee meetings attended by senior management. There was a standard meeting agenda and we saw action points were identified and reviewed.
- In the endoscopy theatre full electronic scope-tracking and traceability records were kept. Endoscopy scope decontamination was undertaken off site at a sister Aspen hospital. Scopes were delivered and collected twice a day.
- Infection prevention and control training formed part of the mandatory training programme for staff. Data provided by the hospital showed that 100% of registered nurses (RN) and 100% of health care assistants (HCA) had completed infection control training.

Environment and equipment

- Patient led assessments of the care environment (PLACE) for the period between February 2016 and June 2016 showed that the hospital scored 97% for condition, appearance and maintenance; which was higher than the England average of 93% for independent hospitals.
- We observed the corridor was generally kept clear of equipment.
- The inpatient service was provided in single accommodation rooms with ensuite bathroom facilities.
- The endoscopy service had a dedicated theatre. Patients would be admitted to single rooms to maintain their privacy. We observed that patients generally walked into the theatres and were wheeled back to the cubicles. Patients who had sedation would recover in the recovery area before being taken back to their room.
- Resuscitation equipment was stored on a resuscitation trolley, readily available and located in a central position in each of the areas. The equipment was checked daily, fully stocked and ready for use.
- Ward staff signed to confirm that they had received training on the use of equipment used on the ward. The ward also had a list of the equipment in use. The instruction manuals were held on the ward so they were available for staff.
- We saw that Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they were inspected and were safe to use.
- Health and safety training was part of the mandatory training programme for RN's and HCA's staff to attend, 100% of RN's and HCA's had completed the training.

Medicines

- The on-site pharmacist was available 8.30am to 7.30pm Monday to Thursday, 8.30am to 5.30pm on a Friday and from 8.30am to 1.00pm on a Saturday. There were specific arrangements for staff to gain access to the pharmacy out of hours, with the resident medical officers (RMOs) and nurse in charge having separate access codes, which meant single access was not possible.

- We looked at the drugs charts for patients on the ward and saw that there were no gaps and that patients received their medications at the frequency and times prescribed. A prescribing audit was undertaken in May 2016 this provided a snap shot of a 72 hour period. This demonstrated the inpatient wards were 96% compliant.
- Staff were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). This included policies and processes for ordering, recording, storing, dispensing, administering and disposing of medicines.
- Controlled drugs (CDs) were stored securely and were checked on at least a daily basis by registered nurses or pharmacists. We looked at the CDs and found that the stock balanced and that the CD registers and order books were completed in line with local procedures. An audit of CDs undertaken in July and August 2016 showed that the compliance was 96% and 97% respectively.
- Patients had access to medicines when they needed them. The pharmacist or the technician would undertake regular stock reconciliation and ensure there were adequate supplies.
- Tablets to take out (TTO) were delivered to the patients who were being discharged. An audit of the TTOs in July 2016 showed that 100% of the time TTOs were completed and ready for collection before the patient was ready to be discharged.
- Refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature fell out of the safe range.

Records

- Patient records were paper based shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could see the record. We reviewed six patient records and saw patients care plans included all identified care needs.
- Risk assessments had been completed on admission; these included waterlow score, venous thromboembolism (VTE) checks, and nutrition and falls risk assessments.
- Patients' allergies were recorded in patient records.
- Nursing records showed that turns charts and fluid charts had been completed and the balance calculated correctly.
- We observed that for patients undergoing an endoscopy safety checks were undertaken using the 'Five Steps to Safer Surgery'. A copy of the World Health Organisation (WHO) checklist (three of the five steps) was held within the patient's notes.
- The hospital audited patient records monthly as part of the audit programme. Audits undertaken between April and June 2016 showed compliance of 99% and 100%.
- Patients' medical notes were stored in lockable cabinets in the nurse's station.
- Once records were no longer required after the patient was discharged, they were stored on site in a secure records office prior to being archived.

Safeguarding

- The hospital had no reported safeguarding alerts in the reporting period of July 2015 to June 2016.
- Staff were able to identify the potential signs of abuse and the process for raising concerns. The hospital had an identified lead for safeguarding.
- Staff had access to the hospital safeguarding policies for children and adults via the hospital intranet and knew who the safeguarding lead was.
- Safeguarding adults and safeguarding children was part of the mandatory training programme for staff. Nursing staff we spoke with on the ward told us they attended safeguarding training. Data provided by the hospital showed that 100% of RN's and 100%of HCA's had completed safeguarding adults level 1 and 94% of RN's and 67% HCA's had completed level 2. 100% and 88% of RN's had completed children safeguarding level 1 and 2 respectively and 100% and 67% of HCA's had completed children safeguarding level 1 and 2. The target for all safeguarding training was 90%.

Mandatory training

- The mandatory training programme included fire safety, health, safety and welfare, Safeguarding adults levels 1 and 2, safeguarding children levels 1 and 2, moving and handling, infection prevention and control, basic life support and adult intermediate life support.

Good

Medical care

- Training was provided via e-learning modules and face-to-face.
- The RMOs received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The resident medical officers (RMOs) received advanced life support (ALS) via the RMO agency.
- Data provided by the hospital showed that the overall compliance with mandatory training was 97% for RNs and 92.6% for HCAs.

Assessing and responding to patient risk

- The hospital had a clinical admissions policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.
- We saw evidence in the eight records we looked at of risk assessments such as waterlow, nutrition and falls being completed. For patients at risk of falling there was a variety of equipment available to mitigate the risk such as pressure relieving mattresses and 'high/low' beds for patients at risk of falling.
- The hospital used the national early warning score (NEWS) charts for tracking patients' clinical conditions and alerting the clinical team to any deterioration that would trigger timely clinical response. We saw NEWS was completed on all the records we reviewed. The hospital undertook an audit of NEWS in May 2016 which demonstrated that the inpatient medical services were 100% compliant.
- Staff we spoke with were clear about the processes to follow if a patient deteriorated. The RMO was available on site 24 hours a day and responded to deteriorating patients.
- The practising privileges agreement for each doctor ensured there was 24 hour clinical support from the named consultant when they had patients in the hospital. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available.
- Adult immediate life support was part of the mandatory training programme for RNs to complete. Data provided by the hospital shows that 94% of nurses had completed immediate life support training.
- Basic life support was part of the mandatory training programme for HCAs to complete. Data provided by the hospital shows that 100% of HCAs had attended basic life support training.

Nursing staffing

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

Medical staffing

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

Are medical care services effective?

Good

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

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. For example, the ward provided care in line with NICE Guideline CG50 that covers recognising and responding to deteriorating patients.
- Clinical policies and procedures were available on the hospital's intranet and staff were aware of how to access them.
- The hospital had an audit programme which set out the audits to be undertaken across the hospital for 2016. The audits included venous thromboembolism (VTE) assessment, patient records, NEWS, pain relief, and intentional rounding amongst others.
- Monthly quality governance meetings reviewed the performance of the hospital in both national and local audit. We saw that action points were identified and reviewed at each meeting.

Pain relief (medical care specific only)

Good

Medical care

- Nursing staff told us they would alert the resident medical officer (RMO) or consultant if a patient required pain management who then could assess the patient and prescribe pain relieving medicines where necessary.
- Nursing staff assessed and recorded pain scores on the NEWS. Records we reviewed demonstrated that pain was managed promptly.
- All patients we spoke with told us they felt their pain was well managed and they received regular analgesia.
- Pain management was audited in May 2016. The audit demonstrated that the inpatient medical services were 100% compliant.

Nutrition and hydration

- Patient led assessments of the care environment (PLACE) 2015 showed that the trust scored 94% for ward food which was higher than the England average of 92% for independent hospitals.
- We saw the patients' nutrition and hydration needs were assessed and met. We observed patients always had drinks available within reach.
- Patient's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- Patients were reviewed by a dietician if there were concerns regarding their weight or food intake.

Patient outcomes

- At the time of our inspection the endoscopy unit was working toward JAG (joint advisory group) on gastrointestinal endoscopy accreditation. The JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale (GRS) standards. Staff told us the endoscopy service had achieved the required Global Rating Score which allowed them to formally apply for the accreditation.
- Between July 2015 and June 2016 there were seven unplanned re-admissions of medical inpatients within 28 days. The number of unplanned re-admissions was low when compared to other independent acute hospitals.
- Between July 2015 and June 2016 there were four unplanned transfers to other hospitals. The number of unplanned transfers was low when compared to other independent acute hospitals

Competent staff

- This service operated one inpatient ward, which was shared with surgical patients. The medical and nursing staff arrangements for competent staff are reported under the surgery services within this report.
- Staff told us they participated in the appraisals process and they had access to regular training updates. On the inpatient ward 100% of nursing staff and HCA's had an appraisal.
- The hospital had recently recruited a dedicated endoscopy nurse practitioner who was leading on JAG accreditation for the hospital and attended Aspen Healthcare group meetings to update on the hospital progress towards the accreditation.

Multidisciplinary working

- Consultants and nursing staff that we spoke with all described good working relationships on the wards and across the hospital. Nursing staff told us that they felt able to raise any patient concerns with consultants. Staff told us that they worked as a team.
- Multidisciplinary team (MDT) working was evident in the patient records we reviewed. For example, a patient was reviewed by a physiotherapist and a further patient was referred to a dietitian.
- There was pharmacist support on the ward and they provided information to patients on their medications.

Access to information (medical care only)

- To ensure continuity of care, nursing staff working on the ward had detailed handover of patients between morning and evenings shifts.
- All nursing staff had access to an online learning management system and hospital policies and protocols via the hospital's intranet. However, agency staff told us that they did not have log on access to the hospital's intranet.

Good

Medical care

- Patients' medical notes stayed on the ward until post discharge checks were completed. Once completed, records were archived on-site. If clinical staff needed to access medical records administrative staff could retrieve them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- Staff told us that they had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training.
- All patient records we saw had consent forms completed. Endoscopy patients told us that the procedure was fully explained by the consultant prior to them signing consent for their procedures. Staff told us that formal written consent was taken by the consultant involved when the patient was admitted for a procedure.
- Patients told us staff asked their permission before care or treatment was given and medical staff explained their treatment.
- The consent process and consent forms were audited in June 2016. The audit demonstrated that the hospital was 95% compliant. An action plan was in place to discuss the process with consultants and at the next MAC meeting.
- The hospital had a policy for 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decision in place. At the time of the inspection no medical patients had a DNACPR form in place.

Are medical care services caring?

Good

Compassionate care

- The hospital used the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. We looked at the latest FFT scores for the period January to June 2016 and these showed satisfaction with the service offered at the hospital was between 95% and 99%.
- We looked at the results of the patient led assessments of the care environment (PLACE) for the period February to June 2016. The hospital scored 86% for privacy, dignity and wellbeing which was higher than the England average of 83% for independent hospitals.
- We saw evidence of thank you cards displayed on the ward. Staff were identified as "kind and caring" and relatives thanked them for looking after their loved ones.
- We observed professional, kind and friendly interactions between staff and patients.
- A patient told us that call bells had been answered promptly and they felt they never had to wait to speak to a member of staff.
- Patients told us that both nursing and medical staff took time to talk to them and their relatives.
- We observed that people were treated with dignity, respect and kindness during all interactions. Patients' privacy was maintained by ensuring the doors and windows were locked and covered during personal care or when visitors were in attendance.

Understanding and involvement of patients and those close to them

- Patients had named consultants looking after them. Patients were allocated a nurse and/or HCA to look after them each shift. Patients told us nursing staff always introduced themselves.
- All the patients we spoke with felt involved in their care and were kept informed about their treatment. Care plans were shared with patients.
- Patients told us that staff explained everything, they could ask any questions and relatives were actively involved in their treatment.
- Staff were able to demonstrate that they were aware of what patients wanted and needed

Emotional support

- Staff took time with patients and their families. We saw staff display empathy and support towards patients and their relatives.

Good

Medical care

- Staff displayed good understanding of the impact of the patient's care, treatment or condition on their wellbeing and on the impact on those close to them.

Are medical care services responsive?

Good

Service planning and delivery to meet the needs of local people

- The endoscopy unit was working toward JAG (joint advisory group) on gastrointestinal endoscopy accreditation.
- Patients were referred to the endoscopy service through the NHS Choose and Book system or local contracts for NHS providers and private patients referred via their GP or self-referred.
- The endoscopy service was available 6 days per week and undertook 1,645 endoscopy procedures in the reporting period of July 2015 to June 2016.
- Medical inpatients were generally referred directly via patients GPs.
- Inpatient medical care services were provided for both private and NHS patients. There were 1,887 inpatient and 5,261 day cases of which 48% were NHS funded while 52% had another source of funding between July 2015 and June 2016.
- 6% of all NHS funded patients and 45% of all other unfunded patients stayed overnight between July 2015 and June 2016.
- The hospital was able to offer an inpatient medical care service and day patient facilities on the wards.
- All patients' rooms were single with ensuite facilities and there were no restricted visiting times for patients. Relatives were able to purchase refreshments.

Access and flow

- The hospital provided care to NHS and private patients undergoing endoscopy. NHS patients were referred through NHS e-referral service. Patients referred by their GP could book a convenient date and time for their appointment through NHS 'Choose and Book' electronic booking system.
- Referral to treatment times (RTT) did not consistently meet the target rate of 90% or above for the period between July 2015 and June 2016.This was because between September and November 2015 and January 2016 the hospital achieved between 72% and 89%. The hospital advised that this was related to funding released by the local commission group. Since February the hospital has consistently met the RRT target for patients scoring 94% or more. Bed capacity was planned on a weekly basis. The ward manager communicated with the hospital admissions team to manage unscheduled overnight stays.
- Endoscopy had a planned number of patients due for procedures each day.
- The hospital had an admissions eligibility policy which ensured suitable patients were admitted to the ward. Consultants told us they discussed patients with their GPs prior to admission to ensure the hospital was the most suitable place for them and they would not admit patients who might need a higher level of care.
- Consultants admitted medical patients by completing a booking form and referring them through the administration team to the appropriate service.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- To take home tablets (TTOs) were timely on discharge from the pharmacy.
- Patients told us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition.
- All patients who were discharged received a follow up call from the nursing team within 48 hours of discharge.

Meeting people's individual needs

- We saw patients had their needs assessed before their admission. We reviewed six sets of patient records and saw their care plans included all identified care needs.
- Intentional rounds were undertaken hourly or two hourly by nursing staff to monitor patients' welfare and

any changes in their clinical condition. This is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.

- The ward had open visiting times which meant relatives could visit their loved ones at any time.
- Patients had single rooms that provided privacy and comfort with ensuite facilities.
- Patients told us staff answered bells straight away. The hospital did not audit patient call bell response times.
- The hospital's hotel service offered a variety of food and drink which patients could choose from a menu which catered for a variety of diets. Special dietary requirements such as Kosher or Halal were provided by external providers. The hospital scored 92% for ward food in the patient led assessments of the care environment (PLACE) for the period between February and June 2016 which was higher than the England average of 82%.
- Nursing staff and HCAs had undertaken awareness training for patients living with dementia. Staff advised us that if a patient was admitted who had specialist needs this would be discussed prior to admission to ensure that appropriate staffing was available. The hospital scored 88% for dementia in the patient led assessments of the care environment (PLACE) for the period between February and June 2016 which was higher than the England average of 80%.
- There was a variety of information leaflets available on the ward though these were only available in English.
- For patients whose first language was not English, staff were able to arrange for interpreters to assist them.
- The hospitals website provided information on the paying for treatment. Patients were able to pay for themselves and fixed price packages were available. Treatment could also be funded through private medical insurance. The hospital also provided services for patients funded through the NHS.
- Aspen Healthcare had a policy in place for managing care of a dying patient which reflected the Five Priorities for Care as set out in 'Once Chance to Get it Right' 2014.

Learning from complaints and concerns

- The hospital's director oversaw the management of complaints. The handling of complaints was monitored to ensure that complaints were dealt within the time frame set out in the Aspen Healthcare complaints policy. Complaints could be raised in person, by telephone, or in writing.
- The hospital reported receiving 66 complaints in the reporting period of July 2015 to June 2016. Details of complaints raised by patients showed these had been followed up and that learning outcomes had been identified in most instances.
- We saw that clinical complaints were reviewed as part of MAC and ward meetings. The minutes of ward meetings also showed that staff were recognised and congratulated on positive feedback received from patients.
- The hospital advised that two complaints had been referred to the Ombudsman or Independent Healthcare Complaints Adjudication Service (ISCAS) during the reporting period of July 2015 to June 2016.
- Staff told us they tried to resolve complaints and concerns at the time these were made wherever possible.

Are medical care services well-led?

Outstanding ☆

Vision and strategy for this this core service

- Staff we spoke with were aware of the hospital's vision and values and how that related to the strategy of the inpatient services.
- Staff we spoke with felt valued by the hospital management team and had the opportunity to get involved in the hospital strategy through staff forums and the Aspen values day.

Governance, risk management and quality measurement

- The service governance processes are the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.

Good

Medical care

Leadership and culture of service

- The same leadership team led the surgical and medical services. For more information on leadership please read this section in the surgery report.
- Ward managers had undertaken leadership and management training provided by the Aspen Healthcare training programme 'Investing in You'.
- Staff we spoke with told us the senior staff were visible on the wards and that the senior staff undertook daily rounds. Throughout our inspection we saw that senior staff members were visible in all areas.
- Staff said there was an open and transparent culture. They were encouraged and felt comfortable about reporting incidents and there was learning from mistakes.
- Staff working on the wards told us they were allocated to do work in different areas of the hospital, for example all staff had the opportunity to work in endoscopy.

Public and staff engagement

- The hospital public and staff engagement processes have been reported on under the surgery service within this report.

Innovation, improvement and sustainability

- The hospital was actively working towards Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated certain quality assurance standards. Staff told us the endoscopy service had achieved the required Global Rating Score which allowed them to formally apply for the accreditation.
- All staff we spoke with working in the inpatient service were positive about the Aspen Healthcare training programme which provided additional training; staff felt they had opportunities to develop in their careers.

Good

Surgery

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

Information about the service

The main service provided by this hospital was Surgery.

Highgate Hospital offer surgical services to adults for elective surgery, including cosmetic, orthopaedic, gynaecology, andrology and general surgery. Surgical services are provided to both NHS and private patients. NHS patients were mainly referred through GP 'Choose and Book' referrals and local contract system with local NHS hospitals. Private patients were a mixture of insured and self-pay. NHS funded patients accounted for 48% of all surgical activity.

The hospital carried out cosmetic surgery through a service level agreement with a third party cosmetic company whereby the patient only attended the hospital for their operation but the pre-operative assessment and aftercare took place at the third party provider. This was also the case for the andrology service.

The inpatient rooms were situated on two wards. The ground floor ward had 19 en-suite single rooms and was mainly used for patients undergoing day case procedures. The first floor ward, where all inpatients were cared for had 15 en-suite single rooms. On the first floor, there was also a two bedded area used for patients requiring enhanced care. There are five operating theatres (two with laminar air flow) with a seven bedded adjacent recovery area.

There were 7,067 surgical procedures reported between July 2015 and June 2016. The five most common surgical procedures performed were:

Breast Augmentation (865)

Rhinoplasty (380)

Endovenous laser treatment (235)

Mastopexy (223)

Multiple arthroscopic operation on knee (including meniscectomy) (152)

Patients were admitted under a named consultant and the Resident Medical Officer was available 24 hours a day. Patients were cared for by a team of nurses, physiotherapist and pharmacist supported by dedicated administrative staff.

We carried out an announced inspection over three days and visited the ward and the operating theatres. We spoke with 18 members of staff (medical, nursing, allied health professional and administrative) and five patients and their relatives. We also reviewed 10 patient records as well as a number of policies and guidelines.

Are surgery services safe?

Good

Incidents

- There had been one never event at the hospital during the reporting period of July 2015 to June 2016. 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. The incident was investigated in a robust way using a root cause analysis model. We reviewed the investigation report and saw that the never event occurred when implants made of a cohesive not consented for by the patient were inserted during breast augmentation surgery. A number of actions were taken

following the investigation such as review of the standard operating procedure for breast augmentation, staff attending human factors training and improved storage and checking of implants. Theatre staff attended focus groups to discuss the never event and share the learning. However, during our inspection, we were informed by the hospital management team that another never event took place in November 2016, involving a wrong breast implant during breast augmentation surgery. At the time of our inspection, the investigation for this never event was ongoing, an external review had been commissioned to review the incident.

- Surgical services reported 248 other clinical incidents between July 2015 and June 2016. Of these incidents, the majority were classed as no harm incidents, indicating a good reporting culture. A further 74 non-clinical incidents were reported during the same period for surgery, which was a higher rate of non-clinical incidents when compared to other independent hospitals we hold this data for.
- Incidents were reported using an electronic reporting system and all staff we spoke with knew how to report an incident. Most staff were able to give examples of incidents they had reported recently and told us senior staff encouraged incident reporting with a 'no blame' culture. Staff told us they received individual feedback on incidents they reported and learning from all incidents was shared at handovers, team meetings and through the patient safety newsletter. We looked at minutes of team meetings and saw that learning from incidents was a standard agenda item. We also reviewed three editions of the patient safety newsletter and saw topics covered included Sepsis 6, medicines and allergies, learnings from never events from across the Aspen Group, incident reporting, near misses, patient safety training, infection prevention and control, and root cause analysis (RCA) investigation amongst others.
- Staff we spoke with had a good understanding of the duty of candour requirement and were able to explain how it applied to their specific roles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence the duty of candour requirement was adhered to when we reviewed the never event investigation report.
- Mortality and morbidity was discussed at the Medical Advisory Committee (MAC), the senior management team (SMT) meetings as well as the HoD (heads of departments) meetings. We saw from minutes of these meetings that the management team monitored the time frame of incident investigations and implementation of actions identified.

Clinical Quality Dashboard or equivalent

- The hospital had a quality governance report dashboard which gave the senior management team information on the safety performance of the hospital for each quarter. The dashboard was colour coded to show if the results were meeting the targets set. This also allowed the senior management team to benchmark the safety of services against other hospitals in the Aspen group.
- The hospital also participated in the NHS Safety Thermometer, which is a scheme used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas.
- Safety thermometer data we saw for the reporting period showed there had been one case of hospital acquired venous thromboembolism (VTE), two cases of slips, trips and falls and no cases of pressure ulcer or urinary tract infection.
- Display boards were visible on the wards, with information on patient survey results, staffing levels and patient safety data.

Cleanliness, infection control and hygiene

- All clinical areas we inspected were visibly clean and tidy. The most recent patient led assessment of the care environment (PLACE) showed the hospital scored better than the England average for cleanliness.
- We saw evidence cleaning schedules were in place and dedicated cleaning staff were available. Cleaning staff had received training to enable them to follow best practice in minimising cross contamination.

Good

Surgery

- All clinical areas were compliant with the Health Building Notice (HBN) 00-09: Infection control in the built environment. The ward corridors were carpeted but staff informed us the carpets were deep cleaned every three months.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. We observed staff, including consultants with practising privileges, complied with the hospital's infection prevention and control policy by being bare below the elbow and decontaminating their hands in between patients.
- Hand wash basins and alcohol hand sanitising gel were available in each patient's room. Hand gels were also available at the entrance and in common areas on the wards and theatres.
- During our visit, we observed patients with known infections were highlighted by having a note placed on the door requesting anybody entering the room to first speak to the nurse in charge. Staff explained for privacy reasons, they did not display an infection sign but the sign displayed allowed the nurse in charge to convey the infection status and necessary precautions prior to staff or visitors entering the room.
- There were clear guidelines for staff to follow to screen patients for the presence of infections such as methicillin resistant staphylococcus aureus (MRSA) and carbapenemase-producing enterobacteriaceae (CPE). We saw that these had been followed in the records we reviewed.
- There had been no incidents of hospital acquired infections such as MRSA or C Difficile during the reporting period. Staff had access to policies to manage infection prevention and control and to guide care for patients with known infections.
- The hospital reported one case of surgical site infection during the reporting period of July 2015 to June 2016. This infection occurred following spinal surgery. A root cause analysis investigation had been completed.
- Servicing of the theatre ventilation systems was undertaken by the service engineer at appropriate intervals and we saw evidence the operating theatres were compliant with HTM 03-01: Specialised ventilation for healthcare premises.
- Surgical equipment decontamination was completed off-site at a sister Aspen hospital. Staff told us there had been some issues with the decontamination process and the timeframe but the theatre manager now met regularly with the manager at the decontamination site and this arrangement was now working well.
- We saw that the disposal of sharps, such as needles followed good practice guidance. Sharps bins were signed and dated when assembled and temporary closures were used when the bin was not in use.
- The Aspen Group clinical director chaired quarterly infection prevention and control (IPC) committee meetings where all matters relating to infection control were discussed. The meeting was attended by staff from the hospital and Aspen group's nurse consultant and doctor in infection prevention and control. The meeting also allowed the hospital team to learn from infection control incidents that have occurred in other Aspen hospitals.
- The ward and theatre had designated infection control link practitioners who carried out regular audits as set out in the Aspen yearly IPC plan. We saw IPC audits looked at the clinical environment, waste and linen management, hand washing as well as equipment decontamination. Audit carried out during the reporting period showed overall compliance of 100% for the wards and 94% for theatre. The audit report had made some recommendation to improve compliance in theatre.

Environment and equipment

- Theatres were located one floor below the ward and there was controlled access via keypad lock. There were five operating theatres, two of which had laminar air flow. Laminar flow is considered best practice for ventilation within operating theatres. One of the theatres was used predominantly for endoscopy procedures. A seven bedded recovery area was situated adjacent to the theatres.

- There was adequate storage for consumables in recovery and on the ward; items were stored in labelled drawers to allow efficient access for staff.
- Essential emergency and resuscitation equipment was available in each of the areas we visited. The resuscitation trolleys were sealed and staff carried out daily checks of equipment stored on the resuscitation trolley and broke the seal weekly to inspect the contents of the trolley. We saw evidence these checks were consistently carried out for both theatre and the ward
- Anaesthetic and theatre equipment were checked and recorded before every list. There was a clear system in place to ensure surgeons informed the theatre team of all equipment required for each case well in advance. The theatre team worked closely with representatives from equipment companies to ensure all loan equipment were delivered with enough time for sterilisation to take place at the sister hospital.
- The theatre manager told us specialist equipment required for certain cases was shared with other Aspen hospitals and this system worked well and allowed for efficient use of the resources.
- There were systems to maintain and service equipment as required. Record of the equipment maintenance was held centrally by the Aspen group engineers and staff had access to the system. All equipment we checked , except for one item in recovery, had been portable appliance tested (PAT) and had up to date servicing.
- Equipment stores on the ward were tidy and all equipment stored safely. We saw a range of mobility and orthotic equipment available to physiotherapy staff.
- The cleaning cupboard on the ward was not locked. We noted cleaning products were not stored in locked cupboard as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH). This posed a health and safety risk. We brought this to the attention of the senior staff and saw evidence a lock for the door was immediately requested.

Medicines

- Medicines were stored securely on the wards and theatres. Nursing staff carried keys to access stock medication and controlled drugs at all times. We checked controlled drugs (CDs) stock on the ward and in recovery and saw that the records for these drugs were complete and accurate. Intravenous fluids were stored securely and correctly. The pharmacy department completed stock checks of medications on wards and in theatres.
- Patients had access to medicines when they needed them. Medicines were supplied to the hospital pharmacy through a centrally managed contract. There was a top-up service for replenishing medicines stock items in all clinical areas and for other medicines issued on an individual basis.
- Access to the pharmacy during opening hours was by designated pharmacy staff only. There were specific procedures for other named staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and senior nurse holding keys and alarm code separately, meaning that single access was not possible.
- Where medicines required cool storage, ambient temperature checks of the storage areas including cupboards and refrigerator temperature checks were carried out and recorded, and were all within the required range. Staff were aware of the process to follow if the temperature should fall out of the safe range.
- The lead pharmacist carried out regular CD audits and we saw the latest audit which took place in August 2016, had an overall compliance score of 97%. The one criteria identified as non -compliant was the amendment of errors in the CD register being correctly recorded. We looked at the CD register and saw a recent error was correctly recorded and the register amended accordingly.
- The pharmacy team also carried out an audit of missed medication doses on the ward in April 2016 and found that nursing staff were recording the reasons for all missed doses and there were no trends identified.

Records

- Records were paper based and included documentation from all members of the multidisciplinary team in a chronological order. The records were in good condition and we saw patients were reviewed daily by their consultant during their stay. The Resident Medical Officer (RMO) also documented a daily review of patients.

- Records on the ward were stored securely in locked cupboards. Staff told us the ward administration team ensured patient records were available on the ward the day prior to their admission.
- Surgical pathways covered the patient journey from pre-assessment to discharge and contained all the relevant risk assessments such as VTE, pressure ulcer, manual handling and screening for MRSA. In the 10 records we reviewed, we saw these risk assessments were completed for most patients.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly and at appropriate times. The WHO Surgical Safety Audit was completed on a regular basis and ten sets of patient records were sampled each time. Audit data for June 2016 showed 100% compliance.
- The audit calendar included monthly records audits. We reviewed audit data for the months of April to June 2016, which showed compliance of 99-100%.
- One of the conditions of practising privileges was the need for all consultants to be registered with the Information Commissioners Office. However, the hospital management team and consultants we spoke with during the inspection told us consultants did not take patient records off site.
- Once records were no longer required after the patient had been discharged, they were stored on site in a secure records office.

Safeguarding

- Staff were aware of their responsibilities to raise safeguarding concerns and there was a named safeguarding lead at the hospital. Staff we spoke with were clear about the escalation process and were able to access the safeguarding lead for advice and guidance.
- The mandatory training matrix required all clinical staff to complete Level 2 safeguarding for adults and children. We saw in data provided by the hospital that training rates for ward staff, nurses and healthcare assistants, was 100% for level 1 training for adults and children; level 2 training rates were 94% for adults and 88% for children for nurses and 67% for both for healthcare assistants. The target for all safeguarding training was 90%.
- Safeguarding training rates for theatre nursing staff were 100% for adult safeguarding level 1 and 93% for level 2. 93% and 80% of theatre nurses had completed level 1 and level 2children safeguarding respectively. Only 50% of operating department practitioners (ODP) had completed level 1 and 2 safeguarding training for adults and children.

Mandatory training

- Mandatory training was a mix of online and face to face training and covered topics such as infection prevention and control, manual handling and fire safety.
- Compliance with mandatory training had reached the 90% target for all modules relevant to staff except for IPC training, which was at 78%.Senior staff told us the mandatory training rates had dropped due to a recent change to include bank staff in the figures but they were closely monitoring training rates to ensure all staff were up to date.

Assessing and responding to patient risk

- The hospital had an admission policy clearly outlining the admission criteria. Staff we spoke with were aware of the admission criteria and told us only patients who the hospital could care for safely were admitted. Consultants used the American Society of Anaesthesiologists (ASA) physical status system to determine if it was safe for patients to undergo surgery at the hospital. The ASA system is a scale used to assess a patients level of risk prior to surgery based on pre-existing health conditions.
- The hospital used the National Early Warning Score (NEWS) system. We checked the NEWS charts of five patients and found that NEWS scores were fully completed and calculated accurately. All staff we spoke with demonstrated a good understanding of the system and knew when and how to escalate concerns.
- The hospital was part of the North West London Critical Care Network and staff were able to access courses through the network to enable them to identify deteriorating patients and those requiring transfer to a critical care unit.
- The five steps to safer surgery, as outlined by the National Patient Safety Agency (NPSA), were included in the theatre paperwork. We checked five records and

found the WHO checklist was fully completed in all five records. We also observed a surgical procedure and saw the five steps to safer surgery was fully embedded into practice by all staff involved.

- A safety huddle involving all members of the theatre team was carried out before each theatre list. We observed the safety huddle on one day of the inspection and found it to be well structured and enabled staff to have the necessary information to ensure patient safety.
- The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. Nursing staff were clear about how they would contact the RMO and felt they were very responsive.
- There was a clear procedure in place for escalating deteriorating patients and the RMO we spoke with was aware of this. They told us they would, in the first instance inform the consultant and anaesthetist and would follow their instruction in arranging the transfer of patients when required.
- There was an on-site blood fridge for use in an emergency situation and this fridge was monitored and stocked by an external blood products company under a service level agreement (SLA).
- Nursing staff contacted every patient by phone within 48 hours of discharge to ensure they were recovering well at home and discuss any concerns or questions patients might have. Staff told us that if they had concerns about the patients' recovery, such as increased pain or wound healing they would inform the consultant.
- The hospital only undertook cosmetic procedures under a SLA with a third party provider. Patients received consultations and aftercare through the third party and only attended the hospital on the day of their surgery. This meant staff at the hospital were unaware if patients had received the appropriate psychological assessments. However, staff we spoke with told us that if they had any concerns, they would highlight these to the consultant.
- VTE screening rates were 95% or higher during the reporting period. In the records we reviewed, we saw all patient had a completed VTE risk assessment, in line with the National Institute of Health and Care Excellence, standard QS3. There was one incidence of hospital acquired VTE during the reporting period.

Nursing and support staffing

- Senior staff used the corporate staffing tool to determine staffing levels and ensure adequate numbers and skill mix are present on each shift to meet the needs and acuity level of the patients on the ward. This was generally done 24 to 48 hours in advance and the actual hours worked by staff on the day were then recorded retrospectively on the tool to allow senior staff to understand variances. Staff told us managers always supported staff when requests for additional staffing were made to meet the needs of individual patients or during busy times.
- The theatre lists were finalised in advance and the theatre manager was therefore able to plan staffing according to the speciality and number of cases being carried out. Staffing in theatres was planned in line with the Association for Perioperative Practice (AfPP) guidelines.
- The senior management team also conducted an annual review of staffing levels using a well known Safer Nursing Care tool, taking into account wider staffing indicators such as sickness and turnover rates.
- Ward nurses met for a handover at the start of their shift, where all patients on the ward were discussed as well as new admissions for the day. We observed thorough and patient-centred handovers which took place in the patient's room. The RMO also joined the morning and evening handover when their workload allowed. However, staff did not use a standard handover sheet with information about reason for admission, medical history and plans for the day for each patient. Instead each staff wrote information from the verbal handover on a blank sheet. This could lead to some important information being missed and all staff not having the same information on their handover notes.
- Administrative assistants were employed in the operating theatre and on the ward to support nursing staff and enable them to concentrate on patient care.
- Data provided by the hospital showed there were 15.8 full time equivalent (FTE) nursing staff and 5.5 FTE healthcare assistants employed on the wards.

Good

Surgery

- The use of bank and agency nurses on the wards was similar to the average of other independent providers. Use of bank and agency healthcare assistants was rare and data showed this was lower than the average of other independent providers.
- Data provided by the hospital showed there were 13.6 FTE nursing staff and 8.0 FTE healthcare assistant in theatres as of July 2016.The use of bank and agency nurses in theatres was generally similar to the average of other independent providers we hold this type of data for during the reporting period. Use of bank and agency healthcare assistants was generally higher than the average of other independent providers we hold this type of data for during the reporting period. The theatre manager explained this was due to vacancies but they had recently appointed staff and therefore expected this number to decrease.
- There was one full time and one part-time physiotherapist employed at the hospital at the time of our inspection. Both physiotherapists had joined a few weeks before our inspection and were in their induction process. Prior to November 2016, physiotherapy service was being provided by locum staff.

Medical staffing

- Patient care was consultant led and the hospital's practising privilege agreement required that the consultant visited inpatients admitted under their care at least daily or more frequently according to clinical needs. We saw evidence of daily consultant review in the records we looked at.
- RMOs were provided to the hospital by an external agency and each RMO usually worked 24 hours a day for one week every month. There was four regular RMO working at the hospital at the time of our inspection.
- The RMO we spoke with during the inspection felt they were adequately supported by the consultant and nursing staff. They were encouraged to contact the consultant for advice and felt the consultants were supportive when they were contacted.
- Surgeons and anaesthetists were required to be within 30 minutes journey time of the hospital if they had patients under their care at the hospital. If, on occasions, this was not possible, they were required to nominate another named consultant (with practising privileges) to provide cover. Up to date contact numbers for consultants were available to nursing staff in wards and operating theatres.

Emergency awareness and training

- All staff received fire training as part of their mandatory training programme; staff told us they had the opportunity to rehearse scenarios and we saw evacuation equipment was available on the ward.
- The hospital had a business continuity plan detailing what to do in various situations that may affect the day to day running of the ward and theatres. Staff described a recent scenario when there was a power outage at the hospital and told us the business continuity plan was implemented successfully to minimise disruption to services.

Are surgery services effective?

Good

Evidence-based care and treatment

- Hospital policies were available on the intranet and staff we spoke with were aware of how to access these policies. We looked at a sample of policies and guidelines and saw these were up to date and referenced to current best practice from a combination of national and professional guidance such as the National Institute of Health and Care Excellence (NICE) and Royal College guidelines.
- The medical advisory committee (MAC) provided clinical scrutiny in relation to evidence based care and treatment. If consultants wanted to introduce new treatment methods or procedures, the evidence and guidelines for these procedures was reviewed by the MAC and approved if this was appropriate.
- We saw evidence the service was compliant with NICE guidance CG 74: Surgical site infections: prevention and treatment in the preoperative, intraoperative and postoperative phases of care.
- The Enhanced Recovery Programme was not embedded for joint replacement surgery, which was not in line with NICE and best practice guidance.

- The hospital participates in national audits including in Patient Reported Outcomes Measures (PROMS), the National Joint Registry (NJR), and Patient-Led Assessments of the Care Environment (PLACE).

Pain relief

- Pain relief for patients undergoing surgery was managed by the anaesthetist, who prescribed regular and 'as required' analgesia to be administered post-operatively. The RMO regularly reviewed the effectiveness of the pain medication being administered and was able to make changes as required. The pharmacy team were also available to provide advice with the prescribing of pain medications if required.
- Pain relief was discussed during pre-operative assessments and patients were provided with information about how to manage post-operative pain.
- Nursing staff assessed and recorded pain scores on the NEWS and we saw pain scores were consistently recorded in all the records we looked at.
- Patients we spoke with all told us they received analgesia regularly and felt their pain was well managed.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed on admission using the Malnutrition Universal Screening Tool (MUST). Patient highlighted as at risk of malnutrition were referred to a dietician. The dietician was based at the sister Aspen hospital but was available for advice and would travel to Highgate Hospital to review patients when required.
- Pre-assessment and ward nurses advised patients of fasting times before surgery and we observed this was in line with the Royal College of Anaesthetists (RCOA) guidelines.
- In the records we reviewed, we saw food and fluid balance charts were maintained when required.

Patient outcomes

- The hospital submitted data to the National Joint Registry for all orthopaedic joint replacement and patient related outcome measures (PROMs) was also collected. However, due to the small number of surgeries being performed, adjusted health gain could not be calculated to compare against national scores.
- Between July 2015 and June 2016, there were four cases of unplanned transfers of an inpatient to another hospital. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified. This number was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- There were seven cases of unplanned readmission within 28 days and 11 cases of unplanned returns to theatre during the reporting period. We reviewed information on these cases and noted reasons for readmissions and returns to theatre were justifiable and unforeseeable.
- The hospital continues to work closely with the 'Private Healthcare Information Network'(PHIN) to improve reporting of patient outcomes across the independent healthcare sector. The senior management team told us they anticipated the work being carried out by PHIN would enable the private sector to have better information transparency, such as that available in the NHS. This level of data would assist patients in making a choice of where to have their treatment.

Competent staff

- Applications for practising privileges were reviewed in the first instance by the hospital director and consultants were required to submit a number of supporting evidence. This was then reviewed by the MAC prior to agreement to grant practising privileges. During the reporting period of July 2015 and June 2016, one consultant was suspended and 40 had their practising privileges removed. The majority of these (21) were voluntary due to retirement and the other 19 was following MAC decision due to reasons such as failure to provide requested information (appraisal or indemnity insurance) or were under investigation by the NHS or GMC.
- There were 268 consultants with practising privileges at the hospital, of which 109 did not carry out any work at the hospital during the reporting period.

Good

Surgery

- 100% of inpatient nurses and healthcare assistant have had an appraisal completed in their appraisal year. All healthcare assistants and ODPs also had their appraisal completed but appraisal rate for theatre nurses were 90%. Consultants we spoke with confirmed their appraisal was carried out by their main NHS employer.
- Surgical staff, both in theatres and the ward, had specific competency documents and we saw evidence staff underwent training and competency based assessments prior to working independently.
- All new staff including agency staff were inducted into their area of work. We were shown completed induction checklists which outlined department orientation and familiarisation with specific policies.
- Staff told us they had access to a range of training from the Aspen group and they felt the opportunities for training had improved since the new hospital director had been in post. Senior staff had access to leadership training and all staff were encouraged and given the opportunity to develop in their role.

Multidisciplinary working

- There was good multi-disciplinary working between surgeons, anaesthetists and medical consultants when managing patients with co-morbidities pre and post-operatively. Staff gave us examples of post-operative patients being under the joint care of surgeon and medical consultants.
- Staff told us there were good multidisciplinary working relationships on wards and within theatres. Staff spoke positively about their colleagues. They told us that communication between pre-operative assessment and the ward was good.
- Physiotherapists received a daily handover from nursing staff .This included discussions about progress made by individual patients and discharge plans.
- Patients who required adaptive equipment or assistance with activities of daily living on discharge were referred to an occupational therapist. The occupational therapy service was provided by an external provider and staff reported patients were assessed promptly, once referred.

Seven-day services

- The RMOs were available on site 24 hour per day, seven days per week. Consultant reviewed their patients daily and we saw evidence of this when looking at patient records. When consultants were on leave, they arranged for another consultant (also with practising privileges at the hospital) to review their patients and the ward nurses were informed of this arrangement in advance.
- Patients received physiotherapy seven days a week. The physiotherapy input at weekend was usually provided by agency physiotherapy staff.
- There was no onsite pharmacist out of hours and at weekends, but there were specified secure arrangements for staff to gain emergency access to the pharmacy during these times.

Access to information

- Staff were able to access hospital policies and procedures via the intranet. Staff told us there were sufficient numbers of computers on wards and in theatres to allow them to do so.
- Patient records were stored on site and staff were therefore able to access records at any time. Staff we spoke with told us they would access the medical records to retrieve notes in cases such as a re-admission or if the patient contacted the ward with concerns.
- Staff told us information was usually cascaded via emails, hospital and corporate newsletter as well as through team meetings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had received training and were aware of Deprivation of Liberty Safeguards (DoLS) principles and the Mental Capacity Act (2005). However, staff explained they rarely cared for patient with cognitive impairment so DOLS application was not something they had experience of.
- We saw consent forms were competed in all the records we reviewed. Consent forms fully described the procedure completed as well as risks associated with it and full signatures from the consenting clinician and patient. Consent forms were completed and signed on the day of the procedure but consultants told us that

the informed consent procedure began in outpatient consultations, with information regarding the risks, benefits and possible outcomes being provided at this time.

Are surgery services caring?

Good

Compassionate care

- Patients were treated with dignity and respect by all staff at the hospital, including nursing staff, housekeeping staff and porters. They were greeted warmly by staff on the reception desk.
- We saw staff interacting with patients in a caring, kind and compassionate way in each of the areas we inspected. Patients told us staff were excellent and provided a good level of care.
- We received 36 comments card from patients and these were all generally positive. Comments included'' the service and treatment I received was first class. I would highly recommend this hospital", ''kind and caring staff'', "fabulous staff with good knowledge, caring and compassionate''.
- The hospital participated in the Friends and Family Test (FFT) survey. We looked FFT data for the period of January to June 2016 and 95-99% of patients would recommend this hospital to their friends and family. Response rates varied month to month but they were generally higher than the England average for independent health hospitals.

Understanding and involvement of patients and those close to them

- Patients told us staff kept them well-informed. They were given opportunities to ask questions about their care and treatment both as inpatients and during pre-operative assessments.
- Patients were provided with information about post-operative care during pre-operative consultations and during their inpatient care to ensure they knew what to expect post-operatively.
- Relatives were actively encouraged to be involved in the treatment and discharge plans where appropriate and were able to speak to a doctor when needed.
- All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharged home.
- All patient we spoke with felt they had been involved in their care from the start. One patient told us the ''procedure was clearly explained '' and they were encouraged to ask questions.

Emotional support

- Patients we spoke with informed us staff were supportive and reassuring and gave them and their family the reassurance to ease their anxiety before and after their procedure.
- The hospital offered reconstructive surgery for andrology patients and staff we spoke were very aware that these patients required emotional support through this process. However, staff told us that although these patients would have undergone extensive psychological assessment prior to their operation, the hospital staff did not have contact details of their psychology team. If staff had concerns about the patient coping emotionally on discharge, they would get in contact with the patient's GP or advise the patient to contact their andrology service for support. Staff also did not have contact details of any voluntary organisation offering support to this group of patients.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- All surgical interventions were elective and so service planning was generally straightforward. The operating lists were planned in advance by the hospital reservations and contracts department.
- Patients were a mixture of NHS patients referred through the NHS Choose and Book system or local contracts and private patients referred via their GP or self-referred.

Good

Surgery

- The surgical service's four theatres and one endoscopy suite were not running at full capacity so we saw that there was space for flexibility and for a greater number of procedures which was the plan for the service.
- Prior to introducing new surgical service lines, the hospital carried out quality impact assessments to understand how the change would affect the quality of service provided and ensure they had the necessary equipment and expertise.
- The hospital senior management team understood the local population and had good links with local commissioners. This meant they were able to plan delivery of services to meet the needs of the local population.
- We saw the hospital had recently invested in a fourth modern theatre with laminar flow in order to increase the range of orthopaedic services offered.

Access and flow

- Data provided by the hospital for the period of July 2015 to June 2016 showed that 19 out of 7,067 procedures in the reporting period were cancelled for non-clinical reasons. The reasons for cancellations included unavailability of equipment, a power outage and late arrival of a consultant due to the overrunning of an NHS list. All of those patients with cancelled appointments were offered another appointment within 28 days.
- Once a decision to operate was made, private patients agreed the timing of surgery directly with their consultant who then booked a slot in theatre. NHS patients were referred through the Choose and Book system. The reservation and contracts team based at the hospital liaised with the patient and the relevant commissioning team to book and arrange a date.
- The referral to treatment time (RTT) target was not met consistently during the reporting period. Less than 90% of patients were admitted for treatment within 18 weeks of referral from September 2015 to November 2015 and in January 2016. We were told by the provider that RTT during this period was delayed by the timeframe for the local clinical commissioning group to release funding and patients being referred late. Since March 2016 the RTT target was consistently met for 100% of patients.
- All patients were admitted on the morning of their surgery and were allocated a room prior to going to theatre. This meant there were no delays in discharging patients from the recovery area back to the ward.
- The hospital was able to assess patients' needs at the pre-assessment stage of the care pathway which meant that the hospital was able to control the level of care given and plan the service to meet patients' needs.
- The Aspen standard operating procedure contained clear admission and exclusion criteria. All patients, except those attending for pain management interventions, underwent a pre-operative assessment with the nurse. When indicated, a pre-operative anaesthetic assessment was also available.
- Discharge planning started at the pre-assessment stage and patients' post-discharge needs were assessed and planned for. Patients were given information about their discharge medication, their follow up appointments and wound care. This information was all placed in a newly introduced bag, along with their take home medication, to ensure patients did not mislay anything.
- Discharge summaries and a list of take home medication were sent to each patient's GP on discharge.

Meeting people's individual needs

- All patients had individual rooms, which facilitated the privacy of patients, with fully accessible en suite bathroom facilities. We saw evidence in patient notes that staff carried out intentional rounding which meant that patients were visited hourly to check pain levels, provide refreshment and deal with any other requirements. Patients we spoke with confirmed that they were visited often by staff who were attentive to their needs.
- During our inspection we observed call bells being answered promptly and that staff were attentive to patients' needs.
- In theatres, windows to operating and anaesthetic rooms were tinted to maintain the privacy and dignity of patients.

Good

Surgery

- All patients were offered food and drink choices from a menu, patients we spoke with were happy with the quality and variety of food on offer. Special dietary requirements such as Halal or Kosher were catered for by external providers with a dedicated delivery service.
- Staff had access to language line to facilitate communication with patients who did not speak English and we observed a nurse arranging the service in advance of a patient's appointment. We also observed a nurse informing a consultant that language line would be required for the consenting process on the morning of surgery.
- The hospital did not often admit patients with a learning disability. Staff we spoke with said that their needs would be identified at pre-assessment. No staff could recall treating a patient with a learning disability.
- Staff we spoke with told us that there had been no patients living with dementia admitted to the hospital during the reporting period. All staff received dementia awareness training at induction and then every three years and evidence provided by the hospital showed that all staff were up to date with this training. In the recent PLACE audit, the hospital scored 88% for dementia against a national average of 80%.

Learning from complaints and concerns

- The hospital had a corporate policy for handling complaints and concerns. Staff we spoke with were able to tell us about how complaints would be received and escalated to appropriate senior staff. Policy stated that complaints must be responded to in writing within 20 working days of receipt. Where this time frame was not possible the hospital contacted patients to explain and agree a new time frame.
- Data provided by the hospital showed that there were 66 complaints between July 2015 and June 2016. This was an increased number compared to the previous two years. However, the rate of complaints based on the number of inpatient and day case attendances was similar to other independent providers we hold this type of data for.
- The hospital director was responsible for the management of the complaints process, with input from the senior management team and heads of departments. Complaints were discussed at the weekly senior management meeting and were also a standing agenda item at the bi-monthly heads of department meeting. Heads of departments were responsible for implementing actions plans and sharing learning from complaints with the whole team.
- All patients were given information on how to raise a concern and the complaints procedure was part of their pre-admission information pack. Patients information folders located in each room also encouraged patient to raise any concerns with the ward staff and referred to the information already provided about the complaints procedure. Senior staff and the management team were available to speak to patients if they raised a concern.
- We reviewed one complaint from January 2016 where a patient's discharge did not follow the standard pathway. The investigation report included details of the involvement and support of the patient affected, detailed findings including contributory factors, root causes, conclusions and recommendations for the future.
- The senior management team also told us during the inspection that they often invited patients to meet with the management team and discuss complaints and what actions the hospital was taking as a result. This was seen as a powerful learning experience and reassured patients their concerns were taken seriously.

Are surgery services well-led?

Outstanding ☆

Vision and strategy for this this core service

- The hospital's mission statement is: "to provide first-class independent healthcare for the local community in a safe, comfortable and welcoming environment, one in which we would be happy to treat our own families".
- Five organisational values underpinned the mission statement.These were developed with staff from across Aspen Healthcare Group. The values were: beyond compliance, personalised attention, partnership and

teamwork, investing in excellence and always with integrity. As part of the induction process, new team members attended a 'values workshop' to ensure they understood the importance and meaning of the values.

- In addition to the organisational values, the hospital had recently launched the local vision called 'Highgate Jigsaw', which is a vision of 'outstanding healthcare'. The Highgate Jigsaw represents a picture where every member of staff has a role to play in achieving outstanding care. This vision was aligned to the CQC's five domains: safe, effective, caring, responsive and well led.
- The hospital had a three year quality strategy plan aligned to the five organisational values.This strategy was embedded in the hospital's quality governance activities with ongoing evaluation through the quality governance dashboard.
- The hospital's quality priorities had been identified for 2016/17 financial year and these were grouped into three areas: patient safety, clinical effectiveness and patient experience. The priorities were focused on ensuring that the care and services were safe, reliable, and clinically effective and of high quality.
- There were clear business growth and efficiency objectives set for 2017 which included: clinical recruitment and retention strategy, JAG accreditation, opening of level 2 high dependency unit (HDU), improved day patient flow, theatre reconfiguration and space utilisation review. We saw that the hospital had a clear, achievable strategy which challenged management and staff to deliver high quality care.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The hospital had a clear and robust governance structure, which was in line with the corporate governance framework. Governance focused on improving patient safety, learning from patients' experience, improving clinical effectiveness and patient experience.
- The hospital had a comprehensive quality governance (QG) framework underpinned by nine quality drivers, which were: clinical safety, risk management, clinical effectiveness, staff development and management, safety and quality focused culture, governance, patient focus, quality information and audit, and regulatory compliance and accreditation. The framework was dynamic and reviewed at least annually to reflect lessons learned and respond to new initiatives.
- The QG dashboard had 70 key performance indicators (KPIs) mapped against the nine quality drivers. The QG dashboard was discussed at the quarterly QG committee meetings attended by clinical and non-clinical representatives from each hospital area. The dashboard was also reviewed at the core group QG meetings attended by the senior management team that took place during the interim months. The QG was the key driver in supporting the hospital's business objectives in the provision of safe, high quality and cost effective care and treatment.
- The hospital staff attended a variety of committees including quality governance, health and safety, infection prevention and control, and medical advisory committees. The committees comprised of senior staff who met quarterly to discuss a range of clinical and non-clinical issues such as patient safety, patient experience, audit results, compliance, action plans, risks, education and training, and policies amongst others. Feedback from hospital-wide meetings was shared with ward and frontline staff.
- The MAC membership was made up of the MAC chair, hospital senior management team and at least one representative for orthopaedics, colorectal, plastic surgery, endoscopy, andrology, anaesthetics, radiology and GP. Representatives were meant to contact their relevant colleagues to disseminate information discussed during a MAC meeting.
- The MAC held quarterly meetings and used a set agenda which included the following topics: review of new practising privileges applications, new procedure applications (to check if the consultant had the expertise), new policies and guidance, incidents, complaints, risk register and national safety alerts amongst others. We reviewed the meeting minutes between October 2015 and August 2016 which focused on good practice, risks and patient safety. We saw that identified actions were recorded and reviewed at each meeting.

- The MAC chair met with the hospital director each month to discuss any clinical and non-clinical issues.
- Staff we spoke with knew what the local risks were and these were listed on the local risk register. The hospital used a risk register module to record, monitor and control risks. We saw evidence risks were discussed and reviewed at quality governance, MAC and heads of department meetings. Each risk had a review date, target completion date and controls in place to prevent adverse events from happening. All risks considered as high were escalated to the Aspen's CEO and reviewed at the corporate quarterly group committee and the quality board.
- The hospital had a system for checking that consultants with approved practising privileges underwent the appropriate checks when working at the hospital. However, when we reviewed a sample of 20 active consultant files (approximately 10%) we saw some gaps in the documentation. Five doctors did not have evidence of the Information Commissioner's Office (ICO) registration, two doctors did not have an up to date Disclosure and Barring Service (DBS) check, one doctor did not have an evidence of a GMC registration, and one doctor was missing a proof of ID. We flagged this issue with the hospital director and a corrective action was taken immediately, including change to the process to ensure there were no other gaps in the consultants' files.
- We reviewed heads of department (HoD), ward, and theatre team meeting minutes, which had structured agendas and were well attended. The HoD met bi-monthly where each representative gave an update on their department and identified new risks. Ward and theatre staff met monthly and focused on operational issues, incidents, patient satisfaction, audits, and training and development.
- The hospital run daily operational safety meetings which aimed to enhances communications between all departments and staff (clinical and non-clinical), and drive continuous improvement.
- Aspen Healthcare Group is a member of the Association of Independent Healthcare Organisations (AIHO) Cosmetic Surgery Forum and a founding member of the Private Healthcare Information Network (PHIN). PHIN was established in 2012 to provide patients with straightforward, easy-to-understand information about the quality and safety of care in the private healthcare sector. The hospital submitted all required data by September 2016, including patient satisfaction, activity data, adverse events, and private PROMS data, to help patients make informed choices

Leadership / culture of service related to this core service

- There was effective and responsive leadership at the local executive level and staff talked positively about the hospital director and other senior leaders. Staff told us senior managers were very visible and approachable. The senior management team did daily walkabouts where they talked with patients, staff and observed clinical practice. We saw the hospital director knew staff at different levels by their first name. All staff we spoke with felt valued and said their line managers were supportive and approachable.
- Management of senior clinical staff was robust and ensured that quality of care and patient safety were central to service planning and delivery.
- All staff we met were welcoming, helpful and friendly. Many staff had worked at the hospital for a number of years, which demonstrated their job satisfaction. They told us they were happy and proud to work for the service and spoke highly of the hospital culture. We observed positive interaction between staff at all levels.
- Senior staff told us they promote culture of openness by speaking with staff and empowering them to challenge others should they have any concerns. Senior staff told us they encourage their staff to report incidents or errors without being blamed, and to learn from the subsequent investigations.

Public and staff engagement (local and service level if this is the main core service)

- The hospital carried out an annual staff survey. Following the 2015 survey a working group was formed to focus on improving satisfaction levels for internal communication and staff recognition. We saw a post-survey plan, which resulted in a number of initiatives being implemented. This included the employee of the month award where every month a clinical and non-clinical employee of the month was recognised with nominations from staff and patients where they witness someone 'going the extra mile'.

- The hospital had a monthly staff recognition scheme where clinical and non-clinical staff mentioned by patients in patients' feedback were acknowledged and commended.
- The hospital director held a monthly employee forum where all staff were invited and encouraged to attend. The forum offered an opportunity to receive an update about the hospital, ask any question and provide suggestions. Staff we spoke with told us they had attended this forum and found it to be very useful. One member of staff gave an example where she had brought up a specific issue at the forum and the hospital director had taken remedial action and personally informed her of the change implemented.
- Senior management held regular staff meetings to inform staff of developments and provide an opportunity to hear their views.
- The hospital carried out a monthly patient satisfaction survey, which focused on all aspects of patient care and treatment; from admission, consultation, nursing care to questions about the environment, catering and discharge. Senior management team regularly assessed and monitored the results so any issues and themes could be addressed in a timely manner. Additionally, every quarter the results were compared to previous months and benchmarked against other Aspen group hospitals. The results were discussed at the governance meetings and patient focus panel. The patient satisfaction results were shared with all heads of department who then share them with their teams.
- Senior management told us they also monitored social media and patient forum websites as these offered an additional important mechanism to obtain feedback on the care they provided.
- Staff told us about improvements that were introduced following patient feedback such as streamlining the discharge process to make it simpler and more efficient, improving Wi-Fi access, or improving catering.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- To improve communication between the MAC and staff the hospital introduced the MAC newsletter. This was distributed electronically to consultants and hard copies were available in consulting rooms, wards and theatres.
- The hospital was actively working towards Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated certain quality assurance standards.Staff told us the endoscopy service had achieved the required Global Rating Score which allowed them to formally apply for the accreditation.
- Recently, the hospital had launched a 'Step-up to Safety' programme, an acronym which stands for 'spot', 'talk', 'examine' and 'prevent'. The campaign aimed to improve patients' safety by making staff appreciate the impact their work has on safety and better their understanding of the contributing factors to patient incidents.
- The hospital staff received a quarterly Patient Safety newsletter, which was another avenue to focus staff on a variety of safety topics. We reviewed three editions of the newsletter, which covered the following topics: Sepsis 6, medicines and allergies, learnings from never events from across Aspen Group, incident reporting, near misses, patient safety training, infection prevention and control, and root cause analysis (RCA) investigation amongst others.
- In 2014 and 2016 the hospital carried out a survey on patient safety designed to provide an understanding of the hospital's strengths and weaknesses as perceived by staff. The responses were also compared to other hospitals within the Aspen group. The survey focused on variety of safety aspects such as reporting incidents, openness, access to patient records, staffing, management support, non-punitive response, organisational learning, teamwork amongst others.
- The hospital launched a 'Speak Up campaign to reinforce best practice in whistleblowing process amongst staff.
- The MAC members attended a patient safety weekend, which focused on supporting the MAC's commitment to safety and hospital governance.
- In 2015 the hospital achieved accreditation with the Association for Peri-Operative Practice (AfPP) for standards in the operating theatres.
- Staff were given the opportunity to develop through a comprehensive training programme offered through the

Good

Surgery

'Investing in You' programme and Aspen Values training. To ensure staff had the opportunity to undertake continuous professional development they had protected training time.

- The hospital achieved Worldhost© customer care recognition status (the same customer care training the London 2012 Olympics Game Makers received) which has resulted in excellent patient satisfaction as measured through satisfaction surveys.

Good

Outpatients and diagnostic imaging

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

Information about the service

Highgate Private Hospital, part of the Aspen Healthcare Group, is a private hospital located in Highgate, North London. The hospital provides a range of services including outpatient consultations, private GP services and diagnostic imaging services. Services are provided to insured, self-paying private patients and NHS patients via referrals from GPs, consultants and local contract systems.

The outpatient and diagnostic imaging services at Highgate Private hospital were located on the first and second floor of the hospital. There were eleven general consulting rooms, a minor surgery room for procedures requiring local anaesthetic only and a phlebotomy room. There were further three GP consulting rooms on the second floor. There were a total of 31,729 outpatient appointments between July 2015 and June 2016. Of these appointments, 35% were NHS funded and 65% were other funded.

The hospital ran a wide range of outpatient clinics including, cosmetics, cardiology, gastroenterology, orthopaedics, sport medicine, general surgery, pain management and rheumatology. The outpatients and diagnostic imaging departments were usually open 8am-8.30pm Monday to Thursday, 8am-7.30pm on a Friday. However, the departments offered more flexible times if the patients requested them.

The outpatient department was managed by the outpatient manager who was new into post. Diagnostic imaging had a vacancy for a service manager. There was a hospital group diagnostic lead in post.

The diagnostic imaging department performed scans and x-rays using a variety of equipment including Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), ultrasound, x-ray and interventional radiography.

During our inspection, a team of inspectors and specialist advisors visited the main outpatients and diagnostic imaging department.

We spoke with six patients and relatives. We also spoke with members of staff including managers, reception and booking staff, nurses of all grades, radiographers, healthcare assistants, doctors and consultants. We observed care in outpatient clinics and in radiology procedures. We received comments from staff focus group events and from patients directly. We also reviewed the systems and management of the departments including the quality and performance information and reviewed five sets of patient records.

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There were no 'never events' reported for outpatients and diagnostic imaging between June 2015 and July 2016. 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.

Good

Outpatients and diagnostic imaging

- No serious incidents involving outpatients or diagnostics had been reported between June 2015 and July 2016. The hospital incident log from the same time period showed outpatients and diagnostic imaging services had reported 62 non-clinical and 28 clinical incidents. Staff told us there was an open culture for reporting and they felt confident to report.
- Incidents were reported using the hospital electronic incident reporting system. Staff received feedback at the daily safety briefings and in departmental meetings.
- We saw that incidents had been investigated and root cause analysis had been completed to identify the causes of the incidents. We saw how practices had been changed in the outpatients department to rearrange the clinic days and times for specific consultants that had been identified as running late clinics through the incident reporting system.
- The hospital had processes in place to report any radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). At the time of the inspection, there were no open cases with the CQC. The diagnostic imaging department staff explained how an incident involving equipment breakdown had been reported and appropriately investigated. The contracted radiation protection service regarded the incident as not requiring any further action.
- Staff demonstrated their understanding of the principles related to the duty of candour and their obligations. 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' andprovide reasonable support to that person. All staff we spoke with confirmed they apologised to patients when care was not as it should have been.

Cleanliness, infection control and hygiene

- On visual inspection, all areas we visited in outpatients and diagnostics appeared clean and tidy, including the toilets and changing rooms. Posters prompting hand hygiene were clearly displayed and hand gel pumps were available across the areas. We observed staff using them during our observation in the main outpatient waiting area.
- We observed all staff adhered to the 'bare below the elbow' guidance and staff wore personal protective equipment (PPE) where necessary. Staff demonstrated appropriate hand washing technique in line with the 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines. This reduced the risk of infections to staff and patients and was in line with good practice. We looked at the hand hygiene audit for July 2016. This showed 95% compliance with hand washing requirements.
- The hospital had an infection and prevention control committee which met quarterly to discuss measures needed to mitigate the risks of any infection. There was an infection control link nurse in outpatients and diagnostic imaging. They attended relevant meetings and fed back to the teams.
- Infection prevention and control policies were available for staff to access on the hospital intranet.
- The outpatients department audited the area on a monthly basis. We saw action plans were put in place if any compliance levels fell below 80% and extra training for staff was given.
- Mandatory training was recorded in September 2016 as 100% for infection and prevention control for outpatient nurses, healthcare assistants and allied health professionals.
- There were a sufficient number of handwashing sinks available. Soap and disposable hand towels were available next to the sinks.
- The consulting rooms were part carpeted and did not have any coving along the skirting board. This did not meet infection control guidelines HBN 00/10 (part A) and HBN 00/09. We spoke with senior staff who were aware of the need to replace the carpet as soon as possible. This was added to the hospital risk register during our inspection.
- All soft furnishings were wipeable and in good condition. This was in line with HBN 00/09 and the section referring to soft furnishings.
- Outpatients used an established wipe system for decontaminating scopes. Although this was good

practice, the process did not include testing the scopes for any retained fluids. This was brought to the attention of senior staff to improve practice. There was a separate clean and dirty utility space.

- We observed waste streaming was in place with the use of hazardous waste bins and recycling bins. We found the temporary closure on sharps bins was in use. However, the minor surgery room did not have any infectious waste bins which did not comply with the Department of Health (DoH) Technical Memorandum (HTM) 07-01, control of substances hazardous to health and the Health and Safety at Work regulations. This was rectified during the inspection and the correct waste streaming process put in place.
- We saw departmental cleaning schedules in outpatients and diagnostic imaging that were completed and up to date. We also saw the use of 'I am clean' stickers on equipment throughout outpatients and diagnostic imaging.
- We saw water was tested and reported to the health and safety committee. This complied with the water safety management regime HTM 04-01.

Environment and equipment

- The consultation rooms were all well-equipped including treatment couch and trolley for carrying the clinical equipment required.
- There was resuscitation equipment available shared across outpatients and diagnostics. We looked at the resuscitation trolley checklists and found them to be checked and signed on a daily basis. There was paediatric emergency equipment available in the GP consulting rooms.
- There was adequate seating and space in outpatients and diagnostic imaging. Outpatient clinics were spread over two floors but could be accessed by stairs or a lift.
- There were no bariatric chairs or high rise chairs suitable for orthopaedic patients available in the outpatient or diagnostic imaging areas.
- X-ray equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturers completed service reports. We also saw evidence of routine surveys of all X-ray equipment and documentation to indicate staff were competent to use the equipment.
- The imaging service had arrangements in place to control and restrict access to ionising and non-ionising radiation areas including warning lights and key pad access to some of the rooms.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.
- Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from any obstructions.

Medicines

- There was an Aspen Healthcare wide medicines management policy in place reviewed in March 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.
- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation. Cupboards containing substances hazardous to health were also locked. Only authorised staff had access to keys for the medicines cupboard.
- Diagnostic imaging kept their medicines in a locked cupboard and had a separate anaphylaxis drug kit to deal with life threatening allergic reactions requiring immediate treatment.
- There were no controlled drugs (CDs) kept or administered in the outpatient or diagnostic imaging departments.
- Medicines management regulations state minimum and maximum temperatures of locked medicine refrigerators and ambient room temperatures. Fridge temperatures were checked and recorded daily and were within the required range to store medicines safely.

Good

Outpatients and diagnostic imaging

- There was a safe and secure process in place for the management of prescription pads. We saw the pads were stored securely in locked cupboards and drawers and a system in place to record and log the usage of the prescription pads by specific clinicians. This meant there was information available to identify the serial numbers of the prescription sheet used, the patient prescribed to or the doctor prescribing. This met best practice guidelines for the use of controlled drug stationary.
- Staff were aware of the policies involving medicines management and knew where they were located in the department and on the staff intranet.
- Emergency drugs were kept on the shared resuscitation trolley and checked daily.

Records

- Records for outpatients were stored securely in the medical records department. Private patient notes were stored in outpatients in a locked cupboard. The notes were available for clinics and then taken back to medical records or the outpatient storage location. These locations were safe and secure and could only be accessed by authorised staff.
- Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins.
- Staff told us records were always available for clinics. Private patient notes were kept on site. A project to compile a comprehensive set of notes for private patients was due to start in January 2017. Staff told us they would then also be stored in medical records when not in use in clinics.
- Consultants had to comply with data protection regulations if notes were to be taken off site but staff told us this would not happen as was against the hospital's policy.
- All imaging, histology and blood results were available electronically.
- The hospital used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- We saw that the radiographers had completed their records accurately by checking patient identification and recording patient dose information.
- We also saw evidence that the radiographers had checked and documented patient pregnancy status in line with departmental protocol.

Safeguarding

- From 1 November 2016, the hospital no longer provided any outpatient or diagnostic imaging services to children under the age of 16. This was to be extended to no children under the age of 18 from 1 January 2017. There was a group children's strategy in place overseen by the Clinical Development Lead who was a specialist in children's care.
- The GP service was available to children. We spoke with staff in the service and they were trained to the appropriate level and had had a good understanding of the policies and procedures to follow for both children and adults' safeguarding.
- The safeguarding training across the hospital met the requirements of the Intercollegiate Document 2014. Safeguarding Level 3 was held by the Director of Nursing and the Nursing Services Manager. We discussed with senior staff the links with the Local Safeguarding Board at Haringey. Local Safeguarding Board contact details were in place in the outpatients and diagnostic imaging departments to ensure that staff could access immediate contact to an expert at the Local Safeguarding Board for support and advice if required.
- We saw policies were in place and in date for both safeguarding children and adults.
- All of the staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed. Diagnostic imaging staff were 100% compliant with their safeguarding training in both levels 1 and 2.
- The hospital had an up to date chaperoning policy. Staff were available for any patient requiring chaperoning. The GP service told us it was never a problem to have a chaperone from outpatients if required.

Mandatory training

Good

Outpatients and diagnostic imaging

- Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good. We saw the hospital had a comprehensive training matrix in place to outline the type and frequency of the course staff were required to undertake.
- Training was automatically monitored online and staff received reminders when a module was due for completion. Managers told us they regularly reviewed the staff's compliance with mandatory training. Compliance rates were at 100% for outpatient nurses and healthcare assistants for the majority of modules. The compliance rate for outpatient nurses in the adult safeguarding module was 84%.

Nursing staffing

- There were dedicated nursing and healthcare assistant staff across the outpatients department and radiographers within diagnostic imaging.
- The staffing in outpatients consisted of the senior lead, 6 whole time equivalent (WTE) registered nurses and 6 WTE healthcare assistants. There were currently vacancies in the registered staff establishment. These posts had been recruited to but not yet started. Some staff told us they felt the staffing levels were low and that there was a high turnover of staff.
- There were no agency nurses working in the outpatient departments in the last three months of the reporting period (April to June 2016) or on the day of the inspection.
- There was a vacancy for an imaging manager within the diagnostic imaging department. Staff told us this was due to go out to advert shortly. We noted support had been given from the group imaging lead during the inspection.
- Arrangements for handovers and shift changes in outpatients and diagnostic imaging ensured patients were safe by ensuring enough staff were available at the right time.

Medical staffing

- Consultants who held clinics were responsible for the care of their patients. Secretaries organised the clinic lists around consultant availability.
- The GP service was staffed by four GPs working different sessions to cover the Monday-Saturday service.
- There were 268 consultants recorded as having practising privileges at the hospital. Of this number, 25% worked regularly at the hospital undertaking a 100 or more consultations from July 2015 to June 2016. A further 26% of consultants undertook between 10 and 99 consultations in the same time period.
- A new Standard Operating Procedure was in place to keep a record of consultants who did not start their clinics within 60 minutes of the scheduled time. This was then reported as an incident.
- There was a medical advisory committee (MAC) responsible for consultant engagement. For a consultant to maintain their practising privileges at the hospital there were minimum data requirements with which a consultant must comply. These included registration with the General Medical Council (GMC), evidence of insurance and a current performance appraisal or revalidation certificate. In speaking with staff we were assured this process was followed.
- Consultant radiologists were not always on site but there was a process for cover in order to access support and advice. We spoke with a radiologist who felt the hospital was a great place to work and they were well supported.

Emergency awareness and training

- The hospital had a business continuity plan in place but had not yet been updated. The review date was September 2016. This covered the steps to take in the case of, for instance a fire or flood.
- Staff in both outpatients and diagnostic imaging were aware of the plan and how to locate it on the electronic system.
- Staff understood what actions to take in response to an emergency.
- Staff told us there was regular testing of fire alarms and they knew where the fire assembly point was and how to evacuate the patients and staff within their immediate areas.

Good

Outpatients and diagnostic imaging

- We saw the hospital had a back-up generator and this had been serviced and tested regularly.

Are outpatients and diagnostic imaging services effective?

Good

Evidence-based care and treatment

- Clinical staff knew of and used the relevant NICE guidelines relevant for their departments. These guidelines could be accessed easily through the intranet. A central team within the organisation supported the hospital to remain updated and informed the hospital of any changes to guidance. Staff told us these were discussed at the governance and risk meetings for sharing further with staff.
- Both outpatients and diagnostic imaging undertook clinical and non-clinical audits. The radiologists peer reviewed their reports on a regular basis. Radiographers undertook a monthly analysis of their rejected films with reasons recorded. Any trends identified were used as a learning opportunity to improve future practice.
- The Radiation Protection Advisor (RPA) recommended an audit in theatre to measure the radiation doses and screening times. We saw the data was recorded on the PACS system for further review.
- The interventional radiology checklist adopted from the World Health Organization (WHO) surgical checklist was used within interventional radiography. We saw evidence from audits of 100% compliance with the use of the checklist.
- There was a radiation protection advisor (RPA) and radiation protection supervisor (RPS) for the diagnostic imaging department. They had been appropriately trained and their roles met the Ionising Radiation (Medical Exposure) Regulations (IRMER)
- We looked at the latest RPA report from December 2015. It stated that the employer's procedures and associated protocols and records relating to IRMER were well presented and formed a comprehensive set of documents. The RPS told us these were reviewed annually. We looked at the policies and procedures and saw they were up to date and all staff had signed to say they had read them. Compliance with the regulations was demonstrated to be at a very high level.
- There were risk assessments in place for all imaging equipment and diagnostic reference levels for optimum patient radiation doses had been set for staff reference and audit purposes.
- The diagnostic imaging department referred to national diagnostic reference levels (DRLs) within their service.We saw DRLs displayed in all areas visited. DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses however, they can be used as a signpost to indicate to staff when equipment is not operating correctly. We saw the annual radiation protection report which had made some recommendations. These had all been implemented.
- We observed staff confirming the correct identification of patients before proceeding with the x-rays and there was documented evidence of quality assurance tests on the equipment.
- There was a range of standard operating procedures (SOP) within outpatients. Any new SOPs were cascaded to all staff for reading and signing.

Pain relief

- Consultants discussed pain management within the consultation process for patients who were going to be booked for a surgical procedure.
- The Resident Medical Officer was also available in the event of a patient requiring a review of their pain management.
- A range of over the counter medications were available from the pharmacy.

Patient outcomes

- Outpatients and diagnostic imaging followed the hospital Did Not Attend policy and records were updated accordingly.

Good

Outpatients and diagnostic imaging

- We saw examples of radiology outcomes listed in electronic records such as treatment times and radiation doses.
- There was a good range of local audits and initiatives within the diagnostic imaging and outpatient department generally to monitor and report on patient outcomes. This included a radiographer led film audit to review quality and reject rates.
- We looked at the audit schedule for 2016 which covered audits such as resuscitation equipment, record keeping and medicines management.

Competent staff

- Most employees had the necessary pre-employment checks completed prior to commencing work. This included Disclosure and Barring Service (DBS) checks, references, qualification verification and formal interview.
- The NHS National Skills Academy provided a comprehensive suite of e-learning modules and this was complemented by the development programme 'Investing in You'.
- We saw all outpatient and diagnostic imaging staff had their appraisals completed in the current year to date (Jan 16 to Dec 16). Staff told us the regular appraisal and six-monthly reviews allowed the hospital to identify and monitor personal development. Staff told us the opportunities for development were excellent.
- All new staff had a thorough induction programme. We saw examples of this in the staff files.
- Staff had training in dementia care and some of the staff we spoke with were dementia champions for the hospital. Although staff told us they did not see many patients with dementia, they found the training very helpful to understand the needs of those patients with dementia and their carers.
- We saw evidence that nurses, radiographers and others had appropriate skills, knowledge and experience to carry out their roles effectively. We looked at competency check lists and saw these were completed and signed.
- Staff administering radiation were appropriately trained to do so. We spoke with the radiology staff who showed us records demonstrating their compliance with the IRMER regulations.

Multidisciplinary working

- Many meetings were multidisciplinary in the hospital. This allowed multi-disciplinary input from nursing, medical and diagnostic staff. There was evidence of collaboration across different services with outpatients and diagnostic imaging. Staff told us consultants were approachable and always willing to give help and advice.
- We heard positive feedback from staff of all grades about the excellent teamwork.

Access to information

- All staff we spoke with told us and we saw that they had access to hospital policies and procedures on the intranet. Overall staff were positive about the electronic access and felt they were always updated on relevant information via email and meetings.
- No patients were seen in outpatients without a paper or electronic record being available.
- We were told that no consultants took the notes off site. It is a requirement of their practising privileges that they register as a data controller with the Information Commissioner's Office if this practice were to happen. We saw this information was held on the consultant's file and checked regularly to ensure compliance with this requirement.
- Access to blood test results and imaging was provided electronically.
- The hospital used a radiology information system and picture archiving and communication system (PACS). This meant patients' radiological images and records were stored securely and access was password protected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent documented in the medical records. We saw forms in the consultation rooms but did not directly observe consent being taken in outpatients.

Good

Outpatients and diagnostic imaging

- Verbal consent was observed in the X-ray room. The consent process included a discussion of the risks to the patient and an opportunity for the patient to ask further questions.
- The provider had a policy in place to guide staff in the correct use and interpretation of the Mental Capacity Act 2005 (MCA). The majority of staff demonstrated an awareness of their duties and responsibilities in relation to patients who lacked mental capacity. However, senior staff told us the referral criteria may not allow those who lacked capacity to consent for themselves to attend the hospital.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- Throughout the inspection we witnessed staff being compassionate and caring. This was supported fully by the patients we spoke to as they all expressed positive views about their experiences at the hospital.
- The comments cards relating to outpatients and diagnostic imaging were positive and praised the staff. One radiology patient we spoke to told us they had attended several times and the staff were, “kind, friendly and professional.”
- We observed staff being respectful at all times and with particular regard to patients’ privacy and dignity.
- The NHS Friends and Family Test (FFT) is an anonymous patient satisfaction survey created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The results from the second quarter of 2016 showed 95% of patients were extremely likely to recommend the service to others.
- The diagnostic imaging department used their own satisfaction survey for MRI. The results showed a consistently high level of satisfaction with the service. We were told that one member of staff in diagnostic imaging was often mentioned in feedback from patients as being exceptionally kind and caring.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt well informed about their care including any investigations that were planned. Patients we spoke to in diagnostic imaging told us that staff were good at explaining procedures and providing opportunities for them to ask questions.
- We spent time in the main outpatient reception area and observed patients being greeted and booked into the clinics. The receptionist always said, “hello, my name is….”There were clear instructions for any paperwork that needed completing and patients were able to ask any questions.
- When patients needed to be moved to a sub-waiting area, they were always called clearly by name and escorted to the appropriate place.

Emotional support

- We observed staff acting in a professional way. Patients told us staff were approachable and had time to explain things.
- We saw relatives being invited to accompany patients into consultation rooms.
- We observed patients being given emotional support prior to entering the MRI machine. This procedure can often make patients feel nervous and the staff offered reassurance during the process.
- Staff told us a quiet clinic room would be made available for breaking bad news if required.
- Chaperones were offered and available if required. Nurses were usually present during consultations and provided further information or reassurance when necessary.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- A wide range of outpatient services were available to meet the needs of the client group.

Good

Outpatients and diagnostic imaging

- The GP service responded to the needs of those who were new into the area and had not yet registered with a GP, were visiting friends and family, were having difficulty accessing a GP appointment or for personal preference for a particular consultation. The service complimented the NHS GP system and all patients were encouraged to register with their local GP.
- NHS patients were able to use the 'choose and book' system to enable them to choose a suitable appointment.
- The environment was appropriate and patient-centred with comfortable seating, refreshments and suitable toilets. There was a toy box for children in the outpatient's waiting room.
- The hospital offered responsive on site diagnostic imaging with Ultrasound, MRI and CT.
- Evening and Saturday appointments were offered to give additional choice and convenience to those who worked or had childcare commitments.

Access and flow

- People were able to access services for assessment, diagnosis or treatment when they needed to. The hospital was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways for their NHS patients at the time of the inspection with results above the 92% target since September 2015. Results in March to May 2016 show results of 100% with a decrease to 99% in June 2016. The provider did not meet the target of 92% of patients on incomplete pathways waiting 18 weeks or less from time of referral in July and August 2015 of the reporting period (July 2015 to June 2016) but this appears to be very much a one-off.
- Opening times for the service were 8am - 8pm Monday to Friday and 8am - 1pm on Saturdays. The service was closed on Sundays.
- GPs referred the majority of new patients attending the department. Some NHS contracts were held to help meet demand on those services. There were 31,729 outpatient total attendances in the reporting period (July 2015 to June 2016); of these 35% were NHS funded and 65% were other funded. The number of outpatient attendances had increased significantly in the past few years.
- Patients we spoke with told us the appointment system was easy to use and they had no problems arranging a suitable appointment.
- Some clinics overran during our inspection. No formal audit was undertaken of clinic wait times although senior staff told us this would be a feature added to the computer system to enable regular monitoring of this.

Meeting people's individual needs

- We noted that water dispensers, a hot drinks and a vending machine were available for patients to use.
- Staff told us interpreting services could be booked for patients attending outpatient or diagnostic imaging appointments and that they could also use a dedicated language line service.
- The staff we spoke with demonstrated a good understanding of the needs of patients with dementia. We were assured the patient who may be distressed or confused would be treated appropriately.
- Patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments.
- During our inspection, we visited the phlebotomy room. Patients could have their bloods taken on the same day as the appointment and staff were trained to do this.
- Reasonable adjustments were made so that disabled patients could access and use the outpatient and diagnostic services. A lift was in use to access the various floors.
- Patients with bariatric needs were not referred to the outpatients or diagnostic imaging departments but staff told us they wanted to improve the facilities to accommodate those with specific needs.
- A range of literature and health education leaflets were on display in the waiting areas.

Learning from complaints and concerns

Good

Outpatients and diagnostic imaging

- Complaints were handled in line with the hospital policy. Senior staff described an open and honest culture and a willingness to accept responsibility for any shortcomings leading to complaints.
- There was a robust system for capturing and learning from complaints. The senior management team were well informed about any complaints and changes were fed back through the heads of departments to frontline staff. Key themes of complaints were discussed at weekly senior management team meetings and we looked at the minutes to confirm this. Once a complaint had been concluded a complaint summary and action plan was circulated to the relevant head of departments. Staff in outpatients told us of three complaints that had recently been shared with the staff for learning.
- The hospital held a patient focus meetings chaired by the Hospital Director to monitor the progress of action plans and see what improvements have been made.
- Results from the recent patient satisfaction survey were displayed in outpatients.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

Vision and strategy

- Staff we spoke with were aware of the hospital's vision and values and how that related to their own departments.
- The new outpatient lead was in the process of putting together an improvement and refurbishment plan to improve environmental concerns such as carpets in the clinical areas.
- The recent change removing the paediatric service was well known by all staff.
- The diagnostic imaging department was without a senior lead. However, staff were committed to the vision of the service and were able to take forward the work required. We noted the diagnostic lead for the wider hospital group was in attendance during the inspection to offer support to the staff. Staff told us they were able to access this support at other times as required. The vacancy was out to advert at the time of the inspection.
- All staff we spoke with from outpatients and diagnostic imaging were positive about the group training programme and felt it was there to support them in their careers and to meet the strategic needs of their services.

Governance, risk management and quality measurement

- The service governance processes are the same throughout the hospital. We have reported about the governance processes under surgery service within this report.
- The outpatients lead described the issues relating to the outpatient department and how they were being addressed. We observed a proactive approach to risk and quality improvement.
- There was a strong emphasis on radiation protection and monitoring of radiation doses within the diagnostic imaging department.

Leadership and culture of service

- The hospital leadership team also led the outpatients and diagnostic imaging departments. For more information on leadership please read this section in the surgery report.
- We saw senior managers visiting the outpatients and diagnostic imaging departments during the inspection. We were told senior staff were very visible and supportive.
- We were aware of several nursing staff leaving outpatients during the inspection but there continued to be a strong sense of teamwork.
- We saw evidence in both departments that the culture of the services was centred on the needs of the patient. Many staff described how the patients' experience of the service was paramount.

Public and staff engagement

- The hospital public and staff engagement processes have been reported on under the surgery service within this report.

Good

Outpatients and diagnostic imaging

- Staff within outpatients and diagnostic imaging engaged in regular informal minuted development meetings.

Innovation, improvement and sustainability

- We spoke with the new outpatients lead and it was clear they came to the role with a great deal of experience and knowledge to make further improvements to the service.
- We noted the diagnostic imaging lead post was currently out to advert and staff told us they hoped the recruitment process would run smoothly to ensure sustained leadership of the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Address the nursing staff vacancies in the outpatients and diagnostic imaging.
- The provider should ensure there is an effective system for checking that consultants with approved practising privileges underwent the appropriate checks when working at the hospital
- The provider should ensure cleaning products are stored in locked cupboards as required by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).