The Holly Private Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Holly Private Hospital is operated by Aspen Healthcare Limited. The hospital has 42 inpatient beds, eight day case beds and two beds and four chairs for oncology day case services. Facilities include five operating theatres, an X-ray department, outpatient and diagnostic facilities.

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

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 24 January 2017, along with an unannounced visit to the hospital on 7 February 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Services we rate

We rated this hospital/service as Good overall.

We found good practice in relation to medicine:

- Staff had a good understanding of incident reporting and duty of candour.
- Patient areas were clean and well equipped and staff followed infection prevention and control procedures.
- The oncology consultants prescribed all chemotherapy treatments using the relevant and current evidence based guidance.
- The chemotherapy suite staff were all trained in oncology and palliative care and had several years experience in the treatment of patients with malignant disease.
- Staff provided patients with a 'chemotherapy record book', which they brought to each appointment. This was updated by the nurse and ensured that the patient always had a record of the treatments given, possible symptoms and side effects and 24-hour contact details should they feel unwell
- The hospital had introduced the UK Oncology Nursing Tool (UKONS) to triage all patients in December 2016, along with a 24 hour on call rota, to ensure patients had access to specialist advice 24 hours a day, seven days per week.
- There were appropriate systems in place to ensure effective decontamination and storage of endoscopy equipment in accordance with Department of Health, Health Building Notes Technical Memorandum 01-06: decontamination of flexible endoscopes.
- The endoscopy service was in the process of reviewing facilities to fulfil Joint Advisory Group on Gastrointestinal Endoscopy (JAG) criteria for accreditation.

We found areas of practice that required improvement in medicine:

- The dirty utility room in the chemotherapy suite had damaged tiling behind the taps and damage to the flooring making it difficult to ensure these areas were sufficiently cleaned and taps did not conform to Department of Health standards.

Summary of findings

- Chemotherapy patient outcomes were not routinely recorded. Staff did not participate in any internal audits, for example in the use of the cool cap.
- Ensure that there is adequate representation at governance meetings.

We found areas of Good practice in surgery:

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- The hospital exceeded the referral to treatment target of 18 weeks for NHS patients every month between January 2016 and November 2016.
  - The NHS Safety Thermometer provides a monthly **'temperature check"** on harms such as pressure ulcers, falls, urinary infection and venous thromboembolism (VTE). Between January 2016 and December 2016 data showed that patients had received 100% harm free care.
- The hospital reported that there were 11 surgical site infections between October 2015 and September 2016. All of the reported surgical site infections were following orthopaedic surgeries; all of the infections were investigated and no common themes or trends were found to link the infections
- The hospital participated in national audits for example patient reported outcome measures (PROMs) for patients who had primary hip replacements, primary knee replacements, and hernia repairs.
- The hospital completed the World Health Organisation (WHO) five steps to safer surgery checklist for each surgical procedure undertaken. The surgical safety checklist audit undertaken by the hospital in September 2016 scored 98% compliance in the completion of the checklist.
- Fasting audits for February, August and November 2016 showed that compliance with the pre-operative fasting guideline policy, and the documentation of fasting time on patients notes were between 95-100%.
- The friends and family test results between April 2016 and September 2016 showed that 99% of patients would recommend this hospital for April and May, 98% for July and August and 97% for June and September.
- There was a clear governance process in place with clear lines of communication between heads of departments, senior management team and the medical advisory committee (MAC).
- The senior management team, although relatively new to the hospital, were all respected by the staff and the positive impact they had on the hospital since their appointments into post.

We found outstanding areas of practice is surgery:

- the hospital had been awarded the Worldhost© customer care recognition status (the same customer care training the London 2012 Olympic Games Makers received) reflecting the work of staff going the "extra mile" to improve patient experience.
- There were systems in place to engage staff at all levels and recognise commitment and achievement. For example there was a '6E's' staff recognition scheme in place, which involved staff obtaining evidence through their work that they were displaying the service's core behaviours of 'exceptional, effective, expert, energetic, efficient, everyone'.
- Monthly observational audits were carried out in patient areas, in which a member of staff would observe interactions between staff and patients, as well as the environmental factors over a set period of time, to drive improvements in patient experience throughout the hospital.

We found areas of practice that required improvement in surgery:

- The hospital cancelled 26 procedures between January 2016 and January 2017 for non-clinical reasons for example consultants starting late. All of the patients were offered another appointment within 28 days of the cancelled procedure in accordance with national guidelines.

We found areas of Good practice in Childrens and Young People:

Summary of findings

- Policies in use were evidence based and reflected best practice and national guidance.
- All inpatient nurses had received an appraisal in the current year to date (April 2016 to January 2017)
- The hospital was working towards all registered staff receiving PILS training. This was to ensure that all staff were able to manage a deteriorating child. This training had been rolled out with a target completion of 90% compliance by March 2017.
- The hospital carried out quarterly audits to monitor compliance with peadiatric early warning scores (PEWS) to identify deteriorating children. Audit results for the months of January 2016, April 2016 and July 2016 showed compliance was 100%.
- The hospital maintained oversight of consultants with practising privileges to ensure they were regularly practicing in their specialist fields to ensure competence.
- Staff had access to a policy relating to obtaining consent from children and young people. The consent policy referenced the Gillick competence with staff demonstrating a working knowledge.
- The hospital undertook a dedicated inpatient survey for children and young people with 99% of patients reporting they felt 'very well looked after'.
- Staff treated patients and their relatives/carers with dignity and respect.
- The service provided a dedicated paediatric nurse, prior to and after surgical procedures to provide emotional support for children and young people.
- The service was meeting patients individual needs through the provision of age appropriate menu choices and environments in both the ward and theatre areas.
- Relatives and carers had access to information to aid understanding of their child's treatment or procedure including post-operative information.
- The children and young person's service had received no complaints in the 12 months prior to our inspection. Patients and their relatives had access to information on how to complain with a clear complaints policy in place to guide staff on the handling of complaints
- The service had a specific paediatric strategy in place.
- In 2016, the hospital launched a new paediatric speech and language service in the aim to complement existing paediatric services.

We found areas of practice that required improvement in childrens and young people:

- The lack of security restricted areas had been recorded on the hospital's risk register in October 2016 however there was no estimated date of completion for this work.

We found areas of Good practice in Outpatients and Diagnostics:

- There was good track record of safety in outpatients and diagnostic imaging department. Three incidents had been reported to the radiation protection advisor (RPA), and deemed low risk and investigated appropriately.
- Areas we visited were visiblyclean and we saw good infection control techniques in line with policy and national guidance.
- Radiology staff all carried film badge dosimeters whilst working clinically which registered the amount of personal radiation exposure they had been subjected to and these were reviewed regularly to ensure staff safety.
- The hospital carried out internal monthly audits on medical records. The most recent audit that included outpatients' notes was in July 2016 and scored 96%.
- Safeguarding training data for the outpatient and diagnostic imaging department showed 100% compliance.
- The hospital used the "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" for interventional radiological procedures.
- For the period October 2015 to September 2016, the hospital performed between 94% and 97%, exceeding the target of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for incomplete patients. These figures related to NHS funded patients only.

Summary of findings

- Outpatient staff spoke of a strong team ethos across the hospital and felt well supported by their managers, and that managers were accessible, approachable and friendly.

We found outstanding procatice in outpatients and diagnostics:

- The diagnostic imaging team won the Aspen quality award for their cardiac MRI service which demonstrated the hospital's priorities of safety, effectiveness and improving patient experience. Cardiac MRI provides an alternative to invasive angiography. Patients which normally would be referred to other hospitals for a cardiac MRI scan now can be offered this service at the Holly.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	The main service provided by this provider was surgery. Where our findings on surgery for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section. Medical care at this hospital included endoscopy and chemotherapy services. There were a very small number of patients admitted to the ward for medical care, for relevant findings regarding inpatient care, please see the surgery report. The endoscopy service provided upper and lower gastrointestinal endoscopy and urological endoscopic investigations. The chemotherapy service offered treatment to patients who attended on a day case basis. • Staff had a good understanding of incident reporting and duty of candour. • Patient areas were clean and well equipped and staff followed infection prevention and control procedures. • Medicines were stored and prescribed appropriately. • Patient records were securely stored to protect their confidentiality. • The oncology consultants prescribed all chemotherapy treatments using the relevant and current evidence based guidance. • The chemotherapy suite staff were all trained in oncology and palliative care and had several years experience in the treatment of patients with malignant disease. • The chemotherapy service provided treatment seven days a week dependent on patients need. • Chemotherapy staff clearly understood the impact of malignant disease on patients and their families and treated patients with respect and dignity. Patients were very complimentary about the care and understanding shown to them during chemotherapy treatment.

Summary of findings

- Patient's chemotherapy treatment usually started within a few days of a decision being made.
- Patients complaints about waiting times for procedures in the day stay unit following theatre list changes resulted in improvements following recent discussion with consultants
- There was a good 'open door' culture from senior management level down and staff felt able to raise concerns.
- During our inspection the staff we spoke to clearly enjoyed their jobs and were very proud of the service they provided.
- There was a transparent management structure with staff clear about their roles and responsibilities.
- However:
- The dirty utility room in the chemotherapy suite had damaged tiling behind the taps and damage to the flooring making it difficult to ensure these areas were sufficiently cleaned and taps did not conform to Department of Health standards.
- Chemotherapy patient outcomes were not routinely recorded, the staff did not participate in any specialist audit and there were no performance indicators to work to, or assess department performance against.

Surgery

Good

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.
We have rated surgery as good over all because;

- The hospital had an effective incident reporting process in place and learning from incidents was cascaded to staff. There were robust mechanisms in place to safeguard patients from harm.
- Equipment was safety tested and up-to-date with servicing. Records of equipment checks demonstrated staff had completed this as stipulated by internal policies
- Policy documents reflected evidenced based practice and referenced national guidance and legislation.

Summary of findings

- There were daily multi-disciplinary handovers to discuss patients. Inpatients had access to services such as diagnostic imaging and pharmacy 24 hours a day seven days a week. Theatre staff worked to an on call rota outside the normal working hours in the event a patient was required to return to theatre in an emergency.
- The hospital planned all surgeries in advance to ensure patient needs were met for example correct staffing ratios and theatre availability were monitored.
- The hospital exceeded the referral to treatment target of 18 weeks for NHS patients every month between January 2016 and November 2016.
- Staff provided compassionate care tailored to the patients' individual needs and were respectful of patient privacy and dignity. Patients praised the staff and gave examples of how staff had gone out of their way on behalf of their patients.
- The hospital had a robust complaints procedure and mechanisms for patients to give feedback. The hospital had evidence of learning from complaints raised.
- The hospital had a clear vision and strategy, which had identified the key challenges for the hospital. The hospital had established lines of accountability within the governance structure to escalate risks.
- Staff praised their managers and the senior leadership team and told us they felt well supported and could discuss any concerns. The ward staff appraisal rate was 100%

Services for children and young people

Good

Children and young people's services were a small proportion of hospital activity accounting for 6% of overall hospital activity between October 2015 and September 2016.
The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good overall because:

- There had been no never events or serious incidents relating to children's and young people's services in the 12 months prior to our inspection.

Summary of findings

- Staff demonstrated knowledge and understanding of their responsibilities in relation to incident reporting and the duty of candour.
- All areas where children and young people were seen or treated were clean, and staff adhered to universal infection control principles.
- There were mechanisms in place for the safeguarding of children and young people.
- There were systems in place to ensure deteriorating patients were identified and responded to in a timely manner.
- Specific paediatric pathways reflected national guidance and evidence based practice.
- The children's and young people's service gained feedback from patients and their relatives to ensure that patients understood and felt involved in their care.
- The children and young people's service was ensuring they met the individual needs of patients by providing an age specific environment where possible.
- There had been no complaints in relation to the children and young people's service in the 12 months prior to our inspection. Patients and their relatives/carers were provided with information on how to complain, with a clear complaint policy in place to support this process.
- Staff we spoke with were positive about senior management within the hospital and felt supported in their role.
- 100% of peadiatric nurses had been trained in peadiatric immediate life support, with the hospital working towards all staff being trained.

However:

- Regular resuscitation equipment checks had not been carried out on a number of days where children and young people were admitted for day case surgery, however this had been rectified by our unannounced visit.

Outpatients and diagnostic imaging

Good

Outpatients and diagnostic services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated the outpatients and diagnostic imaging service as good because:

Summary of findings

- There was good track record of safety in outpatients and diagnostic imaging department. Three incidents had been reported to the radiation protection advisor (RPA), and deemed low risk and investigated.
- There was evidence of learning from incidents, and staff were all aware of the duty of candour principles.
- There were good processes in place to ensure that equipment was stored, maintained and used safely.
- Thyroid protection shields were available in theatres and the fluoroscopy room in line with IR(ME)R recommendations.
- Patients records in outpatients were contemporaneous. Referral letters were always obtained before consultation with a consultant.
- Staff had a good knowledge of safeguarding and the process of escalating concerns.
- There were clear policies in place for transferring deteriorating patients.
- Reasonable adjustments in terms of extended appointment times and allowing relatives to attend consultation appointments were made to meet the needs of patients with learning difficulty or patients living with dementia
- The “World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery” was used for interventional radiological procedures.
- There was an effective process of audits to identify areas for improvement and best practice.
- There was a strong leadership team who supported staff and encourage staff development.

Summary of findings

Contents

Good

The Holly Private Hospital

Services we looked at

Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to The Holly Private Hospital

The Holly Private Hospital is operated by Aspen Healthcare Limited. The hospital opened in 1998. In 2013 the hospital completed a £23 million expansion and refurbishment programme and in 2016 changed the name from Holly House (by which the hospital was previously known) to The Holly Private Hospital, to reflect growth in both the physical setting and number of patients.

It is a private hospital in Buckhurst Hill, Essex. The hospital primarily serves the communities of London, Essex and Hertfordshire. It also accepts patient referrals from outside this area.

At the time of the inspection, a new manager had recently been appointed and their application was in the process of being registered.

The hospital also offers a cosmetic service, a, physiotherapy and sports centre and a GP suite. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,five other CQC inspectors, and two specialist advisors with expertise in surgery. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about The Holly Private Hospital

The hospital has two wards and is registered to provide the following regulated activities:

- Diagnostics and Screening Procedures.
- Surgical Procedures.
- Treatment of disease, disorder or injury.

During the inspection, we visited the wards, theatres, outpatient departments, x-ray and diagnostic imaging. We spoke with staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with patients and relatives. During our inspection, we reviewed 27 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 was inspected in 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (October 2015 to September 2016)

- In the reporting period October 2015 to September 2016 there were 10,536 inpatient and day case episodes of care recorded at The Hospital; of these 51% were NHS-funded and 49% other funded.
- Fourteen per cent of all NHS-funded patients and 24% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 101,456 outpatient total attendances in the reporting period of October 2015 to September 2016; of these 29% were other funded and 71% were NHS-funded.

295 surgeons with practising privileges, 73 anaesthetists and 23 radiologists worked at the hospital under practising privileges. The hospital employed 75.2 (WTE) registered nurses, 28.3 (WTE) care assistants and 176.9 other staff. The Resident medical officers were supplied through an agency, and worked 12 hours shifts on a week on, week off rota.. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

Summary of this inspection

- There was one Never Event in surgery in the reporting period of October 2015 to September 2016.
- There were 335 Clinical incidents reported between October 2015 to September 2016.Of these 292 no harm, 36 low harm, 7 moderate harm, 0 severe harm, 0 death.
- There were three Serious Injuries reported between October 2015 to September 2016.

There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) between October 2015 to September 2016.

There were no incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) for the same period.

There were no incidences of hospital acquired Clostridium difficile (c.diff) for the same period.

There were no incidences of hospital acquired E-Coli for the same period.

There were 88 complaints reported for the same period and no complaints referred to the Ombudsman or ICAS (Independent Healthcare Sector Complaints Adjudication Service.

Services accredited by a national and other body's:

Clinical Pathology Laboratory Accreditation

The Association of Perioperative Practice (AfPP) Accreditation

BUPA approved Breast Cancer Centre

BUPA approved MRI Unit

BUPA Multi-parametric Prostrate MRI Accredited

Decontamination-British Standards EN 1SO 13485:2012

Decontamination-British Standards EN 1SO 9001:2008

Investors in People

World Host Accreditation-Principles of Customer Service

Services provided at the hospital under service level agreement:

- Blood Testing
- Blood Transfusion
- Clinical Waste
- Cytology
- Heamo-Oncology
- Histology
- Laser Protection
- Laundry and Linen
- Medical Equipment
- Microbiology
- Molecular Testing
- Occupational Health
- Radiation Protection
- Resident Medical Officer
- Resuscitation Training

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:

- The hospital reported three serious injuries between October 2015 and September 2016. The number of serious injuries was not high when compared with other independent acute hospitals. We reviewed the root cause analysis investigation reports that related to these incidents, which demonstrated the learning from the incident was shared with staff.
- Staff knew how to report incidents using the electronic reporting database. Incidents were appropriately investigated, with lessons learnt and improvements made as a result. We saw evidence that learning was shared with staff. Staff we spoke to understood the principles of duty of candour.
- There had been one safeguarding incident reported to CQC between the period of October 2015 and September 2016. Correct process had been followed, with full investigation and appropriate action taken.
- Three incidents had been reported to the radiation protection advisor (RPA), and deemed low risk and investigated appropriately.
- The hospital had no reported incidents of MRSA, MSSA (Meticillin-sensitive Staphylococcus aureus), E-coli or Clostridium difficile between October 2015 and September 2016.
- The NHS Safety Thermometer provides a monthly 'temperature check' on harms such as pressure ulcers, falls, urinary infection and venous thromboembolism (VTE). Between January 2016 and December 2016 data showed that patients had received 100% harm free care.
- There was 100% compliance for Venous thromboembolism between October 2015 and September 2016.
- The hospital scored 95% for the National Early Warning Score (NEWS) audit undertaken in August 2016 and had met the hospital target of 95%.
- The hospital carried out internal monthly audits on medical records. The most recent audit that included outpatients' notes was in July 2016 and scored 96%.

However

Summary of this inspection

- The dirty utility room in the chemotherapy suite had damaged tiling behind the taps and damage to the flooring making it difficult to ensure these areas were sufficiently cleaned and taps did not conform to Department of Health standards.

Are services effective?

Good

We rated effective as good because:

- Policy documents referred to national guidelines and best practice.
- The hospital participated in Patient Reported Outcome Measures (PROMs) for NHS patients, the National Joint Registry and in the Patient-Led Assessments of the Care Environment (PLACE).
- Pain was appropriately and regularly assessed, and staff responded appropriately to patients pain.
- The hospital utilised a dashboard of metrics including over 70 measures. There was an integrated audit programme which included audits of patient records, compliance with early warning scores and surgical checklist.
- The hospital was a member of the Association of Independent Healthcare Organisations (AIHO) and the private healthcare information network (PHIN). This network aimed to improve the availability of outcome data in the private healthcare sector.
- The hospital had 17 unplanned transfers to other hospitals between October 2015 and September 2016. The rate of unplanned transfers was not high when compared to other acute independent hospitals. All of the unplanned transfers were investigated and no themes or trends were found.
- The hospital had 13 unplanned readmissions within 28 days of discharge, between October 2015 and September 2016. The rate of unplanned admissions was not high when compared to other acute independent hospitals.

However:

- Chemotherapy patient outcomes were not routinely recorded. staff did not participate in any internal audits, for example in the use of the cool cap.

Are services caring?

Good

We rated caring as good because:

- The friends and family test results between April 2016 and September 2016 showed that 99% of patients would recommend this hospital.

Summary of this inspection

- The internal patient survey between April 2016 and September 2016 showed that 98% of patients would recommend the hospital to friends and family.
- The hospital had introduced an accredited customer care training programme focusing on the principles of customer service.
- We observed interactions between staff and patients that were friendly, respectful and supportive.

Are services responsive?

Good

We rated responsive as good because:

- Patients were offered flexibility and choice for appointments and when arranging admission to the hospital.
- The hospital exceeded the referral to treatment target of 18 weeks for NHS patients every month between January 2016 and November 2016.
- The hospital offered patients having diagnostic imaging that did not attend their appointment a second appointment before their imaging request was returned to the referrer.
- The hospital had a robust complaints process and learning from complaints was shared with staff.
- The hospital had a dementia link nurse to support patients during their stay in the hospital. In addition the link nurse facilitated education sessions for the staff and supported them to tailor care to meet the needs of patients living with dementia.

However:

- The hospital cancelled 26 procedures between January 2016 and January 2017 for non-clinical reasons for example consultants starting late. All of the patients were offered another appointment within 28 days of the cancelled procedure in accordance with national guidelines.

Are services well-led?

Outstanding

We rated well-led as Outstanding because:

- There was a clear governance process in place with clear lines of communication between staff, heads of department, senior management team and the MAC.
- There was a new tripartite governance structure in place consisting of the consultant governance lead, consultant deputy governance lead and director of nursing and clinical

Summary of this inspection

services. A new director of quality and risk was due to start at the end of January 2017 and the senior management team were clear on how they would integrate into the team in terms of governance arrangements.

- The hospital had a number of processes in place to engage with and gain feedback from patients and staff, including a patient focus group which met three times per year.
- There was a positive, team-based culture in all areas of the hospital and within the leadership team. Staff spoke highly of the new senior management team and the positive work within the hospital.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Medical care

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

Are medical care services safe?

Good

Incidents

- There had been no never events. 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. There was one serious incident and two no harm events in the chemotherapy suite, and five mild or moderate incidents attributable to the endoscopy service between October 2015 and February 2016.
- We spoke to one member of staff in the chemotherapy suite and two staff in the day care unit. All were able to describe their responsibilities to raise concerns and record safety incidents on the electronic reporting system. They gave examples of the type of incidents they would report such as chemotherapy medication not being delivered and patient falls.
- Staff said that incident outcomes were discussed face to face at a debriefing meeting and shared at departmental meetings.
- One staff member described a recent serious incident in the chemotherapy suite. We saw the root cause analysis for the incident and were assured that there was appropriate investigation and learning needs considered although there were no learning needs identified.
- We saw evidence of a duty of candour letter that had been sent to a patient following a serious incident. It explained the circumstances and on-going investigation and offered the patient an opportunity for meeting and counselling. 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.
- For our detailed findings relating to mortality and morbidity, see under this sub-heading in the surgery section.

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

- For our detailed findings relating to the use of the clinical dashboard, see under this sub-heading in the surgery section.

Cleanliness, infection control and hygiene

- For our detailed findings relating to cleanliness, infection control and hygiene on the wards and operating theatres, see under this sub-heading in the surgery section.
- The chemotherapy suite and day care unit where most endoscopy patients were seen, were visibly clean. There were dated 'I am clean' stickers on equipment and furniture demonstrating recent cleaning had taken place.
- Staff in the chemotherapy suite and the day care unit followed the arms bare below the elbows policy.
- We observed staff washing their hands before and after patient contact and using appropriate protective equipment in the chemotherapy suite and the day care unit.
- We visited the endoscopy decontamination unit and saw there were facilities for separate one way flow of endoscopes between dirty and clean areas to prevent

cross contamination, and suitable storage of disinfected equipment in a 'clean storage area'. We were assured that appropriate systems were in place to ensure effective decontamination and storage of endoscopy equipment in accordance with Department of Health, Health Building Notes Technical Memorandum 01-06: decontamination of flexible endoscopes.

- Staff performed weekly water testing for bacteria in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. There was a flowchart for actions in case of results being out of range and all results were recorded.
- The day unit staff and the chemotherapy staff consistently submitted data for the regular corporate (quarterly) infection prevention and control audits, the results of which are reported in the section of the surgery report.

Environment and equipment

- The chemotherapy suite comprised a bright and spacious day unit room with four washable electric recliner chairs for patients and two individual en-suite room.
- All areas where chemotherapy was administered had hard vinyl flooring that was easily cleaned and maintained.
- The day stay unit where endoscopy patients were treated had eight patient bays in two separate rooms with curtains separating each bay. This ensured that there were separate four-bay male and female areas. Patients who required overnight stay either prior to or following endoscopy were admitted to one of the wards. For detailed information on environment and equipment on the wards, see this section of the surgery report.
- We checked a range of equipment in the chemotherapy suite (nine pieces) including recliner chairs, infusion pumps and equipment used for monitoring patients. All were within electrical test and service dates.
- There were suitable disposal arrangements for chemotherapy cytotoxic infusion equipment in colour coded sharps disposal bins, which were stored awaiting collection away from patients in the dirty utility room.
- Resuscitation equipment was available on a trolley kept in an unused room on the chemotherapy suite corridor. All drugs and clinical items were in date. The chemotherapy staff informed us that they were not responsible for the daily resuscitation trolley checks. For detailed information regarding the daily checklist for the trolley, see this section in the surgery report.
- The chemotherapy dirty utility room was tidy with appropriate storage areas. Used sharps bins were correctly labelled and closed.
- However, there were individual twist style taps above the enamelled sink, which did not comply with Department of Health (DOH) Health Building Note (HBN) 00-09 - Infection control in the built environment 2013, which meant there was a risk of staff recontaminating hands after washing when turning taps off. There were exposed, rusty pipes under the sink and holes in the wall behind the hot tap and in the flooring. These did not meet the requirements of the DOH HBN 00-10 Part B: Walls and ceilings Health or HBN 00-10 Part A – 'Flooring 2013. This meant that there was a risk of these areas not being cleaned appropriately. This was escalated to the chemotherapy lead.
- All medical devices were checked by an external company. A log of the checks was kept electronically, accessible by senior clinical staff. We observed the external engineer checking equipment during our inspection and they confirmed they attended usually on a weekly basis.
- We checked 12 consumable clinical items and three pieces of equipment in the day stay unit including recliner chairs, infusion pumps and equipment used for monitoring patients. All were within electrical test and service dates.
- A hoist was stored in a room in the chemotherapy suite for use on the ward, and we saw this was within electrical testing and service date.

Medicines

- Medicines were securely stored in the chemotherapy suite, in locked cupboards and a locked fridge in a room only accessible with a keycode. The chemotherapy nurse held the drug cupboard keys. We checked a range of medications and found them to be in date and stored correctly.
- Chemotherapy staff checked the current and high/low medication fridge temperatures daily. We saw logs showing they were recorded consistently in December 2016 and January 2017 and were within acceptable range.

- Prescription records had patient identifying information, were signed and dated and had allergies and patient weights recorded.
- Chemotherapy medications were prescribed by the medical consultant or resident medical officer (RMO) and these included anti emetics for patients who experienced nausea during therapy, blood transfusions and intravenous fluids.
- An external company delivered the cytotoxic medications ready for infusion, and two registered nursing staff always checked cytotoxic medication prior to administration in line with the provider's policy.
- The medical consultant prescribed prophylactic antibiotics to take home (TTAs) to chemotherapy patients who may be at risk of infection due to the action of chemotherapy drugs. Patients were advised to contact the chemotherapy nurse for advice before taking in the event of feeling unwell. This was in line with best practice.
- Controlled drugs were not kept on the chemotherapy suite or the day stay unit.
- The endoscopy service used sedation and intravenous analgesia during procedures for patients comfort. We saw that there was oversight of sedation rates and sedation and comfort scores were monitored as part of their application for JAG accreditation.
- Staff consistently recorded the current and high/low drug fridge temperatures in the day stay unit where endoscopy patients were seen. We saw daily records going back to August 2016. There was evidence of the fridge temperatures being higher than recommended (15 degrees Celsius) during August and September 2016. This had been resolved with a space created at the rear of the fridge to allow more air circulation, and a notice to ensure staff did not store items on top of the fridge.
- We checked a range of medicines including oral pain relief in the day stay unit. All were in date.
- Staff confirmed that a pharmacist visited weekly to stock check drugs and offer support where needed for the chemotherapy and day stay unit.
- For our detailed findings on medicines management arrangements, and medicines access within the theatre environment for endoscopy services, please see the Safe section in the surgery report.

Records

- Patient records were stored securely in a locked cabinet in the office of the chemotherapy suite.
- We looked at two sets of patient records. They contained patient pathways, consultant notes, were legible, signed and dated.
- Nursing records including risk assessments were recorded as appropriate.
- Chemotherapy pre-assessment forms were completed two days prior to admission and included pertinent information to assess risk of infection and side effects to medication. A further more detailed pathway document was completed on treatment days.
- Chemotherapy patients were issued with a treatment diary, which contained regularly updated treatment information so they always had a record.
- Patient records on the day stay unit were securely stored in a cupboard at the nurse's station.

Safeguarding

- There were no safeguarding concerns reported for the chemotherapy or endoscopy services in the period October 2015 to September 2016.
- Chemotherapy and day unit staff were all compliant with adult and children safeguarding level two as part of mandatory training.
- Staff were aware of their responsibilities regarding safeguarding and were able to describe circumstances that would raise concerns. They knew who to contact to escalate a safeguarding concern.

Mandatory training

- Overall figures supplied by the provider showed 82.6% compliance for the ward staff mandatory training; however, the chemotherapy staff were 100% compliant and day unit staff 92% compliant.
- The mandatory training included, but was not limited to, fire, health and safety, infection prevention and control, safeguarding, immediate life support and moving and handling.
- For our detailed findings on endoscopy mandatory staff training (included in theatre staff) see the Safe section in the surgery report

Assessing and responding to patient risk

- The providers admission criteria excluded high-risk patients for procedures such as endoscopies where critical care services might be required following an intervention.

Good

Medical care

- Patients were pre-assessed prior to procedures including endoscopy using a pre-assessment proforma two days prior to admission.
- All patients admitted to the day stay unit including endoscopy patients were monitored post procedure using the National Early Warning Score (NEWS).
- Staff assessed patients two days prior to chemotherapy procedures to reduce the risk of infections and adverse effects of chemotherapy. Staff undertook a further assessment immediately prior to treatment, which included recent medical history, the results of blood tests, changes in sleeping, diet and fatigue, venous thromboembolism and observations such as temperature and blood pressure.
- Patients were monitored during chemotherapy infusion treatment for side effects and discomfort.
- The NEWS system was used to monitor patients during chemotherapy infusions. There was a provider NEWS pathway for escalating the deteriorating patient and staff were able to describe actions such as increasing the frequency of observations, informing the senior registered nurse and the resident medical officer (RMO).
- Staff provided patients with a 'chemotherapy record book', which they brought to each appointment. This was updated by the nurse and ensured that the patient always had a record of the treatments given, possible symptoms and side effects and 24-hour contact details should they feel unwell.
- Chemotherapy patients who became unwell during treatment were not admitted to The Holly hospital. The chemotherapy suite had a recently developed a specific standard operating procedure (SOP) dated 23 January 2017 describing actions for admitting a patient who became unwell and required 24 hour care to the local acute hospital. This had previously been covered under the hospitals transfer and agreement policies and procdures.
- Historically, chemotherapy patients had contacted the specialist nurses directly during both working and non-working hours for advice and assessment. The patients valued this service and staff said it was useful, as often advice from the experienced nursing staff was enough to allay concerns and save patients attending their GP or local emergency centre.
- The hospital had introduced the UK Oncology Nursing Tool (UKONS) to triage all patients in December 2016, along with a 24 hour on call rota. As this had only been implemented in December 2016, no data regarding the number of calls received were available at the time of the inspection.

Nursing staffing

- For our detailed findings on nurse staffing please see this section in the surgery report.
- The chemotherapy unit was staffed by three registered, experienced chemotherapy nurses. The lead nurse was full time and the other two staff members made up a further 40 hours combined per week.
- Staffing levels depended on patient numbers for example; on regular chemotherapy infusion days, there was always at least two nurses on duty. No untrained staff or bank or agency staff were used on the chemotherapy suite.
- The endoscopy unit had two full time theatre nurses trained in endoscopy. Staff told us that there were plans to have a further nurse trained within the next few months.
- There was a recently vacated post for an endoscopy lead at the time of the inspection. We were unable to speak to any endoscopy trained staff, as there was no endoscopy list on the day of inspection.

Medical staffing

- The medical staffing arrangements are reported under the surgery service within this report.
- The chemotherapy staff confirmed that out of hours contact with a consultant was always available for advice.

Are medical care services effective?

Requires improvement

We rated effective as Requires Improvement

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

- The oncology consultants prescribed all chemotherapy treatments using the relevant and current evidence based guidance.
- We reviewed a range of the provider's policies and procedures and saw that they were based on national

guidance and best practice such as; NHS England chemotherapy regimes and National Institute of Health and Care Excellence (NICE) CG151 Neutropenic sepsis: prevention and management in people with cancer.
- Staff used the National Chemotherapy Advisory Group (NCAG) recommendations to assess patients prior to chemotherapy treatment. This meant that patients only received treatment if it was appropriate for them. All assessments were recorded on forms kept in patient notes so they were available to staff who required them.
- All intravenous therapy was administered using electronic pumps to regulate delivery. This ensured that treatments were administered at the correct dose over the correct period of time.
- Staff assessed patients for endoscopy procedures two days prior to procedure to ensure suitability and this was recorded in patient notes.
- The provider was working towards the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation and we saw evidence supplied to support accreditation.
- The provider's company reviewed and provided regular updates to its services on NICE guidance. We saw evidence of this being shared and discussed at clinical governance meetings.

Pain relief (medical care specific only)

- In the chemotherapy suite, two patients we spoke with said that they were always asked if they were comfortable or had any pain during their treatment.

Nutrition and hydration

- There was a hot drinks machine and a cold water dispenser in the chemotherapy suite for patients to help themselves to refreshments.

Patient outcomes (medical care specific only)

- There was no formal audit to measure the chemotherapy service or patient outcomes. Staff commented that it was a small service at present and audit was not felt to be necessary.
- Staff had started offering patients the use of a 'cold cap' during some forms of chemotherapy. This reduces the blood flow in the scalp so the amount of drug reaching the hair follicles on the head is lowered to help prevent hair loss during chemotherapy treatment. Although they described some success, they had not audited progress or outcomes. However, there was a standard operating procedure in place directing staff on the use of the cap.
- The endoscopy service was in the process of applying for Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. We saw their regular audits (of flexible sigmoidoscopy, gastroscopy and colonoscopy) which included analgesia and sedation rates, comfort scores and polyp detection/retrieval to show compliance with JAG criteria.

Competent staff

- For our detailed findings on consultant competencies and practising privileges, see this section in the surgery report.
- The chemotherapy suite staff were all trained in oncology and palliative care and had several years experience in the treatment of patients with malignant disease.
- Two of the chemotherapy suite staff had received appraisals within the previous 12 months. There was one member of staff who had worked on the unit for less than a year and was not yet due an appraisal.
- Staff had one to one meetings with senior nursing staff to discuss progress and opportunities. All chemotherapy staff completed competencies appropriate to their role and we saw evidence in competency folders of regular competency assessments such as cannulation, venepuncture and chemotherapy administration.
- Chemotherapy staff confirmed that they were encouraged to attend specialist conferences such as the UK Oncology Nursing service conference and access external learning to broaden and develop their knowledge. We saw specialist education opportunities on the noticeboard in the chemotherapy suite office.
- The provider's company also held regular three monthly meetings for chemotherapy staff to ensure staff were updated in line with best practice. This included discussions around new treatments and education and support for staff.
- The theatre nurses with specific endoscopy training were assessed yearly by an onsite assessor and there were plans to train a further endoscopy nurse.
- For theatre staff appraisal rates, see this section in the surgery report.

Multidisciplinary working

Good

Medical care

- The chemotherapy staff worked closely with the oncology consultants. The nursing staff attended oncology outpatient clinics to liaise with consultants and patients regarding chemotherapy treatments and offer support to patients.
- All patients care was discussed at a formal MDT prior to the commencement of treatment.This was to ensure that patients recived the most appropriate care.
- The chemotherapy team attended monthly meetings with the oncology consultants and pharmacist to discuss updates of patient treatment regimes, patient pathways and new patients.
- There were no formal arrangements or collaboration with palliative care services; however, staff did liaise with patient's GPs to recommend referral to local cancer support services and a local hospice for patients nearing end of life.

Seven-day services

- The oncology service included most systemic anti-cancer treatments (SACTs). The service offered chemotherapy treatment, assessments and blood tests from Monday to Saturday. If patient treatment regimes required a Sunday attendance, staff changed shifts to accommodate this.
- The chemotherapy suite nurses operated a 24-hour telephone advice line. Nursing staff were able to contact consultants directly for advice, who if concerned, arranged to see patients at the hospital as soon as possible including out of hours if necessary.
- Endoscopy services were organised twice a week as required with lists booked several weeks in advance.

Access to information (medical care only)

- Chemotherapy patient's nursing and medical records were stored in a locked drawer in the chemotherapy suite office. Records were accessible when required.
- For detailed access to information, see this section in the surgery report.
- Patient discharge information was sent to the patient's GP following each episode of care and included any recommendations for changes in treatment regime or referral advice in the case of endoscopy patients.

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

- The nursing staff we spoke to had a good understanding of consent and when it was required such as formal written consent for endoscopies and chemotherapy and gaining verbal consent for nursing procedures.
- Consultants consented patients during outpatient appointments. We saw a signed consent form in a patient chemotherapy notes, which described possible side effects and complications.
- Staff gained verbal consent from patients before procedures such as venepuncture and cannulation.
- The nursing staff we spoke to had a good understanding of the Mental Capacity Act (MCA) although they said it was very rare that they would need to use any assessments. One staff member gave an example of a patient with mild dementia who attended for treatment but was able to confirm that they understood what the treatment involved and were happy to consent.
- The staff did know about Deprivation of Liberty Safeguards and what it would entail, but none of the staff we spoke with had been involved in arranging this for a patient.
- For detailed information about training levels on Mental Capacity Act, see this section of the surgery report.

Are medical care services caring?

Good

Compassionate care

- We observed two patient interactions in the chemotherapy suite and saw that staff greeted patients in a friendly, polite manner.
- We observed two patient interactions in the day stay unit and saw staff offering assistance in a calm reassuring manner.
- Staff treated patients with dignity and respect. This was evident in the quiet, calm manner in which they spoke to patients, the way that curtains were drawn around patients in the day stay unit and with the use of closed doors in the chemotherapy suite.
- The day stay unit where patients were admitted for endoscopies had a separate room where confidential conversations could take place to protect patients' privacy.

Good

Medical care

- We spoke to two patients in the chemotherapy suite and two patient relatives. Both patients and relatives described the staff as being 'friendly' and said 'they can't do enough for us'; and 'we never have to wait'.
- Chemotherapy patients received a complimentary gift bag containing toiletries each time they attended for treatment. Patients we spoke to felt that this was a thoughtful idea and appreciated the gesture as it made them feel pampered during a difficult time.
- We looked at a 25 cards and letters sent to the chemotherapy suite staff in the previous 12 months. Comments were very complimentary such as; 'blessed to have been looked after by you', 'could not have done it without you', and 'stress free as possible'.
- Chemotherapy staff arranged a twice yearly 'tea party get together' for chemotherapy patients and were involved in a breast cancer patient support group that met every three months.

Understanding and involvement of patients and those close to them

- One patient's relative commented that although the nursing staff had been very supportive and given adequate information, they felt that they needed to see the consultant to have further questions answered. The nursing staff responded by organising an appointment with the consultant.
- Another patient and relative stated that they 'had been kept up to date of their progress throughout their treatment' and were 'fully consulted about any changes or variations of treatment'. They described the system of receiving text messages to confirm blood results as 'very useful' and said it made them feel involved in their care.
- Patients and relatives said they were encouraged to bring a relative or friend to appointments for support and this was confirmed by the nursing staff.
- As part of the provider's policy, the same named nurse usually treated patients throughout their treatment in the chemotherapy unit to ensure continuity of care.

Emotional support

- The chemotherapy staff we spoke to had a thorough understanding of the impact of condition and treatment on patients' and relatives' emotional and psychological wellbeing.
- We observed staff spending time discussing treatments, answering questions and reassuring a patient.
- Patients commented that the chemotherapy telephone advice line was a 'great lifeline' when they were feeling down or just needed a bit of reassurance.
- A holistic therapist was available who offered reflexology, mindfulness, and massage.
- A hair stylist attended a patient appointment and also visited patients in their own homes to supply, fit, and cut wigs for patients who experienced hair loss during chemotherapy treatment.
- The chemotherapy nursing staff were clinical nurse specialists and had all received oncology training which included psychological problems associated with chemotherapy and enabled them to support patients and their families.
- A counselling service was available for those patients who needed it.

Are medical care services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The Holly hospital provided chemotherapy services to privately paying and medically insured patients. Treatments were arranged according to appropriate recommended chemotherapy protocols for each individual patient and at patient convenience.
- The chemotherapy suite was recently purpose built, however there were plans to extend the service into a room on the same floor, as they were already outgrowing the space.
- The endoscopy service offered day stay appointments for both private and NHS patients. There was also overnight stay available for those patients who required it either before of following an endoscopy procedure.
- The endoscopy service was in the process of reviewing facilities to fulfil Joint Advisory Group on Gastrointestinal Endoscopy (JAG) criteria for accreditation.

Access and flow

- During the period January 2016 to January 2017, the chemotherapy suite treated a total of 82 patients who attended the chemotherapy suite on 647 occasions.

Good

Medical care

- The provider did not keep data on referral to treat times for cancer patients, so we were unable to confirm how quickly patients were seen however, both staff and patients we spoke to confirmed that treatment was commenced within days of a decision to treat being made.
- There were 751 endoscopies during the same reporting period although this was not broken down to show how many were NHS or fee paying/ medically insured patients.
- Endoscopy theatre lists were booked several weeks in advance with planned open slots. This ensured that those patients needing urgent procedures could be accommodated at short notice.
- Patients referred for endoscopy were assessed 48 hours prior to procedures to ensure that they met the inclusion criteria for day stay admission.
- Patients were usually discharged the same day following an endoscopy. Patients were given discharge letters and follow up letters were sent direct to the referring clinician.
- For detailed referral to treatment times see this section in the surgery report however, data was not broken down by service type so we were unable review endoscopy referral to treatment times.

Meeting people's individual needs

- For our detailed findings, relating to meeting people individual needs see under this sub-heading in the surgery section.
- Patients who expressed a wish to receive end of life care were able to do so and arrangements would be made at another provider, as the hospital did not currently provide end of life care services.
- The chemotherapy nursing staff said they had good informal links with the local hospice and would otherwise liaise with the patient's GP, or other preferred healthcare provider for end of life care.
- The chemotherapy suite and the day stay unit, where endoscopy patients were cared for, were both accessible by lift to assist people with mobility difficulties.
- All departments had access to telephone translation services for patients whose first language was not English and staff confirmed that they would not use relatives to translate.
- A range of information leaflets (some provided by an external charitable organisation) were available for patients to access in the chemotherapy suite. These included information on; living with cancer, understanding chemotherapy, supporting a loved one with cancer and making treatment decisions.
- Endoscopy patients were provided with a photocopied patient information leaflet regarding their procedure from an external company. However the upper endoscopy leaflet we were shown, although comprehensive concerning the type of information a patient needed, expired at the end of December 2015.

Learning from complaints and concerns

- For our detailed findings relating to learning from complaints and concerns, see this section in the surgery report.
- The data supplied by the provider did not contain a breakdown of complaints by service so we were unable to identify any learning from complaints or concerns specifically for endoscopy or chemotherapy but the chemotherapy staff told us they could not recall a complaint being made within the previous year.
- The day care unit staff told us that patients had complained about waiting times for procedures and that this was related to theatre lists being changed at the last minute. They said that this had improved following recent discussion with consultants. It was noted that theatre list changes was an agenda item on the Medical Advisory Committee Meeting held on 12th January 2017 and was being reviewed by senior theatre staff.

Are medical care services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- For our detailed findings related to the overall leadership and culture of the hospital, see this section of the surgery report.
- There was a clear leadership structure for chemotherapy nursing staff. They reported to the ward manager who in turn reported to the director of nursing and clinical services.

Good

Medical care

- Nursing staff from the chemotherapy suite and the day care unit commented that the senior management were open and approachable and two staff members confirmed they had utilised the open door sessions offered by the director of nursing and clinical services and found them useful.
- There was transitional leadership in endoscopy with a recent departure of an endoscopy lead and a new lead not yet appointed. The theatre manager was overseeing processes until the new lead was in place.
- Staff felt that they could raise concerns with senior managers and that action would be taken as a result.
- During our inspection the staff we spoke to clearly enjoyed their jobs and were very proud of the service they provided.

Vision and strategy for this core service

- For our detailed findings related to vision and strategy for the provider, see this section in the surgery report.
- The Holly Private Hospital 2017 business plan included increased medical admissions whilst their five year strategic plan included expanding the chemotherapy service.
- The endoscopy service was working towards achieving the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation in the coming year and were looking at the development of a separate endoscopy suite for the future.

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

- The service governance processes were the same throughout the provider. For detailed governance, risk management and quality measurement, see this section of the surgery report.
- There were no regular governance meetings for the chemotherapy service and representation at the corporate governance meetings was not consistent. Regular representation had been suggested in the quality and governance meeting minutes of 3 August 2016, but there was no chemotherapy representation in the meeting minutes of 23 November 2016 and no reasons were given.
- The chemotherapy department had no risks identified for the service on the corporate risk register; however they included their local risks as part of the wards risk register for local monitoring..
- Endoscopy services fell under the umbrella of the surgical management and are reported in this section of the surgery report.
- There was no evidence of audit of clinical practice or outcomes in the chemotherapy suite to monitor quality and systems such as the use of the cold cap, anti-emetics for nausea or the telephone helpline. This meant that staff could not identify trends or where action could be taken to improve the service.

Public and staff engagement

- For our detailed findings related to public and staff engagement, see this section of the surgery report.
- Locally the chemotherapy service had a folder with patient feedback comments, which was 100% positive and overall very complimentary.
- The endoscopy service had recently devised a specific patient endoscopy satisfaction feedback form but collation of results was not yet available at the time of report.

Innovation, improvement and sustainability

- The provider had recently (20 January 2017) reintroduced an endoscopy users group meeting involving key members of staff, to ensure all compliance data for Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation was in place and to work towards the development of a separate endoscopy suite.

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as Good.

Incidents

- The hospital had one never event between October 2015 and September 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.
- We reviewed the root cause analysis investigation carried out following the never event. There was evidence that learning had taken place and measures put into place to prevent similar incidents in the future. Staff were aware of the incident and the actions taken to prevent it occurring again. The incident was shared with other hospitals in the provider group and learning was included in the patient safety newsletter in July 2016.
- The hospital reported three serious incidents between October 2015 and September 2016, one of which was in relation to the never event. The number of serious incidents was not high when compared with other independent acute hospitals. We reviewed the root cause analysis investigation reports that related to these incidents, which demonstrated the learning from the incident was shared with staff.
- The hospital reported one expected death between October 2015 and September 2016 and no unexpected deaths in the same reporting period.
- The hospital reported 335 clinical incidents between October 2015 and September 2016, of which 44% (147) occurred in surgery. None of the incidents resulted in severe harm or death. The three most common themes related to missing or broken instruments in theatre, inappropriate waste disposal in clinical waste bins and medication issues. The theatre manager reported that all missing or broken instruments were replaced or repaired and the disposal of waste appropriately was discussed at the January 2017 team meeting.
- The hospital reported 182 non-clinical incidents between October 2015 and September 2016, of which 35% (63) incidents occurred in surgery.
- The hospital had an electronic incident reporting system that all staff could access to report incidents. The patient safety newsletter distributed to staff in July 2016 contained incident-reporting tips to help staff to provide all of the details of the incident when reporting an incident.
- Time was allocated within team meetings to discuss learning from reported incidents.
- The provider group encouraged all staff to complete the 'STEP- up' programme. The 'STEP- up' training was a workbook based about incidents, which incorporated reflective learning about incidents. The ward manager and the theatre manager told us that staff knew how to report incidents and the incidents they received were relevant and contained the correct information.
- We spoke to four members of staff about incident reporting and all members of staff were able to give examples of incidents they had reported. Staff told us that they received feedback individually about incidents they had raised.
- Staff had good knowledge of duty of candour and situations where duty of candour was required. We

reviewed two root cause analysis investigation reports, which showed that duty of candour had taken place. In both cases, the process was documented. Providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

- We reviewed the minutes of the medical advisory committee meetings for June 2016 and October 2016. The minutes showed that the committee reviewed incidents, unplanned returns to theatre, serious incidents, and unplanned transfers to NHS hospitals.

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

- The hospital uploaded data to the NHS safety thermometer for NHS patients and collected data for patients internally. The NHS Safety Thermometer provides a monthly **'temperature check'** on harms such as pressure ulcers, falls, urinary infection and venous thromboembolism (VTE).The hospital reported three incidents of acquired venous-thrombus embolism or pulmonary embolus between October 2015 and September 2016. The hospital conducted investigations following each of the VTE events and no themes were identified.
- The hospital used monthly "safety crosses" in clinical areas to monitor trends such as staff sickness, falls and patient conversion from day case to inpatient. We reviewed November 2016 data from the day unit which showed that there had been three episodes of staff sickness, no falls and 2 patients converted to inpatients.

Cleanliness, infection control and hygiene

- The inpatient ward areas and the theatre department were visibly clean and free from clutter. We saw wall-mounted dispensers for hand sanitising gel throughout the inpatient areas and in theatres.
- The theatre department used daily cleaning schedules for each clinical theatre and recovery. We reviewed the cleaning schedules for recovery theatre three and theatre two and found that staff had completed the scheduled cleaning for November 2016, December 2016 and January 2017. Theatre staff had the responsibility for the cleaning of theatres and cleaning staff had responsibility for corridors in the theatres department.
- Patient rooms were visibly clean with hard flooring to aid cleaning for infection control purposes. Each room had wall-mounted dispensers for hand sanitising gel for staff and patients to use. Patient rooms were thoroughly cleaned after each patient use and the nursing staff following the cleaning process inspected these.
- The hospital reported no cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), E-coli, or clostridium difficile (C.difficile) between October 2015 and September 2016.
- The hospital had a MRSA policy in place for staff to follow. All surgical patients were MRSA screened prior to admission. No patients were accepted for theatre without MRSA screening results. However, the ward manager told us that patients having cosmetic or pain injection procedures were not routinely MRSA screened prior to their procedure.
- The hospital had policies for staff to follow for hand hygiene and infection prevention and control. Both policies were up-to-date with review date clearly identified and made reference to best practice and national legislation.
- The ward had a link nurse for infection prevention and control (IPC) who assisted with IPC audits and supported staff.
- We reviewed the hand hygiene audits for the inpatient ward for January 2016 and July 2016. The audits showed staff compliance with the hospital's hand hygiene policy was 97% for January 2016 and 90% for July 2016.
- We observed staff decontaminating their hands appropriately before and after providing patient care with either sanitising hand gel or soap and water.
- Staff wore uniforms and followed the bare below the elbows policy and we saw posters to remind staff and consultants in the theatre department.
- The hospital reported that there were 11 surgical site infections between October 2015 and September 2016. All of the reported surgical site infections were following orthopaedic surgeries; all of the infections were investigated and no common themes or trends were found to link the infections.
- The surgical site infection rate for primary hip replacement, primary knee replacement, and other orthopaedic and trauma surgeries was higher than other acute independent hospitals for which we hold data.

Good

Surgery

- The hospital, as part of their actions to reduce infection rates, had introduced a referral form in the outpatient department for patients attending with potential signs of infections. This ensured that there was timely action taken and oversight from the infection control lead and microbiologist.
- The hospital had a service level agreement in place with an outside agency for the decontamination of reusable surgical equipment,and this was used when the hospital service was out of action. The theatre manager reported that the hospital had a decontamination department separate to theatres. At the time of the inspection, two of the autoclaves were out of use and external equipment decontamination service was in use. An autoclave is a device that uses steam to sterilise equipment and other objects.
- The hospital scored 99% in the patient-led assessments of the care environment (PLACE) for cleanliness between February 2016 and June 2016. This was higher than the England average of 98%.

Environment and equipment

- The hospital had 42 single patient rooms with en-suite bathroom facilities. All patient rooms had satellite television, a direct dial telephone and internet access. One ward area was located on the first floor with 28 patient rooms and a further ward was located on the second floor with 14 patient rooms.. Both ward areas were used for day case procedures and overnight stays.
- The theatre department was situated on the lower ground floor. This comprised of five theatres all with anaesthetic rooms and a six bay recovery area. Three of the theatres had laminar flow and four of the theatres had integrated camera systems for laparoscopic and arthroscopic procedures. The hospital had the facility to undertake endoscopy procedures and these procedures were restricted to theatre four.
- Resuscitation trolleys were available in the theatre recovery and in the ward area. The resuscitation trolleys were sealed with a breakable tag with a unique identification number, which was recorded in the records. The trolleys contained adult and paediatric resuscitation equipment and medicines. The paediatric equipment was separated in different drawers that were clearly labelled.
- We reviewed the records for the daily and weekly resuscitation trolley checks in the ward area for October 2016, November 2016, December 2016 and January 2017. The records were complete without gaps.
- We checked 12 electrical items from the ward and the day-case unit, including a patient hoist, and found all items had been electrical tested. All of the items had a sticker attached with a due date for the next electrical test.
- We checked seven electrical items in theatre including a ventilator and an anaesthetic machine. All of the machines were up-to-date with servicing and electrical testing.
- We reviewed the results of the last environment and equipment audit undertaken in January 2016, which showed the inpatient ward scored 97%.
- The hospital had a separate day care unit, which comprised of eight bays with male and female segregation. All of the bays had personal entertainment systems for patients to use during their stay.
- The hospital scored 98% in the patient-led assessments of the care environment (PLACE) for condition, appearance, and maintenance between February 2016 and June 2016. This was higher than the England average of 93%.
- The theatre department kept an up-to-date implant register. Two books were in use; one for orthopaedic implants and another for all other surgical implants. These records were kept for 10 years following procedures and included the serial numbers for each implant with patient identification.
- Bariatric operating tables were available. However, at the time of inspection to hospital was not undertaking bariatric surgery.

Medicines

- The hospital had medicines management and controlled drugs policies in place for staff to follow. Both policies were up-to-date with a clear review date and referenced national guidance and legislation.
- We reviewed the storage on medicines within the theatre department and in the ward area. In both areas, medicines were stored appropriately in locked cupboards. The cupboards were well organised and tidy. We checked 20 medicines and found all of them were within the expiry date.

- We reviewed the storage of controlled drugs in recovery and in the ward, in both cases we found they were stored in double locked metal wall mounted cupboards. The storage of controlled drugs complied with national legislation.
- We checked the ward controlled drugs stock level, which matched the controlled drugs register. The records showed that staff had checked controlled drugs daily between October and December 2016 and in January 2017.
- The theatre department had a fluid warmer with an alarm to alert staff if the temperature was out of range. In addition, staff checked and recorded the temperature daily. Staff had labelled the fluids with the date they were placed in the warmer and a discard date. We saw records that staff checked the fluid warmer on a daily basis.
- We reviewed the medicines management audit for theatres completed in September 2016, which scored 81% for the correct storage and management of medicines. The hospital target was between 86 and 100%. The result was below the target because the flammable substances storage cupboard was untidy, medicines were not always locked away when not being used. We reviewed the flammable substances cupboard which was tidy and well organised and medications were locked away when not in use.
- The medicines management audit for the ward was completed in May 2016, which scored 84% for the correct storage and management of medicines. The hospital target was between 86 and 100%. The ward had lower than expected results due to the management and recording of medicine fridge temperatures. Records reviewed during our visit showed that medication fridge temperatures were recorded daily.
- We reviewed the results of the missed dose audit completed in October 2016. The audit showed that out of 100 records reviewed there were 11 missed doses with 10 having the correct omission reason. One of the missed doses had no documented reason for omission.
- The prescribing audit for September 2016 scored 100%. The audit looked at the correct prescribing of medicines, legibility and signature of the prescriber. The audit result was lower than the target due to 50% of the medication records did not have allergies recorded. However of the five prescription records we reviewed 100% had recorded allergies.
- The hospital had a blood storage facility located in the theatre department. The local NHS trust supplied units of cross-matched blood to the hospital through a service level agreement and two unit of O negative was available in the event of an emergency. The laboratory service within the hospital was responsible for the monitoring of the blood storage with temperatures monitored electronically.
- We reviewed five patient prescription charts and all prescribed medicines had a signature and date. No medicines were omitted and medicines were given to the patients at the specified times.

Records

- Staff kept patient medical records in one folder with clear sections for consultant and nursing notes, test results and risk assessments. Staff kept patient medical records securely within the staff area of the ward organised by the patient room number. Medicine charts and some of the assessments in regular use such as national early warning score charts were kept in the patient rooms.
- We reviewed seven sets of patient medical records and found that the inpatient records were legible and contemporaneous with a dates and signatures for each entry. However, two patient records reflected that a pre-operative assessment had taken place but the records had no signature or date recorded. Five patient records demonstrated completed pre-operative assessment that were signed and dated.
- We saw seven patient records and all of them contained correctly completed risk assessments for example the malnutrition universal scoring tool (MUST) and venous-thrombus embolism risk assessments.
- The hospital completed a records audit every month, we reviewed the audit for July 2016, which showed that all risk assessments were completed appropriately for all 10 patient records audited.
- We reviewed three patient records for cosmetic surgery records and found that clinic records were kept separately from the inpatient notes. We raised this at the time of inspection and were informed that the hospital was in process of integrating cosmetic surgery patient clinic records with the inpatients records.

Safeguarding

- The hospital had three leads for safeguarding children, the director of nursing, the outpatient's manager and

the ward manager, all of whom had been trained to level three safeguarding adults. The director of nursing had completed her level four safeguarding child training.We saw that safeguarding was on the agenda of all of the quarterly quality meetings where safeguarding issues were discussed and minuted.

- Between April 2016 and January 2017 88% of clinical staff working in inpatient areas and theatres had completed safeguarding adults level one training and 85% had completed the training to level two. This was against a compliance target of 90% which ran from April to March each year. However, the training data related for the time-period between April 2016 and January 2017 and did not reflect a full year of training data.
- The training data showed that 91% of inpatients and theatre staff had completed safeguarding children to level one and 83% of staff had completed the training to level two. The theatre manager had been in post for three weeks prior to the site visit and was in the process of completing the role induction which was to include safeguarding level three.
- We spoke to four members of staff about safeguarding and all of the staff gave examples of situations where they would raise safeguarding concerns to the identified safeguarding leads.
- Policies for safeguarding adults and children were in place for staff to follow. The policies were comprehensive, up-to-date with a clear review date and referenced best practice, national guidance and legislation. The policy also made reference to female genital mutilation (FGM) and how to escalate staff concerns.
- We saw safeguarding boards with flow charts detailing the local process for raising safeguarding concerns in the ward area and in the theatre department. The board also identified the hospital safeguarding leads.

Mandatory training

- The hospital had a programme of mandatory training for all staff. Mandatory training included: Fire safety, health safety and welfare, safeguarding adults level one and two, safeguarding children level one and two, moving and handling, infection prevention and control, basic life support/paediatric basic life support and intermediate life support (for registered professionals).
- The mandatory training data for the period between April 2016 and January 2017 showed a compliance rate of 76% for ward staff and 70% for theatre staff. The target compliance rate for mandatory training was 90% at the training year-end (March 2017). The ward manager told us that one of the junior sisters was responsible for tracking staff mandatory training. We saw an electronic spreadsheet used by the ward to track the completion of staff mandatory training to ensure staff completed this. The service was on trajectory to ensure all staff had received mandatory training.
- We spoke to four members of staff about mandatory training and all of them reported that they had completed the required training. They reported that they had access to eLearning modules and one of the ward sisters alerted them when they were due to complete refresher training.

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

- All admissions were agreed with the admitting consultant and patients were health screened in a nurse-led pre-assessment consultation prior to the procedure. The pre-operative assessment was either by telephone for minor procedure or face to face for surgeries that were more complex. This enabled staff to screen patients for pre-exisiting medical conditions and to discuss the procedure with the patient.
- The hospital had admission criteria for all inpatient admissions set out in the admission and exclusion criteria standard operating procedure. This was in place to ensure that high-risk patients were not accepted for surgery where critical care services may be required following procedures.
- The hospital used the National Early Warning Score (NEWS) to monitor patients for signs of deterioration. The primary purpose of the NEWS is to provide a physiological score to prevent delay in intervention or transfer of critically ill patients. There was an escalation process in place if patients were showing signs of deterioration, which would include review by the resident medical house officer (RMO).
- Consultants would be contacted by staff, if they had concerns about their patients. Consultants were required to be available on site within 30 minutes which was stipulated as part of practising privileges.
- The hospital scored 95% for the NEWS audit undertaken in August 2016 and had met the hospital target of 95%. The NEWS audit was undertaken every three months to form part of the clinical quality dashboard.

- The hospital completed the World Health Organisation (WHO) five steps to safer surgery checklist for each surgical procedure undertaken. We observed the completion of the checklist, which staff and surgeons completed correctly for each of the steps.
- The surgical safety checklist audit undertaken by the hospital in September 2016 scored 98% compliance in the completion of the checklist. Of the 10 records audited, the surgeon at the sign out stage did not sign two of the checklists. The audit was undertaken every three months to form part of the clinical quality dashboard.
- The hospital used the 'sepsis 6' bundle to aid staff in the prompt recognition and treatment of sepsis. The patient safety newsletter sent to staff in October 2016 had an article about the 'sepsis 6' bundle and website link for further information and training videos.
- The hospital had a patient transfer policy in the event of a deteriorating patient and a service level agreement with the local NHS trust in the event of an emergency.
- The hospital had provision to undertake psychological assessments for cosmetic surgery patients. A counsellor was available every Wednesday to review cosmetic surgery patients in the cosmetic surgery suite. The counsellor worked under practising privileges.
- The hospital had an on-call rota for radiologists and radiographers for any out-of-hours emergencies.

Nursing and support staffing

- The hospital used the 'staff manager plus' acuity tool as an assessment to ensure the correct number of nursing staff and skill mix were in place to meet the expected patient acuity. The nurse to patient ratio was 1:4.
- The inpatient ward employed 34.7 whole-time equivalent registered nurses and 9.7 whole-time equivalent healthcare assistants (HCA). The ratio of registered nurses to healthcare assistants was 3.6 to 1.0. This meant that the ward had more nurses than health care assistants. There was one vacancy registered nurse (RN) vacancy at the time of inspection.No agency staff were used on the ward between October 2016 and September 2016.This was lower than the average compared with other acute independent hospitals.'
- Inpatient services used bank nurses to cover unfilled shifts. Between October 2015 and September 2016 the rate of bank registered nurses used ranged from 1% to 9% , and only 2% of bank health care assistants (HCA) was used in August 2016. Staff could also flex between working in the ward area to day care unit to support busier times. The rate for bank use was lower than other acute independent hospitals.
- Theatres employed 29.3 whole time equivalent registered nurses and 14.6 whole time equivalent operating department practitioners (ODP) and HCAs. The ratio of registered nurses to ODPs and HCAs was 2.0 to 1.0. There was one vacancy at the time of our inspection.
- Theatres used bank nurses, ODPs and HCAs to cover unfilled shifts. The rate of bank and nurse used was between 11% and 27% between October 2015 and July 2016 and was 7% for August 2016 and September 2016. The use of bank and agency registered nurse was higher than the average compared with other acute independent hospitals.
- Theatres operated an on-call rota to cover out of normal working hours for any emergencies where patients had to return to theatre.
- The theatre manager reported that they followed the Association for Perioperative Practice (AfPP) guidelines for theatre staffing and the hospital had (AfPP) accreditation. This was to ensure that each theatre team had the correct skill mix.
- Staff had full nursing handovers at every shift change. Information included the surgical procedure any concerns and outstanding actions.

Medical staffing

- The hospital used five resident medical officers (RMO) who provided medical cover to the hospital 24 hours a day seven days a week. An agency provided the RMOs through a service level agreement.
- The shift pattern for the RMOs was 12 hour shifts either days or nights for seven days with a seven-day break.
- All consultants and anaesthetists working under practising privileges were required to be available on the telephone and in person whilst their patients are in hospital. In the event that consultants were unavailable, they had to arrange appropriate named cover and inform the senior management team.
- One of the RMOs reported the medical staff had handovers at the beginning and at the end of their shifts. The handovers took 20 minutes to discuss all inpatients and any concerns. The RMO told us that the handovers were detailed and 'very good'.

Good

Surgery

Emergency awareness and training

- The hospital had a major incident policy in place, which staff could access electronically. The policy set out staff roles in the event of a major incident such as a fire or bomb threat and the process for evacuation.
- The hospital also had a business continuity plan in place in the event of loss of communications or power cuts.
- The ward manager confirmed that staff had fire drills and evacuation practice every six months to ensure staff knew the procedure in the event of an emergency.

Are surgery services effective?

Good

We rated effective as Good

Evidence-based care and treatment

- We reviewed a sample of the hospital policy documents, for example the controlled drugs policy, infection prevention and control and the record keeping policy. Care plans and pathways all followed national guidance and best practice. In all cases we found that they were up-to-date with the next review date and referenced relevant best practice and legislation documents.
- We spoke to four members of staff about policies and all of them knew how to access the policies electronically via the hospital intranet. One member of staff demonstrated how to access the policies.
- The hospital had a clear internal audit plan in place with audits undertaken each month according to the schedule. The compliance to local policy was measured against the audit performance benchmarked against other hospitals in the provider group.
- The hospital was a member of the Association of Independent Healthcare Organisations (AIHO) and the Private Healthcare Information Network (PHIN). This network aimed to improve the availability of outcome data in the private healthcare sector.
- Practicing privileges for cosmetic surgery were held by eight surgeons, and all the surgeons were on the General Medical Council (GMC) specialist register. In addition, all of the surgeons were registered on the national breast and cosmetic implant register. The hospital had started to collect Q-Proms data for cosmetic procedures. This is a way of measuring improvement following surgery however no data had been published.
- Implant registers were kept in theatres one was used for orthopaedic implants and another register for all other implants. The registers were up to date containing implant serial numbers and patient information for each entry.
- The hospital actively took part in the provider company bench marking process. The provider group rated all hospitals within a table for key point indicators and targets. These were colour coded red, amber and green (RAG) rated against each performance marker. The hospital performed in line or better against similar size hospitals within the group.
- The hospital was measured against commissioning for quality and innovation (CQUIN) standards set out by the local clinical commission groups for NHS patients. CQUIN's are a measure of improvement in quality of services and better outcomes for patients.

Pain relief

- We reviewed five patient medication charts that showed pain relief was prescribed during the admission process.
- We observed nursing staff asking patients about their pain and offering pain relief as required giving information about the benefits to regular pain relief.
- We spoke to two patients about pain relief and both patients told us their pain was managed well by staff. One patient told us that staff asked about pain levels and were timely in giving pain relief.We reviewed the pain audit undertaken in September 2016, which scored 100%.10 sets of patient records were reviewed for the purposes of the audit. In all cases, staff reviewed pain and documented on the NEWS chart. In addition, all 10 records evidenced effective pain management was in place throughout the patient journey. The pain audit was undertaken every three months and formed part of the clinical quality dashboard.

Nutrition and hydration

- The hospital offered all inpatients three meals a day from the hospital a la carte menu. The food was cooked on site and the kitchen catered to individual requirement for patients with food allergies or special dietary requirements.

- One patient told us that the food was excellent and staff had made a big effort to provide tasty food for the patient's soft diet requirements after surgery.
- Another patient told us they did not want to go home because the food was so good.
- The ward manager confirmed that patients were advised that they should not eat for five hours before surgery but were able to drink water until two hours before their surgery. This information was sent to the patient prior to their admission.
- Fasting audits for February, August and November 2016 showed that compliance with the pre-operative fasting guideline policy, and the documentation of fasting time on patients notes were between 95-100%.This compliance had improved in line with the staggered admission times and improved communication to patients.
- Staff would contact the responsible anaesthetists if there were theatre delays to ensure patients were able to continue to drink water or whether intravenous fluids were required.
- We sampled a selection of dishes available on the a la carte menu to inpatients. All of the food was well presented and tasty.
- The hospital scored 90% in the patient-led assessments of the care environment (PLACE) for ward food between February 2016 and June 2016. This was lower than the England average of 92%. The hospital had changed the a la carte menu in the autumn of 2016 in response to the feedback they had received.

Patient outcomes

- The hospital participated in national audits for example patient reported outcome measures (PROMs) for patients who had primary hip replacements, primary knee replacements, and hernia repairs.
- The Oxford Knee Score following primary knee replacement surgery 100% of patients reported an improvement between April 2015 and March 2016.
- The Oxford Hip Score following primary hip replacement surgery 100% of patients reported an improvement between April 2015 and March 2016.
- The hospital had 17 unplanned transfers to other hospitals between October 2015 and September 2016. The rate of unplanned transfers was not high when compared to other acute independent hospitals. All of the unplanned transfers were investigated and no themes or trends were found.
- The hospital had 13 unplanned readmissions within 28 days of discharge, between October 2015 and September 2016. The rate of unplanned admissions was not high when compared to other acute independent hospitals.
- The hospital had 10 cases of unplanned return to the operating theatre between July 2015 and June 2016. The theatre manager reported that three patients had returned to theatre following breast augmentation surgery. No trends or themes were found for these cases or in the other seven cases that had returned to theatre.

Competent staff

- The hospital director sort advice from the medical advisory committee (MAC) granting any consultants and allied health professionals practicing privileges regarding their qualifications and registration. The hospital reviewed all professionals with practising privileges every two years following the submission of documentation of registration, indemnity insurance, and revalidation.
- The MAC minutes for October 2016 reported that 93% of consultants had provided a copy of their appraisal documentation, the remainder 7% were being managed locally by the senior management team. The consultant appraisal process took place within the NHS and the hospital liaised with the employing NHS trusts. The hospital suspended practising privileges of consultants if appraisal and revalidation documentation was not received.
- Two consultants had their practising privileges removed between October 2015 and September 2016. One consultant retired and the other consultant failed to provide the required documentation of appraisal and indemnity. In addition four consultants had their practicing privileges suspended as they failed to provide the required documentation and were reinstated once the required documentation was submitted.
- The hospital used agency resident medical officers (RMO). Each RMO was required to produce evidence of mandatory training for example advanced life support training. The RMO also completed a local induction process. One of the RMOs told us that they had completed the hospital induction process at the start of the contract.

- The hospital appraisal year ran from April to March each year and 100% of nursing staff and healthcare assistants for inpatient services had received an appraisal since April 2016.
- The data showed that 88% of theatre nursing staff and 80% of healthcare assistants and operating department practitioners had received an appraisal since April 2016. This was ahead of trajectory.
- The hospital had a policy in place for clinical supervision, which was up-to-date with a clear review date. The policy sets out responsibilities of the department managers in ensuring staff are competent to carry out their roles. All staff should receive one-to-one meetings with their line manager and an annual appraisal.
- We reviewed one staff folder on the ward and found that the competency checklist was complete and included certificates for additional courses and higher education. The provider employed a nurse educator that provided group-training sessions and one to one training which was booked as required.
- The hospital sponsored staff to complete degree modules and has started to sponsor staff to complete nurse training.

Multidisciplinary working

- There was a multi-disciplinary handover each morning, which included the department managers, resident medical officer, physiotherapists and the pharmacist. This ensured that any patient concerns, incidents and complaints were discussed during this handover.
- The theatre manager would liaise with the ward daily to communicate any issues or delays in theatre or on the ward and to confirm the patient admissions.
- Discharge planning for patients started during the pre-operative assessment process and if any support was anticipated, the hospital liaised with community services such as community nursing. This meant that the hospital were able to discuss patient needs prior to their discharge for example the provision of specialist equipment was in place on discharge.
- The hospital had service level agreements in place with outside organisations to provide pathology, microbiology and blood testing services to the hospital.

Seven-day services

- Radiologists and radiographers had on call rotas to ensure that inpatients had access to diagnostic imaging 24 hour a day seven days a week if required. In addition, the theatre department had an on-call rota for any unplanned returns to theatre in the event of an emergency.
- As part of consultant practising privileges, consultants were required to be on-call 24 hours a day for the duration of their patient's hospital stay.
- The hospital had an on-site pharmacy, which was open 8:30 am to 8pm Monday to Friday and 9am to 1pm on Saturdays. The pharmacist was present on site during these hours for advice.
- The ward manager or their deputy accompanied by the RMO had access to emergency drugs in the pharmacy out of hours. The hospital had a standard operating procedure in place for this.
- RMOs were available 24 hours per day in the event of a medical emergency to support the nursing staff.
- Inpatients had access to physiotherapy seven days a week on the ward.

Access to information

- Medical records were stored securely on the ward during patients stay in hospital, which were available at all times. The medical records were stored on site for six months following patient discharge and then moved to an off-site storage facility.
- Prior to discharge staff faxed a letter to the patient's GP and a copy of the letter was given to the patient. The consultants sent a typed letter to the patient and their GP outlining the procedure and recovery following discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a mental capacity act and deprivation of liberty policy in place for staff to follow. Staff were required to complete an eLearning training for the mental capacity act.
- The hospital accepted some patients living with mild dementia and learning difficulties. However the hospital required all patients to have capacity to give informed written consent for treatment.
- We reviewed four sets of medical records for inpatients and saw a correctly completed signed and dated consent form in each of the records.

Good

Surgery

- The theatre manager and the ward manager told us that staff used either telephone or face-to-face translation services when gaining written consent from patient for their procedure.
- The hospital had a policy for do not attempt cardiac pulmonary resuscitation (DNACPR). The hospital had one occasion in the last 12 months where a DNACPR directive was used for a patient who had chosen to die at the hospital.
- We reviewed three cosmetic surgery records, which showed that in all cases patients, had two weeks between the first outpatient consultation and their surgery, which allowed for a cooling off period, as set out in the Royal College of Surgeons professional standards for cosmetic surgery 2016.

Are surgery services caring?

Good

We rated caring as Good.

Compassionate care

- We observed the care nursing staff provided to patients and we found at all times that staff were polite compassionate and sensitive to the individual needs of their patients.
- Staff respected patients' privacy and dignity at all times with doors to private patient rooms closed during the provision of care. In addition, staff closed curtains in recovery and the day-case unit during the delivery of nursing care.
- Patients told us that they felt staff had cared for them well and respected their privacy and dignity at all times.
- One patient told us the care was excellent and first class as staff took the time they needed to give care. The patient planned to write to the hospital following discharge to praise the staff for the care they had provided.
- Another patient told us that the staff were "lovely" and that one of the nurses had purchased chocolate out of her own money because the patient fancied it after surgery.
- The hospital carried out the friends and family test for NHS patients and had an internal patient survey for private patients.
- The friends and family test results between April 2016 and September 2016 showed that 99% of patients would recommend this hospital for April and May, 98% for July and August and 97% for June and September. The hospital friends and family test results were below the England average of 99%during this period.
- The internal patient survey between April 2016 and September 2016 showed that 98% of patients would recommend the hospital to friends and family.
- The hospital scored 79% for privacy, dignity and wellbeing in the patient-led assessments of the care environment (PLACE) between February 2016 and June 2016. This was below the England average of 83%.

Understanding and involvement of patients and those close to them

- Each patient had an allocated named nurse for each shift; patients told us that nurses introduced themselves at each shift change.
- Two patients told us that staff had communicated with them well and involved them in decisions about their care. Both of the patients felt staff had prepared them well for their procedures and answered any questions.
- One patient told us that staff had made sure she had information at every stage of treatment to help make decisions about her treatment.

Emotional support

- One patient told us that staff had supported them following a cancer diagnosis and following the surgical intervention. The patient said that staff had spent time to talk through any worries, which had made a bad diagnosis much easier.
- The hospital had access to specialist nurses who were employed by the provider group to give patients extra support in their area of specialism. In addition, the specialist nurses supported the hospital staff to meet the needs of their patients for example the dementia specialist nurse. The specialist nurses visited the hospital upon request.
- The hospital had a counsellor for cancer and cosmetic surgery patients. The director of nursing planned to have fully inclusive counselling service for all patients in the future.

Are surgery services responsive?

Good

Surgery

Good

Service planning and delivery to meet the needs of local people

- The hospital offered services for private and NHS patients. Privately funded patients had access to treatment by general practitioner referral or by self-referral for treatment. The hospital offered bookings to patients for their procedure at a time that suited them.
- The hospital planned all surgeries and procedures in advance; this allowed the hospital to meet the needs of the patients. The hospital did not accept emergency admissions.
- We spoke to the ward manager and the theatre department manager about service planning and delivery. They both reported they attended the weekly planning meeting and they only took bookings for the existing availability according to planned staffing on the ward and the availability of theatre space.
- Decisions were taken appropriately involving all relevant staff members. For example, the service had recently ceased their bariatric patient service. This was because they did not feel confident they could offer the quality of service they wanted and had limited access to dieticians.

Access and flow

- NHS patients were able to choose an appointment date and time of their initial consultation at their convenience via choose and book. The hospital provided a non-urgent service where patients could book an appointment two weeks after the initial referral.
- The referral to treatment (RTT) rate for NHS patients admitted within 18 weeks was above 93% for every month between January 2016 and November 2016, which was better than the national target of 92%.
- Theatre staff worked to an on-call rota to ensure the hospital could provide surgery to patients requiring an emergency return to theatre 24 hours a day. Both the named consultant and anaesthetist remained on-call for the duration of their patients hospital stay. The hospital cancelled 26 procedures between January 2016 and January 2017 for non-clinical reasons for example consultants starting late. All of the patients were offered another appointment within 28 days of the cancelled procedure in accordance with national guidelines.
- There had been two episodes of procedures of the 26 being cancelled due to the theatre lists starting late. However the theatre manager was in the process of changing the theatre lists to lock the list at 5pm the day before to prevent alterations to the schedule. This aimed to reduce patient waiting times on the ward and to reduce theatre delays. In addition the theatre manager escalated any issues with late consultants with the senior management team.

Meeting people's individual needs

- The hospital had a dementia link nurse to support patients during their stay in the hospital. In addition the link nurse facilitated education sessions for the staff and supported them to tailor care to meet the needs of patients living with dementia.62 staff had been trained as dementia friends and clinical areas had a dementia resource pack. Patients living with dementia were allocated close to the nurses station for closer observation and for staff to be close by to give assistance.
- Staff had access to translation services either face-to-face or via the telephone when a patient's first language was not English. We spoke to two members of staff about translation services and both of them told us the hospital had access to translation services through language line. Face-to-face interpreters would be booked in advance to attend theatre with a patient whose first language was not English.

Learning from complaints and concerns

- Between October 2015 and September 2016 there were 88 complaints. None of the complaints were referred to the Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) for the same reporting period.
- The three main themes of the complaint received between May 2016 and October 2016 were poor consultant attitude, unhappy with nursing care and billing issues.
- The registered manager of the hospital was responsible for the management of complaints and was supported by a team of senior managers. The senior management team discussed all complaints at weekly senior

management team meetings. Learning from complaints was disseminated to staff at team meetings, and complainants were invited for meetings with the hospital director to discuss concerns.

- The hospital sent an acknowledgement of the complaint within two working days and a full response to the complaint within 20 days. The provider governance team monitored the timeliness for complaints responses.
- The hospital reported that all inpatients received information about how to raise concerns and the formal complaints process.
- Patients due to be admitted to the day-case unit were contacted 48 hours before their admission for staff to explain the unit and how it works. This pilot was implemented due to feedback from patients who had treatment prior to the opening of the day-case unit. Patients had expected to be in a private room on their return rather than placed in the day-case unit. However, patients could request a private room for their stay when staff contacted them.
- We spoke to four members of staff about complaints, all of the staff reported they felt able to manage verbal complaints from patients or their relatives or able to escalate complex issues to the line manager. They confirmed that the team discussed complaints at the monthly team meetings.
- The theatre manager and the ward manager both confirmed that complaints were discussed within the department team meetings every month. We saw evidence of the last team meetings (January 2017) for both departments, which showed that complaints had been discussed and lessons learnt.

Are surgery services well-led?

Outstanding ☆

We rated well-led as Outstanding

Leadership / culture of service related to this core service

- There was a relatively new leadership team, as the hospital director, director of nursing and clinical services and development director had all been in post for less than a year at the time of our inspection. However they had integrated well into the hospital, worked very closely with each other and with departmental staff and showed strong leadership.
- There was a positive, team-based culture in all areas of the hospital and within the leadership team. We were told that there had previously been issues around culture within surgery; however a new theatre manager had been in post for three weeks and the senior leadership team told us this had made a noticeable positive difference to the culture. This was also supported by evidence from staff in theatres.
- Staff at all levels, and the senior management team (SMT), were enthusiastic and engaged with their work. The SMT were visible and approachable; we were told of examples where members of staff had approached the matron or hospital director directly to seek advice and the team prided themselves on the open and transparent culture. For example, the matron ran weekly drop-in sessions for any member of staff to speak openly about anything and we were told these had been very popular.
- The MAC Chair told us they were proud of the culture of challenge that existed in the hospital.
- During the inspection, seven registered nurses came to speak to us about working for the hospital. They felt supported by senior staff, spoke highly of the ward manager and the director of nursing, and talked about the open no blame culture. They reported that the director of nursing had an open door policy and was always accessible. They all reported feeling happy in their roles, the hospital was a happy place to work with a strong teamwork approach.Long serving staff were recongised at yearly milestones, and awarded a pin, to signify their dedication to the hospital.
- Staff were given the opportunity to their personal development through the “investing in your traning”, which also incorporated Aspens values.

Vision and strategy for this this core service

- There was a clear vision and strategy for the hospital which was summarised in their five-year strategy 2016-20121, and aligned with the Care Quality Commissions framework on delivering safe, effective, caring and well led care.The strategy had been launched as “project FIRST” and incorporated the hospitals business plan, clinical strategy, staff rewards and recognition scheme.

- Staff in all areas showed engagement with and awareness of the vision for the hospital and were supportive of it.The the strategy had been communicated through a number of workshops, at the time of staff induction and through internal communications.
- The strategy included plans such as growing their proportion of private work to around 70% (at the time of our inspection it was around 55%); building a dedicated dining area for patients and families; and expanding their chemotherapy service.
- The strategy recognised key challenges such as social care in the community and a decline in the number of registered nurses. However, the senior management team were able to give examples of how they were trying to foresee and mitigate these challenges; for example through closer working between the hospital's NHS contracts manager and the local clinical commissioning group (CCG) to identify potential gaps in the local health care community.
- The theatre manager started in post three weeks prior to the inspection and had an impressive knowledge of the service and the areas of improvement required within the department. They had a clear vision for the department and talked at length about the strategic aims for the next 12 months. One of the aims was to develop a hospital pain team to aid staff in post-operative pain management.

Governance, risk management and quality

- There was a clear governance structure in place with clear lines of accountability. For example staff knew who to contact in relation to escalating safeguarding concerns and there was a named staff member responsible for maintaining the risk register. We spoke with this staff member and they were able to explain how the risk register was managed both departmentally and hospital-wide.
- Each speciality had an individual risk register which was reviewed monthly at the health and safety meetings. The hospital used a scoring system for assessing risk. Risks scoring 12 or above were added to the hospital wide risk register and the registered manager of the hospital was notified.
- The senior management team showed good awareness of the main risks in the service. We reviewed the hospital-wide risk register and saw evidence that these were continually assessed and included ownership of risk and dates for review. They were also able to explain examples of actions they had taken to mitigate risks, such as resurfacing the car park to reduce potential hazards for patients, staff and visitors.
- The ward risk register had 19 active risks appropriately identified and each risk had a date added to the register, for example equipment replacement. The replacement of equipment was being addressed by the senior management team.
- The theatre manager was in the process of reviewing all of the risk assessments for the theatre department to help identify any gaps in risk register. The theatre manager had been in post three weeks and wanted to ensure that the risk register was relevant and up-to-date.
- We saw two of the completed risk assessments for electrocution from faulty equipment and the manual handling risk assessment for patient transfer and positioning on the operating table. Both of the risk assessments were comprehensive and had a review date.
- The Medical Advisory Committee comprised of 15 members representing each speciality and had a formal meeting every three months. The MAC chair told us that subjects of discussion included, but were not exclusive to, any safety or quality concerns; business decisions; and updates in legislation or national guidance. This was supported by minutes from MAC meetings for the period January – October 2016.
- The MAC Chair had been in post for a year at the time of our inspection and was at the hospital four times a week in either a clinical or advisory capacity. They met formally with the hospital director fortnightly but had strong links with the hospital director and matron as they were on site so frequently.
- The MAC Chair was visible and approachable to departmental staff and was committed to ensuring all staff were able to have any concerns discussed. For example, although allied health professionals did not attend MAC meetings, they could raise issues to the director of nursing and clinical services who would refer them to be discussed at meetings.
- The MAC chair would also arrange for external speakers to come in to help improve their knowledge; for example at the last meeting in October 2016 a solicitor had attended to talk about legal changes in consent processes.

- There was a new tripartite governance structure in place consisting of the quality governance lead, deputy lead and director of nursing and clinical services. The aim of this was to ensure sufficient oversight of quality, risk and areas for development. A new quality and risk manager was due to start at the end of January 2017 and the senior management team were clear on how they would integrate into the team in terms of governance arrangements.
- Each morning there was a 'huddle' with all heads of department and the SMT to prepare for the day ahead, including discussion of patient numbers and daily key performance indicators (KPIs). This helped ensure there was a clear focus each day for each core service. Following the meeting a communication called the "Holly Herald" was sent out to all staff and displayed on notice boards to ensure all staff had access to the information.
- Clinical heads of department attended the clinical governance committee and cascaded information to their team members. 'Hot boards' across the hospital displayed governance information regarding safety and quality and staff had access to 'our quality' portal via the intranet.
- The quality governance indicator dashboard had 75 key performance indicators (KPIs) mapped against nine quality drivers. The dashboard was discussed as the quartley governance meetings and at the MAC meetings. We reviewed the MAC minutes from January 2017, and the minutes for the quality governance minutes from November 2017, and found both to be comprehensive, with clear review of the KPIs and actions taken if required.
- There was evidence of effective performance monitoring by service leads. For example, there were daily 'comms cells' which were dedicated to reviewing daily key performance indicators (KPIs), incidents and lessons learned, and to communicating key information to heads of department before service activity commenced for the day.
- As part of the clinical strategy, in September 2016, the hospital had run 'STeptember', a programme dedicated to quality and safety improvements.This involved the director of nursing and clinical services, compiling a questionnaire for all staff focusing on safety and behaviours amongst staff. This was completed by 259 members of staff, and led to a number of initiatives such as "LK today" and "back to the floor" (refered to under public and staff engagement section). The questionnaire was due to be re run in March 2017.
- The strategy also included included Aspen's 'STEP-up to Safety' training (attended by 265 staff; staff screenings of 'Barbara's Story' (a dementia traning film) and 'It's a Routine Operation' (attended by 66 staff with further screenings arranged); There was weekly staff drop-in sessions to discuss any issues or concerns; and developing and sharing the clinical safety strategy. The clinical safety survey and strategy was also discussed by the MAC as part of this initiative to improve safety and quality. This was well attended by staff.
- Monthly observational audits were carried out in patient areas, in which a member of staff would observe interactions between staff and patients, as well as the environmental factors over a set period of time. We reviewed one months audits results, and saw how positive observations were recorded, and also areas that required improvement, which were then put onto an action plan for the head of the department to action. This was part of the clinical quality strategy to drive improvements in patient experience.
- The service was engaged in the Private Healthcare Information Network (PHIN) and had submitted all required data to PHIN by 1 September 2016, including patient satisfaction, activity data, adverse events, and private PROMS data. A representative from Aspen as the provider attended all monthly PHIN meetings. At the time of inspection, the service's data quality compliance with PHIN was at 99.8%.

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

- There was a strong focus on engaging with patients and the local community to gain feedback about the service and drive improvement. For example, the hospital ran two to three patient forums a year, with approximately 10 representatives who were regular users of the hospital, to share developments with the patient community and obtain their suggestions for improvement.
- There were monthly Patient Focus Group meetings which focused on areas for improvement highlighted in the patient feedback and discussed any negative patient comments.

- The hospital had introduced customer service training to all staff to ensure that all patients, families and carers received a positive experience when attending the hospital. The director of services and patient experience , responsible for customer service, provided examples of how they had used this to improve customer service, such as encouraging the reception staff to stand when welcoming a patient or visitor into the hospital; and holding discussions with consultants to improve their communication and drive a more patient-friendly approach. The most recent patient survey indicated this had led to improvement in satisfaction.
- Following all staff completing the customer service training, the hospital had been awarded the Worldhost© customer care recognition status (the same customer care training the London 2012 Olympic Games Makers received) reflecting the work of staff going the "extra mile" to improve patient experience.
- A monthly patient satisfaction survey was carried out with results put into a dashboard and red, amber, green (RAG) rated dependent on a set of scoring criteria.
- We reviewed the patient satisfaction dashboard from 2016. There had been a period of six weeks in 2016 in relation to poor feedback regarding consultants communication with patients. This had been addressed through the SMT , and subsequent data showed there had been a significant improvement, with all weeks receiving a green rating.
- There were systems in place to engage staff at all levels and recognise commitment and achievement. For example there was a '6E's' staff recognition scheme in place, which involved staff obtaining evidence through their work that they were displaying the service's core behaviours of 'exceptional, effective, expert, energetic, efficient, everyone'. Staff could document this in a specially designed booklet. The service was planning to expand this, so that new members of staff joining the service would have a buddy or mentor to help them.
- The hospital had organised an "Oscars night" in January 2017 in which staff would be recognised for their achievement and commitments to the hospital, by evidence of achievements, voted for by peers or through recognition from the senior management team. Achievement, such as exceptional evidence of displaying the '6E's' core behaviours, was to be rewarded with prizes. There was an ""Oscar night" planned for September 2017.
- All staff received regular updates via newsletters, for example the patient safety newsletter.
- Heads of departments would work in different areas of the hospital under the heading of "back to the floor", to support staff and identify challenges and find solutions in operational areas.
- The director of nursing and clinical services had introduced "LK today" which was a weekly session offered to staff so that they could discuss any concerns in private. We observed this advertised throughout the hospital.There was also "LK today" mail boxes located around the hospital , which staff could post their comments to the directors of nursing and clinical services.
- The hospital had trialled an initiative called "creating a reflective space" for staff, which had been hosted by a consultant psychiatrist, and aimed to explore how staffs job affected their feelings and emotions The hospital was planning to roll out more sessions during 2017, following successful feedback from staff.

Innovation, improvement and sustainability

- The hospital director, director of nursing and clinical services and MAC chair all told us they were particularly proud of the hospital's 'Project First' initiative. This was the overall framework comprising the five-year strategy; the '6E's staff recognition scheme; the 'Holly Culture'; and the five-year clinical safety strategy.
- The service was looking at potential areas of growth and improvement such as the potential to offer other diagnostic services; and to have a dedicated paediatric outpatient clinic on Friday afternoons. The director of development was able to talk us through areas the hospital was considering developing, such as improving physiotherapy availability in response to patient feedback.
- The theatre manager planned to identify staff to form a hospital pain team to give advice and support to ward staff in the management of post-operative pain. This role will give staff the opportunity for further development and extend their skills and knowledge.
- The hospital was looking to introduce "shwartz rounds" (a structured forum where all staff come together to discuss emotional and social aspects of working in healthcare).

Good

Surgery

- As part of the clinical quality strategy, the service was looking towards gaining “magnet” accreditation, which recognises health care organisations for quality in patient care, nursing excellence and innovations in professional nursing practice.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

We rated safe as good.

Incidents

- There were no serious incidents or never events relating to children and young people's services between October 2015 and September 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 to have happened for an incident to be a never event.
- In the six months leading up to our inspection, the service reported five incidents in relation to children and young people. Staff we spoke with were able to recall two incidents that related to safeguarding. We reviewed the other three incidents and noted that there were no trends in the incidents reported.
- We spoke with one paediatric nurse and the children and young person's lead about duty of candour. Both members of staff could explain the meaning of the duty of candour and were able to give examples of where this should be used. The duty of candour is a regulatory duty that relates to openness and transparency and requires the 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.
- Aspen Healthcare provided quarterly 'patient safety newsletters' for staff. We reviewed newsletters from July 2016 and October 2016, which provided guidance for staff on what constituted an incident, opportunities for training in the duty of candour and incident reporting.
- We spoke with two registered nurses (child branch) that cared for children and young people. Both were able to articulate what constituted an incident and could describe the hospital's electronic incident reporting system. We were given an example of an incident regarding the transfer arrangements for an unwell child. This incident resulted in the formulation of a policy relating to the transfer of non-critical patients. The example demonstrated that staff had reported and learnt from a previous incident.

Cleanliness, infection control and hygiene

- On the day of our inspection, we looked at two paediatric inpatient rooms. Both rooms were visibly clean.
- All inpatient rooms were hard floored to enable effective cleaning to take place.
- Toys in the outpatient's area were cleaned by housekeeping and nursing staff and after each patient use. The children's play area was visibly clean and tidy. With the exception of reading books, all toys were made of materials to enable effective cleaning.
- We reviewed cleaning schedules from 1 November 2016 to 7 February 2016, which demonstrated cleaning records had been completed and signed for on a daily basis during this period.
- We observed staff adhering to universal infection control principles, such as washing their hands after patient contact and following the "bare arm below the elbow" policy.

- Throughout the ward area, aprons and gloves were available at regular intervals. Information to guide staff and visitors on the practice of good hand hygiene was displayed. We saw that all patients had access to sanitising hand gel.
- We requested data on the number of surgical site infections in relation to children and young people's surgery. Data showed that there had been no surgical site infections between the months of January 2016 and December 2016.
- The latest Patient Led Assessment of the Care Environment (PLACE) from February 2016 to June 2016 showed that the hospital scored 99% in terms of cleanliness, which was above the England average of 98% for the same period. This data pertained to the hospital as a whole and not specifically to services for children and young people.

Environment and equipment

- Inpatient and outpatient areas were tidy and well organised with appropriate levels of storage available.
- We observed corridors to be free from clutter therefore allowing safe movement of people within these areas. Clear signage was in place indicating fire exit routes.
- We looked at resuscitation equipment in the theatre department, outpatient department and ward areas. Paediatric specific resuscitation equipment was present along with the Resuscitation Council guidelines 2015 for paediatric basic life support, advanced life support and choking.
- The resuscitation equipment trolley on the ward was checked on a daily basis. Daily checks included the defibrillator, oxygen levels and equipment required immediately in a medical emergency.
- We reviewed records and saw that for the month of January 2017, the trolley had been checked on 5, 11, 12, 23, and 24 January 2017. This meant that the trolley had not been checked consistently. We escalated this point to the children and young person's lead who reported that the equipment was only checked on the days the ward is open, usually Mondays to Wednesdays. This meant that that on eight days out of a possible 11 days during this period on Mondays to Wednesdays, daily checks had not taken place.
- However, after our inspection we saw evidence that this equipment was being checked on a regular basis and that guidance had been updated in relation to who was responsible for the daily checks.
- Access to the ward areas was not restricted by key code. This meant that access to these areas was not restricted to unauthorised personnelHowever key code access was due to be implemented in May 2017.
- Children in the ward area were given bedrooms nearest to the nurses' station to enable maximum oversight of this area.
- Entry to theatre areas was security restricted by key code and the hospital was working towards a roll out of security restricted access to all areas.
- The ward manager told us that all parents were required to stay with their child for the duration of admission on the ward. On the day of our inspection, we saw that no child was unattended at any time and ward staff had good oversight of access routes both to and from the ward.
- Post operatively, children and young people were cared for on the ward in single, en suite rooms.
- We saw that clinical waste and sharps (needles) were segregated and stored appropriately in two clinic rooms.
- The outpatient area contained a dedicated play area for children. This area was located in the main waiting area with oversight from the reception desk. The area provided child seating, a television showing a children's channel and toys. We saw that the window adjacent to this area had a lock, therefore preventing a child from opening it.
- The main waiting area had access to water and a hot drinks machine. Clear signage was in place to warn parents and carers of the danger of hot drinks in this area and that children under the age of 12 years of age were not permitted to use this facility.
- The post-operative area in theatres had a screened off section with a colourful themed wall, to make the environment more appealing to younger children. A member of staff told us that this bay was used specifically for children as due to being large, it could accommodate parents and carers when required.
- We checked a random selection of five pieces of patient monitoring equipment in the ward area. All equipment was within the recommended service date. We saw that equipment was labelled to indicate servicing had taken place and when the next service was due.

- Monitoring equipment was available in a number of sizes for varying patient size and age. We looked at patient monitoring equipment in the surgery department and saw that a range of age appropriate resuscitation equipment was available.
- For our detailed findings on the environment and management of waste and clinical specimens for the ward, theatre and outpatient areas, where children are seen or treated, please see the surgery or outpatient section of this report.

Medicines

- Staff had access to the Aspen Healthcare policy named 'Medicines Management'. We saw this provided guidance for staff on the administration and checking of medicines administered to children and young people.
- Staff had access to reference materials such as the British National Formulary specific to children. This enabled staff to administer medicines safely to ensure the correct dosages and that the indications, interactions and side effects of drugs were taken in to account.
- The storage of medicines in the ward area was secure and separate to adult medicines.
- We reviewed five sets of children's medical records. All records had documented whether or not the patient had an allergy, as well as the patient weight therefore enabling accurate drug calculations to be made based on the patient's weight.
- Paediatric medicine boxes were accessible on resuscitation trolleys in areas where children and young people were seen or treated. Medicines in these areas were subject to weekly checks. We saw records in the outpatient department, theatre department and ward, which showed weekly checks had taken place on a regular basis in the four weeks prior to our inspection.
- For our detailed findings on medicines and pharmacy provision, please see the Safe section in the surgery report.

Records

- Medical records were paper based and stored securely in an office situated on the ward. Medical records were stored off site when not in use and could be recalled if required in a timely manner.
- Medical records were kept contemporaneously and contained both medical and nursing entries.
- We reviewed five sets of medical records that showed that all documentation was securely attached within files and identified which patient they pertained to. Each document had a patient sticker attached with the name, date of birth, treating consultant and hospital number. All five records contained relevant information with clear treatment plans and showed completed paediatric pathways.
- One set of notes had a consent form and operation record, which were illegible in places. It did not clearly identify who the clinician was completing these documents. We showed this to a member of staff who knew which consultant it was immediately.
- The hospital carried out monthly paediatric medical record audits.

Safeguarding

- The hospital's leads for child safeguarding were the director of nursing and clinical services (DONCS) and the paediatric lead nurse, who were both trained to Level three safeguarding. The DONCS had also completed her level four safeguarding child training.
- The RMO had received safeguarding children level three training. Mandatory training provided by the agency through which RMO's were supplied also included training on child neglect and child protection.
- The three registered nurses (child branch) and the outpatient manager had all completed Level three safeguarding, which was in line with the intercollegiate document.
- Compliance for safeguarding children level one was 92% and safeguarding children level two was 80%. This fell below the hospital's target of 90% compliance however this was part of a rolling programme of training which would meet the hospitals target.
- Aspen Healthcare had a policy in place for the safeguarding of vulnerable children. We reviewed this policy and saw that it reflected national guidance and referenced the Intercollegiate Document Safeguarding Children and Young people 2014. The policy contained guidance on child sexual abuse and female genital mutilation (FGM).
- Safeguarding was an item on the agenda at quarterly quality governance committee meetings (QGC). A set of minutes from May 2016 showed discussion taking place

around training rates in relation to the safeguarding of children. This demonstrated that senior management within the service monitored the safeguarding of children and young people.

- We spoke with two members of staff who cared for children and young people. Both were able to articulate what constituted a safeguarding concern and how to report any such concerns. We were given a recent example of where a safeguarding concern had been reported, which demonstrated a multi professional approach and that the correct processes had been followed.
- The outpatient lead told us that if a child required treatment within the outpatient area, a paediatric nurse from the ward area would accompany the patient. A registered nurse (child branch) confirmed this on the day of our inspection. In addition, the outpatient lead had received safeguarding children level three training and was available should staff require any advice or guidance.
- We spoke with one member of staff in the theatre department who could describe the process of escalating safeguarding concerns in relation to children and young people. We were shown a child specific safeguarding flowchart and policy, located in the recovery room of the theatre department.
- There was a chaperone policy in place. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw this policy referenced the role of a chaperone in relation to children and young people and reflected national guidance. The outpatient department had clear signage in place informing patients of access to a chaperone if required.
- For more information on safeguarding children level two training, please see the surgery section of this report.

Mandatory training

- For mandatory training compliance rates please see the surgery section of this report.
- Data for paediatric immediate life support training rates (PILS) showed that 100% of registered nurses (child branch) were up to date with paediatric immediate life support training (three staff).
- The hospital was working towards all registered staff receiving PILS training. This was to ensure that all staff were able to manage a deteriorating child. This training had been rolled out with a target completion of 90% compliance by March 2017. At the time of our inspection, 47% of inpatient nurses, 51 % of theatre nurses, 33% of operating department practitioners and 68% of outpatient department nurses had completed this training.
- The hospital's resident medical officers (RMO's) were trained in advanced paediatric life support (APLS). This training was provided by the agency that employed the RMO's. We were told that an annual quality review of each RMO took place with the provider agency to ensure all RMO's were up to date with required training.

Assessing and responding to patient risk

- There was a standard operating procedure (SOP) in place for the admission of children and young people to the hospital which included clear inclusion and exclusion criteria. The SOP had been updated in September 2016.Exculsion criteria included treatment of children under the age of three years, or those with certain pre-existing medical conditions. The hospital did not accept emergency cases; all surgery was carried out on an elective basis, with day case admission only. The SOP stated that all paediatric admissions should receive a telephone triage call, undertaken by a paediatric nurse.
- Due to the provision of day case surgery only, all children and young people were allocated a theatre slot in the morning. This was to allow for recovery time in the afternoon and for the return to theatre if clinically indicated. This also ensured time for patient monitoring and the arrangement of transfer to an acute hospital if required. In the event of clinical deterioration after discharge, patients or their carers, were instructed to contact their local NHS trust for further advice or treatment.
- There was a Critical Care Transfer policy in place to manage an unwell child. The policy provided guidance on transfer arrangements if a child required urgent critical care.
- Data showed that there had been no unplanned transfers of care for children and young people between August 2016 and January 2017.
- The policy detailed the agreement in place with the regional paediatric transfer service, which would provide intensive care for paediatrics, telephone consultation, liaison with sub-specialists and skilled

inter-hospital transport. This service would arrange admission to a local paediatric intensive care unit (PICU) if required. We spoke with the recovery lead that was aware of the arrangement with this service.

- There was a flowchart accessible to staff which provided guidance and processes to follow in the event of a child deterioration which included referral to the paediatric transfer service. We spoke with two staff who were aware of the arrangements in place for a deteriorating child.
- The hospital used the paediatric early warning scores (PEWS) observation tool, to monitor and detect the deterioration in a child, based on a number of vital signs such as respiratory rate, blood pressure and a child's behaviour.
- We reviewed five sets of inpatient medical notes, and saw that the PEWS scores had been correctly calculated in all medical records we reviewed. At the time of our inspection, there were no children that had required escalation due to elevated PEWS scores.
- The hospital carried out quarterly audits to monitor compliance with PEWS. Audit results for the months of January 2016, April 2016 and July 2016 showed compliance was 100%.
- Paediatric care pathways incorporated an emergency drug treatment chart. This enabled staff to respond to the deteriorating child with the correct drug dosages, based on weight. Children's weight had been correctly recorded in the five sets of records we reviewed.
- The hospital used the "WETFlAG" acronym to assist in planning care when managing a child in a cardiac arrest situation.WETFlAG stands for weight, electricity, tube, fluids, adrenaline and glucose. A member of recovery staff showed us the WETFlAG guidance. We saw that staff could access this information in a folder containing guidance for staff.
- For more information relating to the transfer of deteriorating patients, please see the surgery section of this report.

Nursing staffing

- The hospital employed three registered nurses (child branch) who were based in the ward area. Staffing levels were planned in advance and dependent on the number of children attending for surgery. This enabled a ratio of one registered nurse (child branch) to a maximum of four patients.
- When required, additional nursing staff would be employed through the hospital "bank" system however since the recruitment of a third registered nurse (child branch) use of bank staff was minimal.
- There was a registered nurse (child branch) who was accountable for the whole of a child's clinical pathway.
- The outpatient department utilised paediatric nurses from the ward area to oversee minor procedures taking place in the department. We were told that diary entries were made to inform ward staff when their presence would be required in the outpatient department. In addition, the paediatric nursing staff from the ward carried a bleep to ensure timely attendance to the outpatient department if required.

Medical staffing

- The hospital had 295 doctors withpractising privileges (PP's). Between October 2015 and September 2016, 73% of these doctors carried out more than 10 episodes of care at the hospital. The hospital director told us that 36 consultant surgeons and 11 consultant anaesthetists held practising privileges at the hospital, specialising in paediatric care.
- Post-surgery, staff could telephone the treating consultant for advice. We saw evidence in patient medical records that consultant telephone numbers were documented.
- A resident medical officer (RMO) was available 24 hours a day, seven days a week to respond to and treat children and young people if required. For more information relating to the RMO, please see the surgery section of this report.

Emergency awareness and training

- Please see the surgery section of the report for details of emergency awareness and training.

Are services for children and young people effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Staff had access to electronic and paper based policies in the ward and theatre areas. We saw that policies reflected national guidance. For example, we reviewed the Safeguarding children and consent policy. Both were up to date and ratified.
- The specific paediatric care pathway reflected evidenced based practice by utilising paediatric early warning scores (PEWS).
- At the time of our inspection, the service did not participate in any national audits relating to the care of children and young people.

Pain relief

- Pain assessments for children and young people were child friendly and assessed either by asking the patient or by the use of a smiley/sad face pictorial aid. This enabled younger children to express if they were in pain. In addition, staff told us that they would observe the child's behaviour to ascertain if pain was present.
- We spoke with two patients and their families on the day of our inspection. Both told us that their child had been asked if they were in pain and offered pain relief on a regular basis.
- We saw that pain scores had been recorded, where appropriate, in all of the records that we reviewed.
- The hospital carried out a quarterly paediatric inpatient survey, which included questions related to pain management. Between July 2016 and September 2016, results showed that 77% of nurses always asked about a patient's pain and 93% of patients reported to receiving medicine to make pain better.
- The hospital provided information on discharge relating to pain relief. We reviewed this information and saw it included what a child may expect after a procedure and offered advice on pain relief at home. In addition, staff contacted all patients the day after surgery and questions included those relating to pain management.

Nutrition and hydration

- We spoke with two parents who said they had received adequate information about the need for their child to fast prior to surgery. We were told that theatre lists were arranged to start with the youngest child first, to ensure that particularly young children, did not go longer than necessary without food and drink. Children were not required to fast for extended periods as all theatre slots took place in the morning.
- Where clinically safe to do so, children and young people were offered food and drink following surgery. We saw that the outpatient department had access to fresh drinking water and snacks if required.

Patient outcomes

- The service monitored transfers, readmissions and return to theatres as part of their process in monitoring patient outcomes and was regularly reviewed in the peadiatric operational meetings.
- The service reported between January 2016 and December 2016, there had been no unplanned transfers of care for children and young people who had used the service.
- In the six months prior to our inspection, there was one unplanned return to theatre in the children and young people's service. We reviewed the data and found that the child had recovered and was discharged as planned on the same day of surgery.
- The service admitted day case patients only. If readmission to hospital was required, this would be to the local NHS trust. This information was made clear to patients and their families on admission and prior to discharge.
- The hospital did not participate in any national audits involving children and young people. However paediatric services were audited as part of Aspen integrated audit programme.
- The service carried out inpatient paediatric audits on a quarterly basis. The audit looked specifically at administration, safeguarding, documentation and consultant input in relation to the care provided for children and young people. Data showed that compliance in January 2016 was 98%, April 96% and July 99%.
- A paediatric nurse would carry out a follow up telephone call on the day after discharge to ensure that the child was recovering well. We saw evidence of telephone follow up calls, where applicable, in medical records that we reviewed.

Competent staff

- Between April 2016 and January 2017, 100% of inpatient nurses had received an appraisal, which included three registered nurses (child branch).
- All resident medical officers (RMO's) were required to undertake an induction programme prior to the

commencement of work, which included the guidelines specific to paediatrics. We saw the hospital had an RMO policy framework in place, which defined the roles and responsibilities of RMO's working at the hospital.
- Consultants were required to provide evidence on an annual basis to the number of paediatric cases seen, continued professional development and relevant training. This was to ensure that all consultants were regularly practising in their specialist field. This information was held by the clinical development lead and provided a reference point of which surgeons and anaesthetists were approved to see and treat children and young people.
- Between October 2015 to September 2016, 100% of inpatient nurses had completed validation of professional registration. For further information regarding revalidation of doctors, and nurses, please see the surgery section of this report.
- The hospital had access to an RMO who was trained in advanced paediatric life support (APLS).This meant that there was always at least one member of staff available with APLS skills to respond at all times.
- We spoke with the hospital's clinical development lead who confirmed that training in paediatric advanced life support (PALS) was monitored on an annual basis. These ensured that consultants with practising privileges had received annual training in PALS if seeing and treating children under the age of 12 years. Consultants were required to submit evidence of training to senior management.
- For further information on bank and agency staff induction and, practising privileges please see the surgery section of this report.

Multidisciplinary working

- Children over the age of five years old had access to physiotherapy services at the hospital.
- We spoke with two members of inpatient nursing staff who both said good communication took place between the outpatients, surgery and physiotherapy departments.

Seven-day services

- The hospital's RMO was accessible 24 hours a day, seven days a week to respond to children and young people should the need arise.
- The service provided day case surgery only for children and young people. Staff told us that consultants were easily contactable by telephone should advice be required. We saw evidence in medical records that consultant's telephone numbers were clearly documented. A member of staff caring for children stated that the consultants were approachable and easily contactable, if required for advice.
- For more information relating to the availability of clinics and opening times, please see the outpatient and diagnostic imaging section of this report.

Access to information

- Records were kept contemporaneously and stored securely in all areas that we visited. Medical records stored off site could be recalled if required.
- We reviewed three sets of outpatient notes and saw that medical records contained discharge summaries, copies of which were given to both the patient and their GP. Information included a summary of the procedure carried out, changes to medication and referral to other services if relevant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital consent policy had guidance for staff in relation to obtaining consent from children up to the age of 16 years and young people aged between 16 -17 years of age. The policy referenced the 'Gillick' competence which is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- We reviewed five sets of paediatric inpatient notes. We found that consent was documented in all records. Consent forms had a specific section to allow the child to consent if appropriate to do so.
- We spoke with one member of staff in the diagnostic imaging department. They could articulate how consent should be gained from children using the Gillick competence for a child under the age of 16 years old. In addition, this member of staff also described a recent occasion where consent was gained from a 16 year old young person, prior to diagnostic imaging taking place.
- Consent was discussed at a quarterly medical advisory committee meetings (MAC). Meeting minutes showed key points around the gaining of consent in children and young people, referring to the Gillick competence.

Good

Services for children and young people

Are services for children and young people caring?

Good

We rated caring as good.

Compassionate care

- The hospital undertook a quarterly inpatient survey to gain feedback from children and young people. Survey responses were from both children and young people or their parents/carers. Between July 2016 to September 2016 100% of nurses and 97% of doctors were described as 'excellent'.
- From the same survey, 98% of patients said they would be 'extremely likely' to recommend the hospital to other people and 99% of patients felt 'very well' looked after.
- We observed staff treating children and young people with dignity and respect. We saw that staff spoke with a child in kind and friendly way in a way a young child would understand.
- Staff were seen to act in a compassionate manner with parents who were anxious about their children's condition.
- We saw staff knocking prior to entering patient's rooms therefore protecting the privacy of children and young people. Doors to single rooms were closed and indicated if the room was occupied.
- We spoke with two families who had accompanied their children to the hospital for surgery. One parent said 'this is my child's first time in hospital, the service has been fantastic and we have had the same nurse treating us for the duration of our stay. I feel my child has been very well cared for'. Another parent said 'I wouldn't change anything; they have been checking my child regularly and are so lovely'.

Understanding and involvement of patients and those close to them

- The paediatric inpatient survey showed that 100% of patients felt that the pre-assessment stage of their care was helpful and that 100% of patients were told what to expect in relation to their care and treatment.
- In addition, the survey results revealed that 99% of patients received written information relating to their care/treatment prior to attending the hospital.
- Children who had complex needs were offered the opportunity to visit the ward area prior to the date of their admission. This meant that children could gain an understanding of hospital prior to their admission.

Emotional support

- Prior to admission, telephone pre-assessments were carried out by a paediatric nurse to identify any specific emotional needs a patient may have.
- Parents and carers were welcomed to accompany their child in to the anaesthetic room and recovery areas, prior to and after surgery to provide emotional support. Registered nurses (child branch) were present to offer support to both the patient and their family at this stage and during transfer back to the ward.
- A member of staff in the diagnostic imaging department told us that children and young people awaiting an MRI scan received written literature prior to their appointment. This included a link to a video explaining what to expect when having an MRI scan, in the aim of reducing anxiety and therefore supporting the patient emotionally. We saw this link on the Aspen Healthcare website. The video was age appropriate and explained the process of an MRI scan.
- A phlebotomist described an innovative way of reducing anxiety during invasive procedures. We observed a demonstration of a new device that was due to be used in the phlebotomy service as a distraction aid, therefore helping the child emotionally during blood tests.

Are services for children and young people responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The outpatient department saw children who were self-funded or funded through private medical insurance. Paediatric outpatient clinics took place on Mondays to Saturdays with the exception of Wednesdays. Evening clinics were available to minimise disruption with schooling and to aid parents who were unable to attend appointments during the day.

Good

Services for children and young people

- NHS referrals were received from acute NHS trusts for day case surgery. Surgery mainly took place between Mondays and Wednesdays, however, surgery could be planned on alternative days dependent on demand.
- Patients who were insured or self-funded were able to attend both outpatient and inpatient services with a written referral from their general practitioner or consultant from referring trust in the case of day case surgery. NHS surgical referrals were accepted via an electronic database. The hospital had specific booking teams on site and we were told that a variety of appointment times and surgery dates could be offered to meet people's needs.
- Children aged between zero to 17 years of age were seen in the outpatient department from Monday to Saturday. Children aged three to 17 years of age were accepted for day case surgery. In addition, children and young people had access to diagnostic imaging and physiotherapy services from Monday to Saturday.

Access and flow

- There had been one cancelled procedure in the service between January 2016 and December 2016.
- Prioritisation of theatre lists meant that all children were booked in on specific days to ensure dedicated staff would be available to care for the children's needs.
- Children and young people were booked into morning lists only for surgery to ensure that staff and equipment was readily available to meet the needs of the child.
- A registered nurse (child branch) agreed all admissions for children and young people. All children received a telephone pre-assessment prior to admission for surgery.
- For further information on referral to treatment times (RTT), please see the surgery section of this report.

Meeting people's individual needs

- We spoke with one young child and their family on the day of our inspection and saw that the bedding provided was age specific and that the child had been given toys to play with. Whilst there was no child specific ward for children and young people, staff said these touches made the service more appealing and child friendly.
- Colouring books and teddy bears were given to all children who attended the hospital for surgery. In addition, the ward had a variety of storybooks about going to hospital.
- Staff had access to specialist paediatric advice from Aspen's clinical development lead.
- Staff had access to language line for translation services. In addition, interpreters were available for face-to-face translations if required.
- Outpatient appointments were available for children and young people between Mondays to Saturdays (excluding Wednesdays). Evening and weekend clinic appointments were offered to prevent the need for a child to miss schooling.
- The outpatient department had a flat screen television showing child specific channels to provide entertainment whilst patients were waiting for appointments. The service provided information that was age appropriate to children and young people. We saw that literature and an internet link, for children attending for MRI scanning was age appropriate and informative.
- The outpatient department provided leaflets relating to services provided for children and young people. Leaflets included information on children's blood tests, preparing a child for a stay in hospital and advice on what to expect when a child had been discharged from hospital.
- Discharge leaflets were provided, which contained information on postoperative care, pain relief and how to contact the hospital if required. We saw that this leaflet had space for hospital staff to write down when the child had last received medication, therefore meaning parents and carers had a record to prevent giving repeat doses of medication too soon after discharge home.

Learning from complaints and concerns

- There had been no complaints between May 2016 and October 2016 relating to paediatric services
- Patients and their families had access to information on how to make a complaint. We saw patient feedback questionnaires located in all areas where children and young people were seen and treated.
- Staff had access to a complaints policy. We saw this document had guidelines relating to the timeframes for acknowledging and dealing with a complaint. In addition, the document outlined and referenced who was responsible for dealing with complaints relating to children and young people, and for how long documentation should be retained.

Good

Services for children and young people

Are services for children and young people well-led?

Outstanding ☆

We rated well-led as Outstanding.

Leadership and culture of service

- There was a dedicated children's and young person's lead. The CYP lead reported to the ward manager and director of nursing and clinical services..
- The CYP lead was passionate about the service offered to children and young people. Another member of staff said 'we treat everyone as though they are one of our own family'.
- We spoke with two members of staff who could articulate and describe the senior management structure at the hospital and were clear about their specific roles and responsibilities.
- We spoke with one paediatric nurse who said the hospital's director of nursing was 'very approachable and listened to suggestions on how we can improve'. The staff member also said they felt supported in their role by senior management.
- A member of paediatric nursing staff said 'the culture here is very good, I feel well supported and can use my own initiative. I don't ever feel like I am being micro-managed'.

Vision and strategy for this this core service

- The hospital's mission was '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'.
- The service had a specific paediatric strategy in place. The paediatric strategy detailed the governance structure of the hospital and how this linked with staff from the children and young people's service. The document outlined a set of priorities that reflected the hospital's strategy for CYP services The strategy incorporated Aspen Healthcare's mission statement and detailed aims on how the children and young people's service could be developed and improved.

Governance, risk management and quality measurement

- Where our findings on surgery also apply to the childrens and young peoples service, we do not repeat the information but cross-refer to the surgery section.
- The medical advisory committee (MAC) had a named representative for children and young people. We reviewed meeting minutes from October 2016 and January 2017, which demonstrated attendance from the paediatric representative.
- The MAC minutes showed that paediatric consultants practising privileges were reviewed and consultants who were non-compliant with the hospitals requirements had their PP's removed until compliance could be demonstrated.
- We spoke with the clinical development lead (registered nurse child branch) who explained that the reviews of consultant's training and qualifications were 'RAG' rated which is a method rating for risk, based on red, amber (yellow), and green colours. This information was held by the hospital to ensure that only consultants who were up to date with all required areas of training were allowed to treat children and young people. The appointment booking team did not book apppointements with consultants unless they were green rated.
- We reviewed the quarterly quality governance committee meeting minutes for the months of February 2016, May 2016 and August 2016. Services for children and young people were not a standard agenda item, however since August 2016 paediatrics had been added as a standing agenda item.
- We were provided with meeting minutes from November 2016.These showed discussion around child safeguarding, training rates and paediatric competencies had taken place.
- There was a paediatric working group which met once every two months. We reviewed meeting minutes from the months of September 2016 and December 2016. Minutes demonstrated attendance from paediatric nurses, a paediatrician and the hospitals safeguarding lead for children.
- The hospital held an overarching risk register. The children's lead would escalate any potential risks directly to the director of nursing and clinical services , who would assess and add the risk accordingly.
- The lack of security restricted areas had been recorded on the hospital's risk register in October 2016. We saw that roll out of security restricted areas had begun as

the lift that serviced the theatre department had recently had a keypad restriction installed. The risk register had an estimated date of May 2017 of completion for this work.

Public and staff engagement

- The Director of Nursing held weekly drop is sessions. This enabled staff from children and young people's services to discuss issues of importance or raise any other issues. Staff were welcomed to share ideas, opinions and to give feedback.
- Feedback was sought through a variety of methods including inpatient surveys, comments cards and online feedback forms. The hospital accessed social media to gain feedback from patients, including from parents of children and young people.

Innovation, improvement and sustainability

- In 2016, the hospital launched a new paediatric speech and language service in the aim to complement existing paediatric services.
- The children and young people's service had developed a vision of how they saw the service developing, for example the introduction of a dedicated playroom. At the time of the inspection these suggestion were being put forward to the senior management team for consideration.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Outstanding

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as Good.

Incidents

- There had been no never events or serious incidents within outpatient and diagnostic imaging services between October 2015 and September 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There had been 64 clinical incidents reported within outpatient and diagnostic imaging services between October 2015 and September 2016. The rate of clinical incidents per 100 outpatient and diagnostic imaging attendances had decreased in each quarter of the reporting period, from 26 to six.
- There had been 36 non-clinical incidents reported in the outpatient and diagnostic imaging department between October 2015 and September 2016. The rate of non-clinical incidents per 100 outpatient and diagnostic imaging attendances was variable throughout the reporting period.
- We reviewed three incidents on the hospital electronic recording and reporting system. The hospital thoroughly investigated all of the incidents following a root cause analysis (RCA) approach and feedback provided to staff and any patients involved. There was evidence of a full investigation, lessons learnt and shared.
- We reviewed team meeting minutes dated 6 September 2016, and noted incidents had been shared with the team and actions discussed.
- Staff followed the hospital's reporting and management of incidents policy which provided guidance on what constituted an incident, and definitions of different types of reportable incidents, such as never events.
- All staff we spoke with knew how to report incidents using the hospital electronic reporting system. They were able to give examples of the type of incidents which required escalation and reporting.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R). Diagnostic imaging services had procedures in place to report incidents to the correct regulators, for example the Care Quality Commission (CQC).
- There had been three incidents involving ionising radiation between October 2015 and September 2016 reported on the hospital electronic recording system. These had been reported to the radiation protection advisor (RPA). We reviewed the RPA responses to these incidents and confirmed that the risk was negligible.
- All staff we spoke with within outpatients and radiology knew their responsibility and the process relating to Duty of Candour. The Duty of Candour is a legal duty on services such as hospitals to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

Cleanliness, infection control and hygiene

- The hospital had no incidents of MRSA, E. coli or Clostridium difficile in the reporting period October 2015 to September 2016.

Good

Outpatients and diagnostic imaging

- All areas we visited were visibly clean and tidy. Throughout departments there were sufficient hand washing facilities and personal protective equipment, such as gloves and aprons were readily available.
- Hand sanitiser was available at the entrance to each corridor area and there were notices reminding staff and visitors to clean their hands when entering or leaving wards or departmental areas. There were also notices at hand washing areas providing information about infection prevention and control.
- Staff adhered to the hospital's infection prevention and control policy. All staff wore uniform and adhered to the 'bare below the elbow' policy.
- Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilising the hand sanitiser where appropriate.
- Throughout the departments, clinical waste was disposed of appropriately and in line with the hospital's waste disposal procedures. Staff used yellow clinical waste bags, with foot-operated waste bins, and sharps bins, which were correctly assembled, signed and dated and not over-filled, throughout departments.
- We reviewed daily and monthly cleaning schedules between 1 November 2016 and 7 February 2017 for three consulting rooms and a treatment room in the outpatients department. The schedules were complete and signed by staff with no omissions. We also reviewed the daily and weekly cleaning schedules for the general x-ray and an ultrasound room in the diagnostic imaging department and found these were also complete and signed by staff with no omissions between 1 November 2016 and 7 February 2017.
- Infection prevention control formed part of staff's mandatory training and records from 31 January 2017 showed compliance rate for staff in the outpatient department at 72.4% and diagnostic imaging at 93.7%, against a compliance target of 90%. However this was above trajectory for all staff to receive the training this year.
- The hospital had a designated infection prevention lead nurse, who conducted infection prevention control audits. Information submitted by the hospital showed staff compliance rate with hand hygiene was 100%, in their most recent audit, dated July 2016. We reviewed the infection prevention control meeting minutes from May and August 2016, confirming audit results were regularly discussed.

Environment and equipment

- All areas of the outpatient and diagnostic imaging departments we visited were tidy, organised and free of clutter. The hospital had clear signage to all departments.
- The outpatient department consisted of 15 consulting rooms; these were half carpeted in the seating area and half hard floor in the examination area. The outpatient team also had the use of four treatment rooms and another seven for specific treatments such as audiology, ophthalmology and phlebotomy. All treatment rooms had hard flooring which was in accordance with the best practice guidelines.
- We checked equipment in three outpatient treatment rooms and three diagnostic imaging rooms and noted all equipment were routinely checked and within their respective service or equipment renewal dates. Equipment also displayed "I am clean" stickers to show that staff recently cleaned equipment.
- We randomly checked single use equipment throughout the outpatient department and found that all equipment was properly stored, in date and packaging was intact.
- The outpatient department had their own reception area to meet patients on arrival. Diagnostic imaging shared the main reception area with physiotherapy, and had a further three sub waiting areas where patients would be escorted to by a member of staff.
- Controlled areas within the diagnostic imaging department had light boxes outside indicating when it was not safe to enter. Access to the magnetic resonance imaging (MRI) suite was via a door locked with a keypad allowing only authorised people to access the controlled areas. Staff also confirmed that patients were escorted from the main reception to the waiting area in the imaging department.
- Resuscitation equipment for both adults and children was available within the outpatient and diagnostic imaging departments. We noted that these were securely tagged to ensure contents were kept safe. We checked both resuscitation trolleys and found that they were fully stocked and in date.
- Staff completed a daily and weekly check of the contents of the resuscitation trolley, including drugs and replaced the tag. This ensured the trolley was complete and safe to use. We reviewed the daily check records for both areas from 2 November 2016 to 23 January 2017,

which showed that the resuscitation equipment in the diagnostic imaging department had been checked daily during this period. However the checks for the outpatient department had four gaps in November and three gaps in December. We raised this with the outpatient manager and were told that they would address our concern.This had been addressed at the time of the unannounced inspection.

- There was an asset (equipment) replacement log and a rolling replacement programme for equipment. This was also on the providers risk register.
- Radiology staff used lead aprons to protect themselves against unintended radiation exposure. Lead aprons were in good condition and were checked on a regular basis and replaced when not fit for purpose. Thyroid protection shields were available in theatres and the fluoroscopy room in line with IR(ME)R recommendations. We confirmed that they were visibly checked daily for damage and screened yearly for internal damage to the lead.
- An external supplier serviced and maintained diagnostic imaging equipment for the hospital. The service schedule showed that all imaging equipment received an annual service and were in date.
- The imaging department used a mobile medical imaging device, called a C-arm, which moved across different areas of the hospital. We reviewed the risk assessments, dated October 2016 for this transfer and the equipment maintenance records, both were in date.
- Radiology staff all carried film badge dosimeters whilst working clinically which registered the amount of personal radiation exposure they had been subjected to and these were reviewed regularly to ensure staff safety.
- There was a service level agreement (SLA) in place with a NHS trust which was an authorised radiation protection centre, and provided the hospital with ongoing radiation protection support services. This meant that the imaging service at the hospital had easy access to expert radiation advice.
- The hospital scored higher than the England average in the following areas of patient-led assessments of the care environment (PLACE) scores for the period of February 2016 to June 2016: cleanliness, condition, appearance and maintenance, disability, and food. The hospital's PLACE scores (79%) were lower than the England average (83%) for privacy, dignity and wellbeing.

Medicines

- The hospital had an onsite pharmacist who was available Monday to Friday 8.30am to 8pm and Saturday 9am to 1pm. The pharmacy supplied clinical areas with medicines and checked all the hospital prescriptions. Outside these hours staff could seek advice from the resident medical officer (RMO) at any time if they need further guidance or to obtain urgent drugs.
- There was an appointed Controlled Drugs Accountable Officer (CDAO) who supervised the management and use of controlled drugs within the hospital.
- Staff stored all medication within diagnostic imaging and contrast appropriately in locked cupboards. The keys to this cupboard were only accessible to radiologists, radiographers, consultants or managers. Staff maintained records of room temperatures daily. We checked room temperature records in the ultrasound suite and CT control room, temperatures were within range and staff carried out daily checks between December 2016 and January 2017.
- Emergency drugs were available within the ultrasound suite; staff stored these in a tamper proof bag, provided and restocked by the pharmacy staff.
- The hospital carried out medication audits routinely, and there was a policy and standard operating procedure (SOP) for medicines management available to staff.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- All patient records were in paper format, with the exception of radiology scans which were electronic.
- Outpatient consultations within the hospital were consultant led. All patients attend outpatients with a GP referral letter or their current medical records from a previous appointment or admission were available at the hospital. Should a referral letter not be available at the time of appointment, the outpatient reception staff contact the consultant's medical secretary or the consultant to obtain the referral letter. If the referral letter had not arrived from the GP, outpatient staff would contact the GP practice and request it prior to starting the consultation.
- We reviewed the healthcare records of 13 people who attended the outpatient department. Of the 13 we reviewed, two had information about allergies missing

but the remaining 11 records were accurate, complete, legible and up to date. These records were all stored securely by the hospital medical records. During outpatient clinic the records were kept in a secure cupboard by the nurses station.

- Diagnostic imaging details were recorded on the radiology department information system, which is the core system for the electronic management of imaging departments. Information recorded included the referral details, examination carried out, the patient identification checked, the radiation exposure, and who carried out the examination.
- Staff told us that diagnostic images were requested in advance from the radiology team, ready for the clinic. Diagnostic images were shared through the picture archiving and communication system (PACS).
- The hospital carried out internal monthly audits on medical records. The most recent audit that included outpatients' notes was in July 2016 and scored 96%. This audit found that recording of allergies was inconsistent. The audit results were discussed in department meetings and this was included in meeting minutes dated August 2016.

Safeguarding

- There had been one safeguarding concern reported in the reporting period October 2015 to September 2016.
- There were hospital policies and procedures in place for safeguarding adults and children, which were both reviewed and up to date. Staff had access to these policies and procedures.
- We spoke to five members of staff and they all understood the safeguarding policy, who the safeguarding lead for the hospital was and explained how they would report concerns. Staff gave an example of an incident two months prior to our inspection where they had reported a child safeguarding concern. They explained the process they followed and we were able to confirm this from the electronic incident record that was completed and the investigation that followed with local authority safeguarding team.
- Safeguarding training was part of the hospital mandatory training programme. Records dated 31 January 2017 showed that compliance rate for all staff across the hospital for safeguarding adults level one was 89.7% and level two was 85%. However safeguarding training data seen during our inspection in the outpatient and diagnostic imaging department showed 100% compliance.
- Records for the same period showed compliance rate across the hospital for safeguarding children training was 92.2% for level one and 80.5% for level two.
- The hospital had three members of staff up to date with level three children's safeguarding training.
- The hospital had an up-to-date chaperone policy in place and there were notices throughout the department offering a chaperoning service. Staff told us that they were required to explain the chaperoning procedure to all patients who attend appointments and asked if the patient would like a chaperone in attendance during their appointment.

Mandatory training

- The hospital mandatory training was provided via e-learning and face-to-face training sessions in a variety of subjects, including but not limited to health and safety, safeguarding adults and children, moving and handling, infection control, basic life support and fire safety.
- Data supplied by the hospital in relation with outpatient department staff showed an overall 75% compliance rate and with mandatory training for registered nurses and 71% for health care assistants. This was ahead of trajectory for all staff to receive this training.
- Staff in diagnostic imaging were 100% compliant with their radiation protection training.

Assessing and responding to risk

- We spoke to five members of staff and they were aware of the policy and procedure for the management of the deteriorating patient. They described basic observations, contacting the resident medical officer (RMO) and emergency treatment as required.
- The MRI lead explained the procedure which they follow if a patient becomes unwell. Due to the specific risks within the MRI suite, there were restrictions on the equipment used in the scanner and staff controlled access to this area. Staff had received training to ensure the safety of the patient as well as the safety of clinical staff that would assist in an emergency. The resident medical officers (RMO) received an induction in safety practices and procedures for the controlled area in the MRI suite.

Good

Outpatients and diagnostic imaging

- Throughout the departments we saw notices for staff which reminded them of the cardiac arrest teams telephone number; "2222" in the event of such an emergency.
- Within diagnostic imaging, radiographers were trained in both basic life support (BLS) and immediate life support (ILS). Training records from January 2017 showed all staff were up to date with the necessary life support training according to their job role.
- There were systems and processes in place to enable the effective management and transfer of a deteriorating patient. This is reported on fully under the surgery service within this report. We spoke with three members of the diagnostics imaging staff and they demonstrated that they were aware of policy and procedure for the management of the deteriorating patient.
- The radiology department had up-to-date risk assessments for the prevention of unnecessary exposure to radiation and the protection of both patients and staff. These included policies for staff pregnancy and the transferring of patients.
- We saw evidence of patients completing screening assessments prior to having diagnostic imaging for the identification of metallic items, such as pacemakers or piercings. This helped protect patients from harm when entering the MRI scanner's magnetic field.
- Diagnostic imaging staff reviewed previous patient images as well as asking patients if they had undergone a recent x-ray to reduce the risk of patients having unnecessary repeat examinations.
- The hospital used the "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" for interventional radiological procedures. This reflected evidence-based practice to ensure safety for the procedures. We reviewed three patient notes that had scans with contrast media and saw that the WHO checklist was completed in line with policy in all three.
- The hospital had local policies in place for the risk assessment and prevention of contrast induced nephropathy. We viewed the policy and saw that it was up to date and in line with the Royal College of Radiologists (RCR) standards for intravascular contrast agent administration and the Renal Association, British Cardiovascular Intervention Society and the Royal College of Radiologists guidelines for the "prevention of Contrast Induced Acute Kidney Injury (CI-AKI) in Adult Patients" (2013).
- Diagnostic imaging staff checked the pregnancy status of female patients prior to having a diagnostic imaging. This was in line with the Royal College of Radiographers (RCR) guidelines. Notices were also on the entrance to diagnostic imaging rooms, advising patients to notify the radiographers if there was a chance they might be pregnant.
- The hospital had policies and guidelines for diagnostic imaging department, which included details on 'Local rules', radiation protection supervisor (RPS) and radiation protection advisor (RPA) in line with Ionising Radiation (Medical Exposure) Regulations (2000) (IR(ME)R). RPA support was provided by another NHS trust as part of a service level agreement (SLA), staff we spoke with said that the RPA were very responsive and accessible for help and advice.

Nursing support and Radiology staffing

- The hospital did not use a standardised tool to determine nursing staffing numbers required for the outpatient department. The outpatient manager told us that staffing was calculated to meet clinic workload and if this increased staffing would be arranged accordingly. The clinic lists were reviewed a week in advance and a day before the clinic staffing number confirmed.
- The hospital employed a mix of registered nurses (RN) and health care assistants (HCA). Data supplied by the hospital showed the outpatients department had 11.1 whole time equivalent (WTE) RN's and four WTE HCA's, which equated to a ratio of 2.8 nurses to one health care assistant.
- The radiology department employed seven WTE radiographers, two WTE imaging assistants, one WTE assistant practitioner and one WTE administration staff.
- The rate of sickness for outpatient nurses was variable throughout the reporting period October 2015 to September 2016. However sickness rates between October and December 2015 were between 6% and 15%, which was higher than the average of other independent acute hospitals.
- For the same period, the rates of sickness for outpatient care assistants were variable. Sickness rates were higher than the average of other independent acute hospitals between October 2015 and March 2016. This was significantly higher in February 2016 at 25%. However the rate of sickness returned to an average level in the following months.

Good

Outpatients and diagnostic imaging

- Diagnostic imaging used bank staff to cover staff shortfall or during busy times. A manager told us that they used staff from the bank with previous experience of working in the department.
- Between October 2015 and September 2016, the use of bank RNs working in the outpatient department was lower than the average of other independent acute hospitals. This ranged between 7% and 11%.
- Between October 2015 and September 2016, the rate of use of bank HCAs working in the outpatient department was higher than the average of other independent acute hospitals. This ranged from 15% in July 2016 to 56% in February 2016.
- As of 1 October 2016, there were 0.5 FTE posts vacant for outpatient nurses and two FTE posts vacant for outpatient health care assistants. The diagnostic imaging department had one FTE vacancy for a mammographer, which at the time of our inspection were all advertised for recruitment.
- Data provided by the hospital showed there were no unfilled nursing and support staff shifts between July 2016 and September 2016.

Medical staffing

- Medical staff were predominantly employed by other NHS organisations in substantive posts and had practising privileges to work at the Holly Private Hospital. The hospital employed 295 consultants under practising privileges. A practising privilege is defined as 'permission to practise as a medical practitioner in that hospital' (Health and Social Care Act, 2008).
- The hospital used an external agency to ensure the resident medical officer (RMO) had the appropriate mandatory training including a Paediatric Advanced Life Support (PALS) and Advanced Life Support (ALS). The outpatient and diagnostic imaging department had access to the hospital Resident Medical Officer (RMO) as required.
- Staff we spoke with knew the RMO on duty, found them to be supportive and available when required. The hospital employed five RMOs who worked on a seven day-shift rota and had accommodation on site to support them taking breaks and getting appropriate rests between shifts.
- As part of the practising privileges, consultants were required to be contactable by the telephone or in person out of hours. Consultants were required to arrange cover if unavailable due to other commitments or annual leave. Staff told us that when consultants were not in the department, they could be accessed via the consultants' secretary and access to consultants was never an issue.
- More information about medical staffing is in the surgical report.

Emergency awareness and training

- The hospital had business continuity and a major incident plan policy in place. The plans covered the loss of information technology systems, communication systems, flood, fire and bomb threats.
- We reviewed the business continuity plan policy. This was dated September 2016 and was reviewed every three years.
- Senior staff in the outpatient and diagnostic imaging department were familiar with this document and could access it via the intranet, as well as in folders located in the departments.

Are outpatients and diagnostic imaging services effective?

We currently do not rate effectiveness of outpatient and diagnostic imaging services

Evidence-based care and treatment

- The hospital had a wide range of policy documents in place that were up to date with a review date specified. The policies were constructed around evidence-based practice and national guidance documents. Three members of staff we spoke to were able to demonstrate how policies were accessed on the hospital intranet.
- There were relevant care pathways in place. For example, there was an 'outpatient Hysteroscopy pathway' which reflected best practice guidelines issued jointly by the Royal College of Gynaecology (RCOG) and British Society for Gynaecological Endoscopy (BSGE) (Best Practice in Outpatient Hysteroscopy, March 2011).
- The hospital participated in various audits including the National Patient Reported Outcomes Measures (PROMS), and local hospital based audits for example, infection prevention, protection and control, hand hygiene and medicines management amongst others. We have reported fully on these audits under the surgery core service within this report.

- The hospital conducted audits of radiologist reports every six months, and 20 of these were externally reviewed by a third party. The radiologists received feedback on any discrepancies found. We reviewed the external review report and found that for April 2016 and August 2016, there was no discrepancy.

Pain relief

- The hospital used a pain assessment tool to assess patient pain using pain scale at pre-admission. Staff told that information about pain management was discussed and information in the form of a leaflet given where appropriate. If a patient experienced pain during an appointment or staff observed any change in the patient's pain, then they would initiate a pain review and pain relief offered where appropriate.
- The hospital carried out a pain audit in September 2016. The audit result showed 100 % compliance with pain monitoring, documentation and patient journey.

Nutrition and hydration

- Water dispensers and vending machines were available, offering hot drinks, in the outpatients and diagnostics imaging waiting areas. We witnessed staff assisting patients with these.

Patient outcomes

- The hospital conducted an annual audit on radiation dose levels for diagnostic imaging examinations to ensure that radiation doses were in line with national reference levels (NRL). Where local doses exceeded the NRL, staff adjusted equipment or protocol to bring the dose to within acceptable limits.
- Diagnostics imaging department carried out imaging safety audits to ensure compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) and best clinical practice guidelines. The audit randomly selected 10 patient images and assessed completion of documentation in relation to patient identification (ID), examination, date, documentation that consultant had evaluated the images and secure storage of images. Data from July 2016 and October 2016 revealed 100% compliance.
- The department also took part in magnetic resonance imaging (MRI) and computerised tomography (CT) audits. The audit was carried out using the Royal College of Radiologists framework and was in place to monitor the quality of images. Audit results from April 2016 and August 2016 showed both the MRI and CT department achieved 100% indicating images were to a high quality with accurate clinical opinions and wording of reports.
- The hospital participated in the submission of data to patient reported outcome measures (PROMs). PROMs data is used to measure health gain in patients undergoing hip replacement, knee replacement, and hernia and cataract surgery in England. We have reported fully on this outcome under the surgery core service within this report.

Competent staff

- All staff received a formal induction period, which was in line with the hospital induction policy. We checked this policy, which was in date, and it reflected a comprehensive induction programme which took place over the first two months of employment, leading to a three month, six month and yearly review.
- Data provided showed that 100% of outpatient and diagnostic imaging staff had completed their appraisals for the current year (April 2016 to March 2017).
- Managers encouraged staff to complete higher-level qualifications to improve performance, and were offered a wide range of qualifications to improve competency, for example a variety of radiology courses, and extended scope practitioner courses.
- One staff member, who was initially employed by the hospital as an administrative assistant, told us that they completed their assistant practitioner qualification as part of a career development programme and was supported by their line manager. Another staff told us that they were supported through their training to become a reporting radiographer. The radiographer was extremely complimentary of the training opportunity, the guidance and support.
- The medical advisory committee (MAC) advised the hospital manager before any practising privileges were granted to consultants and allied health professionals. All professionals with practising privileges were reviewed every two years following the submission of documentation of registration, appraisal, indemnity insurance and medical staff revalidation through the professional body.
- Revalidation formed part of staff's annual appraisal, for those who required revalidation of professional registration. For consultants, revalidation occurred at the NHS Trust who employed them and via an allocated

Good

Outpatients and diagnostic imaging

"Responsible Officer." The Holly Private Hospital then reviewed evidence of this process to ensure each consultant had been revalidated with the General Medical Council (GMC).

- There was a Service Level Agreement (SLA) in place with an NHS trust which ensured access at all times to a Radiation Protection Adviser. There was a supporting document in place, which outlined the roles and responsibilities of this advisor. Staff we spoke with said that the RPA were very responsive and accessible for help and advice. Within radiology, there was also an appointed Radiation Protection Supervisor.

Multidisciplinary working

- Staff reported good multidisciplinary working with staff within the hospital. We observed outpatient nursing staff and consultants communicating clearly with one another during the outpatient clinic.
- Radiology staff worked with consultants to develop a list of their preferred protocol for each diagnostic image to create the correct image on the first occasion reducing the need for repeat radiation exposures.
- There were a number of service level agreements (SLAs) in place with local NHS trusts and other providers, and staff told us that they have a, "good relationship" with the staff at the trust or other providers.

Seven-day services

- The outpatient department offered appointments from 8.30am to 9pm, Monday to Friday and 8.30am to 3pm on Saturday.
- Diagnostic imaging services were available from 8am to 9pm Monday to Friday and from 8am to 6pm on Saturday.
- One stop mammography clinics ran on Monday evenings, Tuesday afternoons and Thursday mornings.
- The hospital had access out of hours on call x-ray imaging twenty-four hours a day seven day a week.
- The onsite pharmacy was open Monday to Friday between the hours of 8.30am and 8pm and Saturday from 9am to 1pm, with dispensing services available within those hours.

Access to information

- Staff had access to policies and procedures via the hospital intranet; all staff we spoke with described the ease with which they retrieved information and that they used it frequently. We reviewed a hospital guide for CT guided biopsies/ aspirations/drainage and found this to be comprehensive and up to date.
- Staff had access to diagnostic images and imaging reports via the picture archiving and communication system (PACS). The hospital could transfer diagnostic images taken at other healthcare providers via the image exchange portal (IEP) and make these available to view on PACS.
- The hospital shared all relevant information with the patient's GP, we saw evidence of communication to and from GPs in all five sets of outpatient medical records we reviewed.
- We checked five patients healthcare records, which showed that the hospital communicated with the patient's GP following attendance at the outpatient or diagnostic imaging department. This was via letter format and involved a summary of the consultation, the outcome of any investigation and recommendations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the hospital policy on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policy was in date, comprehensive and in line with national guidance. Staff we spoke with confirmed that they had received training on MCA and DoLS.
- We reviewed the hospital consent policy to treatment, which was reviewed by the hospital in April 2015. The policy was comprehensive, in date and compliant with national guidance such as the Department of Health, Reference guide to consent for examination or treatment (2009).
- Consultants were responsible for gaining patient consent for procedures and treatment. We reviewed six consent forms and noted these were completed appropriately within patient records.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as Good.

Compassionate care

Good

Outpatients and diagnostic imaging

- The hospital participated in the national NHS Friends and Family Test (FFT). The FFT scores for the period April 2016 to September 2016 was between 97% and 99%, which was below the England average. The response rate was also lower than the England average.
- One patient waiting to be seen in the outpatient department described the staff as, "friendly, very kind and polite."
- The hospital also asked patients to complete a satisfaction survey which covered overall experience, admission process, consultant, nursing care, catering and service specific questions. The survey result was scored on a red/amber/green (RAG) scale and data for December 2016 showed patient satisfaction in all areas was scored green.
- We looked at the results of the outpatient feedback forms for July to September 2016 and found that results were consistently positive. The survey asked patients to rate their "overall satisfaction with the care received", and 96% rated it 'very good' or 'excellent'.
- There were chaperoning notices throughout the departments, which reminded staff and provided information to patients and their carers that they could request a chaperone. Staff confirmed that same sex chaperoning could be arranged as required. The hospital had an up-to-date policy on chaperoning in place which staff had access to.
- Staff interaction with patients and visitors was friendly and respectful at all times during our inspection.
- During our inspection a patient arrived to the outpatients area when they need to be in a different department. We observed a staff from the outpatient department take the patient to correct area of the hospital.
- Reception staff greeted patients in a very kind and courteous manner as they arrived for their appointments in the outpatient department and other reception areas.

Understanding and involvement of patients and those close to them

- We observed that extensive information was available to people who used the service which demonstrated that they were involved in their care from initial contact with the hospital and beyond discharge.
- Staff told us that all people who used the service received information about who to contact and when, so that people knew who to contact if they were worried about their condition or treatment after leaving the hospital.
- Patient's experience of using the service was also reviewed regularly throughout the hospital. This was by way of patient surveys, which were audited regularly in terms of overall scores relating to patient experience.
- We spoke to three patients who used the outpatient service and ask them whether they felt involved in their care. All three patients told us they did.
- The hospital undertook an observational' audit of the diagnostic imaging waiting room in January 2016 and the outpatient waiting area in April 2016. The interactions recorded between staff and patients were recorded as mostly positive and a few neutral interactions. There were no negative interactions recorded during the observations.

Emotional support

- Staff spent time with patients before and after their medical procedure, to check on patients' well-being. Staff supported and reassured patients about their treatment throughout their time in the hospital.
- We observed that staff were sympathetic and attentive to patients' needs.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good.

Service planning and delivery to meet the needs of local people

- Figures from October 2015 to September 2016 showed that the outpatient service was supporting the local NHS services by providing 29% of their service capacity to NHS patients.
- Each department and area was clearly signposted and we saw staff were helpful and escorted patients to areas if they were not sure where they were meant to be.
- The hospital offered free parking and disabled spaces were close to its main entrance to promote access for disabled people.

Good

Outpatients and diagnostic imaging

- The reception desk contained information on opening hours, hospital policies, and information on costs. There were also magazines and newspapers available.
- The hospital provided patients with information about the service prior to their appointment; this included their consultant name, direction to hospital and contact details. We saw that the hospital website also provided information to patients about services provided, consultants that worked in the hospital and contact details.

Access and flow

- Between October 2015 and September 2016, 101,456 patients attended the outpatient department, of which 6,659 were children from birth to 17 years of age and 94,797 were adults. Of the total attendances, 29% were NHS funded patients, and 71% either self-funded or funded from other sources, for example, private insurance claims.
- For the period October 2015 to September 2016, the hospital performed between 94% and 97%, exceeding the target of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for incomplete patients. These figures related to NHS funded patients only.
- Targets for non-admitted patients' treatment beginning within 18 weeks were removed in June 2015. It is however positive to note that for the period of October 2015 to September 2016 the outpatient department exceeded its target of 95% for all months except October 2015.
- The hospital offered patients having diagnostic imaging that did not attend their appointment a second appointment before their imaging request was returned to the referrer.
- A manager explained that patients could choose an appointment to suit their needs, as far as reasonably practicable. Patients could do this via the NHS Choose and Book System or by contacting the hospital directly to make an appointment.
- The length of outpatient appointments was tailored according to speciality and treatment required. Staff we spoke with reported the clinics were mostly on time and patients were not subjected to extended waits within the department. However on the day of our inspections, two patients told us that their outpatient appointment was running 20 minutes late.
- We raised the concern of waiting times to the leadership team. During the unannounced visit, we saw that the hospital had developed an action plan to address the issue and a number of items from the action plan had already been implemented, such as installing additional signage in the waiting area to indicate any delays to appointment time. In addition the information was communicated to all consultants via the 'weekly consultant message'.

Meeting people's individual needs

- The outpatients and diagnostic imaging department had access to translation services for patients whose first language was not English. Staff could use 'Language Line,' a telephone system where an interpreter supported patients via a telephone, but more often, the team used a face-to-face interpreter service where an interpreter would attend the hospital appointment with the patient to give them direct support.
- Staff told us that they had access to British Sign Language (BSL) interpreters that they could book in advance if they are made aware of a patient's needs.
- The pre-assessment questionnaire specifically asked questions to identify a patient with any specific needs, for example, special learning needs, dementia, or allergy. This meant that staff could quickly identify specific needs and plan the patient's care and treatment accordingly.
- Staff confirmed that reasonable adjustments in terms of extended appointment times and allowing relatives to attend consultations appointments were made to meet the needs of patients with learning difficulty or patients living with dementia. The hospital was taking part in the Dementia Friends programme and staff we spoke to told us that they have attended the training.
- The hospital had free parking available. The outpatient's reception desk had a lowered area for ease of wheelchair access, and there was adequate room to enable wheelchairs to access disabled toilet facilities and move around the hospital using lifts for access to the first floor ward areas.
- Leaflets and information on conditions, procedures and radiology were available for patients to read. These were also available through the hospital's website.

Learning from complaints and concerns

- The hospital had received 88 complaints for the period October 2015 to September 2016. None of these complaints had been referred to the Ombudsman or Independent Healthcare Sector Complaints

Good

Outpatients and diagnostic imaging

Adjudication Service (ISCAS). The data reported was for the whole hospital and was not broken down by department. There were four complaints received by the Care Quality Commission (CQC) for the same period.

- We reviewed the complaint log from May 2016 to October 2016, 13 of the 44 complaints received by the hospital were in relation to an aspect of treatment received from clinical staff.
- The hospital had a complaints policy in place. All complaints were logged on the electronic reporting system and actions tracked via a local action log. The quality team recorded evidence of compliance with complaints on the system to give assurance that actions were completed and lessons learned. Compliments were also logged on the system.
- Heads of departments discussed complaints at monthly meetings and outcomes of complaints were shared with staff at team meetings, where they had the opportunity to reflect on what went wrong in order to prevent repeated issues in the future.
- The progress of complaints was reviewed in the complaints meeting, and the senior management team also discussed it in their fortnightly meetings.
- Complaints were discussed at medical advisory committee (MAC) and quality governance meetings. We reviewed minutes of both meetings for the last three quarters and saw that complaints was a standard agenda item, and any complaints received in that quarter and the actions taken as result were reviewed.
- The hospital collated an annual report of complaints, which identified themes and actions taken to improve patient experience as result of responding to complaints. We reviewed the annual complaints report for 2015 which included changes made in response to complaints, such as introduction of new enhanced waiting areas.
- Patients were able to submit feedback through the hospital website. In addition patients could access "Your opinion matters", a questionnaire completed by patients whilst in hospital to comment on the quality of service they received. The questionnaire had a free text section for patients to make further comments on their experience.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as Outstanding.

Leadership and culture of service

- Where our findings on surgery also apply the outpatient and diagnostic services, including how the hospital was led, we do not repeat the information but cross-refer to the surgery section. We saw good leadership of the outpatient services.
- The outpatient and diagnostic imaging departments had two dedicated managers, who reported to the director of nursing and clinical services.
- Staff spoke of a strong team ethos across the hospital and felt well supported by their managers, and that managers were accessible, approachable and friendly.
- Senior hospital managers were visible within the department and staff spoke highly of the management team and felt there was a clear 'open door' culture.
- During our inspection we observed a good working relationship between staff of all levels and disciplines. All staff we spoke with enjoyed working at the hospital and were proud of the service offered to patients.

Vision and strategy for this core service

- The hospital had a clear vision in place, "putting safety at the heart of everything we do". The vision was supported by a five year strategic business plan which formed the hospital's current position and a clinical safety strategy which puts patient safety at the heart of everything.
- There were a set of core values in place for staff to follow which included; beyond compliance, personalised attention, partnership and teamwork, investing in excellence and always with integrity. We asked six members staff what the hospital vision and the values were and all staff were aware of the values.

Governance, risk management and quality measurement

- Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.
- The hospital had a clear governance structure in place, with the quality governance committee, heads of

department and senior management team feeding into the medical advisory committee (MAC). Heads of department attended monthly meetings and cascaded information to their teams.

- There was a hospital-wide risk register in place and each department had a risk register which was regularly assessed. We reviewed the risk register for diagnostic imaging dated November 2016, which had listed replacement of aged equipment as the main risk. This was included in the main hospital-wide risk register. The register identified the risks and actions taken to mitigate these as well as the person dealing with the risk and timescales involved.

Public and staff engagement

- Where our findings on surgery also apply the outpatient and diagnostic services, including how public and staff engagement was managed, we do not repeat the information but cross-refer to the surgery section.

Innovation, improvement and sustainability

- The hospital was in the process of replacing and upgrading the CT scanner to support the treatment of more complex patients. We saw the business case dated August 2016 and were told by senior managers that the business case has been submitted to the Aspen group head office and waiting for approval.
- The diagnostic imaging team won the Aspen quality award for their cardiac MRI service which demonstrated the hospital's priorities of safety, effectiveness and improving patient experience. Cardiac MRI provides an alternative to invasive angiography. Patients which normally would be referred to other hospitals for a cardiac MRI scan now can be offered this service at the Holly.
- At the time of our inspection a programme was underway to upgrade the picture archiving and communication system (PACs) and the radiology department information system (RIS). This would improve the management and storage of imaging data. Project update report dated 6 February 2017 showed full implementation by June 2017.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had been awarded the Worldhost© customer care recognition status (the same customer care training the London 2012 Olympic Games Makers received) reflecting the work of staff going the “extra mile” to improve patient experience.
- There were systems in place to engage staff at all levels and recognise commitment and achievement. For example there was a ‘6E’s’ staff recognition scheme in place, which involved staff obtaining evidence through their work that they were displaying the service’s core behaviours of ‘exceptional, effective, expert, energetic, efficient, everyone’.
- Monthly observational audits were carried out in patient areas, in which a member of staff would observe interactions between staff and patients, as well as the environmental factors over a set period of time, to drive improvements in patient experience throughout the hospital.
- The diagnostic imaging team won the Aspen quality award for their cardiac MRI service which demonstrated the hospital’s priorities of safety, effectiveness and improving patient experience. Cardiac MRI provides an alternative to invasive angiography.Patients which normally would be referred to other hospitals for a cardiac MRI scan now can be offered this service at the Holly.

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The provider should carry out works in the chemotherapy suite dirty utility room to comply with Department of Health HBN 00-09 - Infection control in the built environment and ensure that environmental risks are assessed and addressed as per Regulation 15(a) (e) Premises and equipment, The Health and Social Care Act 2008.
- The provider should consider the use of audit in the chemotherapy suite to ensure best practice and evaluation of service.
- The provider should monitor the oncology triage pathway for assessing and advising patients who call the chemotherapy advice line to ensure consistent advice is given.
- The provider should review the patient information leaflets given out in the day stay unit to ensure they are up to date and contain the most recent post-operative or procedure advice.
- Ensure that resuscitation equipment in diagnostic imaging is checked daily in line with policy.
- Ensure that there is adequate representation by chemotherapy staff at goverance meetings.
- Ensure allergires are consistently recorded on medical records.