

Bupa Cromwell 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Inadequate



Overall summary

Bupa Cromwell Hospital is operated by Medical Services International Limited. The hospital was purpose built in 1981 and acquired by Bupa in 2008. Facilities includes 114 beds and four suites, five operating theatres, a seven-bedded level three critical care unit, MRI and X-ray, outpatient and diagnostic facilities.

In the reporting period July 2015 to June 2016, the hospital treated 155,735 patients. The majority of these (89%) were outpatient attendance, 11,166 (7%) were inpatient and 6,689 (4%) were day-case discharges.

Of these, 49% of the patients were UK insurance, 23% self pay, 17% Embassy patients and 1% were NHS patients.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 29 November 2016 – 1 December 2016, along with an unannounced visit to the hospital on 6 December 2016.

The Bupa Cromwell Hospital provides

- Medical care
- Surgical care

Summary of findings

- Critical care
- Services for children and young people
- Outpatients and diagnostic imaging

We inspected all services provided at this hospital during our visit.

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

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

Services we rate

Overall we rated The Bupa Cromwell Hospital as requires improvement because,

- There were issues with the environment and infection control prevention (IPC). In the dialysis day unit, there was no sluice directly attached to the ward. During the course of inspection, we observed bags of dirty linen being left in the entrance of the unit, to be collected by domestic staff. In the neurology ward's sluice, linen bags were found incorrectly disposed of in the green recycling bin. In both the dialysis unit and the oncology wards, there was no documentation of daily or weekly cleaning of equipment, although we did see evidence that green 'I am clean' stickers were in use. Some patients that we spoke to felt that the cleaning standards had dropped since their last visit. In patients' en-suite bathrooms, bars of soap were provided for hand washing.
- Not all portable equipment we checked had been recently serviced and labelled to indicate the next review date. We found seven pieces of equipment in the dialysis day unit that had stickers on them that exceeded review date, as well as one item on the neurology ward, two items in the general/cardiac ward and two pieces of equipment in the iodine suites. The hospital later provided us with records to

indicate that service reviews had taken place on most of these items of equipment, but stickers were used inconsistently at the time of the inspection to indicate that they were safe to use.

- In the dialysis day unit, we found 11 boxes of disposable equipment that had expired. Senior staff told us that some of this was waiting to be returned, and some was for teaching purposes. However, these boxes were not segregated or marked to indicate as such.
- Nursing staff did not always check medication fridge temperatures daily, such as on the general/ cardiology ward and oncology ward. Appropriate actions were not always taken when these were out of normal range. On some of the wards, room temperatures had consistently exceeded recommended levels of 25 degrees centigrade. No actions had been taken even though nursing staff told us that they had contacted building services.
- Across the hospital, 90% of all staff had completed basic life support training and 90% had completed intermediate life support training. However, there was no effective system in place to ensure that competencies of staff in the dialysis day unit were checked on a regular basis.
- Bank and agency usage of both nurses and healthcare assistants (HCAs) in the hospital inpatient departments was higher than the average of other independent acute hospitals that CQC holds this type of data for (July 2015 to June 2016). In the same period, bank and agency usage varied between 25.9% to 44.7% for nurses, and 29.4% to 56.4% for HCAs. However, staff told us that they tried to use the same bank and agency staff where possible, so that they were familiar with local protocols and procedures. The hospital provided evidence that indicated that regular members of bank staff were usually used in most cases, rather than agency staff who were unfamiliar with the unit.
- Although guidance stated that RMOs should only cover a 48-hour shift at the hospital in an emergency, we found several instances of this in rotas dated between August and December 2016 for medical and paediatric services.

Summary of findings

- There was one paediatric resuscitation trolley shared between two theatres, which was not safe.
- The hospital operational policy said shifts should be coordinated to ensure there was always an EPLS trained nurse on duty in paediatrics. However, the paediatric service was not always achieving this.
- The service had closed its paediatric intensive care unit the week before our inspection. However, there were no formal plans in place on what to do in the event of a deteriorating patient.
- Starfish ward and the paediatric outpatient department were not always meeting the Royal College of Nursing's guidelines with regards to children's nurses being on each shift.
- Staff were unable to show us how to access policies and evidenced based guidelines on the hospital's online system. Some staff said the system was not user friendly.
- There was a lack of clinical audit within the paediatric department and the service was not participating in any national audits.
- There were no on-call anaesthetists in place in recovery. This contravenes the Royal College of Surgeon (RCOS) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- Handover from the ward to the theatres was done by telephone which caused some delay and sometimes issues with getting the right patient.
- The recovery area was cramped and lacked natural light.
- Some incidents indicated that the WHO surgical checklist was not embedded into day-to-day practice.
- The hospital participated in six national audits. The medical service submitted data to the British Cardiovascular Intervention Society (BCIS) but did not participate in any other national audits related to medical care or end of life care. This was due to the fact that the hospital provided a limited number of services to a comparatively smaller patient base than NHS hospitals. This meant that it was limited in terms of the national audits that it could submit data to. The hospital had started to submit data to Private Healthcare Information Network (PHIN) in order to perform benchmarking functions, although this project remained in the early stages. There was a plan for local audit for the coming year, although many had not yet taken place at time of inspection.
- The angiography department was not undertaking the recommended amount of percutaneous coronary interventions (PCIs) per year. However, discussions were underway with high volume NHS Institutions to explore 'job-share' partnerships that would allow non-medical staff (nurses/physiologists) to gain further experience. The hospital also hoped to encourage NHS Waiting list initiative programmes to increase the volume of procedures performed in the hospital.
- Many training records for staff competencies within medicine services were inconsistent and unclear, with no assured mechanism in place for senior staff to ensure staff in the dialysis day unit were up to date with required training.
- The palliative care clinical nurse specialist (CNS) had no formal supervision structure.
- We found issues with the environment in the endoscopy department. Although only one patient underwent a procedure at a time, we found several patients present in the unit in various stages of preparation or recovery on the days of the inspection. We found that the waiting and recovery areas were cramped, with no effective means of separation as curtains were not routinely drawn across bays. Relatives could sit with patients but were usually discouraged due to the lack of space, as patients could spend up to three hours in recovery. On the day of inspection, a patient in a gown was waiting in the corridor post-procedure as there was only one changing room.
- There was a lack of space in some other areas of the hospital, too. The dialysis day unit had no waiting room. Patients were called from the downstairs reception. Staff told us that limited space in the unit meant that relatives often had to wait in reception due to limited space by the beds or chairs in the facility.

Summary of findings

- In many areas of the hospital, patient information leaflets were not standardly available in languages other than English, although the hospital told us that any information could be readily translated as required.
- There was no learning disability link nurse for support when children, young people or families might be living with a learning disability.
- There was no clearly defined strategy in place for children and young people's service or to develop end of life care (EOLC) services within the hospital.
- Some staff described the environment as very corporate and business focused. They felt more could be done to support both patients and staff, making them the centre of care.
- We were not assured the service had taken appropriate provisions to ensure they could care for the deteriorating patient before closing the paediatric intensive care unit.
- We were not assured risks were being appropriately managed. There were a number of risks we identified within medicine, surgery and paediatric services, which were not on the services risk register and the critical care risk register had not timeline or action plan.
- There were embedded procedures in place to ensure staff learned and received feedback from incidents and complaints.
- The infection control link nurse, the infection control team and staff both in the theatres and on the wards worked hard to ensure that infection control and good hygiene practices were maintained despite the lack of space.
- There was a multidisciplinary approach to ensuring patients were adequately nourished, including input from both dietitians and speech and language therapists (SALTs).
- Consultant surgeons only received privileges to perform surgery that they were skilled, competent and experienced to perform.
- There were several regular multidisciplinary team (MDT) meetings within the service.
- Patients' cultural, social and religious needs were all determined in the pre-assessment stage.

However, we also found good practice in relation to surgery:

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices that affected children and young people core services. Details are at the end of the report.

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

Medical care services were the main proportion of hospital activity.

The specialities include; cardiology, gastro-intestinal medicine, lung medicine, dialysis, oncology and neurosciences.

We rated this service as requires improvement because:

- There were issues with the environment and infection control prevention (IPC).
- Nursing staff did not always check medication fridge temperatures daily, such as on the general/cardiology ward and oncology ward.
- The on-call rota for RMOs demonstrated that they often covered 48 hour shifts, contrary to policy stating only 24 hour shifts should be undertaken, unless an emergency.
- Staff had variable knowledge of the requirements of patients with a neutropenic diet.
- Some policies in angiography and dialysis were not sufficiently clear or consistently being followed.
- Many training records for staff competencies within medicine services were inconsistent and unclear, with no assured mechanism in place for senior staff to ensure staff in the dialysis day unit were up to date with required training.
- The medical service submitted data to the British Cardiovascular Intervention Society (BCIS) but did not participate in any other national audits related to medical care or end of life care. This was due to the fact that the hospital provided a limited number of services to a comparatively smaller patient base than NHS hospitals. This meant that it was limited in terms of the national audits that it could submit data to. There was a plan for local audit for the coming year, although many had not yet taken place at time of inspection.

However, we found the following good practice:

Requires improvement



Summary of findings

- There were systems in place to report safety incidents and near misses. Learning from incidents that occurred in other departments was shared across the service. Staff were aware of their responsibilities with regards to duty of candour.
- The majority of staff received annual appraisals on their performance, which identified further training needs and set achievable goals.
- The hospital performed well in most measures of their inpatient survey.
- Patients' privacy and dignity was maintained throughout their hospital stay.

Surgery

The surgical specialities at the hospital included: hip arthroplasty, knee arthroplasty, other orthopaedic and trauma, breast, gynaecology, upper GI and colorectal, urological, cardiothoracic and vascular.

The top three surgical procedures were in orthopaedics, gynaecology and urology.

The surgical service was split across two inpatient wards and five operating theatres.

Good



- There were embedded procedures in place to ensure staff learned and received feedback from incidents and complaints.
- We reviewed a sample of hospital policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- Whilst there was no specific outreach team for the management of pain, the pharmacist we spoke with was confident that patients had good access to pain relief.
- There was a multidisciplinary approach to ensuring patients were adequately nourished, including input from both dietitians and speech and language therapists (SALTs).
- There were several regular multidisciplinary team (MDT) meetings within the service.
- Services were adapted and created to meet individual patient needs.
- Two alternating members of ward staff ran the pre-admission service, from 8am to 6pm daily.

Summary of findings

- Patients' cultural, social and religious needs were all determined in the pre-assessment stage.
- Staff knew the importance of delivering the vision through the values of being passionate, caring, open, authentic, accountable, courageous and extraordinary
- Staff spoke very highly of their managers and the executive team.

However

- There were no on-call anaesthetists in place in recovery. This contravenes the Royal College of Surgeon (RCOS) and Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines.
- On the orthopaedic ward – a ward which often treated patients with severe mobility issues – there were six baths located in the en-suite bathrooms. Bars of soap were still in use in some bathrooms on the wards.
- Only 53% of nurses were trained in Immediate life support .
- Some incidents indicated that the WHO surgical checklist was not embedded into day-to-day practice.
- Less than half of the complaints (45%) received were responded to within the hospital mandated time.
- The risks on the risk register did not reflect the negative findings we saw whilst on inspection. For example, the known lack of space on the theatre floor was not on the service risk register.
- There was a high vacancy and turnover rate amongst inpatient and theatre nurses

We rated this service as good because it was effective, responsive, caring and well-led but safe requires improvement.

Critical care

Requires improvement



Critical care services are a small proportion of hospital activity. The hospital has a five-bed and two side room critical care unit providing level three care.

Summary of findings

Services for children and young people

Requires improvement



- The environment of the unit did not comply with national standards and there were no concrete plans to address this.
- Care did not always adhere to current national standards and guidelines.
- At the time of inspection, there were no critical care specific policies in place.
- Service did not always meet the needs of patients. There were no appropriate facilities for specific patients admitted to the hospital.

However,

- We observed staff adhere to bare below the elbow and hand wash recommendations.
- We saw evidence of good multidisciplinary teamwork.
- The unit contributed data to the Intensive Care National Audit Research Centre (ICNARC).
- The unit provided compassionate care and patients were treated with dignity and respect.

Overall we rated this service as requires improvement.

Children between zero and 16 years old were cared for within the paediatric services, which consisted of a 15 bedded ward and a dedicated outpatient department (POPD). There was a paediatric theatre co-located within ward.

- We were not assured the service had taken appropriate provisions to ensure they could care for the deteriorating patient before closing the paediatric intensive care unit.
- Starfish ward and the paediatric outpatient department were not always meeting the Royal College of Nursing's guidelines with regards to children's nurses being on each shift.
- We saw some registered medical officers were working 48-hour shifts.
- Staff were unable to show us how to access policies and evidenced based guidelines on the hospital's computer system. Some staff said the system was not user friendly.

Summary of findings

- Senior leaders were unable to show us how they benchmarked the children and young people's services. Therefore, we were not assured they were measuring patient outcomes.
- There was no access to support groups for patients and relatives.
- There was no learning disability link nurse for support when children, young people or families might be living with a learning disability.

However,

- Staff understood their roles and responsibilities with regards to safeguarding and could tell us how they would escalate any concerns.
- Children and young people were receiving regular pain assessments and pain relief.
- Staff had a good understanding of capacity and consent.
- Relatives told us the staff were respectful and helpful and gave them regular updates and felt suitably involved in patient care.
- Outpatient appointments were available at a variety of times to fit around a child's schooling and parent's work commitments.
- The Magnetic Resonance Imaging (MRI) had taken a number of steps to make the area child friendly.
- There were daily bed management meetings to discuss flow and capacity.

We rated this service overall as requires improvement.

Outpatients and diagnostic imaging

Good



The out-patient department included a suite of 21 rooms where patients can see consultants. The diagnostic department included MRI and CT scanning. The Radiotherapy unit consisted of 2 tomotherapy units, a superficial unit and a Gamma Knife unit. Radiotherapy was located on two floors. There was a full-service pharmacy providing advice, prescription and non-prescription medications on site.

Summary of findings

- We found there was a proactive approach to anticipating and managing risks to people who use services.
- All areas we visited were visually clean and free from dust.
- We saw evidence that cleaning schedules were in place and had been completed. Water temperatures were sampled weekly for legionella precaution.
- Radioisotopes were stored in accordance to local policies; they were stored in secure rooms with locked safes. We saw evidence of daily checking and twice yearly wipe tests being conducted.

However,

- The radiotherapy department had a total of two full-time competent tomotherapy planners, we were concerned regarding this as it may cause unsafe practice or delays to patient treatment in case a member of staff was absent due to unforeseen circumstances. We were shown competency records of treatment radiographers which were rotated in to the planning department; however we noted all staff on the rota were not fully competent in all areas within the planning department.

We rated this service as good because it was safe, responsive, caring and well-led.

Summary of findings

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Requires improvement



Bupa Cromwell Hospital

Services we looked at

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

Summary of this inspection

Background to Bupa Cromwell Hospital

Bupa Cromwell Hospital (BCH) is a private hospital operated by Medical Services International Limited and based in central London, offering treatment for both adults and children. The hospital was purpose built and opened in 1981 and Bupa acquired the hospital in 2008. The hospital has 114 beds and four suites. Facilities include five operating theatres, a seven-bedded level two and three critical care unit, MRI and X-ray, outpatient and diagnostic facilities.

The hospital specialities include; cardiology and heart surgery, gastro-intestinal medicine and surgery, lung

medicine and surgery, cosmetic surgery, renal transplantation and dialysis, paediatrics, oncology, women's health, orthopaedics, neurosciences, general practice and adult intensive care.

The hospital provides service to both UK and international patients with medical insurance, those who are sponsored by their respective embassies, those who self-fund and a very limited number of patients referred through NHS contracts.

The registered manager is also the nominated individual for the hospital and been in post since 2011 and there is an accountable officer in post for Control drugs since 2009.

Our inspection team

The team inspecting the service was led by CQC inspection manager, Michelle Gibney and included CQC inspectors, and specialist advisors with expertise in clinical governance, medicine, surgery, children and young people, nursing care and critical care.

Information about Bupa Cromwell Hospital

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures (10 December 2010).
- Surgical procedures (10 December 2010).
- Treatment of disease, disorder, or injury (10 December 2010).

We inspected five core services at the hospital, which covered all the activity undertaken. These were children and young people's services, medicine, surgery, critical care and outpatients and diagnostic imaging.

We carried out an announced inspection between 29 November 2016 to 1 December 2016 and an unannounced visit on 6 December 2016.

We held six focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Board. In addition to these meetings, we spoke with 201 staff including: RMOs, registered nurses, health care assistants, nursery nurses, reception staff, medical staff, operating department practitioners, radiographers, radiotherapists, security staff, cleaners and senior managers. We spoke with 32 patients and 35 relatives.

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital before our inspection, which enabled staff and patients to provide us with their views and received 43 'tell us

Summary of this inspection

about your care' comment cards which patients had completed prior to or during our inspection. We also reviewed 62 sets of patient records, 22 prescription charts and three DNACPRs.

During the inspection, we visited the dialysis day care unit, cath labs, general/cardiology ward, neurology ward chemotherapy unit, iodine suites, endoscopy, lung centre, the 15 bedded paediatric (starfish) ward, paediatric outpatient department (POPD), the paediatric theatre co-located within the ward. We also visited the surgical services which were split across two inpatient wards (19 bedded surgical orthopaedic ward 4 west including two VIP suits and 17 bedded general surgical ward 3 west), four operating theatres which were located in the basement, the seven-bedded adult critical care unit for level two and three and the outpatient department, radiotherapy department and the diagnostic imaging department which included C.T scanning and X-ray.

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

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016. There were 17,855 inpatient and day case episodes of care recorded at Bupa Cromwell Hospital; of these 1.5% were NHS-funded and 98.5% other funded.
- In the reporting period February 2016 to February 2017, the bed occupancy was 49%. There were 50874 bed days available, 20899 overnight and 3987 day cases bed days were occupied in this time period.
- 70% of all NHS-funded patients and 62% of all other funded patients stayed overnight at the hospital during the same reporting period.
- In the reporting period July 2015 to June 2016, the hospital treated 155,735 patients. The majority of these (89%) were outpatient attendance, 11,166 (7%) were inpatient and 6,689 (4%) were day-case discharges.

- Of the 137,880 (89%) outpatient total attendances 0.1% were NHS-funded and 99.9% were other funded.
- Between July 2015 and June 2016 there were 2,721 surgical procedures of which 1,708 were orthopaedic. In that same time period 51% of procedures were day cases and 49% resulted in inpatient stays.
- Between July 2015 and June 2016 children between zero and 15 years old accounted for 28,068 (18%) of the hospitals attendances. Of these the majority were outpatient attendances (93%), inpatient accounted for 5% and day cases accounted for 2%.
- The service was consultant-led and 588 consultants worked at the hospital under practising privileges including 199 surgeons and 10 surgeons with practising privileges that were registered to carry out cosmetic procedures. 58 regular resident medical officer (RMO) worked on a one in six rota. 212.8 FTE registered nursing staff, 39.6 FTE operating department practitioners and health care assistants and 361.5 other hospital staff including; allied health professionals, administrative staff and receptionists, as well as having its own bank staff. There was a registered manager and an accountable officer for controlled drugs (CDs).

Track record on safety

- Two Never events reported between July 2015 to November 2016.
- Total of 565 clinical incidents in the reporting period (July 2015 to June 2016). Out of 565 clinical incidents 78% (440 incidents) occurred in surgery or inpatients and 1% (four incidents) occurred in other services. The remaining 21% of all clinical incidents occurred in outpatient and diagnostic and imaging services (121 incidents).
- The hospital reported 0.2% of all incidents as severe or death.
- One serious injury.
- One incident of hospital acquired meticillin-resistant Staphylococcus Aureus (MRSA)
- Nine incidences of hospital acquired meticillin-sensitive Staphylococcus Aureus (MSSA)

Summary of this inspection

- Seven incidences of hospital acquired Clostridium difficile (c.diff).
- Sixteen incidences of hospital acquired E-Coli.
- 206 complaints in the reporting period.

Services accredited by a national body:

- Joint Advisory Group Accreditation (JAG)
- ISO 9001:2015 - Radiotherapy, medical physics, Gamma knife and nuclear medicine.

Services provided at the hospital under service level agreement:

- Building maintenance

- Catering
- Maintenance of medical equipment
- Pathology and histology
- Clinical Coding services
- CCTV maintenance
- Perfusion services
- Medical gases
- Radioactive waste collection
- Supply of uniforms
- Supply of pharmaceuticals

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?

We rated safe as requires improvement because:

- There were two never events reported between July 2015 to November 2016.
- There were issues with the environment and infection control prevention (IPC), in the dialysis day unit, theatre and recovery. The two rooms utilised to isolate infectious patients within the critical care unit did not fulfil requirements for an isolation facility.
- Not all portable equipment we checked had been recently serviced and labelled to indicate the next review date. The hospital later provided us with records to indicate that service reviews had taken place on most of these items of equipment, but stickers were inconsistently used at the time of the inspection to indicate that they were safe to use.
- Nursing staff did not always check medication fridge temperatures daily, such as on the general/cardiology ward and oncology ward. Appropriate actions were not always taken when these were out of normal range.
- The environment of the critical care unit did not comply with national standards and there were no concrete plans to address this.
- Although guidance stated that RMOs should only cover a 48-hour shift at the hospital in an emergency, we found several instances of this in rotas dated between August and December 2016 for medical and paediatric services.

However, we also found the following areas of good practice:

- There were embedded procedures in place to ensure staff learned and received feedback from incidents and complaints.
- Nursing staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. They knew how to escalate concerns.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Magnetic symbols were used on patient information boards to identify those patients at particularly high risk.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

Requires improvement



Summary of this inspection

- Not all staff were able to show us how to access policies and evidenced based guidelines on the hospitals intranet. Some staff said the system was not user friendly.
- There was minimal participation in quality improvement projects at the time of our inspection.
- Senior leaders were unable to show us how they benchmarked the children and young people's services. Therefore, we were not assured they were measuring patient outcomes.
- The hospital submitted data in six national audits. Where there was a local audit plan, a number of these audits had not taken place at the time of the inspection.

However, we also found the following good practices:

- We saw evidence of good multidisciplinary teamwork.
- Although critical care unit did not undertake any local clinical audit they contributed data to the Intensive Care National Audit Research Centre (ICNARC).
- Practising privileges were only granted to applicants who held substantive NHS consultant posts in the five years before application. This ensured that consultant surgeons only received privileges to perform surgery that they were skilled, competent and experienced to perform. A formal review of each clinician's privileges was undertaken every two years.
- There were several regular multidisciplinary team (MDT) meetings within surgical service.
- Staff were happy with their access to training for professional development, and said the organisation often supported them to attend additional courses.

Are services caring?

We rated caring as good because:

- Patients were cared for in a caring and compassionate manner by staff throughout their stay. The hospital performed well in most measures of their inpatient survey.
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Psychological support for patients was easily accessible and timely.
- Staff ensured that patients and their families were informed about their care and were fully involved in any treatment decisions. Patients who shared their views said they felt well-informed and involved in their care. They reported staff were kind and compassionate at all times.
- The radiotherapy patient survey results for the period of July 2016 to September 2016 showed that 100% of patients rated

Good



Summary of this inspection

the quality of care in the department “good” to “excellent”, with 89% of patients rating it as “excellent”. This was with a response rate of 62%, a total of 44 surveys were returned out of a patient cohort of 71.

- The radiology department provided data on their patient survey for the period of October 2015 to June 2016 with a total of 322 responses being analysed. The results showed that 82% of patients said they were “likely” to “extremely likely” to recommend the hospital to family or friends.

Are services responsive?

We rated responsive as requires improvement because:

- We found issues with the environment in the endoscopy department. Although only one patient underwent a procedure at a time, we found several patients present in the unit in various stages of preparation or recovery on the days of the inspection. We found that the waiting and recovery areas were cramped, with no effective means of separation as curtains were not routinely drawn across bays. On the day of inspection, a patient in a gown was waiting in the corridor post-procedure as there was only one changing room. There were also staff coffee making facilities directly next to a patient bay.
- There was a lack of space in some other areas of the hospital, too. The dialysis day unit had no waiting room. Patients were called from the downstairs reception. Staff told us that limited space in the unit meant that relatives often had to wait in reception due to limited space by the beds or chairs in the facility.
- The hospital did not currently audit the number of patients dying in their preferred location. There was a process in place for rapid discharge at the end of life, although not all staff were aware of this.
- In many areas of the hospital, patient information leaflets were not standardly available in languages other than English, although the hospital informed us that translation of any written materials could be arranged as required.

However, we also found the following good practices:

- The international patient centre provided helpful support and advice.
- Surgical Services were adapted and created to meet individual patient needs.
- Paediatric outpatient appointments were available at a variety of times to fit around a child’s schooling and parent’s work commitments.

Requires improvement



Summary of this inspection

- Patients were able to access care and treatment in a timely way. There were clear admission processes and no problems with flow or discharge throughout the hospital.
- Translation services were readily available.
- As the outpatients department was a part of independent health it did not have to monitor referral to appointment times, however the department did monitor this to benchmark themselves against the NHS. Hospital data for the period of January 2016 to May 2016 showed there were a total of 14480 patient appointments with an average waiting time of four days. The hospital consistently achieved better than the national target of 18 weeks and also the England national average in March 2016 of 5.6 weeks.
- The radiology department conducted audits for patient's referral to MRI waiting times, the department set a target of 100% of patients to be seen within 48 hours of receiving their referral. Results for October 2016 showed that the department had a total of 540 patients with nearly 100% compliance rate, only 3 incidents amounting 0.5% did not meet target with two of the incidents being clinical or patient travel reasons.

Are services well-led?

We rated well-led as inadequate because:

- There was no clearly defined strategy in place to develop end of life care (EOLC) services within the hospital. There was no formal strategy in place for children and young people's service.
- The hospital participated in six national audits. The medical service submitted data to the British Cardiovascular Intervention Society (BCIS) but did not participate in any other national audits related to medical care or end of life care. This was due to the fact that the hospital provided a limited number of services to a comparatively smaller patient base than NHS hospitals. This meant that it was limited in terms of the national audits that it could submit data to. The hospital had started to submit data to Private Healthcare Information Network (PHIN) in order to perform benchmarking functions, although this project remained in the early stages. There was a plan for local audit for the coming year, although many had not yet taken place at time of inspection.
- The hospital did not meet all the core standards of intensive care units.
- We were not assured the service had taken appropriate provisions to ensure they could care for the deteriorating patient before closing the paediatric intensive care unit.

Inadequate



Summary of this inspection

- We were not assured risks were being appropriately managed. There were a number of risks we identified which were not on the service's risk register.
- At the time of inspection the critical care unit did not monitor performance in the form of any internal audits.
- During inspection, there were no current critical care specific policies in place available for staff, we were shown a draft version which had not been officially released yet.
- There were no formal results of a critical care unit specific patient survey.
- We had mixed feedback from staff regarding morale on paediatric Starfish ward. This was due to the recent closure of the paediatric intensive care unit (PICU). Staff felt they had not been consulted with properly during the closure of the ward and felt provisions to cope with this closure, should a patient deteriorate, had not been put in place. This had left staff feeling the ward was not safe.

However:

- The hospital had developed an overall vision and strategy and communicated this to staff of all levels, enabling them to feel involved in the development of the service.
- Most nursing and medical staff thought that their line managers were supportive and approachable. They felt able to raise concerns. Some staff said they were supported by management but other staff felt they were not listened to.
- We saw collaborative working between all wards and departments within the hospital.
- There was evidence of some quality improvement projects that took place to drive innovation and improve the patient experience.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

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

Are medical care services safe?

Requires improvement 

Incidents

- There were no “never events” reported within the hospital in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff across the departments were aware of hospital wide systems to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. They were able to give examples of when they had used the system to report appropriate incidents. Feedback and learning points from incidents were shared with staff across the service via email, newsletters and during handovers, daily incident meetings and team meetings. Nursing staff told us actions that were taken as a result of incidents that occurred. For example, the most commonly reported incident in the neurology ward was falls, so a new falls pathway had been introduced. There were also monthly governance and leadership meetings which discussed themes and learning from recent incidents.
- Between July 2015 and June 2016, the hospital reported 440 clinical incidents across surgery and inpatient settings. Of these, the hospital reported 0.2% of all incidents as ‘severe’ or ‘death’. The rate of clinical incidents in surgery and inpatients in this reporting period is lower than the rate of incidents in other comparable independent acute hospitals that the Care Quality Commission (CQC) hold this type of data for. The rate of non-clinical incidents was also lower, with 203 incidents of this type occurring in the same period.
- There was one serious incident (SI) reported across the hospital between July 2015 and June 2016. Serious incidents were subject to a full root cause analysis (RCA) investigation and action plans were developed where areas for improvement had been identified. RCAs were also conducted for other notable incidents, not necessarily classified as SIs. We saw detailed examples of these for incidents that had occurred recently. For example, in April 2016, a patient underwent complications following a transcatheter aortic valve implantation (TAVI). This is an operation that involves inserting a new artificial heart valve inside the old valve. As a result, procedural guidelines were updated to recommend more frequent scanning.
- Senior staff attended monthly morbidity and mortality meetings, where all inpatient deaths were reviewed and discussed. Patient deaths were adequately reviewed and discussed, in order to identify trends or issues of concern. We saw minutes from these meetings from between January and August 2016. Ceilings of care, family support and factors that contributed towards the death of each patient were routinely discussed.
- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. Most staff were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

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health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The key principles of the duty of candour regulations were published in leaflets, available throughout the clinical areas that we visited. We saw an example of a letter of apology to a patient from senior staff when things had gone wrong.

Clinical Quality Dashboard or equivalent

- The hospital was not required to use the NHS Safety Thermometer as they are an independent healthcare provider. This is a tool which measures harm to patients which may be associated with their care. However, the hospital monitored incidents of patient falls, pressure ulcers, catheter acquired urinary tract infections and venous thromboembolism (VTE).
- Patients were assessed for risk of pressure ulcers, VTE and falls on admission to each ward. Symbols were placed on the patient information boards on some wards to indicate if the patient was at an elevated risk.
- Between July 2015 and June 2016, 100% of inpatients were risk assessed for VTE on admission. In the same period, there were four cases of VTE or pulmonary embolism (PE) reported.
- Between September 2015 and October 2016, there were two incidents of catheter-related UTIs during the course of a hospital admission.
- Between January and June 2016, there were 25 reported falls and no pressure ulcers of grade 3 or above acquired after admission to hospital. In the same period, 100% of inpatients were assessed for risk of both pressure ulcers and falls on admission. The prevention of falls and pressure ulcers were highlighted as priorities on many of the ward noticeboards. We confirmed that these risk assessments were mostly completed and regularly reviewed in the 19 patient records that we looked at.

Cleanliness, infection control and hygiene

- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Each ward also had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase

awareness of infection control issues and motivate staff to improve practice. There was also a lead IPC nurse for the hospital, who staff were aware of and knew how to contact if necessary.

- On the whole, the wards and communal areas we visited were visibly clean and tidy. In the dialysis day unit however, there was no sluice directly attached to the ward. During the course of the inspection, we observed bags of dirty linen being left in the entrance of the unit, to be collected by domestic staff. In the neurology ward's sluice, linen bags were found incorrectly disposed of in the green recycling bin. In other instances, clinical waste (including cytotoxic waste) was disposed of safely using the correct coloured waste containers.
- In both the dialysis unit and the oncology wards, there was no documentation of daily or weekly cleaning of equipment, although we did see evidence that green 'I am clean' stickers were in use. Some patients that we spoke with felt that the cleaning standards had dropped since their last visit. In patients' en-suite bathrooms, bars of soap were provided for hand washing.
- The Infection Prevention and Control team (IPCT) met every quarter and included the hospital's consultant nurse and a consultant microbiologist. The IPCT discussed any outbreaks of communicable diseases, the risk register, trends in bacteria colonisation and relevant IPC audit results. The IPCT ensured that lead nurses, charge nurses and ward managers oversaw regular environmental inspections. For example, in March 2016, the cardiology and general surgery ward scored 76% in an audit and identified several issues, which had been rectified by the time of inspection.
- Staff adhered to the bare below elbow (BBE) dress code and we observed staff cleaning their hands regularly. We observed staff using personal protective equipment (PPE) such as gloves and aprons appropriately where indicated. Hand hygiene audit results between July 2015 and August 2016 indicated compliance rates of above 95% in all clinical areas. This was apart from a few gaps in data provision and one score of 83% in April 2016, for the oncology ward.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit including the

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main reception and entrance to the units and rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer. Guidance for effective hand washing was displayed at the basins.

- All of the inpatient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required. There was appropriate signage on these doors. Staff of all levels knew of measures they should take to reduce the risk of healthcare-associated infections.
- Between July 2015 and June 2016, the hospital reported one case of hospital-acquired MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. In the same period, there were nine incidents of Meticillin Sensitive Staphylococcus Aureus (MSSA). MSSA is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning. There were also 16 E. Coli infections and seven cases of Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics). The hospital risk register confirms this constituted an increased rate of infection compared with the previous two years. All cases were discussed at the infection prevention control committee (IPCC), RCAs were undertaken where appropriate and subsequent actions were formulated to address deficits in practice.
- The hospital risk register also identified the limited isolation resources in the dialysis day unit as a concern. Both the availability of only one isolation room and the lack of space in the main day unit were identified as problematic, with suggestions of an eventual redesign of the clinical area. In the meantime, guidance stated that those who needed to be barrier nursed should be dialysed in chairs instead of beds. There was also no robust local policy relating specifically to dialysis and isolation or blood borne viruses (BBVs), as well as no documentation trail of any deisolation procedures.

Environment and equipment

- Most equipment used across departments was clean and labelled to indicate it was disinfected and ready to use. However, not all portable equipment we checked had been recently serviced and labelled to indicate the next review date. We found seven pieces of equipment in the dialysis day unit with stickers that had exceeded

review date, as well as one item on the neurology ward, two items in the general/cardiac ward and two pieces of equipment in the iodine suites. The hospital later provided us with records to indicate that service reviews had taken place on most of these items of equipment, but stickers were used inconsistently at the time of the inspection to indicate that they were safe to use.

- Resuscitation equipment was stored securely in designated trolleys and was available in most areas. In the endoscopy suite, we found a suction unit incomplete without inset, tubing or suction catheter. When asked, staff told us that the unit had been taken to another part of the hospital yesterday and had not been restocked since. However, the daily checklist had been signed to indicate that this had been checked and replaced. In all other cases, we saw evidence that nursing staff carried out daily and weekly checks to demonstrate that equipment was safe and fit for use. Appropriate actions were recorded to report any missing or expired items.
- In most clinical areas, disposable equipment was easily available, in date and appropriately stored. However, in the dialysis day unit, we found 11 boxes of disposable equipment that had expired. Senior staff told us that some of this was waiting to be returned, and some was for teaching purposes. However, these boxes were not segregated or marked to indicate as such.
- There were safe systems for managing waste and clinical specimens. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.
- In the dialysis day unit, water treatment facilities were cleaned regularly, although senior staff were unable to demonstrate what actions were taken when water testing results were abnormal. Water quality testing was undertaken locally on a weekly basis, with samples sent to an external provider on a monthly basis for review. Records indicating that this had been completed were provided post inspection.
- There was a schedule for the servicing and maintenance of the endoscope decontamination equipment and records of the servicing carried out by the manufacturers of the equipment.

Medicines

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- Medicines were managed and stored appropriately on most of the wards. There was an automated machine which dispensed most medications, apart from IV fluids and chemotherapy. The machine required a staff login password, fingerprint identification and the barcode from each patient chart in order to access the correct medications. When the machine was running low on medication, the pharmacy distribution team would top it up.
- Staff kept intravenous (IV) fluids in locked cupboards or rooms with restricted access to ensure security. An audit conducted by the hospital found that 83% of the 23 areas visited stored all IV fluids securely, showing a steady improvement since November 2015. Achieving a score of 100% compliance was part of the medicines management improvement plan for 2015/16. The wards had a range of stock medicines to enable frequently used medicines to be available promptly when required. Patients' own medicines were stored separately.
- Staff maintained accurate records of controlled drugs, which were checked twice daily by two registered nurses. Nursing staff were aware of policies on the storage and administration of controlled drugs. A review of medications management in this area had taken place in the 12 months prior to inspection to ensure safe storage and security had been adopted at ward level. A number of recommendations and reminders were circulated following this.
- Nursing staff did not always check medication fridge temperatures daily, such as on the general/cardiology ward and oncology ward. Appropriate actions were not always taken when these were out of normal range.
- Temperatures of storage areas and treatment rooms were checked daily. Ambient temperature monitoring was identified as being part of the medicines management improvement plan for 2015/16. On some of the wards, room temperatures had consistently exceeded recommended levels of 25C. No actions had been taken even though nursing staff told us that they had contacted building services.
- We looked at the prescription and medication records for 22 patients. All charts documented VTE assessments and the allergy status of patients, bar two. Appropriate arrangements were in place for recording the administration of medicines. Records were clear and fully completed in most cases. They showed people were usually given their medicines when they needed them and any reasons for not giving people their medicines were recorded. In a couple of instances, nursing staff had not signed to indicate that they had given a medication, but this had been highlighted by pharmacy staff, who checked the records daily. An audit of pharmacist interventions for November 2015 showed that medication omissions made up 24% of prescribing errors across the hospital. All of these omissions were subsequently reboarded or prescribed, thus preventing actual prescribing errors.
- A record of medication omission incidents between July 2015 and June 2016 showed that four occurred on medical wards, specifically. Two of these concerned diabetic management. Further data showed that six incidents related to the administration of insulin across the hospital between May and October 2016. Of these however, only one occurred in a medical ward or department. A senior member of staff raised concerns that medication incidents relating to the administration of insulin were being under-reported. Whilst on inspection, we looked at three prescription charts and blood sugar monitoring charts of diabetic patients. We found although regular insulin was always administered, PRN (pro re nata or administered as required) insulin was not always given when blood sugars exceeded recommended levels. These had not been picked up or reported as incidents. Only 40% of hospital staff had completed additional training in the management of diabetic patients at the time of the inspection.
- Incident reports were filled out in cases of medication administration errors, with the key themes being identified as omitted doses and administration errors. A monthly medications safety group discussed any medication incidents, relevant audit results, research and policy development. Data showed that between March and June 2016, eight medication incidents occurred in total across medical wards or departments.
- Staff told us the pharmacy services were easily available and pharmacists visited the wards daily. Nursing staff indicated that they were able to contact the pharmacist when required. The pharmacy team aimed to carry out medicine reconciliation within 24 hours of admission across all wards. Medicine reconciliation is the process

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whereby the patients' current medications are reviewed to ensure the most up-to-date prescriptions are used. In recent audits, rates of medical reconciliation within 24 hours of admission varied between 55% in March 2016 and 70% in May 2016. Some pharmacy staff told us that medicine reconciliation could sometimes be a challenge due to the demography of the patient population.

- There was a pharmacy aseptic suite for the reconstitution of chemotherapy, with a separate team of oncology pharmacists to manage this. Chemotherapy drugs were stored separately from other medicines in a locked refrigerator or locked cupboard as required. Cytotoxic drugs are subject to safety restrictions issued by the Health and Safety Executive under the control of substances hazardous to health and should be stored separately from other drugs. An electronic record used for the management of chemotherapy, which allowed staff to manage all aspects of patient care through one electronic patient record including radiation, medical and chemotherapy treatment. Chemotherapy treatment was prescribed on the system to ensure safety checks against local and national guidelines were carried out before administration. There was a specialist pharmacy team in the chemotherapy unit who provided clinical expertise on cancer medicines to the chemotherapy day unit and to the inpatient oncology ward. The unit kept a register of staff who were trained to handle and administer intrathecal chemotherapy.
- We saw that the hospital had guidelines on management of extravasation, and staff informed us how they would deal with extravasation if it occurred. Extravasation refers to the inadvertent infiltration of chemotherapy into the subcutaneous or subdermal tissues surrounding the intravenous or intra-arterial administration site. However, chemotherapy extravasation kits in clinical room were not easily accessible at the time of the inspection as they were kept in a locked cupboard in a locked room. This was raised with the pharmacy team, who agreed that the kits should be kept in the ward during the day for easy access and then locked up at night.
- Anticipatory medications were prescribed for patients at the end of life, including those discharged to their own home or a hospice, to manage pain and common symptoms, if required. In the event of a syringe driver

being used, an additional chart was used to monitor the site and rate of infusion, as well as the battery and maintenance of the device. No patients were receiving medication via a syringe pump at the time of our inspection. Nursing staff had to undergo a syringe pump competency assessment prior to utilising these devices in practice. A recent audit showed 91% of nurses across the oncology department had been trained.

- At the time of inspection, there was no robust policy currently in place for the administration of venofer (iron) to treat iron deficiency anaemia in people with kidney disease. Senior staff told us that a draft policy had been received from a neighbouring NHS trust, which was due to be implemented. Whilst on inspection, we noted that one chart showed a discrepancy in relation to venofer administration. We highlighted this at the time for investigation by the pharmacist, who reported that this had been a recording error.
- Medicines were usually available to facilitate timely discharge of patients who were going home. An audit conducted in December 2015 showed that 93% of take home medications were dispensed by the pharmacy within one hour. A survey of 71 patients conducted on discharge in June 2016 showed that 95% of take home medications were ready when the patient was discharged. In the same survey, pharmacy services were rated positively, with 97% of respondents agreeing they were 'good', 'very good' or 'excellent'.

Records

- Information governance training was mandatory for all staff working at the hospital. At the time of inspection, 98% of medical staff had completed this training, against a hospital target of 95%.
- Hospital staff used paper based patient records to record patients' needs and care plans, medical decision-making and reviews, and risk assessments. Nursing records were kept at the bedside in folders, whereas medical records were stored in locked trolleys near the nursing stations.
- We looked at 19 sets of patients' records. Information was usually concise and clear. Conversations with both the patient and family were documented. Most notes were dated, signed and followed the hospital's note writing protocol, apart from some instances where

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entries by medical staff were not signed and were illegible. However, in five of the sets of notes, the admission profile was not complete and not all risk assessments had been reviewed.

- The hospital conducted an audit of their records between June and August 2016 found that of 333 sets of notes reviewed, there was no written record for 57 patients. Of the remaining notes, 45 had no obvious signature and a further 228 had no designation of the doctor to evidence who was making the record. Actions were recommended to improve this figure and a new audit tool was proposed going forward.
- The cardiology department provided remote monitoring for patients with devices (pacemakers and defibrillators). Data from the patients' implantable devices was uploaded automatically from home to a secure database.
- An electronic system brought together all patients' chemotherapy records including radiology reports, pharmacy and home care. However, staff on inspection told us that test results were not linked with the electronic system and that not everyone had access to it.

Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the up-to-date safeguarding policy electronically and flow charts for the escalation of concerns were available. Safeguarding was part of the hospital's annual mandatory training, and 92% of medical staff had completed level 1 in safeguarding vulnerable people (against a hospital target of 95%). In addition, updated figures showed that 100% of medical staff had completed face-to-face training in level 2 safeguarding. A further 82% of medical staff had completed safeguarding children level 3 training.
- Both medical and nursing staff at all levels knew who to contact if they wanted further advice and told us that the safeguarding leads supported them when they needed advice or guidance. Most staff were able to give examples of safeguarding referrals or concerns that they had raised. Between July 2015 and June 2016, the hospital reported one safeguarding concern to the CQC.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Compliance was monitored through an online system, which alerted staff and managers when their mandatory training was due to expire. At the time of inspection, mandatory training completion rates for staff across the hospital varied between 69% (conflicts of interest) and 85% (infection control), against a hospital target of 90%. The hospital subsequently provided data that indicated that by the end of the calendar year, mandatory training rates had improved across the board and at least 90% of staff had completed all training in all topics. All permanent resident medical officers (RMOs) were required to undertake mandatory training.
- All new clinical starters had sepsis awareness training on induction. A sepsis tool had been in use since 2014, and staff were shown how to use this at induction. A new sepsis protocol, in line with the Sepsis Trust and NICE guidelines (2016) was due to be rolled out from January 2017. On the oncology unit, 100% of nursing staff had completed sepsis training with a focus on neutropenic sepsis.

Assessing and responding to patient risk

- All patients were assessed on admission using national risk assessment tools in nutrition, falls risks, manual handling needs and skin integrity. We saw evidence that initial assessments were completed within 24 hours of admission, with the aim to identify any factor which the patient may need support with and to identify a baseline condition. We observed that processes were in place to ensure that a consultant reviewed all patients within 12 hours of admission, which was in line with agreed national standards.
- Magnetic coloured dots were used on some wards' patient information boards to identify those patients who were at risk of pressure ulcers, falls, or had nutritional or communication needs. Boards also highlighted when patients had similar names to one another, to avoid mistakes being made in their care or treatment.
- Nursing and health care assistant staff monitored all inpatients regularly and used a National Early Warning Score (NEWS) to identify patients who were

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deteriorating. Nursing staff used a separate chart to record observations and corresponding NEWS. In the dialysis day unit, a different observation chart was used. In all cases where escalation was indicated, we found that appropriate actions had been taken. However, there were no official local policies for escalation of a deteriorating patient in the endoscopy or angiography departments.

- Nursing staff told us that doctors were responsive to bleed calls when they were concerned a patient was deteriorating. All RMOs held an advanced life support qualification. Across the medical service, as of 1 December 2016, 95% of all staff had completed basic life support and 94% had completed intermediate life support training. This showed improvement from figures provided to us in the lead up to the inspection.
- Pathways were in place for the referral and transfer of patients to neighbouring NHS hospitals if this was required. There were two unplanned transfers of patients to other hospitals between July 2015 and June 2016.
- Staff in angiography and endoscopy utilised the WHO safety checklist that involves briefing, sign-in, timeout, sign-out and debriefing. The use is to ensure patient safety throughout the perioperative journey. We saw evidence to indicate that this was completed correctly. The National Patient Safety Agency (NPSA) advocates it for all patients in England and Wales undergoing surgical procedures.

Nursing staffing

- Planned staffing levels were appropriate for the acuity and dependency of patients. The hospital used a system that allocated staff in advance based on pre-determined nursing demand. Where patient dependency required 1:1 care, this was provided. The hospital used bank and agency staff to achieve safe staffing levels. Each ward had a supernumerary senior member of staff, to allow flexibility in case load in the case of last minute sickness. Clinical nurse specialists and the lead nurse could also step in and support the wards.
- Bank and agency usage of both nurses and healthcare assistants (HCAs) in the hospital inpatient departments was higher than the average of other independent acute hospitals that CQC holds this type of data for (July 2015 to June 2016). In the same period, bank and agency

usage varied between 25.9% to 44.7% for nurses, and 29.4% to 56.4% for HCAs. The latest figures in March 2017 showed that inpatient bank and agency use was at 26.8% for nurses and 29.8% for HCAs. Staff told us that they tried to use the same bank and agency staff where possible, so that they were familiar with local protocols and procedures. The hospital provided evidence that indicated that regular members of bank staff were usually used in most cases, rather than agency staff who were unfamiliar with the unit.

- Between July 2015 and June 2016, nursing staff sickness rates varied between 1% and 10.2%, whereas HCA sickness rates fell between 1% and 6%. In the same period, staff turnover rates stood at 33.7% of nursing staff and 27.5% of HCAs. This had increased from the previous year. Retention of theatre and oncology specialists was identified by the provider as problematic. A specialist recruitment company had been employed to improve the hospital's ability to attract candidates. Staff told us that the hospital was proactive in terms of recruitment. The hospital provided us with figures to indicate that turnover had fallen to 9.3% for qualified nursing staff between July and December 2016.
- There was no provisional cover for the palliative care specialist nurse when he was on leave. The hospital was considering introducing the palliative link nurses to each ward, who would be able to support other staff in what to do following the death of a patient.

Medical staffing

- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory board (MAB) was responsible for approving practising privileges for medical staff, overseen by the medical director, relevant directorate manager and clinical director. Consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts. Consultant anaesthetists were each sponsored by a consultant and also operated under a practising privileges agreement.
- There was 24-hour cover available for consultants in cardiology, general medicine, palliative care and renal

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dialysis. An oncology registrar was on site Monday through Saturday, to ensure ward rounds took place. Resident medical officers (RMOs) and nursing staff told us they received a good level of support from the consultants. Consultants made themselves available when required, either on site or on the telephone.

- All the wards had arrangements for 24 hour, seven day a week, RMO cover. There were 58 RMOs employed across the hospital. Although guidance stated that RMOs should only cover a 48-hour shift at the hospital in an emergency, we found several instances of this in rotas dated between August and September 2016. However, a recent survey of RMOs conducted by the provider indicated that during a 24-hour shift, each RMO was able to have breakfast, lunch and supper breaks along with a minimum of three or four hours of uninterrupted sleep.

Emergency awareness and training

- The service had a contingency business plan in place in case of an emergency. Staff had awareness of what actions they would take in the event of a major incident, including a fire. For example, staff showed the fire exits and pathway to move patients out of the unit in case of an emergency. Across the hospital, 96% of staff had completed fire safety awareness training. A further 48.4% of staff had completed additional non-mandatory fire marshal training.
- In the event that the manager was not on shift during a major incident, the hospital executive manager on call would be responsible for declaring a major incident. The duty site lead would be the incident coordinator, and would act as a focal point for the coordination of the response to the incident.
- All staff were provided with an emergency card, which stated both the number to call in the event of an emergency and the number of the security office.

Are medical care services effective?

Requires improvement 

Evidence-based care and treatment

- The medical advisory board (MAB) reviewed patient outcomes and the renewal of practising privileges of

individual consultants. It also reviewed policies and guidance and advised on effective care and treatments. Hospital policies were current and appropriately referenced relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines in most cases. However, some policies in angiography and dialysis were not clear or sufficiently robust, with little detail or specificity. For example, there was no local policy for the management of patients with renal impairment undergoing contrast media, or for those taking anticoagulants.

- Patient assessments were based on national tools, such as the Malnutrition National Screening Tool (MUST) and the Braden scale for predicting pressure ulcer risk. Care pathways based on national guidance were in place for conditions such as sepsis, stroke and pressure ulcers. Staff showed awareness of these care pathways and we saw evidence of effective treatment plans in nursing and medical records.
- The endoscopy unit was Joint Advisory Group (JAG) accredited. JAG accreditation covered all factors in the unit (i.e. sterilisation, patient satisfaction) and the clinical outcomes for upper GI endoscopy and colonoscopy completion rates were all within the national standards.
- An end of life care policy entitled 'Implementation of the five priorities of care guidance in end of life care' had been introduced in August 2014. This detailed how staff should care for patients nearing end of life and included guidance on prescribing anticipatory medication and a proforma for a care plan. Staff knowledge of this varied across the hospital, with most familiarity in the oncology wards, where it was most used. Palliative care involvement in other hospital departments was limited.

Pain relief

- The hospital used a variety of tools to assess pain, depending on the needs of the patient. Medical notes showed that the numeric rating scale (NRS) was most commonly used. This tool asked patients to score their pain from zero to 10. In this scale, zero meant no pain and 10 was extreme pain. Adapted pain scoring tools were used for those who did not speak English, or had communication difficulties.
- Appropriate actions were taken in relation to pain triggers to make patients more comfortable. We saw

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examples in the records of pain control managed with PRN (pro re nata or administered as required) pain relief. Patients that we spoke with were generally happy that their pain was well controlled.

- Patients were encouraged to complete a patient satisfaction survey following their visit, which included their views of pain management. In June 2016, 95% of the 71 respondents felt their pain was assessed and managed appropriately.
- We saw evidence that the service strived to meet the needs of those suffering from symptoms in the dying phase of life or because of their illness. The specialist nurse encouraged the use and regular review of both PRN and regular medication in view of changing symptoms.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The malnutrition universal screening tool (MUST) was used to identify the risk level of each patient and this was documented in most of the set of notes we reviewed.
- Dietitians attended multidisciplinary team (MDT) meetings and contributed to discussions regarding appropriate nutrition and hydration. The speech and language therapists (SALTs) worked closely with the dietitians to establish the food and liquid consistency a patient may require if a patient had difficulty swallowing. Assessments and advice from dietitians and therapists were seen in the notes we examined. These dietary requirements were communicated to other staff via signs in patient rooms, whiteboards in each ward kitchen and during handovers. Red trays and jugs could also be used to indicate those who needed help at mealtimes.
- There was a nutrition group that met twice a month. This group helped to introduce menu champions who were part of the external catering suppliers and met with the nurse in charge at two separate intervals during each shift to ensure the patients' needs were met. There were also nutrition links who liaised with the suppliers and reported any issues with the provision of meals. Some staff were concerned that the menu champions and nutrition link nurses did not have a good understanding of specialist areas of nutrition, such as the neutropenic diet. Progress had been made in some

areas, such as provision of diabetic and low potassium meals, but staff felt the catering suppliers still lacked knowledge regarding some patient requirements. Dietitians and SALTs told us that they were going to be involved in selecting the next caterer.

- There was variable knowledge of the neutropenic diet amongst nursing staff on the oncology ward. Dietitians told us that there were plans to provide further training in this area.
- Half of the patients we spoke with reported issues with the food, particularly in regards to temperature and timeliness of meals. Patients who were immunocompromised believed a lack of thought had gone into the choice of food, which was often spicy and not completely heated. In a survey of 143 patients conducted in November 2016, 57% of respondents rated the choice or variety of food as unsatisfactory.

Patient outcomes

- The service submitted data to the British Cardiovascular Intervention Society (BCIS) but did not participate in any other national audits related to medical care or end of life care. This was due to the fact that the hospital provided a limited number of services to a comparatively smaller patient base than NHS hospitals. This meant that it was limited in terms of the national audits that it could submit data to. The service undertook some local audits in some departments, such as the lung centre. There were plans to improve the collection and reporting of data by the end of the year. A new governance structure was created to oversee the planned audit programme, which started in September 2016.
- Between July 2015 and June 2016, there were 20 unplanned readmissions across the hospital within 28 days of discharge. Half of these were following a surgical procedure. Of those that remained, the reasons ranged from nausea and vomiting post-discharge, to a patient experiencing a seizure. There was one planned transfer of care to another provider between January and June 2016.
- The angiography department was not undertaking the recommended amount of percutaneous coronary interventions (PCIs) per year. These are non-surgical procedures used to treat the narrowed coronary arteries of the heart found in coronary heart disease. The British

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Cardiovascular Intervention Society (BCIS) guidance states that institutions should undertake at least 400 of these procedures a year to maintain competency and confidence. The hospital had only undertaken 27 in the year to date, at the time of inspection. However, this was not unusual for a private provider and 36% of all centres undertaking PCIs in 2015 performed under 400 procedures. When we spoke to the clinical director of cardiology services, he told us that this was a challenge and that they ensured that all operators undertaking these procedures operated at a high volume elsewhere. We were provided with data that corroborated this. The hospital had undertaken a review of all PCI operators in early 2016 and withdrawn practising privileges from those not meeting BCIS operator volume guidelines. The issue of institutional volume and competence was being considered by the service, with plans to strengthen links with neighbouring NHS trusts. Discussions were underway with high volume NHS Institutions to explore 'job-share' partnerships that would allow non-medical staff (nurses/physiologists) to gain further experience. The hospital was also encouraging NHS Waiting List initiative programmes to increase the volume of procedures performed in the hospital.

Competent staff

- Most staff told us they had received an appraisal in the last 12 months to assess their continuing professional development (CPD) needs and set realistic and achievable goals. Data showed that 84% of nursing staff and 63% of HCAs received appraisals last year. Staff were complimentary about the CPD opportunities offered by the hospital, particularly in terms of development and leadership. We were told of several staff who had progressed in career pathways within the hospital.
- The medical advisory board (MAB) reviewed each application for practising privileges. The MAB involved the CEO, medical director, chairman of the medical governance committee, the head of clinical governance, and the lead RMO. Their advisory function covered granting, renewal, restriction, suspension and withdrawal of practising privileges. Consultants were appraised through their NHS trust and had to provide a copy of this to the hospital each year. Doctors also usually revalidate with the organisation where they carry out the majority of their clinical work. If a doctor needed to revalidate with the hospital, this was the responsibility of the revalidation officer (who was also the medical director).
- Nursing revalidation is the new process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The hospital had helped nursing staff through this process by offering workshops, guidance and support.
- There were reliable arrangements in place for supporting and managing new staff, including a comprehensive induction and a supernumerary period during which senior staff assessed their clinical competencies. For example, nursing staff in oncology underwent an internal six-month probation, where their competencies around IV and cannulation were signed off. They then attended a chemotherapy study day before completing competencies in a workbook. Data indicated that 100% of staff giving chemotherapy had received or were undertaking sufficient training. All staff were encouraged to complete an external course offered by a specialist tertiary cancer centre. Around half of staff had currently completed this, while the other half of staff were waiting to get a place. Several posts within the oncology team were formally adopted by Macmillan, giving staff access to training and educational materials. Staff from the oncology pharmacy were released to attend national conferences and training to maintain specialist up-to-date knowledge on the latest clinical oncology practices.
- In the dialysis day unit, many training records for staff competencies were inconsistent and unclear, with no records of training undertaken for cannulation. One patient confirmed that some staff were better at cannulation than others, meaning he came to the unit on particular days of the week. Evidence provided by the hospital showed that most staff in the unit had been assessed for competency with central venal catheters (CVCs) in the last year, but two members of staff were last assessed in 2015. It was not clear how senior staff monitored the competencies of junior staff to complete their roles effectively.

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- A renal study day took place in November 2016, which covered topics pertinent to dialysis of patients. A total of 16 staff attended this training, with 96% agreeing that it would improve their practice. The service planned to introduce on-going study days every 3 months.
 - In the general/cardiac ward, only 47% of nursing staff had specialised externally validated cardiac qualifications. Senior staff told us that they tried to appoint nurses with an acute background as there was not always a cardiac trained nurse on duty. They also told us that the nursing team were regularly encouraged to attend in-house cardiac study days.
 - A neurology study day in March 2016 had been attended by 13 staff across the hospital. Topics covered included functional assessment, dementia and delirium. Feedback was generally good but some participants requested more time be spent on each topic.
 - Ward nurses, health care assistants and therapists generally indicated that they felt knowledgeable in terms of supporting patients at the end of their lives. They were able to discuss how to care for a patient in their dying phase in terms of physical health, for example. Some staff told us about additional training that they had attended in end of life care (EOLC), which focused on patient-centred care planning in the last phase of life. In January 2016, 83 staff across the hospital attended this training. Further ward-based micro sessions were planned in topics such as rapid discharge.
 - The oncology counsellor offered clinical supervision to staff, as well as a monthly debriefing group. The group provided a confidential space where staff could reflect on their work and process their feelings. Records kept by the counsellor since January 2016 indicated that this group was regularly attended by between four to seven people per month. The counsellor also offered informal supervision to the specialist nurse in palliative care. However, we were concerned that they had no formal means of supervision.
- specialist nurses or teams (such as the diabetic nurse). We saw examples of referral letters from GPs and responses from the hospital, including previous discharge summaries.
- There was a two weekly oncology and palliative care multidisciplinary team (MDT) meeting that discussed and reviewed treatment plans and discharge arrangements. There were other monthly MDT meetings in breast, endocrine, heart, lung, neurosciences and vascular. Staff told us that meetings would be held more often in the case of complex patients. We witnessed a lung MDT, which was attended by a variety of health professionals. Discussion of each of the patients was holistic and sensitive.
 - All members of the MDT reported feeling valued and respected. Doctors and nurses were complimentary about the support they received from one another and the wider team. We accompanied the specialist palliative nurse to the wards and saw them supporting the work of nursing staff in a constructive and practical way to enhance the care of patients.
 - The hospital worked with other specialist tertiary centres to manage complex patients with disparate diagnoses. For example, oncology patients with particular types of tumour would be cared for in partnership with a neighbouring NHS trust.
 - On-site pathology was provided through a contract with an external agency. Staff reported this worked well. There was a service level agreement (SLA) in place to transfer deceased patients from the hospital to a designated local undertaker. Staff confirmed that there were no issues with these transfers.

Seven-day services

- All patients were admitted under the care of a named consultant who provided consultant level cover in case of absence. Consultants were supported by RMOs 24 hours a day, seven days a week. There were nine cardiology RMOs who provided cover Monday to Friday from the hours 9am-6pm. There were 22 intensive care RMOs covering the hospital on a 24/7 rota. The oncology RMOs worked 9am-5pm, Monday to Friday.
- Pharmacy services were available 8.30am – 5.30pm on weekdays. The outpatients pharmacy was open until 8pm. Weekend cover was provided on Saturdays

Multidisciplinary working

- All relevant professionals were involved in the assessment, planning and delivery of patient care. The care records that we examined confirmed active involvement from health professionals of all disciplines where appropriate, including appropriate referrals to

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between 9am and 2pm. An on-call pharmacist was available out-of-hours and would respond within 20 minutes to a query. The duty nurse and RMO could obtain access to the inpatient pharmacy store using a dual access procedure. Medical and nursing staff were happy with these arrangements, as long as they ordered any urgent medications on Friday.

- The palliative care team visited the oncology ward and other departments regularly during the week and could be accessed at weekends.
- Endoscopy operated between 8am and 6pm on weekdays, but staff told us that they would often start a little earlier or end later to cater to patient needs. There was always one person on call each weekend, who could come in if required.
- There was 24-hour access to the radiography service for urgent inpatient imaging. All inpatient imaging requests were actioned within 24 hours. There was also an out-of-hours urgent interventional radiology on-call service.
- On site interpreters were available every weekday from 7.30am to 8.30pm. Thereafter, there was an on-call rota.

Access to information

- Medical and nursing staff felt they had easy access to the relevant information in order to provide effective care and treat patients in an individualised and timely manner. Patient observations were maintained at the patient's bedside to ensure that they were easily accessible when being reviewed.
- The Lung Centre recently invested in software that hosts an online platform for patient results. This software allowed access to digital copies of results anywhere in the hospital, with an option for remote off-site access planned for rollout by March 2017.
- There were sufficient computers available on almost all of the wards we visited, which gave staff access to hospital information, protocols and policies. The exception was in the chemotherapy day unit, where there was only one computer on wheels to cover seven chairs. This was due to faults with the other machine.
- Paper copies of key policies were also available on the wards, in resource files.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment, which we saw evidence of in patients' notes. We observed staff gaining consent from patients before giving routine care and treatment, such as washing or adjusting their position in bed. Consent was also obtained before proceeding with invasive cardiac procedures and chemotherapy regimens. All of the notes we looked at included signed consent forms. Staff were aware of their duties in relation to obtaining consent. The hospital had an up-to-date consent to treatment policy.
- Consent to endoscopy had been completed appropriately and signed by patients. We were told patients were provided with information about the procedure initially and on the day of the procedure was explained again by the consultant undertaking the procedure and the consent form was signed. This was in accordance with the world health organization (WHO) surgical safety check list and best practice guidance.
- Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). The majority of staff we spoke with were aware of the key principles surrounding capacity assessments, best interests meetings and who they would contact for support and advice. Across the hospital, 60% of staff had completed training related to the MCA. We saw an example of a best interests decision being made whilst on inspection.
- Staff told us that when patients were receiving palliative care and reaching the end of their life, 'ceilings of care' were discussed with them to ensure there was a shared understanding of the patients' wishes in relation to the life preserving treatments that would be given in the event of their deterioration. The decision as to whether cardiopulmonary resuscitation should be attempted was also discussed. We looked at three do not attempt cardio pulmonary resuscitation (DNACPR) forms whilst at the hospital. A DNACPR form is a document issued and signed by a doctor, which tells your medical team not to attempt cardiopulmonary resuscitation

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(CPR). There was a section relating to mental capacity on each DNACPR form, which was filled out by the doctor completing it in all four forms we looked at. The hospital did not currently audit DNACPR forms.

Are medical care services caring?

Good



Compassionate care

- The ward environment ensured privacy as there were only single occupancy rooms. Nursing staff demonstrated a good knowledge of maintaining patient dignity. Nurses and doctors introduced themselves to patients and sought permission to enter their rooms. We saw that staff checked how patients preferred to be addressed and explained any procedures they were about to undertake, gaining clear verbal consent. In a survey of 71 patients in June 2016, 95% felt that they were treated with dignity and respect, with 98% agreeing that they were given enough privacy to discuss their condition or treatment.
- Staff treated patients with compassion and respect. We saw and heard from staff about examples of compassionate care. Patients we spoke with were consistently positive about the care they had received. They said the staff were “wonderful” and “respectful”, with a “positive” attitude. Patients told us that nursing staff made sure they were comfortable and their needs were met. Although patients on some wards recognised that nursing staff were busy, most insisted that this did not affect the service they received and that nurses went “above and beyond” the call of duty. We observed that call bells were usually answered promptly, in line with the majority of feedback we received from patients.
- Patients were asked to complete a questionnaire on discharge about their experience, in which patients expressed consistently high satisfaction in many areas. The response rate varied between 6% and 11% between January and June 2016. In June 2016, 71 (7% of) patients filled out this survey. Of these respondents, 95% said they would recommend the hospital to others, and a further 98% said their overall opinion of the quality of their care was ‘excellent’, ‘very good’ or ‘good’. Furthermore, 97% of respondents were completely

happy with the care that they received from nurses, with 96% of patients happy with the speed of response to their call bells. Due to the demographics of the hospital’s patient base, they offered the questionnaire in English or Arabic.

Understanding and involvement of patients and those close to them

- Most patients told us they felt involved in planning their care, and in making choices and informed decisions about their future treatment. The majority of patients we spoke with knew what their prescribed medications were for and felt that doctors were providing them with regular updates on their condition and progress. All patients felt able to ask questions of those caring for them and felt listened to by their doctors and nurses.
- Written information leaflets were available for patients about a range of treatments and procedures. A wide range of information was produced by nationally recognised agencies, such as Macmillan or the British Heart Foundation. Staff told us that they would give patients verbal information, supplemented with this written information. A patient told us how a specialist nurse gave them a booklet called ‘mummy’s lump’ to help her to explain her diagnosis to her children.
- In a survey of 71 patients conducted in June 2016, all patients felt confident in the consultant treating them, with 100% also agreeing that sufficient information was given to them before and after their procedure or spell in hospital. A further 97% of respondents felt that the nursing staff involved them in planning their care (either ‘completely’ or ‘to some extent’). Regarding relatives, 98% of patients believed they had an opportunity to speak with a doctor if they wished.
- The hospital provided information and support with the payment of fees through the business office, which patients could contact during office hours and on Saturday mornings until 1pm.

Emotional support

- Most patients we spoke with were very positive about the support they received from members of the MDT. Psychological support was discussed routinely in MDT meetings and handovers. The hospital had access to specialist nurses that could offer additional support and advice for example, for patients with chronic conditions

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such as diabetes, or complex diseases such as cancer. Staff had a good understanding of the emotional issues palliative patients could face and described how they might give extra support to the most vulnerable patients, such as those with no family.

- Patients had access to psychological support and counselling services as well as complimentary therapies such as massage and acupuncture. Counsellors would also see patients' families alongside them in sessions. There were no reported issues with waiting times after referral to the service. We were shown records of attendance from January to June 2016, which indicated a steady rise in the number of counselling sessions undertaken by patients. Leaflets that directed patients to this service were freely available in the public areas of the oncology ward.
- The hospital was piloting a bereavement support group, led by the palliative care nurse, for families of patients who died within the hospital. There were a number of other support groups advertised throughout the hospital.

Are medical care services responsive?

Requires improvement 

Service planning and delivery to meet the needs of local people

- We found issues with the environment in the endoscopy department. Although only one patient underwent a procedure at a time, we found several patients present in the unit in various stages of preparation or recovery on the days of the inspection. We found that the waiting and recovery areas were cramped, with no effective means of separation as curtains were not routinely drawn across bays. Nursing staff told us that patients were usually given any results in the recovery area, where there was a lack of privacy. When challenged, staff told us that patients would be moved to the office to be told any bad news. Relatives could sit with patients but were usually discouraged due to the lack of space, as patients could spend up to three hours in

recovery. On the day of inspection, a patient in a gown was waiting in the corridor post-procedure as there was only one changing room. There were also staff coffee making facilities directly next to a patient bay.

- There was a lack of space in some other areas of the hospital, too. The cardiology/general ward had no quiet rooms for private discussions with patients or family, although the hospital told us that finding a spare room for this purpose would not be an issue due to lower bed capacity. The dialysis day unit had no waiting room. Patients were called from the downstairs reception. Staff told us that limited space in the unit meant that relatives often had to wait in reception due to limited space by the beds or chairs in the facility.
- The hospital had an arrangement with a neighbouring hotel to provide reduced room rates for relatives of patients who needed to remain close to the hospital. Relatives of those patients in a very serious condition or nearing the end of life were allowed to remain on the ward in a second room, with each case being assessed on an individual basis.

Access and flow

- There were 17,855 inpatient and day case episodes of care recorded at the hospital in the reporting period (July 2015 to June 2016). Of these, 1.5% were NHS funded and 98.5% were funded privately or by other means.
- Between September 2015 and October 2016, there were 54 deaths within the hospital. The palliative care service received 17 referrals in the same period from patients classified as nearing the end of life. Staff acknowledged that more work needed to be done to increase familiarity with the palliative care service outside of the oncology department. At the time of drafting this report, an external audit was looking into the appropriateness off the palliative care pathway for these 54 deaths.
- There were daily bed management meetings attended by senior staff to plan patient admissions, transfers and discharges. Nurse navigators helped to facilitate patient flow throughout the oncology department.
- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Patients past 16 weeks of pregnancy and those requiring emergency care such as an acute myocardial infarction (heart attack) or acute

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stroke were excluded. Patients with known mental health conditions required a risk assessment by the site lead and relevant consultant prior to admission. Access to the medical and oncology wards was via a consultant.

- There were no 'wait times' for treatments or services at the hospital, as such. Senior staff told us that the hospital responded to patients' needs by flexing their capacity to match them. However, the hospital did record how many patients waited over 10 minutes for admission. In June 2016, there were 36 inpatients and 24 day case patients for who this was the case. This varied each month, with 47 inpatients (13.9% of total patients admitted) and 26 day cases (9.3% of total) waiting over 10 minutes in March 2016. Patients we spoke to were satisfied with the timeliness of the admissions process. In a survey of 71 patients in June 2016, 97% agreed that the promptness of their admission was either 'excellent', 'very good' or 'good'. A further 93% agreed that the process was well organised.
- Diagnostic waiting times were not currently audited by the hospital, but we were told that any requests were actioned within 24 hours. All endoscopy results were given to the patient on the same day as the procedure.
- Staff across the hospital told us they could usually discharge patients promptly. A survey of 71 patients in June 2016 showed that 95% of patients were satisfied with the assistance they received when planning their discharge, and with the speed of the process.
- There was no cardiac rehabilitation service and nursing staff were not involved in the onward referral process to further agencies on discharge. We were told that this would be the responsibility of the patient's GP and that it was not an issue due to the patient group, who were elective and arranged their own rehabilitation and aftercare. However, elective revascularisation patients should still be offered information on rehabilitation. The ward nurses did not give patients information on any aspect of rehabilitation, although we saw some patient information on this topic published by the British Heart Foundation (BHF).

- There was a SLA in place to transfer deceased patients from the hospital to a designated local undertaker. The undertaker would collect deceased patients directly from the ward, after nursing staff had performed last offices.
- The hospital did not currently audit the number of patients dying in their preferred location. There was a process in place for rapid discharge at the end of life, although not all staff were aware of this. The specialist nurse would help patients to arrange and access community resources and support. There was a rapid discharge checklist and care plan available, as well as electronic guidance. The specialist nurse planned to arrange more education sessions with nursing staff to familiarise them with the process and documentation.

Meeting people's individual needs

- The hospital admitted a number of patients from overseas, whose first language was not English. There was a dedicated international patient centre that coordinated the care of patients from outside the UK and provided an on-site interpretation service. Staff were aware of how to access an interpreter and a telephone interpretation service was also available. Cultural awareness training was part of the induction process for all permanent and bank staff.
- In many areas of the hospital, patient information leaflets were not standardly available in languages other than English. We saw some leaflets produced on topics such as reducing the risk of infection produced in Arabic, but these were not available in all departments at the time of inspection. The hospital told us that any information required could be translated as required.
- The hospital had access to a number of multifaith chaplains, through an on-call system with spiritual leads in the local community. Staff told us that they could always get hold of someone when needed. A multifaith room was available, along with two quiet reflection rooms, open to those of any faith.
- Within the catering menu there were many options to cater for those with different nutritional requirements. Menu items catered for those with food allergies and provided halal, kosher and vegetarian options. An Arabic menu was provided for international patients. However, some patients that we spoke with did not feel that their dietary requirements were sufficiently catered for.

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- The hospital did not actively admit patients living with dementia but staff were aware of how to care for these patients. The hospital offered a memory clinic, which was a same day service that assessed memory impairment and aimed to diagnose dementia and memory related conditions early. There were dedicated dementia leads to support both patients and staff. Patients living with dementia were offered 1:1 nursing care. Family members and carers were encouraged to be involved in their care as much as possible and 'this is me' booklets were produced to ensure staff were familiar with the best ways to approach caring for each patient. Red trays at meal times were used to alert nursing staff the patient may require extra help at mealtimes. We witnessed a patient living with dementia being cared for with compassion and patience.
- There was no link nurse for patients with learning disabilities. However, nursing staff told us that hospital passports were used for patients with learning disabilities and showed us a care pathway that staff could refer to.
- Staff told us that if a patient wished to be cared for by staff of the same gender, the hospital was able to accommodate their wishes.
- Psychological counselling services were available for oncology patients suffering from anxiety, stress or pain. Other complimentary therapies like massage and reflexology were also offered.
- The medical service as a whole received 58 complaints between July 2015 and June 2016. Of these, 81% (47) of complainants were sent responses by the hospital within the 20-day corporate target. Analysis showed that the top themes of complaints within medical wards were payment of fees, catering and treatment by individual staff members (particularly agency staff or RMOs, not directly employed by the hospital).
- Learning and action points from any complaints were discussed in the daily incident meetings, as well as regular departmental meetings and the clinical governance committee. Observations and negative perceptions of staff behaviour were feedback to the individuals concerned. Any trends in feedback enabled changes to be implemented more widely. For example, the hospital recently provided further patient information on fee generation and payment processes. Any learning was also published in the fortnightly newsletter. Nursing staff were able to tell us about changes that had taken place as a result of complaints, such as the purchasing of new artwork for the general/ cardiology ward and the adjustment of the catering menu.

Are medical care services well-led?

Requires improvement 

Learning from complaints and concerns

- Informal complaints were dealt with at ward level. Nursing staff told us that a representative from the international patient centre walked round each ward with an interpreter regularly to get feedback from patients whose first language was not English, although we did not witness this whilst on inspection. There were leaflets throughout most wards detailing how to give feedback or make a formal complaint.
- Formal complaints were handled by the complaints department. There was an up-to-date corporate complaints policy available electronically. The hospital aimed to acknowledge all formal complaints within 48 hours. A corporate target of 20 working days was set for a full response. Complaints were discussed in the daily incident meeting to ensure each was being investigated and acted upon.

Leadership and culture of the service

- There was a clear senior management structure within the hospital. The medical director and governance team had clearly defined roles in terms of reporting structure, responsibility and accountability. However, the quality of local leadership at ward level tended to depend on the tenacity and enthusiasm of the individual manager. We found that some departments had little support in developing their service from the organisation as a whole. In particular, we found that the governance of the dialysis day unit was not ideal, with little oversight of staff competency or developments in policy. This was despite initiatives such as quarterly leadership team away days, which tended to focus on strategy and issues topical to the hospital as a whole.

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- Most staff felt well supported by their immediate line managers and felt they could approach them with any issues. The senior leaders were described as visible and proactive by some nursing and medical staff, but others told us that they rarely saw the executive team.
- We saw collaborative working between all wards and departments within the hospital. The medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice. Most staff told us that they were happy and proud to work at the hospital. However, some staff described the environment as very corporate and business focused. They felt more could be done to support both patients and staff, making them the true centre of care.
- The hospital had an open and honest culture and staff said they had no issues raising concerns. There was a service level agreement (SLA) in place to provide 'speak up' services to staff to help them to raise any concerns anonymously. However, not all staff that we spoke to were aware of this as an option.

Vision and strategy for this service

- The hospital's mission statement was 'longer, healthier, happier lives'. Staff aimed to deliver these by adopting a set of values, which was to be passionate, caring, open, authentic, accountable, courageous and extraordinary. Most of the staff we spoke with were aware of these values. Any updates on the vision and strategy were included in the fortnightly staff newsletter.
- The strategic priorities over the next four years were to foster staff engagement and satisfaction, be the main healthcare partner to more people, and to deliver extraordinary business results. To achieve these aims, the hospital's clinical strategy put a strong emphasis on MDTs and collaborative working. The goal of the hospital was to become a learning organisation that engaged staff at every level. They aimed to do this by acting on staff feedback, using the employee net promoter system (eNPS) and helping managers to develop their abilities. The hospital had also modernised and simplified the approach to maternity, sickness and redundancy policies, amongst other measures. To increase patient satisfaction, the hospital had also rolled out a version of net promoter system (NPS) to patients on discharge, and planned to trial new products and services. An example of this was text reminders to fast ahead of

health assessment appointments. To improve business results, the hospital planned to improve the way it benchmarked itself against other providers by improving data collection and grow complexity in key services. Managers attended monthly meetings in which current hospital performance was measured against this strategy. Any outcomes were communicated to wider staff groups through these managers.

- The hospital had introduced the Bupa code, which detailed what the organisation expected from their staff. The code ultimately aimed to help staff to protect all patients, their colleagues and partners. Values were based upon keeping staff, customers and information safe at all times, maintaining high professional standards, celebrating diversity and acting ethically by encouraging staff to speak up. Some staff we spoke to were aware of the code, although it had not yet been fully embedded. The hospital planned a year long programme of customer service training in 2017, which encompassed the code. All staff would be required to attend this.
- There was no clearly defined strategy in place to develop end of life care (EOLC) services within the hospital.

Governance, risk management and quality measurement

- There were clinical governance meetings held on a monthly basis. Daily incident meetings were held to review all incidents, complaints and near misses. This ensured that all incidents and complaints were logged within 24 hours, helping the service respond and manage any concerns in a timely manner. It also provided a chance to review any emerging trends or patterns.
- Senior staff, including the governance lead, were responsible for overseeing risk management, including the maintenance of risk registers. Staff were aware of the risks on the register and who was responsible for maintaining the document. The risk registers were reviewed at the monthly clinical and non-clinical governance committees. There were some issues identified during inspection that we would expect to be included in the risk register, such as gaps in current policy and procedure, that were not.

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- There was a plan for local audit for the coming year, although many had not yet taken place at time of inspection. The medical service submitted data to the British Cardiovascular Intervention Society (BCIS) but did not participate in any other national audits related to medical care or end of life care. This was due to the fact that the hospital provided a limited number of services to a comparatively smaller patient base than NHS hospitals. This meant that it was limited in terms of the national audits that it could submit data to. The hospital had started to submit data to Private Healthcare Information Network (PHIN) in order to perform benchmarking functions, although this project remained in the early stages.
- The medical advisory board (MAB) oversaw clinical governance issues, key policies and guidance and monitored patient outcomes. It also renewed the practising privileges of all consultants. The MAB reviewed each application relating to practising privileges and advised the hospital. Their advisory function covered the granting, renewal, restriction, suspension and withdrawal of practising privileges. A formal review of each consultant's privileges was undertaken every two years.
- All clinical staff are provided with human factor training during their induction and twice monthly human factor meetings were held. These were attended by both clinical and non-clinical staff to discuss incidents or current issues of interest.

Public and Staff engagement

- Patients were provided with a patient survey on discharge from the wards to gather their feedback. Survey results were collected and considered by the service to improve patient experience across the hospital. There were also monthly patient forums to involve them in decision making about the planning and delivery of the service.
- The service collected feedback via regular eNPS surveys, which included anonymised verbatim comments. The eNPS was a way for the hospital to measure employee loyalty. It asked staff two questions and scores could vary anywhere from -100 to +100. A positive score was rated as anything between 10 and 30, with anywhere from -10 and +2- being normal. In quarter one of 2016, the overall score as recommending the hospital as a

place to work was -2 (197 respondents), improving to +2 in quarter three (234 respondents). The score for recommendation of Bupa's products and services was 7 in quarter one, improving to 13 in quarter three.

- Staff attended various ward and divisional meetings, as well as additional forums such as twice yearly executive-led 'in touch' sessions. These provided all staff with an opportunity to find out about the hospital's priorities and vision. The sessions included a question and answer section, which enabled staff to ask questions and give feedback on what they felt was most important to them. There were also fortnightly open door sessions with the hospital manager.
- The hospital celebrated the achievements of staff by having departmental 'stars of the month', which colleagues nominated. There was also an annual staff award ceremony, called 'star awards' where staff were awarded with prizes for their good work.






Innovation, improvement and sustainability

- The hospital had introduced the nurse navigator role, in partnership with Macmillan. This role covered all the tumour groups that were not supported by a specific specialist nurse, providing a consistent point of contact for each patient throughout the care pathway. This partnership with Macmillan also provided staff with further opportunities for training, development and support.
- The sleep clinic within the hospital was hoping to develop further, with the lead clinician completing a higher degree in sleep medicine. As part of this opportunity, the clinician agreed to develop and deliver specialist sessions to employees across the hospital. Information regarding signs and symptoms of sleep disorders was also published on the hospital website blog.
- The angiography department recently commenced a trial of optical coherence tomography angiography (OCTA). This a non-invasive approach that can visualize blood vessels down to the capillary level during cardiac procedures.
- The neurology department had recently made a successful business case for the introduction of home

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video telemetry monitoring. This will allow advanced neurophysiological measures to be taken in the comfort of a patient's home, increasing the reliability of the results.

Surgery

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

Are surgery services safe?

Requires improvement 

We rated safe as 'requires improvement'.

Incidents

- There were no “never events” reported within the surgical service between April 2015 and March 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 found reliable systems and processes in place to keep people safe and free from harm. Staff in the surgical service used an electronic reporting system to record incidents. All staff were aware of how to report incidents. Junior nurses informed us that they received feedback from any incidents they reported and that any lessons from them were disseminated to everyone.
- There were daily incident meetings that discussed and reviewed any incidents that had occurred in the previous 24 hours. The nurses in charge and managers would attend these meetings and then share any learning with staff on the wards and in the theatres. The service shared learning from all incidents in a bid to improve safety in clinical areas. For example, due to a recent spate of patient falls, the hospital ensured that more physiotherapists were present on the orthopaedic ward.
- There were 236 clinical incidents between November 2015 and October 2016. This rate of clinical incidents is lower than the rate of other independent hospitals that the Care Quality Commission (CQC) hold this type of data for. Of these, 177 incidents resulted in ‘no harm’ and 53 resulted in ‘low harm’. The majority of these incidents (21%) related to the admission and extended stay of patients. The next two largest categories related to clinical care (13%) and accidents or issues with health and safety (11%). Near misses were not routinely reported.
- When things went wrong, there were thorough and robust investigations carried out. As an example, we read three recent root cause analysis (RCAs) related to surgery and found them to be thorough and well considered.
- There were no surgical morbidity and mortality (M&M) meetings, as deteriorating patients would be transferred to the A&CU. In the event of death, the M&M would occur in that directorate. There were no deaths occurred on surgical wards.
- All staff were aware of the hospital expectation to speak up when things went wrong and staff of all levels were aware of the principles behind the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. Some staff informed us that they had limited opportunities to employ the duty of candour as issues of this significance rarely arose.

Clinical Quality Dashboard

Surgery

- The NHS safety thermometer is an improvement tool to measure patient “harms” and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections.
- The hospital did not use the NHS Safety Thermometer as it was a private healthcare provider. The hospital did however use their own dashboard that assessed and kept track of key performance indicators. Patients were routinely risk assessed, patient falls were recorded and VTE rates were measured.
- Between January 2016 and June 2016, 100% of patients were assessed for risk of pressure ulcers and VTE. In the same period, there was one case of pulmonary embolism and zero cases of deep vein thrombosis (DVT).
- In the same reporting period, there were 25 patient falls. As a safety goal, the service aimed to have no patient falls. To reduce the number of falls on the ward the service maintained a daily physiotherapist rota and patients were provided with anti-slip socks.

Cleanliness, infection control and hygiene

- On the theatre floor, the scrub area that facilitated two theatres was open to the main corridor. Staff were aware that this was not ideal as infection control standards could be compromised. The theatre manager informed us that they had plans to introduce secure access to the scrub area. We asked for a copy of these plans but none were provided. This was not on the service’s risk register.
- The wards were spacious and well lit. The rooms on the wards were all single en-suite rooms, with adequate natural light. However, on the orthopaedic ward – a ward which often treated patients with severe mobility issues – there were six baths located in the en-suite bathrooms. Bars of soap were still in use in some bathrooms on the wards. All the other rooms on the ward had en-suite showers.
- The hospital had an infection prevention control (IPC) policy and each ward had an infection control link nurse. The IPC link nurse conducted the hand hygiene audits, provided training and ensured that every nurse had a monthly hand hygiene observation carried out. This to ensure that each individual nurse was adhering to adequate hand hygiene and following hospital policy. The link nurse fed into the infection prevention and control team (IPCT) and met regularly with the microbiologist, who was frequently on the wards.
- The IPCT met every quarter and included the hospital’s consultant nurse, the IPCT and a consultant microbiologist. The IPCT discussed any outbreaks of communicable diseases, the risk register, trends in bacteria colonisation and relevant IPC audit results.
- We saw adequate levels of hand sanitising gel in the communal areas and located at the entrance of each single room. We observed staff using the gel before entering a patient room and upon exit from a patient room. We observed all nurses and doctors adhering to the hospital bare below the elbows (BBE) policy. Between August 2015 and August 2016, the surgical directorate audited hand hygiene and found 100% compliance with safe hand hygiene practices each month.
- There were adequate supplies of personal protective equipment (PPE), for example gloves and aprons, on the wards and in the theatre areas. Patient rooms also contained wash basins. Some rooms contained PPE for use by staff. Both junior and senior nurses could accurately and confidently describe the instances where PPE was necessary.
- On the wards, sluice rooms were clean and well organised. We observed green ‘I am clean’ stickers being used by cleaning staff and we saw these stickers were up to date.
- In theatres, decontamination was outsourced to an external company. The decontamination pathway of equipment in the theatres was good. We observed a sound scrub technique that was followed by all staff. Surgeons and theatre staff were scrubbing their hands both pre and post operatively in line with the WHO and Association for Perioperative Pathway (AfPP) guidance. The theatre staff could fast track the cleaning of equipment, ensuring a turnaround time of 24 hours. The progress of each request could be tracked on an online system.
- In theatres, surgical site infections (SSIs) were monitored and patients were prepared for surgery in accordance with National Institute for Health and Care Excellence (NICE) guidelines. There were three SSIs between July

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2015 and June 2016. These patients acquired infections somewhere between seven and 24 days post operation. One of the infections was deep, with the rest being superficial. The rate of infections during primary knee arthroplasty and upper GI and colorectal procedures were above the rate of other independent acute hospitals we hold this type of data for. The service were aware of their SSI rates and had processes in place to mitigate against them in the future.

- In the same reporting period there were zero cases of meticillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection. There was a hospital-wide policy that stated that certain patients should be screened for MRSA prior to admission. This included patients who were on the orthopaedic or oncology pathway. Patients who had come from another hospital, had a history of MRSA or who were from overseas would also be screened. If a positive result was returned the patient would be kept in isolation.
- There was one incident of hospital acquired Clostridium Difficile (C.Diff). C.Diff is a bacterium that can infect the bowel and cause diarrhoea and most commonly affects those people who have been recently treated with antibiotics.
- There were three incidents of E.Coli as a result of surgery. E.Coli is a bacterial infection that can cause severe stomach pain and diarrhoea.
- There was one instance of meticillin sensitive staphylococcus aureus (MSSA) but this was community acquired. MSSA is a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning.
- Infection control was part of the mandatory training programme, which all staff were required to attend. Within the surgical service, 90% of staff had attended training.

Environment and equipment

- In recovery, there was no difficult airways trolley due to the limited space. When we asked staff about this, they informed us that it was located by the operating theatres which were outside the main recovery doors.
- The clinical areas were clean and free from clutter. On the wards, there were wide corridors and all inpatients

had single rooms with televisions and sometimes a sofa bed. All patient rooms were single en-suite rooms, the majority contained showers but there were six baths located on the 19-bedded orthopaedic ward.

- Wards had a strict access policy and visitors were required to sign in at the main entrance before coming up to the ward.
- Resuscitation equipment was stored safely on secure trolleys and was checked either weekly or daily by nursing staff. The drawers of the resuscitation trolleys were checked every Sunday. The top of the resuscitation trolley, including the defibrillator and oxygen cylinders, were checked every day. This was the case throughout the service and we saw evidence of this in the audit diaries on top of the trolleys. All equipment was safety tested and within date.
- On the wards, staff checked equipment in the medical rooms daily. This daily check included calibrating two blood sugar machines, checking one hypoglycaemia box and recording the temperature of the drug fridges. All of the audits to ensure these checks were done were up-to-date and signed for.
- On the theatre floor, there were clear pathways for the collection and drop-off of equipment. All staff were aware of the processes for the collection of equipment due to the clear guidelines in use.
- The arrangements for the management of waste products and clinical specimens were appropriate for keeping patients and staff safe from harm. Sharps bins were used correctly and sluice areas included bins that were adequately labelled and classified to ensure segregation of waste.

Medicines

- There were no medicines cupboards on the inpatient wards. Instead, every morning, pharmacy technicians would load up a machine that would dispense any medicines. The machine required a staff login password, fingerprint identification and the barcode from each patient chart in order to access the correct medications. The pharmacist stated that the machine was “great” and reduced the risk of dispensing errors. When the machine was running low on medication, the pharmacy distribution team would top it up.

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- Controlled drugs (CDs) were stored in locked cupboards and the nurse in charge kept the key. CDs were checked twice a day, once by the morning staff and once again by night staff. Two nurses would check the CDs on both occasions. Nurses were aware of the importance of the CD check. Pharmacists audited the CDs every month. We observed a copy of an audit from July 2015 and found it to be completed thoroughly.
- There was one pharmacist with oversight of the two inpatient surgery wards. This pharmacist worked from 9am to 6.30pm every weekday. The outpatient pharmacy was open until 8pm. After 8pm, staff could either bleep the pharmacist on call or contact the site lead, who had access to the pharmacy.
- If patients had drugs to take out (TTOs), they were sent to the pharmacy department in the outpatient department. An April 2016 audit of TTO prescriptions showed that 75% of TTOs were fulfilled in the required time. It took the pharmacy an average of 73 minutes to complete TTO prescriptions.
- In the records we viewed we saw evidence of microbiology input. The antimicrobial stewardship round was attended by a senior antimicrobial pharmacist, who reviewed all inpatients on antibiotics. These cases would have to comply with the hospital antimicrobial guidelines.
- Pharmacy provided a clinical pharmacy service, stock management service and distribution service to both theatres and recovery. This included: dispensing (fluids and CDs), provision of drug information, safe medicines management and inventory management.

Records

- The service used paper-based records. Over the course of the inspection, we looked at 12 sets of records and found them all to be legible and up-to-date. Records were fit for purpose, detailed and contained input from a wide variety of team members. For example, some records had input from councillors, stoma nurses and the microbiologist. All records on the orthopaedic ward had input from a physiotherapist. All records we observed adhered to General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance.
- The service conducted audits on the completion and quality of medical records. We observed an audit for

May 2016, which showed that 66% of six records were not completed within 24 hours of admission. This showed that records may have been completed retrospectively. The service added an agenda to the monthly meeting to feedback to staff that all note taking must be done immediately.

- Patient records were stored within a non-lockable cabinet but within a lockable nurses' room. The ward clerks had access to discharge notes and would liaise with the records team to have them taken down to the records department when they were not in use.
- The ward staff carried out monthly audits on patient venous thromboembolism (VTE). We looked at two audits and found that the top omissions were the lack of documentation of both verbal and written information.
- If a patient required a copy of their records, there was written guidance on how to access them. They would have to write an application and provide a copy of either their driver's licence or passport. This application process was in line with the Access to Health Records Act 1990 and the Data Protection Act 1998.
- Information governance was part of the mandatory training programme, which all staff were required to attend. Within the surgical service, 91% of staff had attended this training. This was against a target of 95%.

Safeguarding

- Safeguarding policies were up to date and readily available on all units. Staff knew how to access both the hard copy stored on the ward and the copy kept in the policy library on the internet. Both junior and senior nurses were aware of who the safeguarding lead was and the escalation process if they had any concerns.
- All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Staff on the wards understood safeguarding procedures and how to report concerns.
- Staff on the inpatient wards had a high degree of knowledge around female genital mutilation (FGM). One senior nurse informed us that she had recently undertaken the e-learning course, which helped her to understand the importance of recognising the risk of FGM in her patient base.

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- Safeguarding was part of the mandatory training programme and different levels of training were provided to staff with different roles. Within the surgical division, 94% of staff had attended level 1 safeguarding adults training. A further 77% of staff had completed level 2 safeguarding adults training, and 68% of staff had completed level 3 training. Overall, 79% of staff had completed safeguarding of vulnerable adults e-learning training.

Mandatory training

- The hospital mandatory training programme included: health and safety, display screen equipment, working at height, safeguarding vulnerable people, infection management, fire safety, data matters, fighting financial crime and risk culture and incident management.
- Training rates in the surgical division varied between 53% (immediate life support) and 100% (clinical induction). The clinical induction was mandatory for all new staff. Junior nurses we spoke with said they had found the induction helpful and detailed. We received no information on what percentage of staff were advanced life support trained (ALS).
- Permanent resident medical officers (RMOs) were required to undertake a mandatory training programme that included: safeguarding vulnerable people, infection prevention and control, fire safety, data matters and health and safety. These modules were arranged via Bupa's e-learning system and were mandatory.
- Senior staff and supervisors monitored completion rates of mandatory training but staff also had access to an online system that enabled them to view their training modules.
- The hospital mandated target for completion of mandatory training was 90%.

Assessing and responding to patient risk

- Over the duration of our inspection we reviewed 12 records and found that all but one patient had evidence of being reviewed by a consultant within 12 hours of admission.

- On the wards, the white board kept in the nurses' station would identify patients at risk of falls or who needed assistance at mealtimes. On the orthopaedic ward, physiotherapists were always around to assist patients with reduced mobility.
- The Early Warning Score (EWS) is a scoring system that identifies patients at risk of deteriorating, or needing urgent review. The nurses documented each patient's EWS in the paper-based nursing notes that were kept in patient rooms. We witnessed staff in recovery recording patient observations such as heart rate, blood pressure and temperature.
- We observed patients having vital observations recording regularly. For example, blood pressure and oxygen saturation were measured, to monitor their health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
- Nurses on the wards were able to explain the process of escalation if a patient presented with sepsis or if their condition deteriorated. The RMOs were beeped in the first instance. Nursing staff informed us that the RMOs were accessible and contactable when needed. All RMOs were required to hold an advanced life support qualification. The nurse in charge and the site lead would also be informed if the patients EWS score was four or above. In severe cases, the intensive therapy unit (ITU) would act as an outreach team.
- The service audited EWS charts to assess frequency and quality completion. We reviewed one audit which found that 100% of patients had their EWS chart in place and their observations documented frequently.
- There was an adapted sepsis screening tool available both in hard copy on the wards and on the hospital internet. This would be used if the EWS was four or more, or if infection was suspected.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist, which was developed to reduce errors and adverse events, and increase teamwork and communication in surgery.
- We observed three different surgical lists and found that the WHO surgical checklist was embedded into practice

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by the surgeons and theatre staff. We reviewed an audit that measured service compliance with the WHO surgical checklist in recovery. The audit found that 100% of recovery patients received a 'time in' and a 'time out'. This means that all patients audited had their time into theatre and their time out of theatre recorded. All but one had a 'sign-in'. Despite this we reviewed two incidents that questioned whether the WHO surgical checklist was embedded by theatre staff. One of these incidents occurred in the three months prior to our inspection and involved the wrong patient being brought from the ward to the theatre on two separate occasions. When we spoke with theatre staff about this incident they informed us that the call system to the wards for the patients was sometimes ineffective.

Nursing and support staffing

- At the time of the inspection, all wards and theatres were safely staffed with enough nurses, healthcare assistants (HCAs) and operating department practitioners (ODPs). The staffing levels in surgery and theatre were flexed according to activity, and this was reviewed daily by managers.
- The hospital did not use an acuity tool, but instead employed an adapted roster system in order to plan staffing needs in advance, based on pre-determined demand. In the day, there were a minimum of one staff member to four patients, which increased to six patients in the evening.
- For patients requiring 1:1 care, the service relied on the use of bank and agency staff. Between July 2015 and June 2016 the use of bank and agency staff was between 0% and 33%.
- Despite the regular use of bank and agency staff, there were still some unfilled shifts. Between April 2016 and November 2016, the rate of unfilled shifts varied between 1.7% and 10.9%.
- There was a transplant coordinator and breast care clinical nurse specialist (CNS) that was employed directly by the surgical directorate. There were also CNSs for infection control, tissue viability and diabetes/endocrinology, who all provided support within the surgical division. The CNS role included responsibility for staff training, providing support to link nurses, audit and policy development and review of incidents and RCAs.

- Between April and November 2016, the sickness rate across the theatres and inpatients was between 1.7% and 10.8%. At the time of our inspection the turnover rate across the inpatients and theatres was 7%.
- The vacancy rate for inpatient nurses between December 2015 and November 2016 was between 0% and 16%. In the same reporting period, the vacancy rate for theatre nurses was between 4% and 13%. At the time of our inspection there were no vacancies for inpatient nurses. In response to this vacancy rate the theatres informed us that due to the elective nature of the work staffing levels were flexed to meet higher or lower demand. Within the wards, the low bed occupancy (48% for orthopaedics between April and November 2016) meant that service did not always require a full establishment of staff.

Surgical staffing

- Surgeons worked under a practising privileges agreement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Although the granting and retention of practice privileges was at the sole discretion of the general manager, the medical advisory board (MAB) members advised them regarding the ability and experience of the practitioner to undertake unsupervised, independent practice for the declared procedures on a speciality-specific basis.
- The service was consultant-led and there were 199 surgeons with practising privileges at the hospital. There were 10 surgeons with practising privileges that were registered to carry out cosmetic procedures.
- There was an on-call rota for general surgeons, with daily cover including weekends. Records we viewed confirmed that consultants reviewed patients on a daily basis in all cases.
- There were six surgical RMOs employed at the hospital. The RMOs were all in specialist training level and above and would work 24-hour shifts at the service. There was access to RMOs 24 hours a day, seven days a week. The RMOs were usually present on the wards, but were also available by bleep. The RMOs we spoke with informed us that although they worked 24-hour shifts, there was hospital mandated 'protected time' that enable them to rest and eat.

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- There were no formal arrangements for anaesthetists and no on-call anaesthetist rota. The service informed us that this was due to the nature of the surgeon workload. The vast amount of elective work meant that the surgeons and anaesthetists would make themselves available post-operatively. If this did not take place, the theatres held anaesthetists' contact details in case of emergency. We received no guidance on how often this would take place. The service had plans to formalise the anaesthetist rota.

Emergency awareness and training

- The hospital defined a major incident as any event whose impact could not be handled within routine service arrangements and required the implementation of special arrangements.
- There was a major incident policy and a hospital business continuity plan in the case of an emergency. The surgical division also had a contingency plan in place. The service manager would take the lead in the event of an emergency. Staff we spoke with were aware of this.
- In the event that the manager was not on shift during a major incident, the hospital executive manager on call would be responsible for declaring a major incident. The duty site lead would be the incident coordinator, and would act as a focal point for the coordination of the response to the incident.
- All staff were provided with an emergency card, which stated both the number to call in the event of an emergency and the number of the security office.
- Staff in the theatres undertook emergency evacuation training every year, as well as emergency blood simulations.
- In the surgical directorate, 96% of staff had completed the fire safety awareness training.
- We reviewed a sample of hospital policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Policies and guidance were easily accessible to staff on the hospitals internet. Nurses on the wards were able to illustrate how to access policies online.
- The service complied with the Royal College of Anaesthetists recommended fasting time for six hours for food and two hours for clear fluids for surgical patients.
- The hospital contributed to the national joint registry (NJR). The NJR was set up by the Department of Health (DH) to monitor performance of joint replacements in orthopaedic surgery. The service also contributed to other national audits and registers including the National Adult Cardiac Surgery audit and the National Breast and Implant Registry.
- The hospital provided data to the national Patient Reportable Outcomes Measures (PROMs). PROMs use patient questionnaires to assess the quality of care and outcome measures following surgery.
- Whilst the service did not have an annual audit programme, they did perform audits on VTE assessment, EWS completion and cleaning and infection control. The WHO checklist for surgical safety audit was also carried out on a weekly basis.

Pain relief

- Pain was scored using two methods. The first was a numeric rating scale (NRS) that scored pain from zero to 10. On this scale, zero meant no pain and ten was extreme pain. The second tool saw pain assessed from 'low', to 'moderate', to 'severe'. There were also pain scoring tools available for those with communication difficulties.
- During the course of our inspection, we spoke with eight patients and asked all of them about their pain and how it was managed. Patients informed us that their pain was well managed. One patient told us that, "the pharmacist comes every day and my pain is managed responsively".
- The medical records we reviewed demonstrated that patients were provided with regular pain relief post-operatively.

Are surgery services effective?

Good 

We rated effective as 'good'.

Evidence-based care and treatment

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- Whilst there was no specific team for the management of pain, the pharmacist we spoke with was confident that patients had good access to pain relief. The anaesthetist made the initial assessment about the patients' pain thresholds. The pharmacist then reviewed this in the course of a daily ward round to ensure patient pain was managed, considering other medication.

Nutrition and hydration

- When considering nutrition, the hospital created policies based on the NICE guideline 32: Nutrition support in adults.
- Patients' nutrition was assessed on admission using the Malnutrition Universal Screening Tool (MUST). If a patient was identified as medium or high risk of malnutrition, the dietitian would become involved in the care plan.
- The medical records we reviewed showed that the patients' malnutrition score (MUST score) was assessed regularly as part of their observation record. This also confirmed which patients had dietetics input. There was a multidisciplinary approach to ensuring patients were adequately nourished, including input from both dietitians and speech and language therapists (SALTs). There were fortnightly nutrition meetings attended by the dietitians and SALTs. These meetings both shared learning around patient nutrition and raised awareness of patients who needed help at mealtimes.
- There were menu champions in place on each ward that would liaise with the nurse in charge before each meal service to get up-to-date information on patient requirements. Red jugs and trays indicated which patients required assistance at meal times.
- There was a CNS specifically for diabetes to assist diabetic patients with their food choices and help them manage their blood sugar.
- One patient informed us that the food was bland, and another informed us that the menu was confusing for his diet type. This same patient told us that input from the dietitian would have been appreciated. We observed a menu (which changed daily) and found it to be clear and concise.

- Senior ward staff had access to the dietitians' cupboard, in the event that enteral feeding tubes were required. Enteral feeding is what happens when a patient's nutrition is delivered via a tube directly to the digestive tract.

Patient outcomes

- The service participated in the national adult cardiac surgery audit and submitted information to the national joint registry and the breast and cosmetic implant registry.
- The service also participated in reporting to PROMs. The reporting period of January to November 2016 showed that 100% of patients who received hip surgery at Bupa experienced health gain; this is compared to 93.8% in NHS patients. The service completed no data for knee surgery in the same reporting period.
- All foot, ankle, knee and shoulder patients who had surgery were asked to complete condition specific outcome measures prior to treatment and at certain times postoperatively. The results were scored out of 200 for each domain: pain, symptoms, activities of daily living, sport and recreation and quality of life. For all markers, there were marked improvements six months and 12 months after surgery. For knee surgeries, of the 34% of patients that completed a score three months post-surgery, all of the patients had improved.
- Between July 2015 and June 2016, there were two cases of unplanned transfers to another hospital – this is not high when compared to other services of this type and size.
- In the same period, there were 20 cases of unplanned readmission with 28 days of discharge. This is not high when compared to other services of this type and size. Most of these readmissions related to patients vomiting, feeling nauseous or having surgical site pain.
- In the same period there were seven cases of unplanned returns to theatre. This is not high when compared to other services of this type and size. The majority of these unplanned returns to theatres related to post operation complications.

Competent staff

- The Medical Advisory Board (MAB) was a representative body of consultants that met on a regular basis. The

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MAB involved the CEO, medical director, chairman of the medical governance committee, the head of clinical governance, and the lead RMO. The MAB was defined as advising management on clinical issues, reviewing practicing privileges and receiving reports from the CEO, CNO and med director.

- Practising privileges were only granted to applicants who held substantive NHS consultant posts in the five years before application. This ensured that consultant surgeons only received privileges to perform surgery that they were skilled, competent and experienced to perform. A formal review of each clinician's privileges was undertaken every two years.
- If a consultant wanted to introduce a new technique they would have to complete an application form that provided details of the procedure, the inclusion/exclusion criteria and the clinical basis for the procedure. The clinical governance committee would consider the application before this was signed off by the medical director.
- Consultants with practising privileges had their appraisals carried out at their respective NHS trust and had to provide a copy to the hospital each year. Doctors also usually revalidate with the organisation where they carry out the majority of their clinical work. If a doctor needed to revalidate with the hospital, this was the responsibility of the revalidation officer (who was also the medical director). Of the 45 doctors who were due to revalidate with the hospital this year, only 10 (22%) had done so at the time of our inspection.
- A hospital-wide practice development nurse (PDN) ran sessions to assist nurses with their competencies. Staff informed us that they had been to study days organised by the PDN that included: revalidation, tracheostomy, renal, cardiac and orthopaedic study days. Study days included both internal and external speakers. A senior member of staff said, "the PDN is very good, if there is a new bit of specialist equipment she will hold a study day about it".
- A senior nurse informed us that if you could show that a new course was valuable to your practice and the hospital, then assistance would be provided in taking the course.
- In line with NMC guidelines, all registered nurses were required to undertake clinical supervision. This meant

that all registered nurses would have at least one hour per year of a dedicated 1:1 session with their supervisor. The purpose of clinical supervision was to provide a safe and confidential environment for staff to reflect on their professional practice. Staff we spoke with on the wards and in theatres corroborated this.

- We spoke with junior nurses who were new to the surgical service and they informed us that they received a one week induction followed by a three week induction to their department.
- Agency staff would receive a thorough induction and be assigned a buddy for their shift should they have any additional questions. New bank staff would receive a more thorough induction that covered information governance, major incident planning and core competencies such as intravenous (IV) administration, and blood glucose measurement. Bank staff were not able to commence a shift without proof of basic life support (BLS) training or drug administration certificates.
- At the time of our inspection, only 18.8% of nurses had revalidated. We were assured by the service managers that all nurses due to be revalidated by November 2016 had done so. All nurses had received an appraisal in the 12 months prior to our inspection.

Multidisciplinary working

- There were several regular multidisciplinary team (MDT) meetings within the service. Consultants we spoke with spoke very highly of the effectiveness of the MDTs they are part of. One consultant said, "It's not just discussing patient care, it's getting the opinion of respected colleagues and knowing that you don't have to do it alone". Another consultant informed us that the executive team regularly attended MDT meetings to provide support and learn about patients. We reviewed the minutes of an MDT meeting and found it to be well-attended, with eight cases being discussed over the two hours.
- The records we reviewed confirmed active involvement from health professionals of all disciplines where appropriate, including appropriate referrals to specialist nurses or teams. For example, records showed input by a microbiologist and infection control nurse. In others, there was also evidence of input from a stoma nurse and a counsellor.

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- There were a range of therapies available to patients, which included: physiotherapy, occupational therapy, lymphoedema management, hand therapy, speech and language therapy and massage therapy. There was also more specialist input available, such as women's health physiotherapy and neurological rehabilitation.
- The service had several service level agreements (SLAs) that ranged from the provision of RMOs from a neighbouring NHS trust to the supply of blood products and medical equipment. There were six SLAs in total at the time of inspection. The service managers informed us that they were very 'happy' with the effectiveness of their service level agreements. The hospital had a service agreement with a partner group that performed a large amount of their orthopaedic surgery.

Seven-day services

- Pharmacy services were available every day between 9am and 6pm. Between 6pm and 8pm, there was pharmacy assistance available in the outpatient department. After 8pm and out of hours, there was an on-call rota for pharmacists. In the event of an emergency, the site lead had keys to the pharmacy.
- Within the surgical service there was RMO cover 24 hours a day, seven days a week.
- Interpreters were available every weekday from 7.30am to 8.30pm. Thereafter, there was an on-call rota.
- Physiotherapy was available 9am to 5.30pm, Monday through to Friday. On the weekends, bank staff were available.
- Theatres operated from 8am to 9pm each day. The recovery area closed when the last patient left.
- There was 24-hour access to the radiography service for urgent inpatient imaging.

Access to information

- Consultants informed us that they always had access to all the information required in order to treat patients. The senior nurses informed us that the international team played a big role in ensuring that all the necessary records arrived with the patient.

- As well as having access to the hospital internet for all up-to-date policies, staff were aware that policies and pathway information was kept in paper format on the wards.
- On the wards, patient records were kept in one place. Nursing observations were kept in the patients' rooms and the reception team handled discharge notes. The process worked well and staff knew where everything was.
- Theatres wrote up morning and evening surgeries on a white board and rang the wards when they were ready for the next patient. The system was outdated and the service made us aware that they were eager to update their theatre management system to an online system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a hospital-wide policy on the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA).
- All medical records we reviewed contained at least one fully completed consent form, with up to three consent forms in some. There were four different consent forms for overseas patients whose first language was not English. An interpreter informed us that for overseas patients the consultant, anaesthetist and interpreter would explain the whole operation.
- At the time of our inspection the service did not audit consent forms and we were informed that consent forms were only audited in exceptional circumstances e.g. during an investigation process.
- None of the patients whose notes we looked at were on do not attempt cardio pulmonary resuscitation (DNACPR) pathways and this was evident in the notes.

Are surgery services caring?

Good 

We rated caring as 'good'.

Compassionate care

Surgery

- The six patients we spoke with all provided positive feedback about the quality of care and treatment within the service.
- We spoke with one patient who had been admitted for a double hip replacement. This patient said, “everyone is very friendly and caring. They have met my every need”. Another patient said, “care is exceptional, I’m not left wanting for anything”.
- Patients were provided with a patient feedback questionnaire and nursing staff encouraged them to fill it in. The patient feedback response rate for September/October 2016 was between 7% and 11%. Of the patients who responded in the hospital feedback 95% rated their treatment at the hospital as either excellent or good. Also, 95% of patients were likely to recommend the service to their friends and family.

Understanding and involvement of patients and those close to them

- One patient that we spoke with said that he felt very involved in his care plan as he had seen his consultant every day. That same patient informed us that he was offered the opportunity to attend his MDT meeting.
- All patients we spoke with spoke highly of their consultants and had confidence in their care plan. The patient survey saw that month on month patients were highly satisfied with their consultant. In October 2016, 87% of patients rated their consultant as excellent.
- The consensus from patients was that they had been very involved in their care plan and the high amount of elective cases in the service corroborates this.
- Patients and their families had regular updates and information sharing from their surgeons and the ward staff, one patient said “I feel very involved in what’s going on...like I’m part of the team too”.
- Another patient who was recovering post-procedure stated, “everyone is really friendly and helpful, I saw my consultant right after my surgery and he was very reassuring”.
- Patients received a Bupa pack upon discharge. This pack contained key information and contact telephone

numbers for patients post-procedure. The patients were also provided with alternative numbers to call should they be concerned about the development of pressure ulcers or sepsis.

Emotional support

- Psychological support was available via bleep and the palliative care CNS was made available to assist patients who had received bad news. The CNS role included the mandate to provide individual patient advice and support.
- One patient we spoke with informed us that they had been offered counselling services and this was corroborated in the medical records we reviewed. That patient’s family were also offered counselling sessions.
- Patients we spoke with were aware of the financial implications of their procedures and were briefed about finance and cost prior to consent being taken.

Are surgery services responsive?

Good 

We rated responsive as 'good'.

Service planning and delivery to meet the needs of local people

- The service had been adapted to meet the needs of its population. As the hospital offered private care the majority of surgeries were elective. This meant that admissions to the surgical inpatient wards were planned with the patient in mind.
- The housekeeping team could put a compassionate bed in the room of a patient if the patient requested. This meant that a patient could have a relative stay the night. This was especially useful for the international patients.

Access and flow

- The service had a pre-operative assessment room that was maintained by a nurse from the wards. Here, the nurse would use the pre-operative tests recommended by NICE guidelines. The nurse would also screen high-risk patients for MRSA. In order to avoid do not attends (DNAs) for surgery, the nurse would also carry

Surgery

out phone-based pre-operative assessments instead of assessments in person. Two alternating members of ward staff ran the pre-admission service, from 8am to 6pm daily.

- There was a bed management meeting every morning on a weekday to discuss patient admissions, bed capacity and patient discharges. We attended this meeting during our inspection and found it to be concise and thorough.
- A hospital-wide admission and exclusion process was in place. The admission process included an admission checklist that verified patient details, checked patient labels and ensured that the patient's registration information was correct. The admission policy also contained clear exclusion criteria. Patients past 16 weeks of pregnancy, along with those requiring emergency care (for example, those with a heart attack) were excluded. Patients with known mental health conditions required a risk assessment by the site lead and consultant prior to admission.
- Between July 2015 and June 2016, 2,721 surgical procedures took place in the hospital. More than half of these procedures (1708) were orthopaedic. In the same reporting period, 51% of procedures were day cases and the remaining 49% resulted in inpatient stays. Between November 2015 and October 2016, 99.97% of surgery patients were private and 0.03% were NHS patients.
- There were no procedures cancelled for a non-clinical reason in the 12 months prior to the inspection.
- Between January and November 2016, 74% of patients received their procedure within two weeks of their procedure consultation.
- Theatre utilisation was low when compared with other similar hospitals. Data provided by the hospital showed that between November 2015 and October 2016, theatre utilisation varied between 34% and 86%.
- Upon discharge, patients were provided with leaflets on the process of leaving hospital and were informed as to how to apply for their medical records if required. They were also provided with a discharge letter that they could share with their GP and the contact details for the service should they have any concerns.
- Whilst the service did not take emergency admissions, they did admit unplanned surgical patients from the

outpatients department and both consultant and embassy referrals. When we asked for the data on these unplanned admissions, the service informed us that they do not code these admissions as 'emergency' and therefore the data was unavailable.

- There was limited space in the theatre floor. The recovery area received no natural light and beds were positioned close to one another. When we questioned recovery staff about this, they were aware that the cramped conditions were unusual.

Meeting people's individual needs

- Patients' cultural, social and religious needs were all determined in the pre-assessment stage. Several members of the ward staff had learned some basic Arabic in order to understand international patients' needs.
- There was a proactive international team in place that assisted with the care pathway of these patients. Six interpreters on the team could be bleeped whenever necessary. Ward staff informed us that the interpreters were 'very helpful' and 'always available'. We observed interpreters responding to calls quickly and being present on the ward within a few minutes.
- Staff did all they could to accommodate cultural needs of patients. Where possible, they would provide male or female nurses based on patient preference and necessity.
- Whilst learning difficulty patients or patients suffering from dementia were not part of the exclusion criteria, the service did not actively admit patients with learning difficulties or dementia. The majority of therapies staff were trained in dementia every three years. There were also 'dementia friends' staff throughout the hospital.
- Leaflets relating to surgery and post-surgery were available in different languages and we observed leaflets in Arabic being provided to Arabic speaking patients.
- Patients had access to a trained, accredited healthcare chaplain who could provide support to patients. The chaplains provided pastoral, spiritual and religious care. A multi-faith room was available, along with two quiet reflection rooms, open to those of any faith.

Surgery

- Patients we spoke with had mixed views about the food. The majority of patients informed us that the food was good and there were a lot of choices.

Learning from complaints and concerns

- Patients were aware of how to raise complaints and concerns and were provided with information on how to do so. There was a corporate patient complaints policy in place and information on how to raise concerns or make complaints was available in each patient room. We also saw complaint leaflets on both inpatient wards. One patient informed us that, “I’ve never had a reason to complain as the sister in charge comes to see me every day to ask if everything is okay”.
- Complaints went to the senior nurses in the first instance, who would inform their manager if they were unable to resolve the complaint. Senior nurses informed us that most of the informal complaints were due to patients’ issues with food. Staff would resolve this by having daily meetings with the catering team and discussing patient preferences.
- The hospital had a policy to acknowledge receipt of complaints within two working days. The expectation was that complaints were then responded to within 20 working days.
- In the 12 months prior to the inspection, there were 40 complaints arising out of the surgical division. Less than half of these complaints (45%) had been responded to within the hospital mandated time of 20 working days. 27% of complaints related to general clinical care, 20% related to communication issues and 20% related to clinical treatment. There were no trends in the complaints made.
- Feedback from the complaints and learning was shared with staff every week, in both handovers and ward meetings. Along with weekly managers’ meetings where complaints were discussed, there were daily incident review meetings every morning at 8.45am. These meetings discussed both the incidents and complaints from the previous 24 hours.

Are surgery services well-led?

Good 

We rated well-led as 'good'.

Leadership and culture of the service

- Surgical services possessed a clear management structure both in the wards and theatres. The medical director sat within the MAB which regularly reported to the general manager. The service was overseen by the service manager who also managed endoscopy. At the time of the inspection there was a senior sister who acted as a matron to both surgical wards. There was a theatre manager role who had oversight for the theatre floor.
- Theatre staff reported to the medical director who was responsible for theatre staff professionally. Operational responsibility of the theatre staff sat with the theatre manager.
- Staff spoke very highly of their managers and the executive team. A senior nurse informed us that the executive team were very friendly and approachable. Nurses on the wards referred to the general manager as “a real people person”, and said they were “very approachable” and “always willing to listen”. Staff throughout the service referred to the “family feel” of the hospital as a whole and reported that it had a very “open and honest culture”. A senior sister informed us that they felt able to challenge the status quo and have positive changes implemented as a result. As an example, night staff did not previously have anywhere to have their break, but after discussion with managers it was agreed that night staff could use the doctors’ lounge.
- Staff of all levels reported that they didn’t have to wait when it came to getting what they needed for their patients as the executive team were very responsive to requests. Consultants informed us that if they required a piece of technology for a surgery they could go to the executive team who were open and receptive to each case.
- We spoke with two members of ward staff who had started working at the hospital within the six months

Surgery

prior to the inspection. They both stated that they had been made to feel at “home” and that everyone was very friendly. The wards had photos of the MAB and executive teams so new staff knew who everyone was.

- Staff could call a phone line to talk to someone privately about any concerns or queries they may have. At the time of the inspection, there was no reason to believe that staff were unhappy. Theatre staff mentioned that they did previously have issues with bullying but management were very responsive and individuals were replaced.
- On a practical level, ward and theatre staff were very happy with the benefits they received, such as use of the gym and corresponding therapies. They also received a discount on medical procedures for them and their loved ones.

Vision and strategy for this core service

- The hospital vision was to help people ‘live longer, healthier, happier lives’. This message was embedded across the service. Staff knew the importance of delivering the vision through the values of being passionate, caring, open, authentic, accountable, courageous and extraordinary.
- The hospital had written up a Bupa code that was shared with all staff members and was visible in clinical areas. The Bupa code detailed the hospital expectations of staff. These included: putting customers first, staying safe, keeping information safe, working to high professional standards, celebrating diversity, playing by the rules, acting ethically, declaring conflicts, representing Bupa, being prepared for the worst, taking care of the planet, and speaking up. Staff were aware of the Bupa code and could recall several of the values when questioned.
- The strategy for the surgical service fed into the Bupa strategy to be completed by 2020. The strategy for the general surgical ward was to aim for 66% of registered nurses to have their mentorship course and for nurses to continue to participate in educational audits. Some of the strategies on the orthopaedic ward were for nurses to undertake formal orthopaedic training, to evaluate patient outcomes via PROMs, to give staff the opportunity to rotate to general surgery and to participate in a structured clinical audit programme. The service endeavoured to complete these aims by

following the Bupa code and maintaining strong relationships with the finance department, marketing colleagues and with each other. Staff were aware of strategies and some had been consulted in the process of building strategies for the service.

Governance, risk management and quality measurement for this core service

- There were clinical governance meetings held on a monthly basis. Daily incident meetings were held to review all incidents, complaints and near misses. Both these meetings were fed back to the operations director who sat on the executive board.
- Senior ward staff knew what was on the risk register and could outline the implications of the risks for ward staff. There were 14 open risks on the surgical risk register. Of these, five were clinical and the rest were non-clinical. There was one extreme risk, which related to the risk of aggression from patients towards staff. When we questioned managers about why this was an extreme risk, they told us that this was an old risk and shouldn’t be on the register at all. Overall, the risks on the risk register did not reflect the negative findings we saw whilst on inspection. For example, the known lack of space on the theatre floor was not on the service risk register.
- The local surgical risk register was the responsibility of the directorate manager, with escalation to operations director and hospital committees, for monthly review.
- There was a medical advisory board (MAB) in place. The chair was elected on a rotational basis. The board met every month and discussed issues ranging from redevelopment updates to clinical governance. The general manager and chief nurse attended the MAB meetings.

Public and staff engagement

- ‘In touch’ sessions took place twice a year and were run by the general manager. We spoke to staff who had been to these sessions and found them very helpful. All staff were aware of the sessions and had attended at least one.

Surgery






- A senior member of staff informed us that the general manager held forums in the canteen every month with the heads of department in attendance. Several members of staff informed us that the executive team had an 'open door' policy.
- At the Cromwell Star Awards in July 2016, there was a new category of award, 'most frequently complimented in the patient satisfaction survey'. Seven of the 10 staff who were named as receiving the most compliments worked within the surgical division.
- Patient forums were held monthly and were led by the surgical directorate manager. We viewed the minutes from the November 2016 session and found that seven patients were involved in total. The opinions of these patients were taken on board and some opinions even galvanised actionable change.
- The eNPS was the way the hospital collected feedback and measured employee loyalty. It asked staff two questions and scores could vary anywhere from -100 to +100. A positive score was rated as anything between 10

and 30, with anywhere from -10 and +2- being normal. In quarter one of 2016, the overall score as recommending the hospital as a place to work was -2 (197 respondents), improving to +2 in quarter three (234 respondents). The score for recommendation of Bupa's products and services was 7 in quarter one, improving to 13 in quarter three.

Innovation, improvement and sustainability

- The consultants we spoke with were proud of their ability to utilise cutting edge technology.
- The service had plans to improve the theatre booking system. At the time of our inspection a working group comprised of theatre staff had been developed and plans were in place to review more modern theatre booking systems.
- In October the service introduced an online patient survey. This survey saw response rates rise by 33% which enabled the hospital to gain more views from their patients.

Critical care

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

Are critical care services safe?

Requires improvement 

We rated safe as 'requires improvement'

- The environment of the unit did not comply with Core Standards for Intensive Care Units and there were no concrete plans to address this.
- The rate of bank or agency staff exceeded recommendations by Core Standards for Intensive Care Units.
- The two rooms utilised to isolate infectious patients did not fulfil requirements for an isolation facility.
- Hand wash basins in the unit were difficult to access.

However,

- The unit and equipment appeared visibly clean.
- We observed staff adhere to bare below the elbow and hand wash recommendations.

Incidents

- There were 82 reported incidents between November 2015 and October 2016. Of these incidents, 98% resulted in no harm or low harm.
- 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 never event reported within the adult intensive care unit (AICU). The team failed to spot that a nasogastric feeding tube had entered the patient's pulmonary tree after an episode of vomiting. Feed had been restarted without establishing that the tube had remained in the correct place. The patient had suffered no lasting harm as a result.
- We saw a comprehensive root cause analysis of the never event with lessons learned, recommendations and action plan. Learning from the never event was shared in various ways across the hospital, including emails, team briefings and governance meetings. Duty of candour had been applied in form of a written apology. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Lessons learned from incidents were shared during daily team briefings, handovers, emails and via hospital newsletters.
- All staff were aware of incident reporting procedures and knew how to raise concerns. Staff reported incidents on an electronic incident reporting system. Staff said they felt encouraged to report incidents.
- We saw evidence of AICU staff attending the monthly morbidity and mortality meeting. Hospital staff reviewed patient cases and learning was shared across the teams, for example from the never event.
- All staff we spoke with understood the duty of candour and were able to give examples. We saw evidence of duty of candour being applied.

Critical care

Clinical Quality Dashboard or equivalent

- There was no clinical quality dashboard or equivalent in use.
- The unit reported four incidents of pressure ulcers between November 2015 and October 2016.

Cleanliness, infection control and hygiene

- The unit had two separated single rooms that were used for isolating infectious patients. These were cubicles located at either end of the unit, with sliding doors. However, those rooms did not fulfil requirements for an isolation facility. Requirements for isolation facilities are outlined in Health Building Note 00-09. The rooms did not have lobbies, special ventilation or local temperature controls and hand wash basins were difficult to access and located behind the beds. The doors were not tight fitting or sealed. This was against the code of practice, published in The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.
- Patients from critical care units overseas had a high risk of carrying multi drug resistant pathogens and required initial isolation. However, the unit did not have appropriate isolation facilities. These patients were admitted to one of the separated cubicles in the AICU, which did not fulfil requirements for an isolation facility.
- Neutropenic patients from the oncology department would be admitted to the unit if required. However, there were no appropriate facilities to accommodate these patients needing reverse isolation. These patients were admitted to one of the separated cubicles in the AICU, which did not fulfil requirements for an isolation facility.
- The hand wash basins at all bed spaces were difficult to access. They were located behind the beds and obscured by equipment. Due to generally restricted space in the unit between bed spaces, the sinks could only be reached with difficulty. This did not encourage hand washing after patient contact. However, the hospital audited hand hygiene on a monthly basis and the AICU had a compliance rate of 100% from February 2015 to August 2016.
- The unit did not comply with Core Standards for Intensive Care Medicine and HBN 04-02 requirement of 2.5 meter wide unobstructed circulation space at the foot of each bed space. The required bed separation is imperative for infection control reasons and to aid positioning of equipment.
- The unit looked very clean and well maintained. The entrance to the unit was uncluttered and the corridors leading to the unit were clean and well lit.
- There were dispensers with hand sanitising foam situated in appropriate places around the unit. During our visit, we observed staff making use of them adequately. Staff adhered to the “bare below the elbow” policy.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons were available and we saw staff using these appropriately.
- All equipment we examined were visibly clean. Equipment had green “I am clean” stickers to indicate when it was last cleaned.
- Housekeeping staff cleaned the department throughout the day. The cleaning trolley was kept in an adjacent corridor. Disposed waste was stored in the same corridor and was locked in line with Department of Health Safe Management of Waste Guidelines.
- Disposable curtains around the beds were clean and stain free with date of first use indicated on them.
- A meticillin resistant *Staphylococcus aureus* (MRSA) screening audit between November 2015 and October 2016 showed 94.4% compliance with positive screening result of 1.9%. The unit had no MRSA case during November 2015 and October 2016. The unit reported no incidents of *clostridium difficile* infection.

Environment and equipment

- The environment did not comply with recommendations of Guidelines for the Provision of Intensive Care Services (GPICS) and Core Standards for Intensive Care Units, published by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS). In that case, GPICS and Core Standards of Intensive Care Units require hospitals to indicate when the facilities would be upgraded. At the time of inspection, there was no time frame for refurbishment known to senior staff or presented in the unit's strategy plan.

Critical care

- There was a general lack of space throughout the unit, especially space around the beds in the open bay was limited and filled with equipment. Additional medical equipment, for example hemofiltration machines if needed, or chairs for mobilisation made it even more difficult to move around the bed spaces.
- There was no separate clinical treatment room; all medicine and storage cupboards were placed behind the nurses' desk and there was limited space for movement.
- The relatives' room located in the corridor outside the unit was small and not well lit.
- Patients and visitors shared the same entrance. This was against recommendation of GPICS, Core Standards of Intensive Care Units and HBN 04-02 to prevent visitors from observing patients coming in and out of the critical care unit.
- Access to the unit was swipe card secured; visitors were required to ring the bell.
- Equipment was checked and labelled. Servicing was provided by a specialist healthcare facilities maintenance service. We were shown an equipment log, which provided information of purchase, serial number, service agreements, service history, records of breakdowns and records of repairs.
- Staff completed specialised equipment training. We were shown training records of this.
- The resuscitation and difficult intubation trolleys were clean, secure and fully stocked. We saw evidence of documented daily checks.

Medicines

- Medicines were stored securely in locked cupboards and were available for patients when needed, including controlled drugs. Staff knew how to access medicines out of hours.
- A specialist critical care pharmacist spent time on the ward daily to review medication plans and prescriptions. Pharmacists took part in regular departmental meetings and provided excellent clinical input and advice to staff and patients.

- Controlled drugs (CD) were stored in a separate locked cupboard, which the nurse in charge held keys for. We looked at the CD register, which was managed accurately.
- Paper based prescriptions we saw were written clearly and administrations were signed for or coded and recorded to why they were not given.
- We reviewed ten prescription charts in patient records which contained appropriate documentation of medicines prescription and administration.

Records

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

Safeguarding

- Safeguarding vulnerable adults and children level one and two was part of mandatory training for all staff. Evidence showed a compliance rate of 100% for AICU staff.
- Staff knew about their responsibility regarding safeguarding of patients. However, they had not made any recent referrals and rarely came across any case, which raised safeguarding concerns.
- Safeguarding policies were up to date and readily available for staff.

Mandatory training

- Mandatory training for AICU staff included induction, fire safety, basic and intermediate life support, infection control, display screen equipment, managing conflicts

Critical care

of interest, patient handling, information matters, risk culture and incident management, medical gases, safeguarding vulnerable people and children level two, working at height and staying safe at Bupa. The AICU staff met the hospital target of 90% for all topics.

- The training was delivered via e-learning or face to face. Each member of staff had their individual training record and staff told us they would receive email alerts when training was due.

Assessing and responding to patient risk

- Staff used a standardised sepsis screening tool and sepsis care pathway.
- There was no dedicated critical care outreach service. Deteriorating patients on the wards were reviewed by the ward RMO and then AICU RMO if requested. Consultants would be available for further decision making. If necessary, an AICU nurse would be arranged to look after the patient on the ward. Site leads had experience in critical care, were trained in advanced life support and would help transferring patients to AICU if required.
- A daily safety meeting was held on the unit to give an overview of critically unwell patients on AICU or the wards. All hospital RMOs, the site lead and AICU nurse in charge attended this meeting.
- The hospital had a resuscitation team for emergencies. Team members were assigned specific roles in the daily safety meeting. The AICU RMO was usually part of the resuscitation team.
- All AICU RMOs were trained in advanced life support (ALS). Nursing staff on AICU were trained in basic and intermediate life support.
- Hospital staff used an early warning scoring system (EWS) to monitor patients for signs of deterioration. Patients who triggered a review were seen by the AICU RMO and where required escalated to the consultant. We saw evidence of EWS in use in medical records.
- AICU staff used assessment tools, for example SSKIN (five step model for pressure ulcer prevention) for assessing and responding to patients' risks.

Nursing staffing

- Staffing levels were based on a set staff to patient ratio of one registered nurse to one level three care patient and 1:2 for level two patients. We observed patients receiving 1:1 nursing care. There was a supernumerary nurse in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care and the Intensive Care Society (2013).
- The unit had an establishment of 24 full time nursing posts. There were 31 staff in post, including four ward sisters, one charge nurse, six senior staff nurses, 18 staff nurses and two health care assistants. A ward clerk worked Mondays to Fridays.
- There were 12 nurses registered on the critical care bank team. 75% had post graduate critical care qualification. The unit employed from a pool of 23 agency nurses, 74% had critical care qualification. The unit manager completed monthly rotas and made sure that at least two members per shift had the post graduate critical care qualification. One of these staff members would always be the shift lead, supported if required by the bank or agency staff holding critical care qualification.
- The nursing establishment did not provide staffing for the unit occupied at capacity. Staffing was adequate for three to four patients. However, occupancy of the unit varied (occupancy rate of 67% July 2015 to June 2016) with an average of four patients on the unit according to nursing staff. Bank or agency staff would fill remaining shifts. The rate of use of bank and agency staff in inpatients department ranged from 26% to 45%. This was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period July 2015 to June 2016. This was against recommendation of Core Standards for Intensive Care Units, which recommend a maximum of 20% of bank or agency nurses on any one shift.
- The AICU reported one vacant post between August and October 2016. The sickness rate for the same period was 7.3%. This was higher than the national average of about 4%.

Medical staffing

- The AICU fulfilled all medical staffing requirements of Core Standards for Intensive Care.

Critical care

- There were four consultants working a one week in four rota to provide 24 hours a day seven days per week cover. The consultants we spoke with confirmed they had no other clinical commitments whilst on call. They performed ward rounds twice daily, meeting the Intensive Care Society Standards.
- Consultants worked under a practicing privileges arrangement. The granting of practicing privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory board (MAB) reviewed each application for practicing privileges and advised the hospital general manager.
- The unit had 23 RMOs who worked 12 or 24 hour shifts to provide 24 hours, seven a days a week cover. All RMOs also held NHS contracts and had advanced experience in intensive care and anaesthesia. This met the Intensive Care Society guideline for ensuring there was immediate access to a practitioner who had skills in advanced airways techniques.
- All staff we spoke with confirmed that sufficient medical staff were available to care for patients.

Emergency awareness and training

- All staff received fire training as part of the mandatory training programme. We saw a fire evacuation plan on the unit and staff were aware of it.
- In the event that the manager was not on shift during a major incident, the hospital executive manager on call would be responsible for declaring a major incident. The duty site lead would be the incident coordinator, and would act as a focal point for the coordination of the response to the incident.
- All staff were provided with an emergency card, which stated both the number to call in the event of an emergency and the number of the security office.

Are critical care services effective?

Requires improvement 

We rated effective as 'requires improvement'

- Care and treatment did not always reflect current evidence-based guidance, standards and best practice.

- The unit did not undertake any internal audits to ensure consistency of practice.
- At the time of inspection, there were no critical care specific policies in place.
- There was no dedicated clinical educator for staff available.

However,

- We saw evidence of good multidisciplinary teamwork.
- The unit contributed data to the Intensive Care National Audit Research Centre (ICNARC).

Evidence-based care and treatment

- During inspection, there were no critical care specific policies available. We were shown a draft version of a collection of AICU guidance and policies that was not yet released. However, staff could access national guidelines on computer terminals.
- The hospital did not perform any local critical care audits.
- Patients were not daily assessed for their level of delirium as recommended by the Intensive Care Society Standards and NICE guidelines.
- The hospital used a sepsis screening tool and sepsis care pathway based on the 'sepsis six', which is national screening tool for sepsis. However, this was not audited.
- We saw evidence in medical records of patients receiving daily physiotherapy as required by the Intensive Care Society Standards.

Pain relief

- Staff assessed pain using a 0-3 pain score. This was not consistent with the rest of the hospital where we saw 0-10 pain score in use. We saw evidence of staff assessing and recording patients' pain in medical records. However, the unit did not audit pain management.
- Pain was managed by the consultant or RMO with input from the clinical nurse specialist for palliative care if required.

Nutrition and hydration

Critical care

- Patients were enabled to eat independently during mealtimes if possible. We observed that drinks were placed within the patient's reach.
- A dietitian visited the unit daily and attended the twice weekly multidisciplinary meetings on the unit. The dietitian reviewed patients who required oral, enteral (via nasogastric or gastric tube) or parenteral (via central venous catheter) nutrition. Dietitians assisted in prescription of total parenteral nutrition and would organise it.
- Staff used a nutrition scoring tool as part of the risk assessments but did not audit this. We saw evidence of staff using it in the medical records we reviewed.
- Out of hours, nursing staff would initiate enteral feeding if required, following an enteral feeding protocol.

Patient outcomes

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), meaning the outcomes of care delivered and patient mortality would be benchmarked against similar critical care units nationwide. The latest ICNARC report at the time of our inspection was for the period April 2016 to September 2016.
- ICNARC data for April 2016 to September 2016 showed that more than half of all admissions (55%) were patients following elective surgeries. Almost a third of all admissions (29.1%) came from the wards. Patients transferred from other critical care units made 6% of admissions, 4% unplanned admissions following elective surgeries, 4% admissions following emergency surgeries and 1.3% unplanned direct admissions.
- In the same reporting period, there were more unplanned readmissions (2.9%) within 48 hours from discharge compared to similar units (1.3%). There were no themes identifiable for those readmissions.
- According to the ICNARC report there were 8.1% high-risk admissions from the ward, this was higher compared to similar units. There were no high-risk sepsis admissions from the ward, this was below the rate for similar units (10.4%).
- There were 1.6% unit acquired infections in blood (rate per 1000 patient days). This was lower compared to similar units (3.4%).

- There were no out of hours discharges to the ward and no non-clinical transfers to another unit. This was better compared to similar units (0.4% and 0.2% respectively).
- The risk adjusted acute hospital mortality (Exponentially Weighted Moving Average plot) was within the calculated expected acute hospital mortality.

Competent staff

- Staff underwent an induction programme that ensured they were competent to carry out their roles. Data from December 2016 showed compliance of 96% for AICU staff (hospital target 90%).
- Staff had completed additional training in specialised equipment, for example, ventilators used in the unit and defibrillator machine.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover.
- There was no clinical educator for intensive care available for staff. This was against Core Standards for Intensive Care Units.
- 74% of the nurses held a post-registration award in critical care nursing. This was above the recommended minimum requirement (50%) of the Royal College of Nursing. However, permanent staffing provided cover for bed occupancy of a maximum of four beds. Remaining shifts were filled with bank or agency staff.
- All staff without post-registration award in critical care nursing had recently started on the National Competency Framework for Adult Critical Care Nurses. We saw evidence of training files for all staff.
- Bank and agency staff underwent an induction programme to ensure they were competent to care for patients. We were shown evidence of this.
- The appraisal rate for staff across the unit was 100%. Staff told us they had completed three appraisals within the last 12 months.
- Consultants with practising privileges had their appraisals and revalidation undertaken by the NHS trust they had contracts with. For RMOs, a copy of their appraisal and revalidation undertaken at their NHS trust was provided to the hospital.

Multidisciplinary working

Critical care

- We observed an excellent multidisciplinary team (MDT) meeting on AICU. It was attended by the consultant, RMO, nurses, pharmacist, microbiologist, dietitian, and physiotherapist. A friendly and relaxed atmosphere allowed everyone to speak. The team discussed all patients and the dialogue between the whole team was professional and caring. We saw excellent discussion about a patient's medication with the pharmacist sharing detailed knowledge about drug interactions. The MDT meeting took place twice weekly.
- The AICU RMO provided cover for 24 hours, seven days a week. The consultant intensivist was available 24 hours a day, seven days a week and was available to attend the unit within 30 minutes.
- There was a daily morning safety meeting attended by all hospital RMOs where the team was made aware of critical patients in the hospital.
- The RMOs we spoke with did not experience inappropriate ward referrals. There was good working relationship with other hospital RMOs.
- We looked at 10 sets of patient records and all of them showed evidence of physiotherapy sessions once or twice daily. Physiotherapy service was available seven days a week.
- A dietitian was available five days a week with on-call cover out of hours.
- A speech and language therapist (SALT) was available on referral.

Access to information

- Staff had access to hospital wide policies and protocols and staff knew where to find them.
- Staff had access to patients' care plans, risk assessments and medical notes in the patients' records folder. It also contained other information like test results, reports and letters.
- The RMO wrote discharge letters before discharging patients to the ward. We saw discharge letters in medical records we reviewed and they contained all relevant information and were signed by the RMO.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are critical care services caring?

Good 

We rated caring as 'good'

- Staff treated patients with respect and we saw staff interacting in a friendly and professional way with patients and visitors.
- The unit provided compassionate care and patients were treated with dignity and respect.
- Patients and relatives were kept informed of on-going plans and treatment.

Compassionate care

- We observed staff speaking to patients and relatives in a caring, sensitive and compassionate manner. Staff treated patients and visitors with dignity and respect.
- We observed staff ensuring patients' privacy and dignity was maintained at all times by closing doors and blinds. Curtains were drawn around the bed in the bay when providing personal care.
- We spoke with one patient and three relatives. All were very happy with the care on the unit and had no criticism.
- We saw thank you cards from patients and relatives directed to AICU staff.

Critical care

- The AICU did not formally collect patient feedback during time of inspection. The hospital provided results of the Friends and Family test (FFT) for January to June 2016, which showed that 95% to 100% of patients would recommend the service to friends or family. The response rates were between 6% to 11%, this was lower than national average.

Understanding and involvement of patients and those close to them

- Staff introduced themselves and their role to the patients and relatives. This was relevant because most staff wore the same colour and type of uniform.
- Staff told us how they tried to involve relatives in the personal care of their family member. This helped alleviate their sense of helplessness that often occurred in unwell or unconscious patients.
- Discussions with patients and relatives were evident in the medical records we looked at, including discharge planning, obtaining consent and planned treatments.

Emotional support

- The AICU nurse manager visited all patients individually on the unit before the ward round to assess whether they had any concerns.
- Staff explained tasks before performing them on the patient to reduce anxiety.
- In-house counselling service was available for patients, relatives and staff.
- There was a 24/7 multi-faith chaplaincy service available for patients and relatives and staff knew how to access it.
- A prayer room and reflection rooms were available in the hospital for visitors and staff.

Are critical care services responsive?

Requires improvement 

We rated responsive as 'requires improvement'.

- Service did not always meet the needs of patients. There were no appropriate facilities for specific patients admitted to the hospital.

- Facilities for patients' relatives were not appropriate.

However,

- The international patient centre provided helpful support and advice.

Service planning and delivery to meet the needs of local people

- The unit provided care to complex elective surgical patients whose admissions were planned in advance to ensure bed capacity. The AICU also admitted deteriorating patients from the wards and from other critical care units overseas. The unit provided an in house transfer team that was trained to perform long distance transfers of critically ill patients.
- Patients from critical care units overseas had a high risk of carrying multi drug resistant pathogens and were admitted to one of the separated cubicles in the unit, as were patients with other infectious diseases. However, those were not appropriate isolation facilities. Deteriorating neutropenic patients from the oncology department would be admitted to the unit, requiring reverse isolation. However, there were no appropriate facilities to accommodate these patients needing a facility with negative pressure. Senior staff were aware of this and acknowledged it as a risk. However, it was not on the risk register and there were no mitigation plans in place.
- The relatives' room was not appropriate in size and furnishings for a seven-bedded unit. The room could only accommodate two to three people. The room had no window, no decoration and was very basic overall.
- The lack of space around the beds in the open bay discouraged relatives from sitting at the bed space.
- The International Patient Centre (IPC) helped facilitate admission, treatment and discharge of patients from overseas. They provided translation services and liaisons with embassies and insurance companies. Staff told us that the IPC was very efficient and helpful in their role.

Access and flow

- The unit cared for 266 patients between November 2015 and October 2016. There were 13 expected deaths in critical care during that period.

Critical care

- There were 2745 level three critical care bed days available in the hospital during July 2015 to June 2016. 1846 level three critical care beds were used, giving an occupancy rate of 67%. There were 1281 level two bed days available in the same period and 583 level two bed days were used. This gave an occupancy rate of 46%.
- ICNARC data for April to September 2016 showed there had been 0.3% bed days of care post eight hour delayed discharges. This was higher than similar units (0.1%) were.
- There had been 0.2% bed days of care post 24-hour delayed discharges in the same period. This was higher compared to similar units (0%).
- There was no occurrence of non-clinical transfer out of the unit in the same period. This was better than similar units (0.2%) were.

Meeting people's individual needs

- The patient and relatives we spoke to felt safe on the unit.
- Staff underwent dementia training and understood the needs of patients living with dementia. However, they rarely came across these patients and they were not aware of any additional support available for patients living with dementia or learning disability.
- Staff told us that a significant number of patients came from overseas and did not speak English. In-house interpreters were available when needed and staff knew how to access them or telephone translation services.
- Staff were aware of cultural differences and needs of patients and did their best to accommodate this, for example female patients would be admitted to one of the side rooms if possible.
- Staff explained how they tried to involve relatives in the care by encouraging them to help with washing or feeding.
- The hospital offered special reduced rates for a nearby hotel if relatives required accommodation.

Learning from complaints and concerns

- Most concerns were dealt with informally on the unit by nursing or medical staff and clinical nurse manager.

- There had been five formal complaints relating to adult critical care between November 2015 to October 2016. Complaints were recorded on the electronic incident reporting system within two working days and were reviewed in weekly hospital wide meetings by the Incidents, Complaints and Risk Committee. In addition to a written response within 20 days, staff would call the complainant on the phone or arrange face-to-face meetings. The clinical nurse manager disseminated learnings from complaints to AICU staff.
- We did not see information leaflets on the unit regarding complaints procedures. But staff knew how to file a formal complaint and were ready to help patients or visitors.

Are critical care services well-led?

Inadequate 

We rated well-led as 'inadequate'.

- There was limited monitoring of performance and delivery of high quality care was not assured. The arrangements for governance and performance management did not always operate effectively.
- The risk register was ineffectively managed and identified risks had not always been addressed appropriately.
- Leadership did not provide staff with critical care specific current policies or protocols to ensure best practice care.
- There was a limited approach to obtaining views of patients and relatives.

However,

- Local leaders were dedicated and motivated and had started to implement quality and safety improvements. They were aware of requirements for the unit and the goals for the service. A structured action plan was developed for the unit with goals to fulfil standards in intensive care.
- Staff told us about supportive culture on the unit, good team working and approachable leaders.

Leadership and culture of service

Critical care

- The clinical nurse manager was in charge of the unit and reported to the lead nurse. Two charge nurses and two sisters supported the nurse manager in her duties.
- The clinical lead of the AICU worked closely with the nurse manager. Nurses and RMOs we spoke with felt well supported by AICU consultants.
- Staff said that managers were approachable and supportive. According to AICU staff, the clinical nurse manager had made good improvements since her appointment, especially in terms of staff morale, staffing and education. A daily team briefing before handover had been initiated to enable staff to communicate any issues with the team, inform about incidents and feedback.
- We observed that the AICU team worked well together, with RMO and consultants being available for nursing staff to discuss patients. There was collaborative working between the critical care staff and allied health professionals like physiotherapists, pharmacists and dietitians.
- All staff we spoke with enjoyed working in the department and were passionate about providing empathetic care. They praised teamwork and felt proud to work in the AICU.
- Staff told us about a visible senior management team who undertook weekly walk-arounds and also visited the AICU. Staff felt confident to address senior managers with ideas or problems and mentioned their open door policy.
- All nursing staff without critical care competency had recently started on the National Competency Framework for Adult Critical Care Nurses. This was to achieve competencies in critical care nursing.

Vision and strategy for this core service

- The hospital had no plan of action to improve the environment of the AICU despite obvious lack of space and non-compliance with recommendations of the Core Standards for Intensive Care Units. There was no strategy to adjust to current requirements of building structure for an intensive care unit of that size.

- The hospital's mission statement was 'longer, healthier, happier lives'. Staff we spoke with were aware of this and of the promoted values, which were to be passionate, caring, open, authentic, accountable, courageous and extraordinary.

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure for the hospital. The incidents, complaints and risk committees met once weekly and escalated issues to the clinical governance committee if necessary. All lead nurses and the medical director attended the clinical governance committee. The minutes and referrals went to the medical advisory board and the executive team. They also produced a governance report and news, which went to heads of departments. The clinical nurse manager and clinical director of the AICU were members of the clinical governance committee and presented critical care issues to the meetings.
- There was a hospital wide risk register, which included critical care unit risks, such as the environment of the unit. The design of the unit did not meet recommendations of the Core Standards for Intensive Care Units. However, there was no clear action plan or timetable to respond to risk.
- The unit did not meet all the core standards of intensive care units. However, senior staff told us that some actions had been taken for improvement. For example, the team was developing a delirium policy to ensure systems and tools were in place to assess patients for delirium.
- At the time of inspection the unit did not monitor performance in the form of any internal audits. However, the clinical nurse manager had developed an audit calendar with local critical care unit specific audits. Each audit had been assigned to a member of staff. The audit calendar was intended to start in early 2017.
- During inspection, there were no current critical care specific policies in place available for staff, we were shown a draft version which had not been officially released yet.
- The leadership team of the critical care unit told us about their plans to make the unit safer, more efficient

Critical care

and more responsive. They had identified fields that needed improvement and had a strategy of how to improve things. The clinical nurse manager had written an action plan based on guidelines for the provision of intensive care services 2015. Each topic was rated in red, amber or green and was assigned to named individuals. The goal was to fully adapt to the standards in intensive care to improve quality of care and safety.

Public and staff engagement






- There were no formal results of a unit specific patient survey. Feedback from patients and relatives had been received on an ad hoc basis. The clinical nurse manager showed us new unit specific patient and relative satisfaction feedback forms that were about to be distributed. However, the hospital collected feedback in a hospital wide patient survey and emails were sent to patients on discharge with an electronic link to the patient survey.

- Staff received information via emails, newsletters, briefing documents and regular meetings. A daily team brief enabled staff to discuss problems, give feedback or spread information.
- The hospital undertook staff surveys and we were shown results presented as word clouds. The word 'staff' stood out in both the positive as well as negative key themes in 'place to work'. However, actions from the survey or evidence of change as result were not provided.
- Senior management informed us about newly implemented team days for team building, shared learning and progress projects together to improve work culture, team and leadership.

Innovation, improvement and sustainability

- The AICU had plans to initiate various quality and safety improvements, including reviewed and revised critical care policies, unit specific patient and relative feedback survey, audit calendar starting in 2017 and development of a teaching programme for nursing staff.

Services for children and young people

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

Are services for children and young people safe?

Requires improvement 

Incidents

- The paediatric department reported one never event between July 2015 and June 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. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurring for that incident to be categorised as a never event. The never event involved a wrong tooth extraction. There was a never event board visible in the department providing information and actions taken because of the never event. This included better ways to ensure the correct tooth was identified before a procedure.
- Incidents were reported via online forms that could be accessed by all staff and completed on any hospital computer.
- Between November 2015 and October 2016, the paediatric department reported 152 incidents. Of the 152 incidents, the most common type of incident was specimen issues (15%), medication issues (13%) and unacceptable patient behaviour (10%).
- Serious incidents (SI) are those that require investigation. Between November 2015 and October 2016, the service reported three serious incidents (SI).
- Staff across paediatric department were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations.
- Learning was shared in a variety of ways including via email and during unit meetings. We looked at minutes from unit meetings and saw incidents and learning were a regular agenda item.
- Daily incident meetings were held hospital wide to discuss incidents reported the day before. The focus of the meeting was to review the previous day's incidents and discuss what could be learned and shared to prevent similar incidents from happening again.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff understood the term 'duty of candour' and their responsibilities related to this, especially with regards to being open and transparent with patients and relatives.

Cleanliness, infection control and hygiene

- The service followed their policies and procedures for hand hygiene and infection prevention and control and audited hand hygiene on a monthly basis. Between January 2015 and August 2016, compliance for Starfish ward was 100% every month except May 2016 when there was no data. For the Paediatric Outpatient

Services for children and young people

Department (POPD) compliance varied between 90% and 100%, however there was no data for May 2015, September 2015 and January 2016. For the paediatric theatre compliance was between 90% and 100% over the same reporting period.

- The service had carried out a paediatric infection prevention and control (IPC) audit in November 2016 and compliance was reported as 91%.
- There were dispensers with hand sanitising gel situated in appropriate places around the departments including the main reception, where there was also a sink available for hand washing.
- During our visit, we observed staff consistently complying with hand hygiene practice.
- There was a dedicated infection control link nurse on Starfish ward and within POPD, who provided infection control advice and education to staff. IPC posters were displayed around the services, including hand hygiene instructions and advice on how to prevent infections.
- We observed adequate supplies of personal protective equipment (PPE) including gloves and aprons, were available and we saw the majority of staff using these appropriately. However, on one occasion we saw a staff member enter an isolation room with an apron but without gloves. A sign on the door said both should be worn. We saw the manager challenge the staff member about this.
- We noted that staff adhered to the 'bare below the elbows' policy in clinical areas, and saw staff appropriately challenge others who were not adhering to this.
- All of the equipment we examined such as vital sign monitors and weighing scales were visibly clean. We observed green 'I am clean' stickers were used to indicate when equipment was cleaned. We observed staff cleaning equipment with sterile wipes and cleaning the bed areas.
- Sharps bins throughout the children and young people services had the date recorded of when they were assembled.

- The paediatric service had no cases of Methicillin-resistance Staphylococcus aureus (MRSA) cases between October 2015 and September 2016. The service also recorded no cases of Clostridium Difficile (C-Diff) during the same reporting period.
- The paediatric service had two cases of Escherichia coli (E-Coli) between October 2015 and September 2016.
- Starfish ward had its own dedicated cleaners. We observed domestic staff cleaning the department throughout the day in a methodical and unobtrusive way. We did not see any evidence of a cleaning audit.
- We observed the toy-cleaning rota in the POPD and staff showed a good understanding of how to clean the toys. We observed toys on Starfish ward and in the POPD were visibly clean and in order.

Environment and equipment

- All children cared for on Starfish ward were cared for in single rooms with en-suite facilities. There were built in wardrobes with pull down beds available for parents to use if they wished to stay with the patient.
- Starfish ward was bright, well-lit and a spacious environment. There was a playroom available, which had a variety of toys, games, craftwork and books for children and young people. The playroom was open seven days a week and parents were encouraged to visit the playroom frequently with their child.
- The POPD waiting area was child friendly and provided a range of toys, books and games for children and young people to play with whilst waiting. Furniture was clean and water dispensers were available.
- We checked various and numerous equipment during the inspection and found it all to be safety tested and within date.
- Paediatric resuscitation trolleys were available on Starfish ward and in the outpatient department. The trolleys were clean and secure, fully stocked and had been checked and logged on a daily basis.
- The paediatric theatre had a paediatric resuscitation trolley. During the inspection, we were told some children had surgery within the adult theatres. We were told the paediatric resuscitation trolley was shared between the two theatres on these occasions. This meant if two children were having surgery at the same

Services for children and young people

time there was only one resuscitation trolley available for use, which posed a significant risk. The theatres were also not within close proximity of one another, which meant moving the resuscitation trolley would not be quick and easy. During a feedback session with the hospital we were told the resuscitation trolley may be shared between the theatre and the ward not the two theatres. Therefore, we received conflicting messages regarding the sharing of the resuscitation trolley. Following the inspection we were told a fully stocked resuscitation trolley had been made available in the main theatres and recovery area.

Medicines

- Medicines for children and young people (CYP) were stored in a locked room on Starfish ward. All medicines and controlled drugs were locked in a secure electronic drug cabinet that could only be accessed by trained staff via fingerprint.
- Stock of medication was managed to ensure there were sufficient supplies and within expiry dates. All medication we checked was labelled appropriately with dates opened and within the expiry date.
- A pharmacist visited the ward throughout the day to review all prescription charts and speak to staff regarding any issues or concerns.
- We reviewed five prescription charts and saw they were fully completed. All prescriptions were dated and signed and allergies were clearly documented. We saw antibiotics were prescribed as per guidelines.
- We saw evidence of second signatures, total balances maintained accurately when being moved from page to page and the appropriate storage of these medicines.
- Some medicines were stored in fridges and we observed that staff were checking and recording fridge temperatures on a daily basis.
- On Starfish ward, all controlled drugs (CDs) were stored and recorded appropriately and checked twice daily by two nurses.

Records

- Records were stored at the nurse's station, however they were not stored within lockable cupboards. Records relating to the current admission were stored in individual patient bedrooms.

- At the time of the inspection there were seven patients admitted to Starfish ward. We reviewed six sets of these patients' notes. All notes were clear and detailed. Entries were dated, timed and signed with the grade of doctor and nurse who reviewed the patient. In all cases a consultant saw the children/young people within 12 hours of admission, management plans were documented and nutritional assessments and pain scores were recorded.
- We looked at three sets of outpatient notes and saw age, weight and height were recorded and consultant notes were signed and dated.
- Care pathways contained relevant risk assessments that were completed at pre-operative assessments or on admission.
- Information governance was part of mandatory training and was called 'data matters'.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable children and could locate and describe the organisation safeguarding policy.
- Nursing staff were able to give examples of what would constitute a safeguarding concern and told us they would seek advice from senior staff members and the hospitals safeguarding team if they had any concerns.
- Staff had a good understanding of female genital mutilation (FGM) and FGM as included in the safeguarding policy.
- Safeguarding training was part of the hospitals mandatory training programme. All staff who provided direct care to children and young people were required to complete safeguarding children level three training. We reviewed some clinical governance minutes and saw minutes from November 2016 highlighted safeguarding level two and level three training as a concern. Safeguarding level two compliance was 60% and level three was 59%. However, data provided following the inspection indicated that compliance with safeguarding children level one, two and three was 100%, against a hospital target of 90%.

Services for children and young people

- There was a named safeguarding lead for children at the hospital and the lead nurse and clinical educator were trained to level four.
 - The department had set up a Safeguarding children committee in 2015 and meetings were held on a quarterly basis. The purpose of the meeting was to provide a strategic direction for BUPA Cromwell in relation to safeguarding children and young people. We reviewed minutes from the meeting and saw staff training, incidents, alerts and case reviews were regularly discussed.
 - The lead nurse from the children and young people services was part of the Private Hospital Safeguarding Network in Westminster, which ensured links with other services. We reviewed minutes from the meeting and saw a range of different areas were discussed including domestic violence mental health, serious case reviews and the Multi Agency Risk Assessment Conference MARAC process.
 - Between July 2015 and June 2016 there had been 26 safeguarding incidents reported on electronic reporting system. We saw that when safeguarding concerns had been identified that appropriate steps were taken to liaise with other health workers and social services to ensure the child was safeguarded from abuse. Four cases were referred to health and social care services.
 - Access and exit from the unit and the POPD was via a locked door with an intercom. This ensured that children could not leave the unit unescorted and that access to the department was restricted to authorised staff and visitors.
 - We reviewed the children safeguarding policy and saw the policy did not include up to date national guidance. The policy referenced the Working Together 2013 government guidelines and the London Child Protection Procedures 2013. Both of these guidelines had been updated in 2016 and 2015 respectively.
- (100%), managing conflicts of interest (92%), patient handling (97%), risk culture and incident management (100%), safe use of medical gases (96%), staying safe at Bupa (100%), working at height (100%) and clinical induction (94%).
- All permanent Resident Medical Officers (RMOs) were required to undertake a number of mandatory training modules including safeguarding, infection prevention and control, fire safety, data matters and health and safety. These modules were managed through Bupa's e-learning system 'Bupa Learn'. Compliance was monitored on a weekly basis and updates were sent to the individual's line manager for review.
 - Compliance for paediatric basic life support was 93% and intermediate life support 93% against a hospital target of 90%. The service was achieving 71% compliance with advanced life support.
 - The operational policy said shifts should be co-ordinated to ensure there was always an European Paediatric Advanced Life Support Training (EPLS) nurse on duty on the paediatric unit. However the service was not always meeting this guideline.
 - All RMOs were trained in paediatric advanced life support.

Assessing and Responding to Patient Risk

- Children and young people were monitored for signs of deterioration using a paediatric early warning score (PEWS) to monitor patients, with different parameters set out for different age groups. This structured method for communicating critical information contributed to effective escalation and increased child safety. All staff showed a good understanding of PEWS.
- We reviewed six patients nursing charts and found that PEWS scores were recorded in all cases.
- The service had conducted an audit looking at PEWS completion and found 80% of staff were correctly scoring patient triggers.
- Staff said that the use of PEWS enabled them to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required.
- However, a number of staff raised concerns about the paediatric intensive care unit (PICU) being closed. The

Mandatory training

- Mandatory training was a mix of online and face-to-face training and covered topics such as infection control, fire safety and patient handling.
- The mandatory training target set by the hospital was 90%. The service was achieving this for fire safety (96%), infection control (97%), information matters

Services for children and young people

PICU was a four bedded unit that was closed the week before our inspection. Senior leaders said the PICU was closed because the lack of admissions meant staff were becoming de-skilled. Staff had concerns about the safety of a deteriorating children as there was inappropriate provision to support this at the time of the inspection. For example, there was no formal policy for the transfer/retrieval of the deteriorating child in place. Senior leaders told us this was still being formalised.

- Staff had been told they could contact another hospital if a PICU was required. However, this was not a formalised agreement and therefore there was no assurance a bed would be available if required. Therefore, there were no arrangements in place for the transfer of critically-ill children to specialist centres. Senior staff members also raised concerns about the management of these types of patients and the clarity amongst staff.
- We saw no evidence that the admission criteria had been reviewed since the closure of the PICU. Therefore, this still included some procedures that might require PICU support.
- We observed a morning medical handover between RMOs and found this was well structured and detailed.
- A number of staff had attended a sepsis study day at an external hospital to improve their knowledge.

Nursing staffing

- Within Starfish ward the Whole Time Equivalent (WTE) establishment was 23 (16.8 nursing staff). At the time of the inspection there were number of vacancies including the ward sister post, 1.6 wte senior staff nurse posts, 6.8 wte staff nurse posts and one wte healthcare assistant. Within the POPD the wte establishment was 7.2 (6.3 nursing staff). There was currently 1wte staff nurse and 0.6 wte healthcare assistant vacancy.
- Bank and agency staff were required to complete an induction checklist before starting their first shift on the ward. We looked through the induction checklist folder and found a number of forms had not been signed and dated. Therefore, there was no assurance that bank and agency staff had gone through this prior to working on the ward.
- Between June 2016 and November 2016 bank and agency usage varied between 2% and 24% each week. Data showed bank and agency usage had decreased between June and November.
- Starfish ward assessed staffing levels and skill mix based on the Royal College of Nursing (RCN) standards. The ward did not always meet the RCN staffing guidelines, which are a series of standards, which detail the minimum essential staffing requirements for all providers of services for babies, children and young people.
- There should be a minimum of two registered children's nurses at all times in all inpatient areas. Children and young people were not always cared for by registered children's nurses. Between April 2016 and October 2016 the percentage of shifts on Starfish ward with no registered children's nurses varied between 15% and 54%. Due to the closure of the paediatric intensive care unit (PICU) in November 2016, there were more trained nurses available to cover shifts. This was not on the services risk register therefore we had no assurance the risk was being mitigated.
- Between April 2016 and October 2016 the percentage of shifts in the POPD with no registered children's nurse varied between 7% and 44%. The percentage had increased due to staff leaving and maternity leave.
- At least one nurse per shift in each clinical area should be trained in advanced paediatric life support APLS/ EPLS depending on the service need. The service was not always meeting this national guidance. Between April 2016 and October 2016 the percentage of shifts with no trained nurse on Starfish ward varied between 0% and 35%.
- RCN guidelines also state that a competent, experienced band 6 or equivalent is required to work throughout the 24-hour period to provide support to the nursing team. This helped provide an experienced nurse to advise on clinical nursing issues relating to children across the service. The lead nurse told us that Starfish Ward was not always meeting this standard.
- Data provided by the organisation showed that between July 2016 and October 2016 209 out of 368 shifts were recorded as being understaffed. We reviewed the services incident log and did not see any incidents reported relating to staffing issues.

Services for children and young people

- The lack of trained children's nurses and nurses trained in paediatric advanced life support was not on the services risk register.
- When surgery was performed in the adult theatre there was not always a children's nurse in the theatre recovery.

Medical staffing

- Access to resident medical officers (RMOs) were available 24 hours a day. The RMOs had paediatric experiences and supported the accountable consultants and provided onsite medical care. The accountable consultants were responsible for their patient's care.
- We reviewed the RMO rota and saw between October 2016 and December 2016 there were a number of occasions where RMOs were working 48-hour shifts. On one occasion, an RMO worked a 24-hour shift, a night shift and a 48 shift over consecutive days. Between 14 November 2016 and the 11 December 2016, one doctor was rostered to work six 48-hour shifts over the period.
- Consultants were required to hold specific practising privileges for the treatment of children. The service had a number of specialties available including general paediatrics, general surgery, urology, ENT (Ear Nose and Throat), ophthalmology, orthopaedics, neurology, neurophysiology allergy, cardiology (POPD), clinical genetics, dermatology, gastroenterology, plastic surgery & respiratory medicine.

Emergency awareness and training

- There was a hospital business continuity plan and major incident plan. This outlined the hospital's and staff's roles and responsibilities in the event of a major incident, for example a fire or power failure.
- Staff had a limited knowledge of the major incident policy and could not remember any exercises taken part.

Are services for children and young people effective?

Requires improvement 

Evidence-based care and treatment

- We asked staff how they accessed policies and guidance and they told us they used the electronic management system. However, when we asked staff to show us how they used this there were a number of staff who found it difficult to navigate the system. The system was not very user friendly and access to policies and guidance was not easy.
- The service was conducting a pain audit and an audit on Paediatric Early warning Scores (PEWS) to ensure baseline National Institute of Health and Care Excellence (NICE) assessments had been completed. However, in general we found a lack of clinical audits within the children and young people's services.
- The service was not participating in any quality improvement or accreditation schemes, for example "You're Welcome" accreditation scheme. This is a scheme with set quality criteria to ensure young people friendly healthcare is provided within the hospital.
- The children and young people's services (CYP) were not auditing completion of the WHO surgical checklist. This was only done for adult theatres.
- We found no evidence that the service was auditing compliance with national guidelines and evidenced based care and treatment.

Pain relief

- We observed staff using a variety of age appropriate pain tools. For younger children staff used the 'Wong-Baker smiley FACES' where children were asked which face best described their pain. We observed the use of a numerical rating scale for older children, who were asked to describe their pain on a scale on one to 10. In the case of smaller children a Face, Legs, Active, Cry and Consolability (FLACC) behavioural tool was used.
- At the time of the inspection the play specialists post was vacant. However, we observed nursing staff assisting children in preparing for procedures. Distraction and relaxation techniques were used to help children manage their pain prior to receiving an injection or having bloods taken.
- We reviewed six patients' records and saw pain scores had been recorded in all instances, and were reviewed on a regular basis.

Services for children and young people

Nutrition and hydration

- Dietician formed part of the multidisciplinary team (MDT) and maintained regular input into the care plans of children who were at risk of malnutrition. There was 0.8 Whole Time Equivalent (WTE) dietician input dedicated to the paediatric service.
- We spoke with the services dietician who told us the paediatric service used an adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risks. We saw nutritional screening assessments completed in five of the six patient records we looked at. The service was not auditing use of STAMP at the time of the inspection.
- Children and young people were offered a choice of meals that were appropriate to their age group. Parents were also provided with food and drinks.

Patient outcomes

- The service was not participating in any national audits in relation to the care of children and young people.
- Senior leaders were unable to show us how they measured patient outcomes or benchmarked the service. Bupa Cromwell was the only hospital under Bupa, which meant there was no internal benchmarking.
- We were told there were no deaths within paediatric services over the past 12 months.

Competent staff

- Any practitioner who wanted practicing privileges at the hospital would submit a completed application. There were processes and policies in place to confirm consultants were competent to work. Consultant applications to work under practising privileges were approved by the medical advisory board.
- Practising privileges application process included level 3 safeguarding training, led by the Medical Director, and involved the Paediatric Directorate Manager, and/or the Paediatric Directorate Manager. Following interview, the applicants were referred to the Practice Privilege Committee and finally the Medical Advisory Board for ratification. There was an induction programme for new consultants which was offered once practising privileges had been granted.

- The hospital's medical director ensured all medical staff were revalidated and had up to date appraisals.
- There was suitable control to confirm consultants were appropriate to work, in line with the practising privileges policy. Disclosure barring service, indemnity and registration were checked in line with expiry and a record held.
- Staff were able to access training internally and externally including training specific to services for children and young people. Staff said they were supported to attend training for professional development. The service was funding training for general nurses to become registered children's nurses.
- Most of the staff we spoke with had access to supervision from senior nurses and told us they received a good level of support from their managers.
- New staff attended a corporate induction followed by mandatory training modules. Nursing staff competencies were monitored by senior staff and signed off.
- Revalidation for nursing staff was in line with Nursing and Midwifery Council Standards and nurses were supported to attend continuing practice development.
- Student nurses said the induction to the organisation was comprehensive and covered many topics enabling them to fulfil their role effectively.
- All nurses we spoke with said they had received their annual appraisal. Data provided by the hospital showed compliance was 100%.
- Throughout the inspection, we observed a high level of integrated collaborative working between specialities.
- All staff said they worked well as a team and there was good multidisciplinary (MDT) working between all professionals. Staff told us consultants were approachable and supportive.
- There was access to a pharmacist between 8.30am and 6pm Monday to Friday and between 9am and 2pm on Saturdays. Outside of these times staff accessed pharmacy support via a hospital on-call system. Pharmacists were involved in multidisciplinary team (MDT) meetings and attended ward round where possible.

Services for children and young people

- There were varied therapies that supported the service including physiotherapy, dietetics, occupational therapy, speech and language therapy. The play therapist post was vacant at the time of our inspection.
- Staff told us that there were ad-hoc MDT meetings for children and young people who were complex cases.

Access to information

- There was good access to patients' medical records. Staff said they had access to information required to treat children and young people. However, some staff said it was difficult to access policies and procedures on the hospital's computer system. This was due to the system not being very user friendly and slow.
- We asked some staff to show us how to access guidelines for particular illness and staff were unable to do this.
- Outpatient records were held by the consultant in the outpatient department and therefore were available for paediatric clinics. Records included the initial referral letter from the GP and detailed letters sent from the paediatric consultant to both the parent and GP. This demonstrated information had been shared appropriately with other healthcare professionals.
- Staff accessed results of diagnostic investigations via digital services. If required hard copies could be printed off and added to the patient's medical records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that consent to treatment for patients was obtained following the correct guidelines and procedures.
- There was clear guidance for staff to follow when taking consent for a child or young person in the care of children policy. Additionally, there was a Bupa consent policy in place. All staff spoken with were aware of the organisation's consent procedure and could describe the legislative requirements regarding consent in young people. Staff were able to describe Gillick competencies and the requirements for seeking consent from children and young people. The Gillick competence is a test in

medical law to decide whether a child of 16 or younger was competent to consent to medical examination or treatment without the need for parental permission and knowledge.

- We reviewed six patient records and saw evidence of consent forms being completed and signed. Consent forms were completed and signed on the day of the procedure. Consent forms should detail formal consent prior to the day of procedure, with an appropriate 'cooling off period' followed by confirmation of consent on the day of the procedure.
- The consent form had a section for young people to give consent or assent.

Are services for children and young people caring?

Good 

Compassionate care

- Parents we spoke with were extremely positive about the care and treatment they received within the paediatric department. Parents said things like "I am very happy with the care here", "Staff treat my child with kindness and the nurses work hard", "It's been amazing here I cannot fault it", "The service meets mine and my child's needs".
- We observed staff chatting with patients and asking them questions about their interests. Parents told us they were made to feel comfortable.
- We observed staff maintaining patient's privacy and dignity at all times by keeping the room door closed during assessments and when washing patients.
- We observed several interactions between staff, patients and relatives and saw staff speaking to them in a calm and reassuring manner, and listened to what they had to say.
- All staff treated patients in a compassionate and courteous manner.

Services for children and young people

- We observed medical staff during rounds and found they interacted appropriately with patients and relatives. Staff took extra time to explain care and treatment options and answered any questions the patients or relatives had.
- The department collected patient satisfaction data for September 2016 which showed 97% of patients and relatives said they would recommend the service to friends and family.

Understanding and involvement of patients and those close to them

- Staff were described as having a high level of expertise and helped involve parents in the care of their children. Parents in general commented that staff took their point of view on board and always kept them informed of clinical decisions.
- We observed doctors and nurses offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of. Patients and relatives told us staff would always explain things in a language they could understand.
- Relatives told us they were always kept informed of any treatment plans and staff explained any test that their child was due.
- The Paediatric Outpatient Department (POPD) had a 'you said, we did' board which gave feedback on changes that have been made because of patient and relative feedback.
- One parent said they would like to have been shown around the ward during admission and had things explained, such as how to access drinks.

Emotional support

- There was no permanent psychologist available within children and young people's services. However, staff told us they could make a referral to a psychologist who had practising privileges if required.
- At the time of the inspection, the play specialist post was vacant. Play specialists support children by preparing them for treatment and teaching them coping strategies. This can help reduce the anxiety of the child and increase treatment compliance. However, we observed staff using hand held computer devices with children and young people to help distract them during

painful procedures, such as taking blood. One parent said her child had regular blood tests and the staff were "fantastic at distracting my child who hardly notices the blood being taken".

- Starfish ward provided a 48-hour follow up phone call following discharge from a member of the nursing team. This offered an opportunity for staff to provide any additional information or support as required.
- There was no bereavement support service available within the children and young people's services.

Are services for children and young people responsive?

Good 

Service planning and delivery to meet the needs of local people

- Outpatient appointments were available at a variety of times to fit around a child's schooling and parents work commitments, including on Saturdays. The department was open till 8pm Monday to Friday and till 2pm on Saturdays.
- The Paediatric Outpatient Department (POPD) had a number of child friendly leaflets available including leaflets on allergies and what to do if the child had a reaction.
- The playroom and POPD had toys and games appropriate for children and young people. The POPD had age appropriate decoration and activities.
- We observed other departments across the hospital where children and young people might use and visit. For example, the Magnetic Resonance Imaging (MRI) area had taken a number of steps to make the area 'child friendly'. Such as ensuring there were books and games available in the waiting area, offering music and stories for children and young people to listen to whilst using the machine. Finally offering children and young people the opportunity to pick a visual image and themes for the MRI room, which made it colourful for when they arrived.

Access and flow

Services for children and young people

- There was clear guidance within the care of children policy to indicate which groups of children and young people could be admitted to the hospital and what types of procedures would be excluded. This had not been updated since the closure of the paediatric intensive care unit (PICU).
- To book appointments in the POPD parents called the appointments desk and were given the next available appointment. Parents we spoke with in the POPD were positive about access to appointments. Some comments included: "We have been seen quickly", "very fast from referral to time seen, I am very happy with this".
- In November 2016, 84% of children were seen within a two week period of booking their appointment. Data provided by the hospital showed the average waiting time from self-referral to first outpatient appointment was five days. The average waiting time from self referral to first procedure was nine days.
- The unplanned readmission rate between July 2016 and December 2016 was 0.07%.
- Discharge letters were sent to GPs within 24 hours to allow ongoing care and monitoring.
- There were daily bed management meetings, which was attended by all the hospital's clinical leads'. We attended one of these meetings and observed discussions around capacity. During this meeting all young people aged over 16 years old were identified and discussed. This gave the clinical leads an opportunity to discuss the needs of young people cared for outside the children's services.

Meeting people's individual needs

- Starfish and POPD had disabled toilets and rooms were wide enough to allow wheelchair access.
- The playroom on Starfish ward and been refurbished to include an oxygen port which allowed children receiving oxygen to still be able to use the room to play.
- Laptops, hand held computers and mobile phones were allowed on Starfish ward and within the POPD.
- Translation services were available in house. The service had a number of international clients who required translation services. Staff confirmed the interpreter

service was easy to use and there were no problems with interpreters attending the wards. During the inspection we observed interpreters being accessed easily.

- We did not see any information leaflets available in other languages during the inspection. However, staff said they can be translated if required.
- The POPD had a separate entrance and waiting area for children and young people, with age appropriate décor and activities. We spoke to a number of parents who said the following: 'There is enough for my child to do whilst we wait', 'the waiting area is very child friendly with games and books'.
- There was a dedicated paediatric theatre and child friendly anaesthetic room attached to Starfish ward. Paediatric patients were recovered in a child friendly recovery area. However, some children were seen in the adult theatre and recovery which was not equipped to be 'child friendly'. Between January 2016 and November 2016, 175 children were seen in the adult theatres. Parents were able to accompany their child in the anaesthetic room and from recovery.
- Facilities were available in all patient bedrooms to allow parents to stay overnight. Parents were provided with meals and refreshments were available on request.
- The children's food menu was child friendly and offered a range of options each meal. This included halal and vegetarian options as well as healthy heart options. Healthy heart options were choices that were lower in total fat, saturated fat and sugar and were suitable for diabetic patients. The menu was available in Arabic.
- We were told transition clinics were held in the outpatient department to support those moving to adult care. Clinics would be jointly ran by adult doctors and paediatricians.
- There were no support groups in the paediatric ward or POPD available for parents and families.
- There was no link nurse for patients living with learning disabilities. Staff told us the previous play specialist had been knowledgeable in learning disabilities, but since this person had left, there was no one to ask for support and advice. Staff could not describe how they would care for and communicate with patients who had learning disabilities.

Services for children and young people

- We were told there were plans to introduce a passport for children with learning disabilities. However, this was not set up at the time of the inspection.
- The service admission criteria stated Starfish ward did not accept patients requiring child and adolescent mental health services (CAMHS). There was no psychiatric provision with the hospital and a psychologist was only available on request. We were told if a patient required this type of support a referral would be made to an external organisation, such as a local NHS trust.

Learning from complaints and concerns

- Information was available for patients and relatives to access on how to make a complaint. The first point of call was to make contact with a member of the team. Patients and relatives were told if they were not satisfied with this response, or if they wished to speak with a more senior member of the team to get in touch with the directorate manager.
- Patients and relatives were also told they could put their complaint into writing and were provided with information regarding where this should be posted to.
- One parent told us that they had raised a complaint with the staff and the service had responded quickly to ensure this was resolved.
- There were 25 complaints for children and young peoples services between January 2016 and August 2016. The majority of complaints were around medical fees.

Are services for children and young people well-led?

Inadequate 

Leadership and culture of service

- The paediatric senior team consisted of a lead nurse, directorate manager and a clinical director. The clinical director, also a consultant paediatrician, was part of the senior management team. This role also sat within the Medical Advisory Board (MAB).
- All staff we spoke with were passionate about providing empathetic care. Most staff told us they enjoyed working

in the department and said staff got on well. Staff including RMOs, nurses, administrators and cleaners worked supportively to meet the needs of children and young people

- We had mixed feedback from staff regarding morale on Starfish ward. This was due to the recent closure of the paediatric intensive care unit (PICU). Staff felt they had not been consulted with properly during the closure of the ward and felt provisions to cope with this closure, should a patient deteriorate, had not been put in place. This had left staff feeling the ward was not safe.
- Some staff felt very supported by their manager and said the senior leaders had an open door policy. The culture was open and honest and staff said they had no issues raising concerns with senior leaders.
- However some staff felt their opinions were not listened to and taken on board. Some staff said the company was very business focused and not always patient focused.

Vision and strategy for this core service

- Staff knew how their work contributed to the wider vision of the hospital and were aware of the hospital values.
- The organisation had recently introduced the Bupa code which set out what the hospital expected from their staff. The code set out a number of values for staff to follow in order to protect their customers, colleagues and partners. This included keeping staff, customers and information safe, having high professional standards, celebrating diversity and acting ethically and encouraging staff to speak up. Some staff was aware of this code although it had not been fully embedded.
- The senior leaders told us the children and young people's service were having to rethink the strategy due to the closure of the paediatric intensive care unit (PICU). We were told there were plans to hold a strategy meeting, however this had not taken place at the time of the inspection.

Governance, risk management and quality measurement

- Children and young people's services did not have their own governance structure but rather sat within the hospital's governance. Senior leaders told us there were

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paediatric representatives on the medical advisory board which ensured children and young people's services were on the hospital's agenda. The lead nurse told us that paediatric staff attended all governance meetings to make sure children and young people services were represented.

- There were clinical governance meetings held on a monthly basis in which paediatric services were discussed. Daily incident meetings were held to review all incidents, complaints and near misses. This provided the service with the opportunity to analyse any emerging themes and trends.
- Both Starfish ward and the Paediatric Outpatient Department (POPD) held monthly team meetings to discuss recruitment training, infection prevention and control, governance and learning from incidents.
- The paediatric intensive care service (PICU) had been closed the week before our inspection. The service had closed the PICU without formalising any plans on what to do with a deteriorating child. Senior leaders told us there was a verbal agreement with a local hospital to use their PICU facilities. Senior leaders said the PICU staff were still working on Starfish ward so they could help manage any children whilst the PICU was closed. However, this was not formalised and therefore there were no assurances that this could be accessed in the event of an emergency. Within the operational policy, it stated the service had patients with central venous catheter and tracheostomy (an opening at the front of the neck so a tube can be inserted into the windpipe to help patient's breath). This group would require a higher level of dependency. The closure of the PICU had not been added to the services risk register despite posing a significant risk should a child require this higher level of support.
- Senior staff, including the lead nurse were responsible for overseeing risk management, including the maintenance of the children and young people services risk register. Senior staff were aware of the risks on the register and who was responsible for maintaining the document. There were a total of 35 risks listed, however the risk register did not reflect a number of concerns we found within the service. For example, the closure of the PICU, the number of shifts without a registered children's nurse or nurse trained in paediatric life support were not on the services risk register.

- There was no clear audit plan for national, hospital and local audits and we were unsure how audit results were fed back to staff. We were provided with a list of some audits that were due to take place in the future. However, at the time of the inspection there was a lack of audits taking place. In addition, the service was not conducting any audits to assess compliance with national guidance and evidenced based care and treatment.
- The service was not benchmarking themselves against other similar services. Therefore, we were not assured the paediatric service was measuring quality.
- There was a governance newsletter produced on a monthly basis, which gave staff updates regarding clinical governance and any learning from incidents and never events.

Public and staff engagement

- The service regularly collected feedback from children and young people and their parents/carers. The service had developed some child and young person friendly leaflets which asked questions in a more 'child friendly' way, such as the use of faces. The feedback was posted in the nursing station, in September 97% of staff recommended the service to others.
- Several members of staff informed us that the executive team had an 'open door' policy. There were monthly team meetings where staff could give feedback and highlight concerns.
- The hospital held an awards night called 'star awards' once a year where staff were awarded with prizes for good work. There were also departmental star awards on a monthly basis for all staff.
- Senior leaders told us there was not a lot of engagement work done with children and young people. The lead nurse said the service would like to include a young person in interviews of new staff in the future. However, this was not in place at the time of the inspection.





Innovation, improvement and sustainability

- There were plans to participate in the Department of Health "You're Welcome" accreditation scheme in the

Services for children and young people

future. This is a scheme with set quality criteria to ensure hospitals provide 'young person friendly' healthcare. However, the service was not participating in this at the time of the inspection.

Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients and diagnostic imaging services safe?

Good 

Incidents

- The hospital had a strong comprehensive security and safety management system in place which took account of current best practice and anti terrorism models
- We found there was a proactive approach to anticipating and managing risks to people who use services.
- Staff received regular training on safety from the security team.
- Between July 2015 and June 2016 there had been three serious incidents and 565 clinical incidents had been recorded across the hospital, a total of 121 of these had occurred in outpatients and diagnostic imaging departments. One of which had related to diagnostic imaging. There had been 66 non-clinical incidents within the outpatient department in the same reporting period.
- One of these events had resulted in a patient receiving an overexposure of radiation when a CT scan had been repeated due to a delay and omitting to administer the contrast medium. We saw that all due process had taken place in reporting and investigating the incident. The duty of candour policy had been clearly followed. The patient had been informed and received a follow up letter with findings from the investigation which proved the amount of radiation received was comparable to other CT scans.

- Learning from this has resulted in a change of practice. All radiographers must seek advice from a consultant radiologist before re-scanning a patient. If the consultant radiologist was not available the senior radiographer was to be consulted.
- Consultants applying for practising privileges at the Cromwell go through a robust and vigorous process. A formal review of each clinician's privileges was undertaken every two years which included review of appraisal and sight of relevant audits in relation to their practice and activity.
- If a serious incident takes place or a concern arises relating to a consultant with practising privileges, this would be raised via the hospital's medical director to the responsible officer in the consultants employing NHS trust. This was a two way process and the medical director also receives information from the NHS trust responsible officer that may affect a consultant's practice at the Bupa Cromwell hospital.
- The hospital used an electronic reporting form and all staff we spoke with knew how to report incidents and concerns. Staff confirmed with us that they received feedback regarding reported incidents.

Cleanliness, infection control and hygiene

- All areas we visited were visually clean and free from dust.
- We saw evidence that cleaning schedules were in place and had been completed. Water temperatures were sampled weekly for legionella precaution.
- We saw equipment had stickers stating they had been cleaned and dated.

Outpatients and diagnostic imaging

- We saw an appropriate amount of hand sanitiser dispensers strategically placed in prominent positions throughout the hospital outpatient and diagnostic areas we visited.
- Personal protective equipment was available in all clinical areas we observed.
- Data provided by the hospital for hand hygiene audit results showed that radiotherapy had 100% compliance in the period of September 2015 to December 2016, radiology and nuclear medicine also had 100% compliance for the same period except December 2015 and January 2016 where there was no data. Outpatient department data for the same period showed that there was 100% compliance except for September 2015 where there was 90% compliance, February 2016 where there was no data and June 2016 where there was 79% compliance.
- Infection control audit data provided by the hospital showed that compliance target was 100%, with a score of 71-99% requiring action, 50-70% with urgent action required and 50% and below being an urgent hospital priority. Data showed that the outpatient department had a compliance rate of 75% in October 2016, the main areas of concern that were highlighted included equipment stored on the floor due to lack of space and the poor state of repair of soft furnishings. The gamma knife department had a compliance of 90% the slight areas of concern included lime scale on the taps and an unsuitable toilet which was due to be refurbished. The well women compliance rate was 85% with the areas of concern including lack of storage for equipment and incorrect sharps bins being utilised. We saw evidence to show that there were regular audits and the findings were reviewed and actions taken appropriately.
- We observed completed daily cleaning audits in radiotherapy for the period of June 2016 to October 2016; these audits checked the cleanliness of consultation room, function of oxygen and suction equipment, availability of clinical equipment and stationary.
- We observed completed equipment and cleaning audits in the gamma knife department for the period of June 2016 to September 2016; these audits checked the cleanliness and availability of gamma knife specific equipment, function of oxygen and suction equipment,

availability of general clinical equipment, linen and computer equipment. These checks were not completed daily but only when the gamma knife was operational, however the sharps bin was checked daily.

- Nursing staff in the outpatients department told us they had a good amount of well-maintained equipment available to them.

Environment and equipment

- The diagnostic imaging department within the hospital had a good amount of equipment for example MRI and CT scanners. The radiotherapy and medical physics department had two tomotherapy treatment units, a superficial unit and a gamma knife unit. The gamma knife treats tumours both benign and malignant as well as arteriovenous malformations. The gamma knife enables high doses of radiation to be focussed on a small area. The CT scanner that was co-shared by the radiotherapy and radiology departments was on the risk register as it was six years old and difficult to maintain, this was confirmed by our observations because whilst we were inspecting the CT scanner broke down for two hours and was unable to be used. The scanner was on the risk register and was scheduled for replacement in 2017.
- Business cases were being developed to replace the tomotherapy units.
- We saw a good amount of personal protective equipment for staff and guards for patients.
- Both the radiology and radiotherapy departments had radiation signs outside all rooms for safety. However the general signage from the main outpatient department to radiology was very small. Once at the lift there was no sign at all.
- The department accommodates children and young people for general x-rays, ultrasound and (consultant-led) MRI scans. The separate children's and adults' waiting areas were small which resulted in patients having to stand whilst awaiting appointments when the department was busy as seating was limited.
- The reception area in radiology was quite open and staff told us it was hard to maintain confidentiality.

Outpatients and diagnostic imaging

- All resuscitation equipment we looked at had been checked daily. We saw evidence of faulty equipment which had been reported was dealt with by in-house engineers within 24 hours.
- We were told the hospital had plans to start work refurbishing the outpatients and diagnostics imaging departments in January 2017. Staff told us they had been consulted on the refurbishment, however we did not see evidence of this at the time of inspection.

Medicines

- Within the outpatient department there was a pharmacy that was able to dispense both prescription and non-prescription medication.
- Within the CT and MRI areas contrast medium and all drugs were locked securely with keys kept with the lead radiographer. All drugs given were correctly documented and audited.
- Radioisotopes were stored in accordance to local policies; they were stored in secure rooms with locked safes. We saw evidence of daily checking and twice yearly wipe tests being conducted.

Records

- An electronic patient archive can be accessed; the system was called “file vision”. Patients who have not returned to the hospital within six months have their paper notes electronically scanned and archived on the electronic store system. Medical records officers have access to the software and can print out a paper copy for physical review.
- We viewed twelve sets of patient notes and records. The notes viewed were comprehensively completed legible, timed, dated and signed. All records were stored on-site and brought up to clinic areas when necessary.
- All Radiotherapy records were well maintained both electronically and on a paper treatment sheet. It was discussed with the team the potential to ensure that it was clear who was taking responsibility for delivery of the fraction especially when staff are undergoing training.
- The Hospital policy states that no medical records should be taken off site without prior authorisation. This policy was enforced with all consultants and staff at BCH and monitored by the medical records team.

- Patient notes within the cardiac catheter lab, based within the out-patient department had been double reported to enhance patient safety.
- Consent had clearly been obtained and was comprehensive in content. The “Do you think you may be pregnant” form to be signed outside the room prior to radiation exposure was seen in English and Arabic. This was evident in Radiology and Radiotherapy departments.
- Within the Radiotherapy and Radiology department there was a three step I.D safety check system, which included name, date of birth and address.

Mandatory training

- The out-patient staff told us they had undertaken a three day induction and were given competencies to have signed off once competent prior to working independently.
- The staff had access to the hospitals on-line training system Evidence of training was available on electronic system. There was evidence of the relevant audits that had been undertaken in Radiotherapy. The electronic system also contained all the hospital's policies and data. For example lone working, health and safety and resuscitation policies.
- One staff member told us the hospital was paying for their master's degree and have been very supportive of this.
- In the radiology department there was evidence of a comprehensive three month induction period for new staff members. We saw image work books for radiographers containing lots of reflective practice. Staff has access to the MRI practice course, approved by the Royal college of radiographers and other external training as appropriate to their role. We were informed by staff there was no official induction, for bank staff just feedback from the consultant and other senior staff. Post inspection we were informed that all bank staff complete the hospital induction programme on appointment and human resources department managed this.
- Radiotherapy showed evidence of appropriate and relevant staff training and competency records. Imaging workbooks were available for the radiographers

Outpatients and diagnostic imaging

- We saw evidence from the November 2016 peer review in radiotherapy there had been concerns around maintaining competencies due to low patient numbers of some tumour sites. Due to this the department ran site-specific workshops and produced dummy plans to allow staff to refresh their practice.
- Data submitted to us showed that outpatient and diagnostic department staff compliance with safeguarding training was 95% with level one, 92% with level two and 97% with level three training.

Nursing and allied health professional staffing

- Within the outpatient department there were 34.8 trained nurses and two whole time equivalent (WTE) vacancies. In the reporting period of July 2015-June 2016.
- Staff retention within the outpatient department was very good. In the reporting period from July 2015-June 2016 there was 0% sickness leave taken by trained nurses/midwives. However the sickness leave taken by health care assistants was higher than the national average in independent hospitals in the months of July, August, November and December. There had been mitigating circumstances for these figures. Long term leave had been granted and support to the individual was given by management.
- The outpatient department had a new manager who was starting in January 2017. The other WTE vacancy had been covered by using two permanent bank nurses for greater flexibility. This meant that in January 2017 the department would have a full complement of staff.
- There was an establishment of 18 whole time equivalent radiographers. The vacancy rate was 5.5% which was one whole time equivalent. The hospital were employing agency to cover this. However we were told there was not really an induction for agency staff either.
- The radiotherapy department had a total of two full-time competent tomotherapy planners, we were concerned regarding this as it may cause unsafe practice or delays to patient treatment in case a member of staff was absent due to unforeseen circumstances. We were shown competency records of treatment radiographers which were rotated in to the planning department; however we noted all staff on the rota were not fully competent in all areas within the

planning department. The competency records for the staff member who most recently was in the planning department did not complete an adequate number of radical treatment plans as part of the framework in common treatment sites. The radiotherapy department explained that in case of unforeseen absence treatment radiographers with valid planning competencies and medical physics staff would provide support to the planning department.

- Data submitted to us showed that current pharmacy OPD establishment was budgeted at 17.7 WTE. They currently have one vacancy in OPD and the vacancy rate was 5.6%.

Medical staffing

- The hospital had a team of 58 resident medical officers (RMO's) who worked on a 48 hour rotational basis to cover all aspects of the hospital and its services out of hours. The hospital takes into account any other work therefore RMOs' had no clinical shifts booked the day prior to or the day after their Bupa Cromwell shift.
- Within the outpatient department there were only visiting consultants with practicing privileges.
- Within diagnostic imaging which included, radiotherapy and radiology there were 35 radiologists with practising privileges who had regular slots in the department.

Emergency awareness and training

- The Security team ran "simulated emergency exercises" around various departments of the hospital on a monthly basis. All of the staff we spoke with told us they were aware of the emergency evacuation procedure and major incident plan for the hospital.
- The security team manager employed actors who try and infiltrate the hospital security. This was used as learning and training tool across all departments within the hospital.
- The security team, as well as providing training for hospital staff, received regular training from external agencies for example the metropolitan police, MI5, and anti-terrorism personnel.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

We do not rate effective for this core service.

Evidence-based care and treatment

- The nuclear medicine department has participated in the DaTSCAN Audit 2015 conducted by the British Nuclear Medicine Society. We were shown a valid certificate of participation.
- Audits of compliance with IR(ME)R 2000 were completed. We saw evidence that there were annual radiation safety audits conducted by the medical physics expert and that the relevant findings were action planned appropriately.
- Ionising radiation group meetings were held quarterly to discuss radiation governance issues in the radiotherapy and radiology departments. We saw minutes of the last three meetings held in 2016 which showed a variety of topics were discussed including; incident learning, implementation of new regulations, and audits
- The radiation protection medical exposure committee met twice yearly to discuss radiation safety throughout the hospital. We saw minutes of the last meeting held in 2016 which showed a variety of topics were discussed including; incident learning, reviewing current procedures, radiation protection advisor appointments, and equipment.
- The radiology department conducted regular annual audits designed to review the best practice guidelines against the current working practices in relation to CT scans conducted to diagnose pulmonary embolisms. The audit looked at 70 studies performed at the hospital between May 2016 and November 2016, the results of the audit showed that the radiology department had a high standard of image quality as 87% of the examinations were either good or excellent. The audit also found that 65% of the examinations could have further optimised the use of contrast medium. We saw evidence to show that an action plan was created and a repeat audit was to be conducted in six months to check progress.

- The results of the MRI quality audit for the period of July 2016 to September 2016 showed that in a 5% cross section cohort of all MRI scans conducted in each of those months that 100% of MRI scans met the criteria required for a scan to be considered good.
- A monthly radiotherapy and medical physics “journal club” session was held where staff presented and discussed evidence based practice and advancements in the radiotherapy field. Staff told us that these sessions were positive in initiating changes to working practice.
- Safety alerts were received by the outpatient and diagnostic imaging managers and all relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings

Pain relief

- Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care, in an urgent scenario if the consultant was unavailable the RMO could be used to assess the patient and prescribe the relevant pain relief.

Patient outcomes

- Patient outcomes were monitored and audited for trends primarily by the use of patient feedback questionnaires. Hard copy questionnaires were available for inpatient and day case patients, and patients visiting outpatient and diagnostic imaging departments. Any complaint was handled promptly and good comments were fed back to staff via departmental heads.
- The radiotherapy, gamma knife, medical physics and nuclear medicine departments were accredited for ISO 9001:2015 for their quality management system. This accreditation ensured these departments followed a stringent audit schedule for continual review and improvement of internal processes.
- An audit conducted by the radiology department in December 2015 showed that out of a total of 1032 MRI scans which were intentionally double reported upon, 90.5% of radiologists agreed with each other's reports, 8.3% agreed with the report conclusions but disagreed over the presentation style and only 1% had any clinically significant radiological discrepancies.

Outpatients and diagnostic imaging

- Radiotherapy planning turnaround time data showed that 61% of the patients planned in the period of October 2016 to December 2016 were completed within three days, 35% of plans were completed between four and eight days and 4% of plans were completed in more than eight days. We were told that the planning radiographers aspired to keep turnaround times to a minimum, however workload planning was done on a priority basis and patients who elected for delayed treatment also had their planning delayed in order to allow an efficient workflow.

Competent staff

- Nursing competencies were fully assessed in a timely fashion by senior nursing staff. Nursing staff members told us that they felt confident to undertake procedures as they were fully trained and had their competencies regularly assessed to perform.
- There was a comprehensive and consistent hospital education and training plan. Staff told us they felt confident to discuss further training requirements with their managers and some had been granted funding for masters degrees and projects to enhance their clinical practice.
- All consultants working at BCH had practising privileges which gave them the authority to undertake private practice within the hospital. All consultants underwent an annual rigorous appraisal system to retain their practicing rights, this review audited the consultants mandatory training, criminal record checks, GMC validation and scope of practice
- The resident medical officers had to prove their continuing professional development (CPD) and competencies log was to be kept up to date with their employment agency before they were able to be employed at BCH.
- Hospital data showed that in the period of January 2015 to December 2015, 76% of registered nursing staff and 89% of health care assistant staff had received their appraisals in other outpatients departments. Data for the year of 2016 was not provided as the hospital was in the mid-year of the appraisal process and was still awaiting final results, however we observed the training matrix within each department we visited and the results suggested an improvement in figures.

- There were three superintendent, nine senior one and six senior two radiographers in the diagnostic department.
- Every radiation controlled area needs local rules and at least one RPS. Bupa Cromwell hospital had a total of 13 RPSs in post, Each area had a radiation protection supervisor (RPS) and an overall radiation protection expert; The local rule stated two RPS in radioiodine suite, two in general radiology, one in CT, one in angiography, one in theatres (sentinel lymph node localisation), two in medical physics, two in radiotherapy, one in PET CT and nuclear medicine and one RPS in Gamma Knife.
- There were detailed and comprehensive induction and competency framework being used in the radiotherapy, radiology and nuclear medicine department and we saw examples of those for radiotherapy department. This covered all areas including pre-treatment, planning treatment, image registration, ultrasound bladder scanning and reflective practice.

Multidisciplinary working

- There was very good communication between all MDT multidisciplinary teams, outpatients and diagnostic imaging. Staff from radiotherapy regularly attended the monthly oncology MDT meetings.
- The departments had full access to physiotherapists, occupational therapists, counsellors and interpreters.
- The outpatient department was open from 8 am-8 pm Monday to Friday and 8 am -2 pm Saturdays. For patients who could not make an appointment on these days they could be seen out of hours by special arrangement. The hospital had Resident Medical Officers RMO's who covered the hospital between them 24 hours per day.

Access to information

- Information leaflets were available on a number of health topics including asthma, bronchiolitis within the outpatient settings, in a variety of languages for example Arabic and Polish.
- Health promotion information and access to local services was available for adults, children and young people.

Outpatients and diagnostic imaging

- Information on how to access hospital services was available for people within clinical areas and on-line via the hospital's web-page.
- All clinical areas had hospital policies and procedures available which were accessible to staff on the hospital's web page and online documentation and audit system.
- There were local radiation safety rules booklets available to staff in each area.
- All leaflets seen were written in English and Arabic however we were informed that information could be obtained in other languages on request. The outpatient manager informed us that they also had access to two resident translators and language line out of hours if required. Most nursing staff had been taught basic Arabic to help assess if patients needed a drink, food or the toilet facilities.
- Patients had free access to Wi-Fi throughout the hospital which helped kept them connected with the outside world and business. One patient waiting in the outpatient department told us "The internet access and speed here is excellent".
- We observed in all areas we visited that staff provided compassionate and dignified care; for example, women were handled sensitively within the radiology department regarding dress and chaperoning.
- The hospital provided a report regarding the patient satisfaction results collated in the period of November 2016 to December 2016. The results showed that there were a total of 242 responses with 56% being from inpatients and 44% being from day cases. Out of these responses 95% of patients said they were "likely" or "extremely likely" to recommend the hospital to family or friends.
- The radiotherapy patient survey results for the period of July 2016 to September 2016 showed that 100% of patients rated the quality of care in the department "good" to "excellent", with 89% of patients rating it as "excellent". This was with a response rate of 62%, a total of 44 surveys were returned out of a patient cohort of 71.
- The radiology department provided data on their patient survey for the period of October 2015 to June 2016 with a total of 322 responses analysed. The results showed that 82% of patients said they were "likely" to "extremely likely" to recommend the hospital to family or friends.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent to treatment forms in radiotherapy and radiology. We observed consent being obtained in the diagnostic imaging department outside the rooms prior to patients receiving radiation.
- We saw all policies on deprivation of liberty safeguards and mental capacity were available on the hospital's web page. All patients were reviewed prior to radiotherapy but staff told us that incidents of patients who lacked capacity for consent and treatment were very rare. Due to this documentation was not available regarding any patient who had been treated recently under MCA the Mental Capacity Act.
- The gamma knife patient survey results for the period of July 2016 to September 2016 showed that 100% of patient said they were "likely" or "extremely likely" to recommend the department to family or friends. This was with a response rate of 53%, a total of 19 surveys were returned out of a patient cohort of 36.
- The nuclear medicine patient survey results for the period of October 2016 of showed that 100% of patients rated the quality of care in the department "very good" or "excellent", This was with a response rate of 38% of the total number of patients seen in the period.
- We were not provided current data for outpatient department's patient satisfaction results, the hospital explained that a new outpatient satisfaction questionnaire was in development and was due to be launched in 2017. Data provided for the period of quarter three of 2015 showed that 74% of patients were "likely" to "extremely likely" to recommend the hospital to family or friends. This was calculated by analysing 109 responses.

Are outpatients and diagnostic imaging services caring?

Good 

Compassionate care

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- We observed staff in all departments we visited taking time to interact with patients, friends and relatives.
- We were told by outpatient staff, “Bupa has seven values, one of which is caring, this is at the heart of everything we do. Giving our patients a personalised service which is right for them”.
- We observed patients in the radiology department being asked regarding their concerns about intimate tests. We observed that a chaperone service was offered and if the patient declined the service this was then documented on the electronic patient record.
- We saw a member of nursing staff apologise to a patient when their appointment was five minutes late asking them if they had the capacity to wait.
- The hospital patient satisfaction results for the period of November 2016 to December 2016 showed that 84% of patients said they were involved as much as they wished to be in decisions about their care or treatment, this was with 238 responses.
- The radiotherapy patient survey results for the period of July 2016 to September 2016 showed that 95% of patients felt they received sufficient information prior to consenting for treatment. This was with a response rate of 42 out of a patient cohort of 71.
- The radiology department data on patient satisfaction for the period of October 2015 to June 2016 showed that 97.5% of patients said the explanation of the radiology procedure was “good” to “excellent”.
- Patient were provided with detailed information about the cost of treatment in the form of a leaflet and a phone call by a reception supervisor to explain the process. For self-funded patients a list of cost for each treatment was given to them and there was a flexible payment option as well.

Emotional support

- Nursing and allied health professional staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.

- Psychological and counselling services were available for patients and their relatives.
- All oncology and radiotherapy patients had the option to receive complimentary counselling services and massage sessions. Breast cancer patients were always introduced to the breast clinical nurse specialist and encouraged to join the hospital breast cancer survivorship programme.
- The radiotherapy patient survey results for the period of July 2016 to September 2016 showed that 93% of patients said they found the support services useful.

Are outpatients and diagnostic imaging services responsive?

Good 

Service planning and delivery to meet the needs of local people

- We saw clear evidence of the service being planned to meet the care needs of local and overseas patients. For example appointments were available out of office hours to accommodate cultural requirements. There was an Arabic menu, free access to interpreters, and a prayer room. Most staff had learnt basic Arabic to ask if patients needed the toilet and to assess their pain.
- The hospital management used the patient satisfaction survey to improve the service. For example refurbished accommodation and newspapers in English and Arabic.

Access and flow

- In the reporting period from July 2015- June 2016 a total of 137,880 patients were seen in the outpatient department of this 0.1% were NHS funded and 99.9% privately funded.
- Patients could be referred to Bupa Cromwell hospital in a number of ways, via GP, Consultant or self-referral.
- There was good access and flow to the service with minimal waiting times for appointments across all speciality services being offered within the outpatient department and diagnostic imaging.
- In the cardiology department there was also no waiting list for tests. Tests were undertaken by a well-trained

Outpatients and diagnostic imaging

team of physiologists, and exercise tests were supervised by a resident medical officer. The tests are double reported by a physiologist and one of the consultant cardiologists who provide good supervision feedback and training. In addition the reports of investigations were systematically audited.

- Patients could receive an appointment for diagnostic imaging usually within 48 hours. If clinical need arose patients could be offered same day surgery. However the booking department had not been auditing these figures.
- Radiotherapy had efficient plan to treatment time and no waiting list. Due to rotation of staff and staff leaving, the number of staff trained in tomotherapy treatment planning was only two which occasionally caused a minimal delay if staff were sick. However staff were aware of this and this was being addressed with more staff undergoing appropriate training.
- As the outpatients department was a part of independent health it did not have to monitor referral to appointment times, however the department did monitor this to benchmark themselves against the NHS. Hospital data for the period of January 2016 to May 2016 showed there were a total of 14480 patient appointments with an average waiting time of four days. The hospital consistently achieved better than the national target of 18 weeks and also the England national average in March 2016 of 5.6 weeks.
- The radiology department conducted audits for patients' referral to MRI waiting times, the department set a target of 100% of patients to be seen within 48 hours of receiving their referral. Results for October 2016 showed that the department had a total of 540 patients with nearly 100% compliance rate, only 3 incidents amounting 0.5% did not meet target with two of the incidents being clinical or patient travel reasons.
- Radiology staff, outpatient nursing staff and reception staff told us waiting times in the departments were tried to be kept minimal, and any delays were managed appropriately, with the patient always remaining informed.
- The radiology department conducted an audit for a one day snapshot of the walk-in general x-ray service in November 2016. The department set a target for all patients to be seen within 15 minutes of arrival. The

results showed that a total of 17 patients were seen with an average wait time of five minutes with the shortest time being one minute and the longest time being 16 minutes.

- Pharmacy outpatient turnaround time audit data showed that in April 2016 the average wait time for a prescription was 10.5 minutes. Results for May 2016 showed that the average wait time had increased to 17 minutes; however the audit only included 19% of the total prescriptions the pharmacy received.
- Radiology turnaround time data for the period of July 2016 to October 2016 showed that 98-99% of general x-rays were consistently reported on within 24 hours and 100% were completed within 48 hours. Data for mammography procedures showed for the period of July 2016 to October 2016 that 96-99% were reported on within 24 hours and 100% were completed within 48 hours.
- The outpatients department had a 'did not attend' rate of 0.9%, there were a total of 1318 patients not attending out of 135385 outpatient appointments in the reporting period.
- Hospital data provided to us showed that in the period of January 2016 to December 2016 the hospital ran 13,842 clinics with a 99.9% running rate, data showed that a total of 11 clinics were cancelled where appointments had to be rescheduled and in this period 12 patients had to be cancelled.
- Data provided by the radiotherapy department showed for the period of October 2016 to December 2016 a total of 51 radiotherapy referrals were received, with 30 of those patients being for radical treatment with intent to cure and 21 being palliative with intent to improve quality of life. As the hospital was part of independent health, it was not required to monitor the national 31-day cancer waiting time target, however the radiotherapy department data showed that average wait time for all patients in that period was 15 days. There were six incidents where patients waited more than 31 days and one incident where the referral date was not noted so data was not recorded. We were told that delays in patients receiving treatment were usually due to patients themselves electing for later treatment due to other personal commitments.

Meeting people's individual needs

Outpatients and diagnostic imaging

- Staff reported there was access to a translation service via In house interpreters and “language line” should this be required. The departmental manager informed us of available information to support people with different languages and cultures.
- We were told by one of the nurses that all patients who attend the outpatient department or diagnostic imaging were treated and assessed on an individual basis. Patients who have special need requirements were dealt with sensitively with input from relatives/ carers for example what time of day suits the patient best, the patients likes and dislikes all of which were recorded for future visits. This enabled the appointment to be as stress free as possible for the individual.
- We saw from the November 2016 radiotherapy Peer review they had identified an opportunity for future development for patients with additional needs, particularly patients attending with dementia.
- There was a small coffee stall located inside the hospital's main reception area allowing patients awaiting appointments to purchase drinks and snacks. A larger canteen area was available in the basement level adjacent to the radiotherapy department; this was open to both patients and staff.
- We saw a good amount of patient information leaflets across all departments available in many languages.
- Newspapers were available in many languages with free internet access for patients as required.

Learning from complaints and concerns

- The hospital had a clear complaints procedure for when things go wrong and complaints were acted on in a timely and appropriate fashion.
- The hospital's electronic reporting system was used to log all incidents or complaints and staff were actively encouraged to use this system.
- Complaints were looked at daily at the incident and complaints meeting. This ensured that every complaint had the correct clinical or operational lead assigned for investigation and any immediate action. All complaints were reviewed weekly by the hospital executive team.

This included an overview of all complaints received during the week, whether the complaint was upheld (if it has been closed) and any learning to be shared back with department staff and cascaded down.

- Following receipt of a complaint a handler was assigned by the complaints administrator. This was based on the primary/most significant area/topic within the complaint. The handler was then responsible for overseeing the investigation in full liaison with other managers/staff in order to obtain recollection of event forms from staff involved. The handler provided all of this information and documentation to the director of clinical services or complaints administrator who reviewed the information. If anything was unclear the handler was asked for clarification and prepared the response letter to all points raised in the complainant.
- The hospital received 66 formal complaints for the outpatients department in the period of November 2015 to October 2016. The data showed that 23% of those complaints related to finance, 15% were related to general clinic care, 14% were related to communication issues, 11% were related to staffing issues, 11% were related to appointment times, 8% were related to diagnostic tests, with the remainder being a mixture of other topics.
- The hospital received 20 formal complaints for the radiology department in the period of November 2015 to October 2016. The data showed that 35% of those complaints related to the diagnostic imaging the patients underwent, 30% were related to communication issues, with the remainder relating to delays, equipment issues, staffing and finance.
- We were made aware of one complaint regarding a patient who had received greater than intended exposure of radiation when a CT scan had been repeated because incorrect protocol was selected. This had led to a change in policy and procedure. All radiographers must now seek advice from a consultant radiologist before re-scanning a patient.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Good 

Leadership and culture of service

- The oncology outpatients, radiotherapy, medical physics, gamma knife, audiology and therapies departments were a part of the oncology and theatres directorate. Each department had a mix of staff at various grades with junior staff taking direction from senior staff, however all staff reported to their designated service managers. The service managers for the named departments reported to the directorate manager who in turn reported to the hospital manager.
- The general outpatient, medical records and radiology department were a part of the diagnostics directorate. All outpatient and radiology nursing staff of all grades reported to the lead nurse for the service who in turn reported to the directorate manager. The radiology department was separated into specialty areas where administration staff reported to the administration lead who in turn reported to the directorate manager. CT and general radiology radiographers reported to the CT and general superintendent and MRI radiographers reported to the MRI superintendent, the superintendent radiographers reported directly to the directorate manager.
- The nuclear medicine department was a part of the oncology and theatres directorate as well as the diagnostics directorate. The department consisted of one physicist and two technicians who reported to the nuclear medicine lead. The nuclear medicine lead reported to the diagnostic directorate manager, but was also able to report to the head of medical physics.
- The leadership of the service was cohesive, transparent and visible to all staff members. The service had an open culture where incident reporting was actively encouraged and used for training to improve care. Staff and public engagement was sought via satisfaction surveys for staff and patients.
- Staff told us that the general manager held open door sessions twice a month for staff to come and discuss any issues for example training needs or patient care.

- Staff gave us good personal examples of how they have been supported both clinically and personally at local and senior management levels.

Vision and strategy for this core service

- There was a clear vision and strategy at Bupa Cromwell which included the “Longer Healthier Happier Lives” and Bupa Code to be passionate, caring, open, authentic, accountable, courageous and extraordinary. Most staff spoken with could tell us about the Bupa code and hospital values. However only one had seen the Bupa code booklet.

Governance, risk management and quality measurement

- The hospital had a governance lead that ensured the appropriate risk registers were in place for clinical and non-clinical governance, as well as supporting local directorates with risk management.
- Risk registers were reviewed monthly by clinical and non-clinical governance committees where approval was sought for inclusion onto the risk register. This took into account all details including the risk score. Once risks were on the register review dates and plans were put in place. The risk register was reviewed by the leadership team for final approval then submitted to Bupa UK assurance risk and compliance committee.
- The governance team also facilitated a daily incident and complaint meeting which looked at all complaints that had been logged within the previous 24 hour period. This ensures the hospital can respond to all complaints and incidents in a timely manner.
- Serious incidents were escalated within 24 hours to Bupa UK. All incidents and complaints were assigned to an appropriate person and immediate action was identified and managed. Any learning from incidents was shared with staff through the monthly governance newsletter.

Public and staff engagement

- There appeared to be good management engagement with staff. Every member of staff spoken with told us the management was supportive accessible and visible.
- The BCH had a staff appraisal scheme which placed the Bupa Code, vision and strategy at the heart of the scheme.

Outpatients and diagnostic imaging

- The hospital heads of departments attended monthly meetings with the leadership team and cascade updates and knowledge through regular staff departmental meetings.
- There were twice yearly “in-touch” sessions which allowed staff to find out about priorities, vision and strategy of the hospital. Staff had question and answers session which allowed a two way flow of information. For example what works well and what does not work well. It also gave staff a chance to feedback what was important to them.
- The general manager ran fortnightly open door sessions to discuss any issues with staff. For example, extra training requirements, equipment or ideas for improvement.
- We were told the executive team regularly attend team meetings across different departments and spends time walking around the hospital engaging with staff visitors and patients. We saw and heard evidence that this was happening.
- The hospital conducted an annual staff survey, data provided to us for October 2016 showed that 88% of radiotherapy staff viewed the department and hospital favourably. The response rate for the department was 82%. Data for the radiology department showed that 67% of staff viewed the department and hospital favourably. The response rate for the department was 62%.
- The hospital took part in the friends and family test with consistently high results, in the reporting period from July 2015- June 2016 between 95-100% of patients would recommend the hospital to their friends and family.

Innovation, improvement and sustainability

- There was a plan for the future sustainability of the hospital for example investing more money in updating the outpatient and diagnostic imaging areas to improve the environment for patients and staff. However we did not see the plans.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must operate effective systems and processes to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);
- The provider must operate effective systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity
- The provider must ensure that the risk register is up to date and maintained. The provider must ensure the risk register includes all risks with action plans and clear timeline.
- The provider must ensure that the environment does not compromise infection control practices in theatres.
- The provider must ensure that it takes prompt action to address concerns identified during the inspection in relation to the closure of the paediatric intensive care unit. The provider must ensure appropriate formal provisions are in place to deal with any deteriorating patients.
- The provider must ensure there are sufficient qualified children's nursing staff to meet the needs of the patients.

Action the provider **SHOULD** take to improve

- The surgical service should establish a reliable on-call rota for anaesthetists.
- The surgical service should ensure that all staff non-compliant with BLS and ILS training completes the training.
- The surgical service should ensure that complaints are dealt within the hospital mandated timeframe.

- The paediatric service should ensure each theatre and the ward has their own paediatric resuscitation trolley.
- The paediatric service should ensure that risks to patients are identified, assessed and monitored consistently on each ward, and that action plans in assessments and care plans are updated and contain enough detail to enable staff to reduce those risks effectively.
- The paediatric service should take action to ensure there are enough nursing staff with advanced paediatric life support training to suitably cover shifts.
- The paediatric service should ensure the children's theatre is auditing completion of the World Health Organisation (WHO) checklist.
- The hospital should ensure care and treatment on the AICU adheres to Intensive Care Society Standards.
- The hospital should ensure that AICU environment comply with recommendations of Guidelines for the Provision of Intensive Care Services (GPICS) and Core Standards for Intensive Care Units, published by the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS).
- The hospital should improve isolation facilities on AICU.
- The hospital should improve hand washing facilities on AICU.
- The hospital should consider how to address the higher rate of use of bank and agency staff.
- The hospital should consider how to collect further data in order to complete audits and ensure quality of care and safety.
- The hospital should implement policies and guidelines for critical care.

Outstanding practice and areas for improvement

- The hospital should consider employment of a clinical educator for critical care as per recommendation of Core Standards for Intensive Care units.
- The hospital should improve facilities for relatives on the AICU.
- The hospital should consider how to collect AICU specific patient feedback.
- The hospital should improve adherence to infection prevention control across all departments within the hospital by adapting existing environments and providing further staff training.
- The hospital should rethink the procedure for isolating patients within the dialysis day unit through creation of a robust local policy, as well as standardised documentation of any deisolation procedures.
- The hospital should ensure that all portable equipment is regularly serviced and any missing items or missing stickers to indicate latest service date are replaced.
- The hospital should train staff to keep daily logs of both fridge and ambient room temperatures in treatment rooms. Action should be taken to lower ambient room temperatures which consistently exceed recommended levels.
- The hospital should ensure that nursing staff should be provided with further training in the management of diabetic patients.
- The hospital should revise the on-call rota for RMOs, ensuring that they only cover 24 hour shifts, unless in an emergency.
- The hospital should consider how to work with the catering suppliers to offer better provisions to those patients with a specialist diet.
- The hospital should improve the way in which competencies are monitored in the dialysis day unit.
- The hospital should consider revising the environment in the endoscopy department to provide a more pleasant environment for patients.
- The hospital should provide further education and support to staff around end of life care, particularly around rapid discharge.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1)(2)(a)(b) The provider failed to operate effective systems and processes to: <ul style="list-style-type: none">• assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);• assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1)(2)(c) The provider failed to provide care and treatment in a safe way by failing to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.