

The Wellington Hospital







Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Wellington Hospital is the largest HCA hospital in the United Kingdom, it is owned and run by HCA International Ltd. The hospital is located in St. Johns Wood in the London borough of Westminster with easy access to public transport and main driving routes. The hospital does not provide an Accident and Emergency service, however there are seven NHS services within a 3.7 mile radius. Services are provided from four buildings; the North, Central and South buildings located on Wellington Road and the Platinum Medical Centre located on Lodge road.

The hospital employs over 900 staff and is registered for 206 beds including a 46 bedded Neurorehabilitation unit, 24 level three Intensive care beds and 10 bedded Prolonged Disorders of Consciousness Unit (PDOC). 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 hospital provided 12 operating theatres with surgical specialities at the hospital including: orthopaedics, general surgery, interventional cardiology, ophthalmology, gynaecology, neurosurgery, gastro-intestinal, oncology, head and neck and cardiac surgery. Medical specialities at the hospital include: acute Medicine, Oncology, Cardiology, Neurorehabilitation Unit and PDOC.

Outpatient and diagnostic services are provided for all patients, there is also a children's service provided to patients aged three to 16 and full services to young people aged 16 and over. The paediatric service is supported by a dedicated paediatric nursing team and the hospital does not provide a paediatric inpatient service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection of The Wellington Hospital on 27th - 29th September 2016, along with an unannounced visit to the hospital on the 5th October 2016.

The inspection team inspected the following core services:

- Medicine
- Surgery
- Critical Care
- Outpatients and Diagnostic Imaging
- Termination of Pregnancy

All services at this hospital were inspected during our visit.

We rated The Wellington Hospital as 'Good' overall with all core services achieving a good rating. We found staff to be enthusiastic and passionate about the care and services they provided and we found a cohesive and responsive senior management team who supported and encouraged staff to deliver a high standard of care.

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.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Summary of findings

Services we rate

We rated this hospital as **Good** overall. Below is a summary of reasons broken down by core service.

Overall we rated the medical care as good because:

- There were clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- Medicines were stored appropriately, with a separate locked cupboard for controlled drugs. Fridge temperatures were checked daily.
- Staff were encouraged to report incidents and we saw evidence of learning taking place as a result of incidents.
- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance.
- There was good access to seven-day services and the unit had input from a multidisciplinary team. Staff managed pain relief effectively and monitored patients' nutrition and hydration needs closely.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- The endoscopy unit was Joint Advisory Group (JAG) accredited.
- The acute neurorehabilitation unit was CARF (Commission on Accreditation of Rehabilitation Facilities) accredited.
- Readmissions for oncology patients undergoing treatment were triaged through the acute assessment unit using the UKONS tool kit.
- Staff treated patients with respect and we saw staff interacting in a friendly and professional way with patients and their families.
- The medical services in each area provided compassionate care and staff ensured patients were treated with dignity and respect at all times. Many staff signed up to the hospital 'Dignity Pledge'.

- Patients spoke positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received.
- Access and flow was clear, there was no waiting list for chemotherapy and no problems with bed availability.
- All staff had good understanding of meeting the needs of patients living with dementia and patients with learning disability.
- There were good governance structure within the hospital and interlinked with medical services.
- Staff felt their contribution was valued and the morale was high in each area we visited.

However,

- The quality of the documentation could be improved as there were no documentation of MDT discussion in any records, entries were not clearly signed and dated and resuscitation forms were not completed in full.

Overall we rated surgical services as good because:

- All staff showed in depth awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLs) and were aware of the processes in place if their patient needed to be restrained.
- The service boasted outstanding cutting edge technology and had plans to ensure the technology they used within surgeries was cutting edge.
- Staff understood how to report incidents on an online system and the service ensured that learning was disseminated to all staff.
- The service was clean, well-organised and free from clutter.
- We found there to be a sufficient number of staff including nurses, surgeons and resident medical officers. There was 24 hour, seven-day resident medical officer cover for wards.
- Automatic alerts were sent to the outreach team if a patient's observations were deteriorating via the electronic National Early Warning Score tool (NEWS).

Summary of findings

- Care was evidence based and based on national guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. The service also had a programme of annual local audits.
- The service maintained good clinical outcomes for patients.
- The surgical service provided a caring, kind and compassionate service which involved patients in their care. All the feedback from patients and their relatives were positive.
- There was an effective system of clinical governance and risk registers were up to date and proactively managed. Learning from risk issues was disseminated to staff and staff understood their role within the hospital.
- All complaints were dealt with in an efficient manner within the provider mandated timeframe.
- At the time of our inspection, 100% of critical care staff were up to date with mandatory training.
- Staffing levels met the guidance the Intensive Care Society (ICS) core standards for intensive care units.
- Critical care contributed to the Intensive Care National Audit and Research Centre (ICNARC) case mix programme.
- An acute pain team and consultant pain specialist was available Monday to Friday and a pain control nurse was available 24-hours, seven days a week.
- The service was benchmarked against the national Intensive Care Society (ICS) core standards for intensive care and against other similar units within the provider's network.
- We found good MDT working throughout the service.
- We observed that patients were involved in discussion and decisions about their care and treatment.

However

- None of the consultants we observed adhered to the Bare Below the Elbows Policy.
- Not all patient records were locked away.
- Not all equipment was in date and safety tested.
- Electronic risk assessments were not made available in paper form in the patient notes.
- There was no clear vision for the surgery services that could be embedded into practice.
- Less than 0.5% of patients experienced an out of hours discharge or a discharge delayed between four hours and 12 hours. Less than 0.2% of patients experienced a discharge delay of over 24 hours.
- The service used an 'Eye Gaze' system enabling patients with very restricted physical and communicative capability to form messages to staff.
- Between April 2016 and October 2016, there had been no formal complaints.
- We saw evidence that there was effective governance in place and the service's management took an active stance to governance, risk management and quality measurement.

Overall we rated critical care services as good because:

- All incidents had been investigated by an appropriate member of staff and had a clear outcome with learning identified.
- Controlled drugs (CDs) were stored and managed appropriately and met the standards of clinical guidance 46 of the National Institute of Health and Care Excellence.
- The critical care outreach team (CCOT) used a live electronic system to monitor patients across the hospital, alerting them to patients who were deteriorating enabling them to respond rapidly.

However;

- Staff inconsistently documented fire escape checks on the south unit. For example, in September 2016 only two out of four weekly checks were documented and between June 2016 and August 2016 eight out of 13 checks were documented.

Overall we rated the outpatients and diagnostic imaging services which included paediatric services as good because:

Summary of findings

- There was a genuinely open culture in which all safety concerns raised by staff and people who use the service were highly valued as integral to learning and improvement.
- Outpatient and diagnostic imaging areas were clean and equipment was well maintained. Staffing levels were as planned for safe care. Patient records were available for appointments.
- Staff told us there were good opportunities to develop their skills and knowledge further with access to internal and external courses.
- Patients told us and we observed that staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care.
- Patients were able to access services in a way and at a time that suited them. We saw examples where care had been individually tailored to patients.
- There were effective governance processes in place. Staff worked well together in teams, and were positive about the leadership of the service at both local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.
- Infection prevention and control (IPC) measures ensured that both the ward and mezzanine theatres were clean and suitable for purpose. The service was well-organised and free from clutter.
- Medicines were managed and stored appropriately. Pain relief medications were employed post-procedure to manage patient's symptoms.
- Documentation was concise and clear. We saw evidence that legislation relating to the termination of pregnancy (TOP) was followed in all cases examined.
- 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 and were up-to-date with appropriate levels of training.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Automatic alerts were sent to the outreach team if a patient's observations were deteriorating via the electronic National Early Warning Score tool (NEWS). Appropriate procedures were taken post-procedure to ensure that patients were safe prior to discharge from the hospital.
- Nursing staffing and medical levels in the ward and mezzanine theatre were sufficient for staff to perform their roles. There was 24 hour, seven-days a week, resident medical officer cover for the ward.
- Hospital policies were current and appropriately referenced relevant national guidance. These were regularly reviewed and updated, including the TOPS policy.
- Patients were given verbal and written information on what to expect following a TOP procedure. Patients were able to contact the ward 24/7 after discharge for support or advice. Counselling was available to all patients before, during and after they had received treatment.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement. The specialist nurse audited records of all TOP procedures to ensure that all Department of Health Required Standard Operating Procedures (RSOPs) were met.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy or the regulated activities they provide but we highlight good practice and issues that service providers need to improve.

We found the following areas of good practice:

- There were systems in place to ensure both the reporting of incidents and the sharing of lessons learned from these across the hospital were effectively managed. Staff were aware of their responsibilities with regards to duty of candour requirements, confirming there was an expectation of openness when care and treatment did not go according to plan. The governance structure provided accountability and oversight of risk.

Summary of findings

- All relevant professionals were involved in the assessment, planning and delivery of patient care. Staff reported that they felt valued as a member of the multidisciplinary team (MDT). All staff participated in annual appraisals.
- Consent and capacity were considered by nursing staff when a patient was admitted for a TOP procedure. All staff demonstrated an awareness of the Mental Capacity Act (MCA) and its implications.
- Patient's privacy was maintained throughout their stay, as they were admitted to single occupancy rooms. Feedback from patients about the ward where TOP patients were cared for was consistently positive.
- All patients referred to the service received timely treatment.
- Translation services were readily available for those who first language was not English.
- Patients were given sufficient information to make an informed choice about the sensitive disposal of pregnancy remains. Appropriate storage arrangements were in place.

- Hospital-wide processes ensured that any complaints would be reviewed and responded to appropriately.
- The hospital had developed a clinical vision and strategy and communicated this to staff at all levels. Nursing staff reported that their line managers and the senior team were supportive and approachable. All staff we spoke with told us they felt able to raise concerns.

However, we also found the following issues that the service provider needs to improve:

- In the recovery area of mezzanine theatres, we found equipment that was out of date and some equipment was not safety tested.
- Not all staff had attended recent additional training in women's health. Only 55% of staff on 4th floor south ward had attended the women's study days in either April or September 2016.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good ●	<p>Medical care was the main activity of the hospital. The medical specialities were located in three buildings (south, north and the platinum medical centre).</p> <p>As part of this inspection End of life care was also reviewed and is included in this report as the numbers of patients receiving end of life care at the hospital was low.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Surgery	Good ●	<p>Surgical care was a large service for the hospital with 12 operating theatres.</p> <p>The main three surgical procedures are orthopaedics, general surgery and cardiac interventions. The surgical services were located in three buildings (south, north and the platinum medical centre).</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Critical care	Good ●	<p>The hospital has two critical care units in two separate buildings. The north building has a 15-bedded intensive care unit for level 3 care and the south building has a nine-bedded intensive care unit for level 3 care and a seven-bedded high dependency unit for level 2 care.</p> <p>The south unit has two negative pressure rooms with linked anterooms.</p> <p>We rated this service as good because it was safe, effective, caring, responsive and well-led.</p>
Outpatients and diagnostic imaging	Good ●	<p>The Outpatient department provided facilities for consultants with practising privileges to assess and examine patients and to provide clinical areas where minor procedures can be undertaken. The outpatient department was situated within the Platinum Medical Centre (PMC).</p> <p>Outpatient diagnostic imaging was mainly conducted from the PMC. Inpatient imaging was provided from the South building. In the North building there were outpatient therapy services which included; physiotherapy, occupational therapy and speech and language therapy.</p>

Summary of findings

As part of this inspection Children and young persons services were also reviewed and is included in this report as the numbers of patients receiving this service at the hospital was low and only restricted to outpatients. The service is supported by a Paediatric Lead Clinical Nurse Specialist and paediatric staff nurses.

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

Termination of pregnancy

We do not currently have a legal duty to rate this service or the regulated activities it provides but we highlight good practice and issues that The Wellington Hospital needs to improve.

Summary of findings

Contents

Summary of this inspection	Page
Background to The Wellington Hospital	11
Our inspection team	11
Why we carried out this inspection	11
Information about The Wellington Hospital	11
The five questions we ask about services and what we found	16
<hr/>	
Detailed findings from this inspection	
Overview of ratings	23
Outstanding practice	92
Areas for improvement	92
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Good 

The Wellington Hospital

Services we looked at

Medical care; Surgery; Critical Care ; Outpatients and diagnostic imaging including services for children and young people; Termination of pregnancy.

Summary of this inspection

Background to The Wellington Hospital

The Wellington Hospital is operated by HCA International Ltd. The hospital opened in 1974 commissioned by the British and Commonwealth Shipping Group, later it was bought by Columbia/HCA and PPP healthcare Ltd and operated under partnership, until in 2000 it was solely acquired by HCA International Ltd. It is a private hospital in St. Johns Wood, Westminster, London located near Regents Park. The hospital serves a very wide demographic of privately insured, self-funding, embassy or NHS funded patients. The majority of patients it serves are UK residents, however a very large portion of its patients are from overseas primarily from the Middle East.

The hospital is the largest HCA operated independent hospital in the UK, providing 206 beds including 24 level three intensive care beds. The hospital has three main buildings; north, central and south all respectively located on Wellington Road, in 2011 the hospital opened the Platinum Medical Centre which houses the majority of its Outpatients services located on Lodge Road. The

hospital also operates a satellite centre for outpatients and diagnostic services in Golders Green, however this is registered separately with the CQC and is not part of this inspection.

The hospital has had a registered manager in post since August 2014. At the time of the inspection the CEO, also the registered manager, was leaving and a new manager had recently been appointed and was in the process of becoming registered with the CQC.

The CQC has previously inspected this hospital on five occasions. The last occasion being a focussed inspection on their Acute Assessment Unit conducted in December 2013, the hospital met all standards in this inspection and there were no requirement notices. This current inspection will be the first carried out using the new methodologies with the aim to providing a rating.

The hospital also offers primary medical services such as GP appointments, this service was not inspected as part of this inspection.

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, nursing care and critical care.

Why we carried out this inspection

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

Information about The Wellington Hospital

The hospital is registered for the following regulated activities;

- Diagnostic and screening procedures (12 November 2010)
- Family planning (12 November 2010)
- Management of supply of blood and blood derived products (06 July 2011)
- Surgical procedures (12 November 2010)

Summary of this inspection

- Termination of pregnancies (12 November 2010)
- Treatment of disease, disorder or injury (12 November 2010)

During the inspection, we visited Acute admission unit (AAU), Oncology ward, Interventional Cardiology / Cardiac Medicine ward, endoscopy unit, neuro-endocrine Therapy room, three cardiac catheter laboratories, neurological rehabilitation unit, prolonged disorders of consciousness unit, all pre-operative assessment areas, the surgical wards, anaesthetic rooms, 13 theatres, the north critical care unit, south critical care unit, pressure rooms, all outpatient consulting rooms and services in the platinum medical centre including the imaging department, the south imaging department and the therapies department.

We spoke with, 107 staff including; registered nurses, health care assistants, reception staff, medical staff, consultants with practice privileges, operating department practitioners, and senior managers. We spoke with 34 patients and relatives. We also received 39 'tell us about your care' comment cards which patients had completed prior to our inspection, these included 11 cards completed by staff members. During our inspection, we reviewed 63 sets of patient records. We also conducted six interviews with senior managers and six focus groups with different staffing groups.

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 five times, and the most recent inspection took place in December 2013, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Summary of this inspection

Activity (April 2015 to March 2016):

- In the reporting period April 2015 to March 2016, there were 12,733 inpatient and day case episodes of care recorded at the hospital of these 3% were NHS funded and 97% were other funded.
- 39% of all NHS funded patients and 44% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 44,754 outpatient total attendances in the reporting period of these 0.3% were NHS funded and 99.7% were other funded.
- 907 consultants including surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. The hospital had 9 full time equivalent (FTE) resident medical officers (RMO). 358 FTE registered nursing staff, 46 FTE operating department practitioners and health care assistants and 505 other hospital staff including; allied health professionals, administrative staff and receptionists, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the chief nursing officer.

Track record on safety:

- There were no never events
- Total of 1203 clinical incidents in the reporting period (Apr 15 to Mar 16) Out of 1203 clinical incidents 69% (833 incidents) occurred in surgery or inpatients and 19% (226 incidents) occurred in other services. The remaining 12% of all clinical incidents occurred in outpatient and DI services (144 incidents). The hospital reported 0% of all incidents¹ as severe or death.
- 10 serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Four incidences of hospital acquired Clostridium difficile (c.diff)
- Nine incidences of hospital acquired E-Coli
- 43 complaints in the reporting period of which three complaints have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service).

Summary of this inspection

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Joint Advisory Group on GI endoscopy (JAGS) accreditation
- Commission of Accreditation of Rehabilitation Facilities (CARF) accreditation for the neurorehabilitation unit
- Central Sterilization Services Department (CSSD), accredited by SGS (our notifying body)
- Housekeeping GoldCap
- ISO 9001 Quality Management accredited by Comparative Health Knowledge Systems (CHKS) for Oncology
- Working towards Association of Perioperative Practice (AfPP) accreditation in theatres.

Service provided under a service level agreement:

- A/C servicing & Maintenance
- AHU cleaning / disinfection
- AHU filters suppliers
- Ambulance Services
- Archive services
- Archive services
- Biomedical Devices Management
- Courier Services
- Deep Cleaning Services
- Electrical works
- Fire & Security
- Generator maintenance & Servicing
- Health and Safety
- Laundry
- Lift maintenance & servicing
- Medical Gases
- Medical Physics
- Microbiology
- MRI chiller maintenance
- Multi-faith Chaplaincy services
- Pathology
- Patient Surveys
- Pest Control
- Radiation Protection
- Sanitary Waste Disposal
- Sterile Services Microbiology Assessments
- Sterilizer/Washer Maintenance
- Surgical Instruments
- Translation of existing literature
- Waste Management
- Water machines
- Water systems maintenance & servicing
- Windows Cleaning

Summary of this inspection

Termination of pregnancy

The Wellington hospital offers only surgical abortion under general anaesthesia to patients over the age of 18 years. The service was able to provide surgical terminations up to 23 weeks plus six days gestation, although they had not performed any surgical abortions after 12 weeks gestation between April 2015 and March 2016.

A total of 18 surgical abortions were carried out at the hospital between April 2015 and March 2016. Of the services provided, early surgical termination (vacuum aspiration) under general anaesthetic accounted for 100% of activity.

The service only accepts private patients, who must be referred by one of the three consultants, who

have practising privileges to perform the TOP procedure at the hospital. There are no dedicated consulting or screening rooms for this procedure on site. The consulting rooms are registered separately, and so were not inspected as part of this inspection. The patients arrived at the hospital having already undergone a consultation.

All patients were admitted directly to single occupancy rooms in the gynaecology and general surgery ward (4th floor, south building). The hospital used a multi-purpose operating theatre and recovery room based on the mezzanine floor of the south building to undertake TOP procedures. Most patients would attend as day cases, unless they were international patients, who would stay on the ward overnight to ensure their safety post-procedure.

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 good because:

- Between April 2015 and October 2016 there were no never events in the hospital. We found there were systems in place to report safety incidents and near misses. Learning from incidents that occurred was shared across the service. Staff were aware of their responsibilities with regards to duty of candour.
- The medical governance committee and medical advisory committee reviewed every patient death. In addition, morbidity and mortality (M & M) meetings were held where a patient death was unexpected or where clinicians felt there was learning to be made.
- There were clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- There was a 24/7 pharmacy team with out of hours provisions in place.
- There were adequate processes in place to identify and reduce the risks associated with surgical procedures. The service complied with the World Health Organisation (WHO) Surgical Safety Checklist in theatres.
- We found staffing levels and skill mixes were planned, implemented and reviewed to keep people safe at all times across the hospital. Any staff shortages were responded to quickly through the appropriate use of bank and agency staff.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Appropriate procedures were taken post-procedure to ensure that patients were safe from avoidable harm.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire.

However,

- The quality of the documentation could be improved as there was no documentation of MDT discussion in some records we looked at, some entries were not clearly signed and dated and resuscitation forms were not completed in full.
- Very few consultants we observed adhered to the “Bare below the elbows” policy.
- Not all patient records were locked away.
- Not all equipment was in date and safety tested.

Good



Summary of this inspection

- Electronic risk assessments were not made available in paper form in the patient notes.
- We saw some hand hygiene practices which were not in line with hospital policy or best practice when caring for patients with specific infections.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy, we found the following areas of good practice:

- Although no incidents had been reported for termination of pregnancy services (TOPS) in the year previous to the inspection, we found 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.
- Infection prevention and control (IPC) measures ensured that the environment was clean and suitable for purpose.
- Medicines were managed and stored appropriately.
- Patients were assessed for a variety of risks on admission to the wards, using nationally recognised tools. Appropriate procedures were taken post-procedure to ensure that patients were safe from avoidable harm.
- 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 and were up-to-date with appropriate levels of training.
- Nursing and medical staffing levels in the ward and mezzanine theatre were sufficient for staff to perform their roles relating to TOP procedures.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire.

However:

- In the recovery area of mezzanine theatres, we found equipment that was not safety tested.

Are services effective?

We rated effective as good because:

- Hospital policies were current and appropriately referenced relevant national guidance.

Good



Summary of this inspection

- Patients were cared for by appropriately qualified staff who received an induction to their department and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- Bank and agency staff competence was also assessed regularly and they had appropriate clinical qualification.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- Care was evidence based and based on national guidance from the National Institute of Clinical Excellence (NICE) and the Royal Colleges. The hospital had a programme of annual local audits.
- The hospital had a pain clinical nurse specialist (CNS) in post that worked alongside the pain team and reviewed patients every day.
- There was evidence of good multidisciplinary team working across all staff groups.
- Most services were available 24 hours 7 days a week, with the exception of Outpatients.
- New evidence-based techniques and technologies were used to support the delivery of high quality care. We saw that opportunities to participate in benchmarking, peer review, accreditation and research was proactively pursued by staff.
- The continuing development of staff skills, competence and knowledge is recognised as being integral to ensuring high quality care.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy, we found the following areas of good practice:

- Hospital policies were current and appropriately referenced relevant national guidance. These were regularly reviewed and updated, including the TOPS policy.
- Patients were given verbal and written information on what to expect following a TOP procedure. Patients were able to contact the ward 24/7 after discharge for support or advice. Counselling was available to all patients before, during and after they had received treatment.
- Nursing and medical staff completed a variety of local audits to monitor compliance and improvement. The specialist nurse audited records of all TOP procedures to ensure that all Required Standard Operating Procedures (RSOPs) were met.
- Pain was assessed and well managed on the ward, with appropriate actions taken by staff to keep patients comfortable.

Summary of this inspection

- Care was delivered by a range of skilled staff who participated in annual appraisals.
- All relevant professionals were involved in the assessment, planning and delivery of patient care. Staff reported that they felt valued as a member of the multidisciplinary team (MDT).
- Consent and capacity were considered by nursing staff when a patient was admitted for a TOP procedure.

However:

- Only 55% of staff on 4th floor south ward had attended the women's study days in either April or September 2016.

Are services caring?

We rated caring as good because:

- All staff we observed treated patients with respect and we saw staff interacting in a friendly and professional way with patients and their families.
- All patients we spoke with explained positively about the care they received and the attitude of motivated and considerate staff and were satisfied with the care they received.
- Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and were given clear information about their treatment.
- Staff maintained patient privacy and staff demonstrated dignity was a high priority by signing up to the hospital's dignity pledge.
- Patients had access to a neuro-psychologist and health psychologist to meet their mental health needs. This team also worked closely with therapies staff to ensure patient's emotional needs were met. Patients also had access to other complimentary therapies such as; reflexology and aromatherapy.
- Patient's social needs were understood and patients were supported to maintain and develop their relationships with those close to them, their social networks and community.
- Appropriate information was provided on discharge and patients had access to 24-hour advice, should they need it.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy, we found the following areas of good practice:

Good



Summary of this inspection

- Patient's privacy was maintained throughout their stay, as they were admitted to single occupancy rooms. The records we reviewed indicated that staff had a good awareness of ensuring patients' dignity was maintained whilst providing them with care and treatment.
- Feedback for the ward where TOP patients were cared for was of a consistently positive.
- Patients were provided with emotional support by nursing staff and had access to an independent counsellor. Appropriate information was provided on discharge and patients had access to 24-hour advice, should they need it.

Are services responsive?

We rated responsive as good because:

- There were clear admission pathways for patients to access the medical services.
- Access and flow was clear, there was no waiting list for chemotherapy and no problems with bed availability.
- All staff had good understanding of meeting the needs of patients living with dementia and patients with learning disability.
- The neuro-rehabilitation unit exceeded in meeting their patient's individual need.
- The service was responsive when planning services to meet the needs of patients.
- The admission and discharge processes were clear and thorough.
- The hospital took progressive and innovative steps towards ensuring that their patients were assisted in their individual needs.
- There was an effective complaints process, with evidence of appropriate investigations and there was culture of learning from complaints across all areas.
- Complaints were dealt with in a timely manner in accordance with the provider policies and met the hospitals' timeline target.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy, we found the following areas of good practice:

- Patient flow was well considered in relation to TOP procedures. All patients referred to the service received timely treatment. There were robust admission and discharge processes in place to support patients throughout their hospital journey.

Good



Summary of this inspection

- Patients were given sufficient information to make an informed choice about the sensitive disposal of pregnancy remains.
- There were no recent complaints relating to TOPS but there was hospital-wide processes ensured that any such complaints would be reviewed and responded to appropriately.

Are services well-led?

We rated well-led as good because:

- We saw good senior and local leadership. Staff across the service enjoyed working at the hospital. They described an open culture and felt supported by their immediate and hospital management teams.
- Staff felt their contribution was valued and the morale was high in each area we visited.
- The management team had oversight of the risks within the services and mitigating plans were in place.
- Senior management and divisional managers were visible on wards
- There was an effective system of clinical governance and risk registers were up to date and proactively managed. Learning from risk issues was disseminated to staff and staff understood their role within the hospital.
- The hospital gathered patients' views using patient feedback surveys. We saw that results were analysed and service improvements were made as a result.
- The leadership drives continuous improvement and staff are accountable for delivering change. Safe innovation is celebrated. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.

However:

- We found through staff interaction there was no clear vision for the surgery services that could be embedded into practice.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy, we found the following areas of good practice:

- The hospital had developed a vision and strategy and communicated this to staff of all levels, enabling them to feel invested in the development of the service.
- The service ensured that all patients admitted for a TOP procedure had the correct documentation in place. The governance structure provided accountability and oversight of risk.

Good



Summary of this inspection

- Nursing staff thought that their line managers and the senior team were supportive and approachable. Executive and divisional leads held regular meetings to facilitate staff engagement.
- There was an open culture and staff felt able to raise any concerns.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Termination of pregnancy	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Good	Good	Good	Good	Good	Good

Medical care

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

Are medical care services safe?

Good 

Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents on the system. Incident reporting training was included in the staff induction programme, which all staff attended when they commenced employment at the hospital.
- All staff were aware of the incident reporting procedures and knew how to raise concerns. Resident medical officers (RMO) and nursing staff showed us how they reported incidents on an electronic incident reporting system. Staff said they were encouraged to report incidents.
- The medical services reported 385 clinical incidents between April 2015 and March 2016. 72.7% of these incidents resulted in no harm, 26% incidents resulted in low harm to the patient. The top three categories for incidents were accident that may result in personal injury, implementation of care or on going monitoring/ review and medication errors.
- There were no Never Events reported within medical services. 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 type 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 occurrence for that incident to be categorised as a never event.

- The medical services reported one serious incidents during April 2015 to March 2016. We looked at the investigation reports of a fall incident on fourth floor north, which included detailed chronology of events, investigation and root cause analysis. There were recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the hospital. For example, nurses should remain in the patient’s room while patients at high falls risk were using the bathroom, review of the post-falls response by the falls committee and cascade of correct procedure to all departments. We saw falls posters to raise staff awareness and use of yellow tags on outside patients room the door, that were at high risk of falls.
- Lessons learned from incidents were shared across teams via emails and during handover. The oncology nurse lead told us incidents were discussed at the patient safety and quality meeting and action plans and learning arising from incidents were disseminated to staff at each shift. We saw evidence of these meetings.
- We saw nursing staff discussing incidents and learning from these at the three nursing handovers we attended.
- Incidents were a standing item on the agenda of the daily hospital operational meeting.
- Oncology lead pharmacist told us of dual prescribing of paracetamol incident and actions taken to share learning including teaching and posters developed for staff.

Medical care

- Monthly Morbidity and Mortality meetings were held, where both expected and unexpected deaths were discussed. Unexpected deaths were referred to the coroner who would decide about a post-mortem or inquest to be held. We saw documentation of these meetings on a standardised form which included clinical details with time line of events leading to death, cause of death and review details including points of discussion and identified learning or areas for improvement.
- Duty of Candour was embedded into practice in the medical services and all staff were fully aware of the duty of candour and were able to give examples of how they could apply this requirement in practice. The Duty of Candour (Doc) sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff told us that they receive training on duty of candour at induction.
- We saw examples in incident documentation where the duty of candour regulations were applied correctly
- The wards followed their policies and procedures for hand hygiene and infection prevention and control and audited hand hygiene on a monthly basis. In quarter one and two (January 2016 to June 2016) medicine wards average compliance for each areas was; AAU 95.5%, cath labs 100%, endoscopy unit 97%, neuro rehab- fifth floor 99.8%, fourth floor north 93.3%, sixth floor north 89.6%, oncology 93.4% and cardiology ward was 97.8% compliant.
- Staff adhered to the bare below elbow (BBE) dress code and we observed staff cleaning their hands regularly. However, we noticed on three occasions when doctors did not comply with this and were either not bare below the elbow or wearing a wrist watch.
- We observed staff using personal protective equipment (PPE) such as gloves and aprons appropriately when indicated, such as whilst administering intravenous chemotherapy.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit including the main reception and entrance to the units and rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer. The seven-step guidance for effective hand washing was displayed at the basins.

Safety thermometer or equivalent

- The hospital was not required to use the NHS Safety Thermometer. This is a tool which measures harm to patients which may be associated with their care. However, the hospital had developed their own dashboard which monitored pressure ulcers; falls; catheters and UTIs; VTE.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We confirmed this in our review of 11 patient records that VTE risks were completed and in accordance with NICE Quality Statement 3.
- All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. We observed green 'I am clean' labels were in use to indicate when equipment was cleaned. We observed staff cleaning equipment with sterile wipes.
- We saw that clinical waste, including chemotherapy waste and sharp objects, were disposed of safely. Waste was separated in different coloured bags to signify different categories of waste. All containers were labelled correctly. The cupboard where disposed waste was kept was locked in line with hospital policy. Waste segregation and storage was in line with Department of Health 2011 Safe Management of Waste guidelines.

Cleanliness, infection control and hygiene

- All wards and clinical areas looked clean, well maintained and hygienic. The wards main entrance and corridors were clean and uncluttered.
- All the patient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required.
- Across the hospital, fabric curtains were used in all rooms. We randomly inspected curtains in four rooms and all were clean and stain free. We inspected the linen storage areas and noted that there was sufficient clean linen available. Oncology nurse in charge told us that

Medical care

curtains were checked after each patient discharge and these were changed when the room was deep cleaned. The nurse in charge inspected each room on their wards daily to ensure the rooms were clean.

- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. There was a named infection control lead nurse and infection control link nurses. 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.
- Cleaning audits of the acute medical wards were undertaken monthly. We looked at cleaning audits for July 2016. The cleaning audits monitored the cleaning undertaken by different functions within the hospital; these included cleaning undertaken by nursing staff, the cleaners, catering and estates. The audits showed that all wards achieved compliance in the range of 92% to 100%.
- There were no incidents of Meticillin resistant staphylococcus aureus (MRSA) or MSSA in the reporting period April 15 to March 2016. A corporate MRSA screening and management policy was in place.
- The hospital reported four cases of C.difficile and nine cases of E-Coli during the same reporting period. We saw that information was shared with staff and displayed on the staff notice board.

Environment and equipment

- Throughout our visit we found the wards, endoscopy unit and catheter labs to be clean, well-lit and bright with appropriate equipment.
- Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks. Electrical equipment we saw was marked as having undergone safety testing. Equipment maintenance was planned and carried out in accordance with manufacturer guidance.
- We saw the results of the environment audit for September 2016 for medical wards and units and included audits of public area, patient room, patient

bathroom and dirty and clean utility. The result showed AAU was 89% compliant, oncology 80%, fourth floor north 84%, fifth floor north 95%, sixth floor north 93% and endoscopy unit was 96.8% complaint.

- We spot checked a number of equipment, such as syringe pumps, bed mattress and cardiac monitor and all equipment were checked and had safety tests within date.
- Resuscitation equipment was stored securely in designated trolleys and was available in all areas. We saw records of daily checks. All drawers and shelves were fully stocked with consumables and medicines that were in date. Drugs about to expire were marked with “do not use after” stickers. Emergency equipment was clean and ready for use. Staff were trained in its use as part of their mandatory training.
- The environment within the endoscopy unit comprised 12 single cubicles for patients before and after their procedure. 10 of the cubicles had an en-suite toilet and we were told these were normally utilised for patients undergoing procedure on their bowel and lower intestinal tract. There were three endoscopy procedure rooms and these were spacious and appropriately equipped to enable safe working practices. The environment throughout the endoscopy unit was suitable to facilitate the required cleaning and decontamination between patients.
- The endoscopy unit was compliant with Department of Health Technical Memorandum 01-06 relating to the management and decontamination of flexible endoscopes. Arrangements were in place for the safe handling of endoscopes and the segregation, decontamination, and storage of endoscopes. We reviewed the flow of instruments through from use to cleaning, decontamination, storage and saw there was good separation of clean and dirty instruments.
- 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.
- We saw the JAG environment checklist April 2016, which showed that the endoscopy unit met all criteria for patient environment and equipment standard (QP3) for JAG accreditation.

Medical care

- The hospital used T34 syringe drivers for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia (pain relief medication delivered via a needle or soft cannula under the skin). The syringe drivers had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations. Nursing staff told us there were no problems in accessing syringe drivers whenever they were needed for patients.

Medicines

- Medicines were stored safely and available for patients when they needed them, including controlled drugs. Staff we spoke with were aware of how to access medicines out of hours.
- A specialist oncology pharmacist spent time on the ward and was involved in multidisciplinary meetings and decisions about patient care. There was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. Nurses could describe to us how learning from medication errors was disseminated to them from the pharmacist by way of emails and attendance at meetings.
- Medicines were stored in a secure, temperature-controlled room, which staff checked and documented for safe temperature twice daily. A temperature checking system was in place for refrigerated medicines that complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance.
- Controlled drugs were stored in a locked cupboard, which the nurse in charge held keys for and were checked twice a day. Nurses described how they would access these medicines in a safe and timely manner when required. The nurse in charge, along with a qualified nurse, checked drug stock daily and a spot check of the register confirmed levels were correct. We saw the unit meeting minutes of April 2016, which showed 100% compliance with CD audit.
- Inpatient chemotherapy was managed appropriately. We saw extravasation and spillage kits were available if required. Chemotherapy was prescribed via an electronic system by a consultant doctor, which was then clinically checked by a specialist pharmacist. Specialist oncology nurses administered all chemotherapy. No intrathecal chemotherapy was administered.
- We reviewed 11 prescription records across the medicine specialty. All prescriptions were written clearly and administrations were signed for. However, there was one chart where a medication for 8 am were not signed for until 10:30am in cardiology and one chart in oncology had no time indicated for application of ointment and medication was prescribed for 8 am and not given till 9:30 am.

Records

- We found patient records were detailed, fit for purpose and included evidence of personalised care adhered to the guidance of the General Medical Council (GMC) and the Nursing and Midwifery Council.
- We looked at a random sample of 11 patient records and we observed how these were reviewed and updated during ward rounds. All records we looked at included details of allergies, a daily treatment care plan and risk assessments. Specialist assessments were conducted and recorded appropriately, including feeding, neurology and respiratory needs. However, the quality of the documentation could be improved as there were no documentation of MDT discussion in any records, ceiling of care / Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form was not appropriately filled out in three cases where it was applicable, entries were documented under RMO and no name of the doctor or dates were written. In cardiology admission/clinical data sheet was not filled in, two operative notes were not legible, no date or time was documented and there was no signature on one operation sheet.
- The hospital recently introduced the care plan booklet and referral forms for End of Life Care (EoLC), but the documentation of discussion with patients and decision making in relation to palliative care was not well imbedded across the hospital. The hospital was working on various initiative including a working group for EoLC and EoLC training for all staff was introduced in June 2016.

Medical care

- Staff demonstrated a good understanding of the need for confidentiality and we observed them using electronic password protection systems effectively.
- Patient bedside physiological and ventilation monitoring equipment was linked to the electronic patient record and the record was continuously updated. RMOs and nurses were able to view patient telemetry at the nurse's station and staff escalated concerns as appropriate.

Safeguarding

- The Chief Nursing Officer was the safeguarding lead. Safeguarding concerns were discussed at the hospital site meeting daily. We attended two hospital site meetings and observed that safeguarding concerns was a standing item on the agenda.
- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff at all levels knew who to contact if they wanted further advice. Nursing staff gave an example of an overseas vulnerable patient, for whom they got restraining orders against the alleged abuser and relevant embassy was informed about this, however they were not able to do anymore once the patient returned to their home country.
- Staff had access to the safeguarding policy on the intranet. Flow charts for the necessary escalation procedures regarding adult safeguarding concerns were seen within both units and staff knew how to escalate any concerns.
- Safeguarding was part of annual mandatory training. Safeguarding children level 1 & 2 training was mandatory for all nursing staff. Records indicated that 92.3% of staff across the medicine service had completed this training and 81.9% staff completed the safeguarding vulnerable adults training.
- There was good awareness of female genital mutilation (FGM) amongst both junior and senior staff. We observed posters in staff rooms and nurses we spoke with could explain the escalation process for suspected FGM. The specialist nurse had provided training sessions to staff addressing FGM.

Mandatory training

- Managers were responsible for ensuring all staff were up to date with their mandatory training and completion

was linked to salary increments. Mandatory training records provided and maintained by the individual departments showed that the overall compliance for the medicine services was lower than other specialties in the hospital and below hospital target of 95%. For example, 77% of staff had up to date fire training, 71.9% had health and safety training, 75% staff had training of Mental Capacity Act 2005.

- Bank and agency staff were expected to complete the hospital's mandatory training, and were provided with access to the hospital's training programme.
- Life support training(basic/intermediate/advance life support) was part of mandatory training for all staff. Hospital data showed that 77.4% of medical staff had completed BLS/ALS/ILS training.
- The hospital provided a mandatory training update day to all staff, The RMOs also have access to e-learning via the hospital intranet service. All RMO staff were required to have a current Advanced Life Support Certificate and the hospital monitored this.

Assessing and responding to patient risk

- Patients clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital.' A scoring system based upon these observations known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The electronic system allowed early warning scores to be automatically calculated within the electronic record system.
- Assessment tools were used for assessing and responding to patients risks. For example, the Malnutrition Universal Screening Tool (MUST), venous thromboembolism tool (VTE) and Safer Skin Care (SSKIN) were all in use. This information was utilised to manage and promote safe patient care.
- RMOs were able to view patient telemetry at the nurse's station and staff escalated concerns as appropriate.
- The unit monitored incidents of falls, pressure ulcers, venous thromboembolism (VTE), central venous catheter infections and catheter associated UTIs. Nurses in charge (NIC) were tasked with checking risk

Medical care

assessments completed prior to end of shift, monitored by senior nursing team. We reviewed 11 set of patient records, NEWS was documented in all cases and all included evidence that VTE assessments were completed daily on every patient.

- Staff in cath labs utilised the WHO safety checklist that involved briefing, sign-in, timeout, sign-out and debriefing. The use is to ensure patient safety throughout the perioperative journey. The National Patient Safety Agency (NPSA) advocates it for all patients in England and Wales undergoing surgical procedures. The cath lab audited the WHO safety checklist on monthly basis and evidence submitted to us showed compliance between January 2016 to September 2016 with in the range of 90% to 98%.
- Falls risk assessments were undertaken in patients with impaired mobility. Management plans involving physiotherapists and mobility aids were put into place. Staff were encouraged to communicate the 'Call, don't fall' message to all patients.
- There was an emergency call bell in every room.
- The members of the resuscitation team were assigned specific roles daily and this was reviewed at the start of the evening shift. All members of the emergency team were trained in advanced life support and were contactable by emergency bleep.

Nursing staffing

- Staffing skill mix at the hospital was reviewed twice daily against patient numbers, patient level acuity and dependency across the hospital at the operational site meeting. The staffing establishments were designed to exceed those staffing ratios recommended through national guidelines. A maximum nurse to patient ratio of 1:4 was factored into staffing rotas on general wards. For areas of higher acuity and dependency such as oncology, a ratio of 1:3 registered nurses was considered into the staffing establishments. All departments were also supported by a supernumerary ward manager, with additional support of a matron for a small group of wards. Healthcare support workers were also part of the ward teams in some areas and were additional to the registered nurse to patient ratios.
- The establishment for the rehabilitation department included 76.4 WTE (whole time equivalent) staff including 36.6 physiotherapists, 16 occupational

therapists, 12 speech therapist, one hydro therapist, 5.8 neuropsychologist and five dieticians. This was in line with the British society of rehabilitation medicine (BSRM).

- The average staff sickness rate for medicine departments was 3.85% in August 2016.
- The cumulative staff turnover for medicine department was 2.93% during May 2016 – August 2016.
- During the handover, staffing and patient levels were discussed and it was confirmed that the staff to patient ratio met RCN guidelines. Availability of the resuscitation team, supernumerary staff, times of any planned procedures or outstanding test for patients were confirmed and contact with multidisciplinary colleagues was discussed. After the detailed handover nurses handed over to each other at the patient bedside again to ensure all pertinent information was communicated. We observed good leadership skills from senior staff during handovers.

Medical staffing

- All patients were admitted under the care of a named consultant. Lead consultants were available on admission and were reachable on-call at all other times. They reviewed their patients regularly and communicated any changes or concerns with the Resident Medical Officer (RMO). Patients told us they saw their consultant once or twice daily and once on weekends.
- During normal working hours, there were two RMOs present on the oncology ward and one RMO on the cardiac ward. They were responsible for reviewing patients on a daily basis and communicating with the patients' lead consultant.
- 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 committee (MAC) was responsible for approving practising privileges for medical staff, chief executive officer (CEO) had the oversight and this was reviewed centrally on annual basis. Consultants with practising privileges had their appraisals and revalidation undertaken by the medical

Medical care

director if they did not work at an NHS trust. For RMOs who also worked in an NHS Trust, a copy of their appraisal and revalidation undertaken at the NHS trust was provided to the HR department of the hospital.

- There were structured handovers between the RMOs at shift changes and there was a daily multidisciplinary ward round held at 9 am, led by the RMO and involved the nursing staff, physiotherapist, pharmacist, dietitian and infection prevention and control nurse. Every Wednesday the complementary therapist also attended these MDT ward round.
- The hospital at night was supported by a site manager team and an outreach nurse. Nursing staff told us that there was an ITU RMO in both north and south buildings 24/7 and there were a minimum of five RMOs working out of hours across the hospital site.

Major incident awareness and training

- The hospital had major incident and business continuity plans in place. Staff we spoke with were familiar with how to access the guidance and instruction cards for their respective areas.
- All staff we spoke with were able to describe the process to follow in case of a major incident and plans were in place for wide range of uses. For example, staff showed the fire exits and pathway to move patients out of the unit in case of an emergency.
- There were business continuity planning tools for medical services. We saw the business continuity plan for the endoscopy unit, which was comprehensive.

Are medical care services effective?

Good 

Evidence-based care and treatment

- Policies and procedures were available on the hospital intranet. Clinical policies and procedures we reviewed all referenced relevant NICE and Royal College guidelines. We audited six guidelines and all were in date.

- Appropriate care pathways and protocols were available for the management of complex oncology admissions and for the management of gastrointestinal endoscopy patient.
- Staff demonstrated how they accessed guidance, policies and procedures on the hospital intranet. Staff told us the guidelines were clear and comprehensive and updated frequently. For example, neutropenic sepsis, escalation policy for acutely ill patients and managing gastrointestinal bleeding.
- In June 2016, the oncology department audited compliance with NICE guidelines for suspected neutropenic sepsis patients admitted to AAU with high grade fever. Although there were only two out of five patients that were neutropenic, there were key recommendations to improve practice for the management of this group of patients. For example, improved access to clinical letters (on Mosaic) for AAU doctors, placed flow chart of management of suspected neutropenic patients on the board on AAU and to ensure these patients were discussed immediately with oncology team.
- 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.
- The acute neurorehabilitation unit was CARF (Commission on Accreditation of Rehabilitation Facilities) accredited.

Pain relief

- Patients could receive pain relief in various formats; patient controlled analgesia (PCA), epidural, intra-venous or orally. Staff told us pain relief medicines were reviewed frequently to ensure pain control was optimised and patients were weaned from analgesia when they were ready.
- We reviewed 11 patient records, which showed that staff used a standardised scoring tool of 1-10, to assess patients' pain and recorded pain assessments in patients' notes. We saw that pain scores were documented hourly in electronic patient records by staff who demonstrated good understanding of how pain could be assessed.
- Patients were encouraged to complete a patient satisfaction survey following their visit, which included

Medical care

pain management. Survey responses in regard to patient pain management were monitored monthly by wards. The results for patient satisfaction for medical wards regarding pain control and analgesia ranged between 65% - 100% for example, AAU -70%, Oncology -61%, Neuro rehab on fourth floor 50% and on sixth floor 100%. A patient told us that staff were always able to provide timely pain relief if they needed it.

- In addition, staff monitored pain scores frequently via mobile electronic system and escalated to the hospital's pain management service.
- A pain audit was conducted quarterly to determine compliance with effective pain management assessment and management for inpatient areas, in line with corporate provider's policy. The re-audit findings in June 2016 showed improvement in several auditable items including prescription according to analgesic ladder, checking effectiveness of analgesia, analgesia history in drug chart. However, there were specific recommendations for AAU, cardiology and neuro rehabilitation departments regarding prescribing regular opioids and to improve referrals to pain CNS when patient reported poor pain control.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we reviewed. Training in the use of MUST was mandatory for all nursing staff.
- Dieticians reviewed patients on the wards if required and attended multidisciplinary team (MDT) meetings.
- The hospital nutrition and hydration committee reviewed all relevant feedback from patient surveys to ensure all components of this important basic element of care were addressed.

Patient outcomes

- The hospital participated in the NICOR- national audit of percutaneous coronary interventions (PCI) audit. The data from January 2012 to 31st December 2014 showed that the mortality and outcomes all matched favourably with national averages. The data showed 100% of NSTEMI cases were treated within 72 hours which better than national average (56.43%). 99.64% of cases survived to 30 days post PCI procedure, which was better than national average of 97.98%.

- During February 2012 to January 2016, there were 3331 acute admission in AAU. 32.2% patients were discharged home from the AAU, 63.6% were admitted to general ward, 3.1% went to ICU and 0.4% died in AAU.
- AAU data submitted to us showed that average response time to clerk (RMOP) admissions in AAU was 22.6 minutes.
- Of those within AAU for longer than 24 hours, a consultant saw 54.5% patients within three hours of admission and 72.7% were seen within six hours.
- During 2013-2014, there were 24 expected deaths of cancer patients within the oncology department.
- Readmissions for oncology patients undergoing treatment were triaged on the basis of UK oncology nursing society (UKONS) tool kit through the acute assessment unit.
- Monthly Morbidity and Mortality meetings were held where both expected and unexpected deaths were discussed. We saw examples of well-documented mortality review sheets with named attendance of each member of the multidisciplinary team (MDT).

Competent staff

- All nurses and allied healthcare professional we spoke with told us that they were very happy with the standard, frequency and quality of training and that it helped them to develop their clinical skills. Some of the senior nurses told us that they had the opportunity to attend international conferences paid for by the hospital.
- All staff nurses had undergone an appraisal in the last year and this was 100%.
- Agency nurses worked under the supervision of unit staff and received an orientation on their first shift.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover. We observed this at the two handovers we attended.
- Clinical nurse educator monitored nurse competencies on a rolling basis to ensure that nurses maintained competencies based on national benchmark standards.
- We reviewed three competency documents that included the use of patient controlled analgesia, cardiac monitoring, insertion of catheters and removal of chest drains. The documents showed evidence of the

Medical care

completed assessments and competency checks. Staff told us they had their competencies assessed by a senior member of staff and they could approach senior staff for help and support.

- Data submitted to us showed AAU nursing staff clinical skills assessment included managing pain relief, oral care, syringe pump and using Enteral Feeding pump.
- There were systems to ensure staff (RMOs and nurses) were competent to carry out their role. This included an induction programme that ensured new staff were familiar with local policies and procedures, particularly in relation to standards of patient assessment, neutropenic sepsis and record keeping.
- Medical staff used regular meetings, such as unit meetings and governance meetings to review practice guidelines and identify areas of good practice and areas of improvement.
- The AAU clinical lead told us that bed occupancy was higher as there were intensive care unit or post-operative cases treated in the AAU and this was encouraged to allow nursing staff to maintain their nursing skills.

Multidisciplinary working

- A broad range of MDT meetings were held regularly. For example, oncology and cardiology MDTs took place on a weekly basis. The nurses within the department told us that the meetings were 'a great learning tool that provides a holistic approach to patient care'.
- We witnessed an oncology ward based weekly MDT meeting that was attended by a variety of allied health professionals, including complimentary therapist. Discussion of each of the patients was holistic and sensitive.
- The oncology nurse lead we spoke with told us there were also monthly MDT meeting for gastrointestinal, skin, pelvic floor and breast cancer. All records of the meeting including attendance and discussion outcome were documented and summaries were scanned into electronic record system.
- There were daily operational site meetings to communicate key safety issues regarding patient care. We attended one meeting and standing agenda items

included; safe staffing, outreach team roles, incidents, safeguarding and vulnerable adult referrals, mental capacity issues, unplanned readmissions, pressure ulcer and any falls overnight.

- The oncology service operated within the wider HCA network, offering patients access to a comprehensive and integrated pathway through collaboration with the provider's neighbouring hospital for clinical oncology.
- There was an End of Life Care (EOLC) working group made of MDT staff including nurses, physiotherapists, occupational therapists and pain CNS.

Seven-day services

- Medical and nursing staff provided cover for 24 hours a day, seven days a week. A consultant physician was available 24 hours a day, seven days a week and was available to attend the ward within 30 minutes. There were twice daily consultant led ward rounds and a weekly ward round on PDoC.
- All patients were admitted under the care of a named consultant who provided consultant level cover in case of absence. Consultants were supported by specialty specific RMOs 24 hours a day seven days a week.
- Inpatient therapy service was provided between 9 am – 5.15pm, Monday to Friday. A Saturday service was provided on the Rehabilitation Unit / PDoC Unit, which consisted of one treatment session per patient of an appropriate therapy discipline (Physiotherapy, occupational therapy or speech and language therapy).
- A therapy outpatient service was also available between 9 am – 5.15pm, Mondays to Friday. Referrals were accepted from the patients' consultant or General Practitioner.
- An emergency on call Physiotherapy service was offered out of hours seven days a week.
- There was a radiologist rota cover 24 hours a day seven days a week.
- Endoscopy services provided Mon-Fri, 8 am – 8 pm. On call arrangements were in place for out of hours emergencies.
- The cath Lab operated Monday to Friday with an on call service over the weekend.
- A dietitian was available for five days per week, 9 am – 5 pm.

Medical care

- Pharmacy services are available Monday to Friday 9am – 5.30 pm, 5.30 – 8 pm in the Platinum Medical Centre, 9 am – 12.30 pm on Saturdays & Sundays and an on-call service outside of these hours.
- Imaging service was available 9 am to 5 pm Monday to Friday and out of hours cover was via on-call system.
- The International Relations department is available between 9 am -9 pm with an on call service available out of hours.

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.
- Before leaving the hospital, patients received two copies of their discharge letter, one for provision of the GP. Patients were given a card with a telephone number to use if they experienced any problems after discharge. Oncology patients were also given key contact details for out of hours and in case of emergency for cancer nurse specialist.
- Staff had access to an online learning management system and hospital policies via the intranet

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was 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.
- The consultant reviewed and obtained consent from cardiac patients, on the ward or the day care unit (DCU), before procedures took place in the cath labs. Consent from was completed appropriately in all relevant care records we reviewed, except in one patient record on cardiology ward where we couldn't find the consent form for the procedure.
- 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 had good understanding of Deprivation of Liberty Safeguards (DoLS). We reviewed the care record of a patient who we were told, was not able to make their own decisions. There was comprehensive documentation in the care record and a range of professionals were involved in concluding that a DoLS authorisation was required.
- 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. However, nursing staff told us that majority of the patients due to their religious beliefs would not consider this.

Are medical care services caring?

Good 

Compassionate care

- There was a corporate privacy and dignity policy in place.
- The hospital was committed to ensuring patients were treated with dignity and respect and launched ‘Dignity Pledge’ and over 500 members of staff signed the pledge. We saw many staff wearing the dignity pledge badge on their uniform.
- Patient consultations, treatment and personal care took place in private rooms that ensured privacy and dignity.
- The August 2016 dignity and respect audit showed compliance for all medical wards was 90% or above with endoscopy at 100%. This was above the hospital standard of 80%.
- We observed interactions between nursing staff and patients. Staff were professional, kind and friendly.
- We observed staff ensured patients’ privacy and dignity was maintained at all time by closing doors. We observed all staff always knocked on the door of patient

Medical care

room before entering and the privacy and dignity of each patient was preserved. The patients we spoke with felt safe in their environment. One patient said they had no issue with confidentiality. Staff always introduced themselves and patient felt involved in their care.

- We observed health care assistants and cleaners interacting with patients and found they were polite, friendly and helpful.
- There were many examples of health professionals who went that extra mile. An inpatient told us that “catering staff are excellent, they make me fresh ginger tea every day and nursing staff are so kind”.
- Staff showed great commitment to encourage patients to gain independence in their care and tried innovative ways to motivate patients to recover.
- We saw thank you cards from patients stating, “You helped me put a smile on my face” Patient told us, “Admission process was swift and smooth, everything explained thoroughly by doctors and nursing staff”.

Understanding and involvement of patients and those close to them

- Discussions with patients and families were evident in all of the notes that we examined, including discharge planning and obtaining consent. Family involvement was also discussed in the handovers that we attended.
- One patient who was going to be discharged on the day told us that discharge process was thoroughly explained.
- We saw a discharge care plan and time table of weekly therapy sessions of a patient, which was translated into Arabic in order for them to understand.
- Neurorehabilitation lead told us that neurorehabilitation patients participate in their multi-professional case conferences for goal setting and design of their 24-hour care routine.
- The care of neurorehabilitation patients was tailored towards the patient’s individual need. For example, they used different switches for patient to control TV. In another case staff a trialling Another example was a cortically blind patient who we are just starting to trial using switches to allow a bling patient to control the radio, something they had to ask other people to do for them since their injury.

Emotional support

- The nurse in charge visited all patients and relatives on the unit daily to assess if they had any concerns with their stay.
- All the patients and relatives we spoke with told us they felt supported throughout their journey. Patients said the support provided by staff from consultation, pre-assessment, treatment and therapies was all very good. Patients told us that this included both the clinical and non-clinical staff.
- The hospital provided in house psychological supportive services, including counselling and alternative therapies, to patients and their relatives. Alternative therapies offered included: aromatherapy, relaxation and reflexology. There were also a variety of support groups for cancer patients after their treatment such as the Macmillan team.
- Patients had access to multi-faith spiritual support. Chaplains attended the hospital daily and visited patients and their families on request.
- Staff were aware of the procedures to follow in the event of a bereavement of a patient. Support was offered from the bereavement team who would come to the unit at any time if needed. Staff showed us the information booklet for relatives and friends relating to the death of a patient at the HCA hospital.

Are medical care services responsive?

Good 

Service planning and delivery to meet the needs of local people

- Due to the large demographic of international patients, the hospital had a dedicated international relations department which coordinated patient admissions and supports the patient and family throughout their stay. The department works closely with the corporate provider’s overseas office.
- Staff were equipped to provide a service that met people’s needs outside of the clinical treatment plan. Religious and cultural needs were met and staff had access to a comprehensive portfolio of advice from religious organisations to help them to provide care that

Medical care

met the needs of individuals. For example, there were separate male and female waiting areas, staff organised Eid group to celebrate Eid, extra staff would be allocated for Jewish patients on certain days for their care.

- All staff we spoke with had good understanding of meeting the needs of patients living with dementia and patients with learning disability.
- An international patient coordinator worked closely with the relevant embassy to facilitate the admission and discharge of international patients.

Access and flow

- We were told there was no waiting list for chemotherapy and no problems with bed availability. Chemotherapy was not given at weekends and bank holidays.
- Patients talked positively about the ease of access to services and the communication between departments.
- The endoscopy unit was open from 8 am to 8 pm Monday to Friday and there was a 24 hours on call emergency service for gastro-intestinal bleeding. There were provision of endoscopy related instruments and scopes for theatres for medical emergencies.
- The average RMO response time in acute admission unit (AAU) to clerk admission was 22.6 minutes.
- We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Access to the medical and oncology wards was via a consultant.
- The lead consultant for the AAU told us that they would not admit some patients who required emergency care such as an acute myocardial infarction (heart attack) or acute stroke and no obstetric and paediatric patients were accepted. Doctors referring patients with acute chest pain or with severe life threatening haemorrhage were advised to call for an NHS ambulance.
- During February 2012 to January 2016, there were 3331 acute admission (including 2808 new patient admission) in AAU, this equates to 2.3 admissions a day. Staff told us that there was a seasonal and weekly variation in admissions.
- Data submitted to us showed that 54% of patients were admitted between 8 am and 4 pm, 27% were admitted in the evening and 19% overnight.

- We saw the oncology department's admission pathway for the neuroendocrine tumour patients to the neuroendocrine tumour unit, with clear steps to review patients at various stages.

- 2865 patients attended the hospital with a diagnosis of cancer in 2013- 2014. 1,408 of these were new patient and of which 318 had a new diagnosis made at the hospital.

Meeting people's individual needs

- Patients told us that they felt safe in the hospital and they had adequate pain relief in a timely manner.
- The facilities in the relatives and visitors waiting area were well maintained, clean and had sufficient comfortable seating available with access to toilet and free refreshments. There was a coffee machine with a selection of hot beverages, well stocked fridge, water dispenser and selection of current newspapers and magazines.
- A multi faith room catered for variety of faiths was available on the ground floor of north building and relatives were allowed to pray by the patient bedside if they wished to do so.
- All staff we spoke with had good understanding of meeting the needs of patients living with dementia and patients with learning disability. the oncology lead nurse, told us that they use magnetic flowers on the outside the patient's room door, to ensure all staff are aware of the needs of these patients.
- Psychological counselling services were available for oncology patients suffering from anxiety, stress or pain. Other complimentary therapies like massage, reflexology, aromatherapy and reiki were also offered.
- The wards had a range of information leaflets available for patients and relatives. We saw detailed information leaflets for patients and relatives attending endoscopy unit, cardiac service and acute admission unit explaining what to expect during their stay and patients told us that they were well informed and prepared for their stay. There were facilities to translate leaflets into different languages if required and we saw leaflets available in Arabic language.
- We saw a variety of leaflets on information related to cancer and cardiac diseases on the wards. Additional cancer information was available through the Macmillan centre in the hospital.

Medical care

- A high proportion of the international patients admitted to the hospital were Arabic speaking. We saw many signs and instructions in Arabic and staff were able to access interpreting services at any time. We saw an exercise care plan for neurorehabilitation patient translated into Arabic. There was a full time Arabic liaison co-ordinator to liaise with families and foreign embassy.
- We saw evidence that the service strived to meet the needs of those suffering from the side effects of treatment, such as nausea, fatigue and vomiting. The specialist team encouraged the use and regular review of both PRN (pro re nata or as required) and regular medication in view of changing symptoms. Complementary therapies were also available to patients to help manage symptoms and side effects.
- Dementia passports were in place for patients admitted with a history of dementia, and there were dementia champions in each department. The oncology lead nurse showed us the dementia passport, a photocopy of a completed passport was kept in the notes.
- There were no designated EOLC beds at the hospital as all rooms were single rooms. Relatives were able to stay overnight to spend time with their loved ones at the end of life.
- Every private room had a refrigerator and the hospital allowed relatives to bring in food.
- Patients we spoke with were generally happy with the standard and choice of the food provided to them.
- There were many examples, which showed that neuro-rehabilitation unit exceeded in meeting the patients individual need. For example, a variety of devices was available to assist patients with physical and communication impairments to express themselves. This included access to 'Eye Gaze' technology, which allowed patients to control computer software with their eyes. There were therapies group every day including ladies lunch, breakfast, upper limb, communication, making sense of it and exercise group.
- There was a tracheostomy team consisting of dedicated nurses, therapists and consultants, who were experts in the field of tracheostomy tube safety and weaning streamlined the care and management of this highly complex patient group.
- The ward managers and matrons had an enthusiastic approach to learning from complaints and this was reflected in the discussions we had with staff. All staff we spoke with were confident in speaking with relatives who had minor concerns or issues.
- There were seven formal complaints in during February 2016 – July 2016. We saw that where a complaint had been made, the investigation and response processes were robust. Learning from complaints were monitored via the patient experience meeting and action plans were created and shared with relevant teams and groups.
- We saw evidence of complaints that resulted in change. For example, oncology ward introduced denture pots and offered this to patients who had dentures, to prevent loss of dentures as a patient's dentures were lost when catering staff mistakenly took away those with the food tray. Another complaint was about patient not being seen by nurses as often as the patient should have post cardiac procedure, as a result of this staff training was done and monthly audits were completed which showed improvement in compliance from 50% to 100%. The hospital also introduced white boards inside patient rooms to facilitate communication and patient empowerment and involvement.
- We were informed that staff aim to resolve concerns immediately if possible, and inform their manager of the concerns raised. A complaints leaflet was available in all areas which described the process should a patient want to raise a concern. Patients we spoke with were aware of the complaints process and said that staff were always there to resolve any concerns. A 'guide to making complaints and comments' was provided to patient as part of the patient's admission pack and was also available on the hospital website.

Are medical care services well-led?

Good 

Leadership and culture of service

- There was a lead clinician, a service/ward manager and matron within each sub speciality to lead the medical services.

Learning from complaints and concerns

Medical care

- There was a strong team spirit from top to bottom and each member of staff said, in their opinion, their contribution was valued, which meant morale in the department was high. We observed good team working among nurses and unit manager.
- We saw collaborative working between wards, physiotherapy, pharmacy and dietician teams. We saw that the medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice.
- We noted staff were proud of the team dynamics and the willingness to go the extra mile to deliver care.
- All staff we spoke with were passionate about providing empathetic care. Staff including ward hostess and cleaners, worked supportively to meet the needs of patients. They spoke highly about their work and were able to contribute as part of the team. One staff said, “We are really proud of what we do here.”
- There was clear communication with staff regarding their role and responsibilities for the shift. Staff said managers were approachable and they could discuss any issues with them. The senior management team were visible to staff and were contactable if issues arose.
- All staff we spoke with told us that the CEO and CNO did regular walk rounds and were very approachable. The CNO created a ‘no meeting clinical Friday’ when all leadership team with clinical qualification would be in the clinical areas. Staff felt they benefited from this and had a rapport with the leadership team and could talk to them easily.
- Lines of accountability and responsibility in the unit were coherent and staff were clear of their roles and how to escalate problems. The nurses and RMO we spoke with were clear about their lines of supervision.
- Ward staff knew how their work contributed to the wider vision of the hospital and were aware of the hospital values. Staff told us values were discussed at their supervision and appraisal sessions and was embedded in their practice.

Governance, risk management and quality measurement for this core service

- There was a defined governance and risk management structure from corporate provider level to hospital and department level. There was also a designated reporting structure for patient safety, quality, and risk management that fed into the medical board.
- The wards performance and quality indicators were discussed monthly at matrons quality indicator meetings. We noted from the minutes of these meetings that infection control, audit activity, complaints, incidents and emerging risk were discussed, evaluated, and monitored.
- Risks were identified and logged on the departmental risk register, which was monitored with action plans in place. The register recorded the level of risk and the target level of risk. We saw evidence of these risk registers being updated on regular basis and discussed at patient safety and quality group. We saw evidence of these risk registers displayed within staff rooms. All staff we spoke with were aware of how to contribute to the departmental risk register. Managers we spoke with were aware of the risks relevant to their specific areas.
- The Medical Advisory Committee (MAC) had specialist representations including medical representation from endoscopy and oncology. The MAC met five to six times a year. The MAC remit included clinical governance, reviewing practicing privileges of all consultants, reviewing key performance indicators and advise management.

Public and staff engagement

- From speaking with staff, reviewing the minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback and input into the running of the service. All of the staff we spoke with told us they felt listened to and could tell us who they would approach with different ideas for the service or when they had concerns. There were various opportunities for staff to engage, for example ‘Ask the Board’ sessions, CEO forums and Open Hour.

Vision and strategy for this this core service

- There were service plans for each sub speciality in medicine. The leadership team provided evidence of those plans, which outlined their key areas for improvement and their vision for the service. Some of these had already been implemented such as refurbishment of the endoscopy unit in 2012. There were plans to move the PDOC unit to second floor north building so all rehabilitation facilities are in one place.

Medical care

- Nursing staff told us that appraisals were a useful process and development was positively encouraged. Many staff had been on various courses and done a Masters as part of their development supported by the hospital. All staff told us they felt valued for the work they did and it was like a second family.
- Patients and relatives were asked to complete a feedback questionnaire about their experience and stay in the hospital. Relatives and three patients we spoke with told us that they felt involved in care and treatment decisions and that the level of information given to them was appropriate and very clear.
- The hospital implemented a new 'excellence reward scheme' in early 2016 for recognition and reward key individuals and team for their outstanding performance. Staff spoke highly about this scheme and it increased staff morale when the team received the awards.






Innovation, improvement and sustainability

- The neurorehabilitation department introduced a specialist group of occupational therapist and speech and language therapist, who were able to provide assessment and recommendations at request from patient's teams in acute and rehabilitation in Augmentative and Assistive Communication (AAC) and environmental controls. There were joint assessment sessions and depending on the needs, department was able to recommend trial and assisted in obtaining

funding for a variety of interventions. For example, adapted nurse call bells to a variety of different switches, if patients were unable to press a standard call bell, they could use switch or head control for power wheelchairs to provide increased independence or control in mobility. Another example was the use of English and Arabic language software in eye gaze and switch controlled communication, which had been set up with a number of patients.

- The acute neurorehabilitation unit was awarded specialist international patient centre of the year in 2015 and maintains CARF accreditation (Commission on Accreditation of Rehabilitation Facilities). It was first accredited in 2011 and re-accredited in 2014 for 3 years.
- The endoscopy unit was JAG accredited in 2015 and re-assessed on an annual basis.
- Staff told us that they participated in Project World Class to maintain quality customer services
- The oncology department offered psychological services and complementary therapy in conjunction with conventional medicine to all cancer patients receiving treatment. This holistic approach did not increase profit but definitely benefitted patients.
- The therapies managers told us that the spinal team were working to develop a spinal education brochure, which was planned to be launched in developing countries. The aim is to improve patient understanding and knowledge across developing countries.

Surgery

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

Are surgery services safe?

Good 

Incidents

- There were no “never events” reported within the surgical service between April 2015 and March 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 type 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 occurrence for that incident to be categorised as a never event.
- We found reliable systems and processes in place to keep people safe and free from harm. Staff were aware of how to report incidents and junior nurses informed us that they received feedback and learning was disseminated to everyone. All incidents were reported through a hospital wide electronic reporting system.
- There were 1203 clinical incidents between April 2015 and March 2016. Of these, 69% (833) occurred within surgery and inpatients. This rate of clinical incidents is lower than the rate of other independent hospitals. The majority (84%) of incidents reported resulted in no harm.
- Lessons learned from incidents were shared across teams via newsletters and emails. The consultants shared learning from serious incidents via the medical advisory committee (MAC) meetings and shared

minutes from these meetings with all consultants. Following a serious incident about a patient fall, the hospital published a booklet with information on patient falls and prevention.

- Mortality and Morbidity (M&M) meetings were detailed and held monthly. We reviewed minutes of M&M meetings and found that the case studies were discussed at length including contributory factors for each death. Minutes from the meetings were discussed at MAC meetings and learning was disseminated to all staff. Minutes demonstrated that discussions were both supportive and highly challenging.

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.
- All staff were aware of the duty of candour and we found that it was embedded into practice in the service. Staff were aware of who to escalate duty of candour concerns to and were able to provide examples of when the duty of candour had to be used in their department.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- 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.
- Instead of the NHS Safety Thermometer the hospital used their own auditing programme for monitoring falls

Surgery

and VTE's. VTE risk assessments were logged on the electronic patient record. VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it's called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it's called a pulmonary embolism or PE.

Cleanliness, infection control and hygiene

- The hospital had a policy on the Corporate Standard Infection Control Precautions that identified precautions to be followed in the care of all patients at all times. During the inspection we found the tenets of this policy to be followed.
- Both theatres and inpatient wards were clean, tidy and well organised. The wards were well lit with spacious corridors.
- Patients we spoke with were satisfied with the cleanliness of the hospital. We observed cleaning staff proactively cleaning and there were clear guidelines for cleaning duties. We observed that all equipment had green 'I am clean' stickers affixed to the surface.
- In theatres, surgical site infections were monitored and patients were prepared for surgery in accordance with NICE guidelines. There were 11 surgical site infections (SSIs) in total between April 2015 to March 2016. In the same reporting period the rate of infections during spinal and cranial procedures was lower than the average of NHS hospitals. There were no SSIs resulting from primary hip arthroplasty, primary knee arthroplasty, breast, urological or vascular procedures.
- In the reporting period of August 2015 to August 2016 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 all patients admitted should be screened for MRSA prior to admission. All patient rooms on the wards were single occupancy, therefore isolation was not required.
- In the same reporting period there were zero cases of hospital acquired Clostridium Difficile (C.Diff) and Escherichia Coli. 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.
- All nursing staff in all clinical and surgical areas adhered to the hospital bare below the elbows (BBE) policy.

However, it was observed that consultants did not always comply with this policy and we witnessed several consultants on surgical wards wearing full business attire.

- The hospital had employed a consultant nurse in infection control who was tasked with maintaining the good practice around keeping infection rates low.
- Disposable curtains were in use in recovery areas and these were all within date and clean. All clinical areas possessed bright green 'I am clean' stickers and all that we observed were in date.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons were available and we saw staff use these appropriately.
- Throughout the service we observed fantastic hand hygiene practices. The staff were very good at washing their hands with soap and water and we witnessed staff using alcohol gel between dealing with patients. We observed that decontamination in the theatres and with all equipment used in theatres were good. We observed a sound scrub technique followed by all staff.
- There was an annual programme to screen radiation protection jackets for damage or contamination.
- Isolation was a given for all patients as all patients were provided with single rooms with en-suite. The single rooms ensured that they could screen patients on admission for MRSA and can get the results within 24 hours.
- Staff used trays with small sharps disposals for blood tests or drug administration so sharps could be disposed of in the patient room, which reduced the risk of injuries. Sharps bins were closed and discarded when they were three quarters full. There was also a blue bin for the recycling of clinical plastic.
- Sluices in wards were witnessed to be clean, tidy and well organised. The sharps bin disposal was located in the sluices.
- Infection control was part of the mandatory training programme which all staff were required to attend. Within the surgical service 89.2% of staff had attended training.

Environment and equipment

- Patients were protected from the risks associated with an unsafe environment because all clinical areas were clean and free from clutter. There were wide corridors and all inpatients had single rooms with televisions and sometimes a sofa bed.

Surgery

- All the wards were well organised, clean and bright. All equipment we checked was clean and had 'I am clean' stickers to demonstrate they had been sanitised.
- The resuscitation area was clean, tidy and well organised. The location of the resuscitation trolleys was conducive to the needs of the patients on the wards. The trolleys were recorded as being checked daily and were easily accessible.
- In recovery, we found equipment that was out of date and some equipment was not safety tested. When we questioned staff about this they informed us that this was located on the hospital risk register.
- Theatres were all well maintained and contained adequate equipment for the procedures being carried out.
- Health and safety was part of the statutory training programme which staff were required to attend. Within the surgical service almost 90% of staff had completed the training.
- We looked at 13 sets of patient records and found all of them to be completed legibly and were up to date. We found patient records were detailed, fit for purpose and included evidence of personalised care and when necessary, multidisciplinary input that adhered to the guidance provided by the General Medical Council (GMC) and Nursing and Midwifery Council (NMC).
- Patient records were stored within locked cabinets in all but one of the wards we visited. There, the medical records were out on the front desk within full sight of people passing by on the ward.
- Inpatient records were paper based with nursing notes. Risk assessments and observations were kept on an electronic system which was accessible via several handheld devices on each ward.
- Information Security was part of the mandatory training programme which all staff were required to attend. Within the surgical service 88.8% of staff had attended training.

Medicines

- We observed that medicines were stored safely in locked cupboards and fridges which were set at the right temperature.
- Medicines were managed using a manual prescription and dispensation process, between the prescriber and the pharmacy.
- On the south and north wards there was pharmacist cover from 9am until 5.30pm whilst in platinum medical centre the pharmacy services ran until 8pm to take into account the patient needs within the outpatient department.
- After 8pm the on call pharmacist was available across the three sites and one pharmacist covered the out of hours shift for a week at a time.
- Pharmacists would be called in for the handling of controlled drugs (CD) out of hours. The site manager and RMO's had access to the pharmacy department out of hours as well.
- We audited the contents of a CD cupboard against the CD registers and found they were correct.
- We took sight of five medication records of patients within the surgery service and found that the administration of medicines was recorded appropriately. Records were fully completed and legible.

Records

Safeguarding

- Safeguarding policies were up to date and readily available on all units. Staff knew where they were and how to access both the hard copy and the copy kept in the policy library on the intranet.
- All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. There were safeguarding policies available on the hospital intranet and printed out information available on the wards. Staff on the wards understood safeguarding procedures and how to report concerns.
- We found good awareness of Female Genital Mutilation (FGM) amongst both junior and senior staff. We observed posters in staff rooms and nurses could explain the escalation process of suspected FGM. Junior staff told us that they were provided with engagement sessions addressing FGM, the laws around it, what to do when a patient presents with FGM and how to report it.
- Safeguarding was part of the mandatory training programme and different levels of training were provided for different roles. Within the surgical division 88% of staff had attended level one and two safeguarding training. 94% of staff had completed safeguarding of vulnerable adults training. 100% of staff had taken part in Safeguarding Children Level 3 training.

Mandatory training

- The hospital target for mandatory training was 80%.

Surgery

- The mandatory training programme included: health & safety, ethics, fire training, infection control and manual handling. Mandatory training compliance rates for the surgical division were between 86% and 94%.
- Staff were clear that it was their responsibility to keep up-to-date on training. We observed that team leaders and managers had systems in place to ensure that their staff were trained.
- Each ward manager took responsibility of tracking the training needs of the nurses in their ward. Staff were sent an email every three weeks to remind them if any of their training was due to expire.

Assessing and responding to patient risk

- The service rated their patients using the same classification system as the American Society of Anaesthesiologists (ASA). The rating went from 1 (being low risk) to 5 (being high risk). Under these guidelines ASA 1 would be a normal healthy patient and ASA 5 would be a moribund patient who is not expected to survive without the operation.
- The case mix at the Wellington Hospital consisted of younger and fitter patients with lower ASA scores – 4% as compared to 14% with a score of more than ASA3+ which is the national average.
- The National Early Warning Score (NEWS) is a scoring system that identifies patients at risk of deterioration, or needing urgent review. The nurses documented the NEWS in the electronic patient record. We observed that this was done correctly and in a timely fashion.
- For high warning scores the electronic system would automatically send a warning to the outreach team who would then contact the nurses on the ward. For a genuine high score ward managers informed us that the outreach team could be with the patient in minutes.
- Nurses carried out risk assessments on an online system. However, a copy of these risk assessments were not made available on the paper based notes. When questioned, the surgical leads did appreciate that there is a disparity between the paper based notes and the online risk assessments. They had plans to integrate all notes in the future.
- There was a bed management meeting every morning on a weekday to discuss patient admissions, bed capacity and patient discharges.
- 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.

- As well as the WHO surgical safety checklist being embedded into practice the nurses and doctors carried out additional steps to ensure patient safety. There was a newly developed pre and post procedure checklist where checks were made by three different clinicians.
- We reviewed an audit for the service compliance with the WHO surgical checklist. Where compliance was not 100% the audit noted action plans for surgical staff. This was done monthly.
- Surgeons used a 'TIME OUT' in procedures where prosthetists were being implanted. This ensured that the surgeon and the rest of the team took a pause before implanting to ensure the correct device had been used.
- There was a sepsis pathway in place which included neutropenia treatment. The service manager was working with key groups to adapt an updated sepsis pathway.
- VTE risk assessments were carried out on patients within the surgical division. There was a four step process for a VTE risk assessment. Step one was assessing whether or not prophylaxis was required. From the reporting period August 2015 to August 2016, 89% of patients had step one completed in their VTE risk assessment.
- There was an initiative in place called 'Call don't fall'. There was a poster in each patient room and patients were encouraged to call a nurse if they needed to stand up.
- Basic Life Support was part of the mandatory training programme which all staff were required to attend. Within the surgical service, 88% of staff had attended training.

Nursing staffing

- During our inspection, all wards and theatres were safely staffed with enough nurses and healthcare assistants. The staffing in surgery and theatre was flexed according to activity and was reviewed daily by managers.
- Staffing skill mix was reviewed twice daily against patient numbers and patient acuity level.
- During the reporting period September 2016 to August 2016 the nursing turnover rate was 25.1%. This was

Surgery

higher than the average of other independent acute providers. When the surgical leads were questioned about this they informed us that although there had previously been a high turnover this has been rectified by a successful recruitment drive.

- In the same period the nursing sickness rate was only 2.4%, this was lower than the average of other independent acute providers.
- The nursing vacancy rate at the time of the inspection was 13.1%; this was similar to the rate of other independent acute providers.
- Nurses on the surgical wards handed over at the beginning of each shift. We observed a handover with comprehensive briefings about all the patients on the wards.
- The rate of use of bank and agency staff was lower than that of other comparably sized independent acute hospitals.

Surgical staffing

- The service was consultant led. Records we viewed confirmed that consultants reviewed all patients on a daily basis.
- Patients told us they saw their doctors often and on individual request.
- A team of surgeons and anaesthetists provided 24 hour cover for theatres. We reviewed the out of hours anaesthetic rota and found that each day a different anaesthetist was on call.
- Medical staff 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.
- All the wards had arrangements for 24 hour, seven day a week resident medical officer (RMO) cover. All RMO's were required to have a current Advanced Life Support Certificate. The RMO's worked 12 hour shift patterns from 9am-9pm and 8am to 10pm.
- There were four whole time equivalent (WTE) RMO's within the surgical services at the time of the inspection. Two of these RMO's were research fellows on a service level agreement (SLA) from a large NHS Trust in London. One RMO was a full time neurosurgeon who was able to assist with neuro-spinal surgery and the other was an anaesthetics fellow on a three month rotation.

- As on call RMO's were required to be able to attend the service within 30 minutes, the hospital provided off site accommodation for RMO's on 24 hour shifts.

Major incident awareness and training

- There was a hospital wide major incident policy. The duty manager had overall responsibility to maintain an overview of all the incidents which could have the potential to affect the hospital. In the event of an emergency the duty manager would manage the emergency control room and be in charge of the response.
- Staff in the wards and theatres were not generally aware of any major incident training. They were however required to take part in PREVENT e-learning that was put together by the MET police and formed part of the mandatory training programme.
- Fire Training formed part of the mandatory training programme. Within the surgical division, 84% of staff had received this training.
- Within theatres, the major incident plan was in the health and safety folder.

Are surgery services effective?

Good 

Evidence-based care and treatment

- 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 hospital's intranet.
- The hospital complied with the NICE CG50 (2007) guidance on recognition of and response to acute illness in adults in surgery services.
- 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 service took part in the Cardiac Surgery Society of Cardiothoracic Surgery (SCTS) audit. This monitors the mortality for all forms of cardiac surgery.
- The services surgical pathways were delivered in line with referenced national clinical guidance. Senior managers and nurses took an active role in the

Surgery

development of policies e.g. the sepsis policy that took the Sepsis 6 initiative one step further by ensuring that patients with suspected sepsis were treated within evidence based recommendations.

- We reviewed the sepsis policy and found that it identified roles and responsibilities, as well as rating risk factors. The policy followed NICE guidelines with regards to training of staff, transfer of patients and the importance of communication.
- The service also took part in the National Joint Registry (NJR) for their orthopaedic surgeries. Between April 2014 and March 2015 the hospital recorded 115 joint procedures with the national average being 516.
- The service had a comprehensive and varied audit programme. Aseptic and clean touch technique, continuing care of central venous catheter (CVC) and insertion of CVC were all audited 10 times a month for each surgical ward. VTE, MUST, falls risk assessment as well as pain, discharge, Water low and Early Warning Scores (EWS) were all audited 20 times a month. The assessment and management of neutropenic sepsis as well as chemotherapy documentation were audited quarterly.
- The WHO checklist for surgical safety audit was carried out on a monthly basis.

Pain relief

- The service used a pain assessment scoring tool from one to ten.
- The medical records we reviewed showed that the patients' level of pain was assessed regularly as part of their observation record. They also confirmed that patients had been given appropriate pain relief.
- Patients we spoke with were satisfied with their pain relief. They said it was being well managed and if they required more support they got it quickly. All patients got their pain assessed daily.
- There was a hospital wide pain CNS who worked in conjunction with the pain consultants. Out of hours, there was an outreach team available for pain relief and there was an out of hours schedule for anaesthetists.
- At the team brief in theatres before the surgery commenced the team discussed patient controlled analgesia, epidural anaesthesia and the patients' needs around these.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to identify patients at risk of malnutrition. We also observed scales on all wards.
- Patients post-procedure were encouraged to drink plenty of water. In house catering provided patients with a wide variety of choices.
- There were provisions in place for patients with food allergies and intolerances as well as those on a specialised diet. One Jewish patient we spoke with informed us that they were always provided with the option of having a kosher meal.
- There was a nutrition and hydration committee. The aim of the service was to ensure that a patient's nutritional status or symptoms were monitored and/or maintained wherever possible. Dietitians were available in the hospital if required.
- All the patients we observed within theatres were provided with iv fluids as they were nil by mouth.

Patient outcomes

- The hospital submitted data on surgical site infections, unplanned readmissions and unplanned returns to theatre.
- The service submitted cardiac data to the Society for Cardiothoracic Surgery in Great Britain & Ireland (SCTS). From 2011 to 2014, the service boasted a 98% in hospital survival rate for cardiothoracic procedures.
- We found that the service performed better than the national average for NSTEMI door to balloon times with patients treated within 72 hours. Within the service, 100% of patients had been treated in this time compared with the 56% national average. The National Audit of Percutaneous Coronary Interventions audited this.
- The National Joint Registry from April 2015 to March 2016 showed that less than five hip revision procedures took place and this was well below the national average of 25.
- There were two unplanned transfers between April 2015 and March 2016. The number of unplanned transfers was not high when compared to the performance data submitted by other acute independent hospitals.
- Within the same reporting period, there were 52 unplanned readmissions within 28 days of discharge. This was lower than other independent acute hospitals of a similar size. On inspection it was clear that the service had learned from these incidents and had made changes to practice.

Surgery

Competent staff

- If a practitioner wanted practicing privileges at the hospital they would have to submit a completed application. They would have to provide details of revalidation information and relevant certificates. The CEO considered the application before progressing it to the Medical Advisory Committee (MAC).
- The MAC was a representative body of consultants that met on a regular basis. The MAC involved the CEO, medical director, chairman of the medical governance committee, the head of clinical governance, and the lead RMO. The MAC was defined as advising management on clinical issues, reviewing practicing privileges and receiving reports from the CEO, CNO and medical director.
- Consultant credentials were reviewed monthly via a report provided to the CEO through the centralised credentialing and registration service based within the corporate office.
- The majority of consultants (95%) were appraised through their NHS Trust. The remainder with no NHS affiliation were required to report to the responsible officer in the hospital. There was 100% completion rate of validation of registration for doctors and dentists working with practicing privileges.
- There was 100% validation of professional registration for both inpatient and theatre nurses in the reporting period of April 2015 to March 2016.
- A practice development team within the hospital were able to support staff through revalidation and answer any other questions they might have.
- All inpatient nursing staff in the surgical division had a folder on the ward with their individual competency checks. Here they were able to keep their certificates and information relating to upcoming competency opportunities.

Multidisciplinary working

- Several regular multidisciplinary team (MDT) meetings within the surgical division were as follows: complex knee, pelvic floor/gynaecology, urology, gastro intestinal and cardiac MDT. These meetings provided opportunities to review patient care and recommend improvement.

- The medical records we reviewed contained adequate MDT input where necessary. We reviewed an MDT meeting and found it to be well attended by allied health professionals, clinical nurse specialists (CNS) and doctors.
- There were various CNS in post to support ward nurses.
- As the service did not have in house pathology services they set up an agreement with HCA labs to do laboratory work and some pathology.
- There was one service level agreement for cardiac valve homographs with four other hospitals in London.

Seven-day services

- The surgical wards were open seven days a week. The following services were available: radiology including on call CT scanning and surgical theatre services. Radiology services also had subspecialties which were available out of hours.
- Neurophysiology services were open Monday to Friday and provided on call services seven days a week.
- Pharmacy services were split across the three sites and were available seven days a week. Pharmacy services were available every day from 8.30am to 8pm Monday to Friday and 9am until 12.30pm on Weekends and Bank Holidays.
- There was 24/7 RMO cover on all wards and consultant surgeons were available if their patient required urgent review.
- Physiotherapists including on call respiratory physiotherapists were available seven days a week.
- Across the three sites, on call pharmacists were available out of hours 24/7.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff. Patient risk assessments were recorded electronically so that the outreach team could easily have access to records if there was a deteriorating patient.
- Patients could not be admitted to the wards without past medical record being released.
- There was an effective theatre management system in place and theatre bookings were well managed with a clear system.
- Discharge information was communicated to GPs via a letter from the treating physician.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient notes contained a copy of patients' consent forms. The consent forms we saw were legible and included the risks and benefits of the procedure the patient was undergoing.
- There was an impressive weekly Mental Capacity Act (MCA) meeting and grand round, chaired by the CNO. This was well attended by a variety of staff including: matrons, neurophysiologists, site managers, physiotherapists, speech and language therapists, HCA's and sisters.
- Discussion points included patients who were to receive DoLS applications for example. The meeting was highly interactive with questions being asked of different services and opportunities for Q&A's. The staff spoke very highly of the meeting and one member of staff said "this meeting has enabled me to put so much thought into safeguarding patients. The discussion is brilliant".
- There was a transfer checklist for patients being admitted to the ward who lacked capacity. At the time of the inspection one patient lacked capacity.
- There was a "Think Capacity; Think Consent" presentation provided by the matron and neuro-psychologist with lots of slides on the awareness of consent.
- There was a hospital wide policy on the Deprivation of Liberty Safeguards (DoLS) that covered the DoLS element from the Mental Capacity Act.
- Mental Capacity Act training formed part of the mandatory training programme. Within the surgical division, 82% of staff had received this training.

Are surgery services caring?

Good 

Compassionate care

- The five patients we spoke with provided unanimous positive feedback about the treatment and care they received from the hospital staff.
- One patient said "it feels more like a family, this hospital is a lot better than others I've been to". Another patient said "the staff are fantastic, the nurses and doctors are very caring".

- We observed staff being kind, respectful and polite when speaking to patients and delivering care.
- All patients received a patient experience questionnaire upon admission and were encouraged to complete them. We observed nursing staff encouraging patients to fill out the forms and offering to post them to the headquarters that collated the results.
- We observed that patients' privacy and dignity were respected in theatres as well as on the wards.
- The hospital did not submit to the Friends and Family test for patients but the hospital had in place a dignity in care pledge that had seven main tenets. The first priority was a pledge to the patient to "treat you and your family with kindness, politeness and compassion at all times".

Understanding and involvement of patients and those close to them

- We saw staff explaining to patients and their relatives the care and treatment that was being provided. Patients informed us that they were given sufficient information both pre and post procedure.
- We observed patient pamphlets with information on the cost of procedures. Patients informed us that they were given information on pricing structures on admission.
- We observed patients being shown around day surgery before being assigned a room. Patients and their relatives told us that they could ask staff about their care and treatment.
- Patients' rooms had their consultants' names on the front so all patients knew who their named consultant was.
- Patients and their relatives informed us that they received adequate information on the pricing structure of services.

Emotional support

- There was a hospital wide psychological support and a counselling service available to patients.
- Patients had access to a trained, accredited healthcare chaplain who could provide support to patients. The chaplains provided pastoral, spiritual and religious care. The chaplains made regular visits to ward areas and patients were able to contact chaplains directly through the multi-faith chaplaincy team.
- There were male and female prayer rooms located in the hospital to accommodate those of the Muslim faith.

Surgery

Are surgery services responsive?

Good 

Service planning and delivery to meet the needs of local people

- The service had been adapted to meet the needs of its population because needs were assessed and reviewed from a service perspective.
- The range of surgical services had been developed in response to demand and the specialities of the consultant surgeons using the hospital with practicing privileges.
- The service had a service level agreement with four units in London for cardiac valve homographs. The service had this agreement in place to ensure they were able to locate the best human tissue possible for their patients.
- As most of the surgeries that took place were elective, the admissions were staggered throughout the day. This was in order to mitigate against busy times in the day surgery.

Access and flow

- A provider based admission and exclusion policy approved by the CEO was in place hospital wide.
- The admission process included an admission checklist that verified patient details, patient labels and ensured that the patient registration information was correct. Scheduled admissions took place between 6am and 6pm, Monday to Friday. Out of hours (after 6pm Monday to Friday; weekends and holidays), admissions would be arranged by the site manager. Consultant referrals would require the consultant to be present.
- In the 12 months prior to our inspection, the service had cancelled nine procedures for non-clinical reasons. All of these nine patients were offered another appointment within 28 days of the cancelled appointment.
- In the day surgery, the patient admissions are staggered throughout the day. This ensured that patients were not waiting too long for their pre-op appointment. For this same reason, waiting times were not monitored. Patients we spoke with said they did not need to wait long to be seen by a doctor or nurse.

- Some surgical patients presented at the Acute Admissions Unit (AAU). The average time a patient waited from admission to being reviewed by an RMO was 22 minutes. Of the patients presenting at AAU 25% of them ended up having surgery.
- The discharge process was thorough and clear and the service aimed to discharge patients on the fourth or fifth day post procedure. Prior to the procedure the nurse would discuss discharge planning and provide the patient with all relevant discharge information including a number to call should they require. After the procedure, the consultant would discuss the outcome of the surgery with the patient. The patient would then receive a letter from the consultant outlining the procedure that they could share with their GP.
- If a patient required post procedure treatment e.g. suture removal, the service would arrange for this to be done in the outpatients department of the hospital.
- Post procedure, if a patient was transferred to another hospital for recovery, they would be provided with medication for two weeks, a detailed discharge letter and a copy of their drug chart.
- If patients were to be discharged home and became unwell, they would be able to call the ward who would then advise them to come back either to the ward or to the AAU.
- The hospital had an exclusion policy that excluded women over 20 weeks pregnant or in labour, bariatric patients (over 159kgs), acute trauma, acute myocardial infarction requiring thrombolysis or primary PTCA, patients with newly diagnosed acute mental health issues, highly contagious infections and children under the age of 16 or young adults between 16 – 18 who weighed less than 40kgs.

Meeting people's individual needs

- The top three patient origin groups were patients from the UK, patients from Kuwait and patients from Qatar.
- The majority of patients admitted were Arabic speaking. We saw many signs and instructions in Arabic and staff were able to access an in house interpreting service.

The interpreting service could be bleeped or called and were often required for gaining patient consent.

- There were various catering options for patients including halal and kosher food. We spoke with a patient of the Jewish faith who told us that he was offered “good kosher food”.

Surgery

- There was a hospital wide Supporting People with Dementia policy.
- For patients from countries that the hospital did not have an interpreter for, the service would contact the embassy and ask them to provide an interpreter. Language line was also available.
- There were various leaflets at the entrance to each ward with specialised information relating to various surgeries.
- There was step free access in both the theatres and wards and all inpatient rooms had step free access to bathrooms.
- Some inpatient wards were able to facilitate one family member spending the night in rooms that had futons and pull out beds.

Learning from complaints and concerns

- 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 comment cards in each inpatient bedroom, which patients were encouraged to use to share feedback.
- All formal complaints were logged on the hospital reporting system and monitored via an internal database. The hospital had a target of acknowledging all formal complaints within 48 hours of receipt. The HCA wide expectation is that complaints were then responded to within 20 working days.
- In the 12 months prior to the inspection there were 15 formal complaints arising out of the surgical division. 100% of these complaints had been responded to within the hospital mandated timelines.
- Learning from these complaints was monitored and shared via the patient experience meeting and action plans were created and shared with relevant teams and groups.
- The Complaints and Patient Experience Committee (CPEC) occurred monthly and was attended by senior managerial staff.
- The CEO took overall responsibility for complaints working with the Chief Nursing Officer (CNO) and supported by the Patient Experience Manager.

Are surgery services well-led?

Good 

Leadership / culture of service

- There was a clear management structure within the wards and theatres. The surgical services manager took responsibility for the day to day management of the service.
- Each ward apart from one had a permanent ward manager. One ward had an interim acting ward manager until a new ward manager was recruited.
- All ward managers were supernumerary and staff informed us they had good access to the ward managers as they were very visible.
- All staff spoke very highly of their managers, matron and CNO. Junior nurses on the wards said they saw the CNO at least two times a week.
- Consultants unanimously spoke highly of their RMO's and said they felt very supported by the RMO's who sometimes worked 24 hour shifts. Some RMO's we spoke felt as though the term RMO did not adequately explain their expertise and consultants we spoke with agreed with this.
- Equal opportunities training formed part of the mandatory training programme. Within the surgical division 83% of staff had received this training.
- The executive team were highly engaged with the service. Members of the executive team told us that the CEO and medical director were very supportive and always available. One consultant informed us that he required a new piece of equipment and was provided with it after a call with the HCA President and Chief Executive Officer.
- There was a medical advisory committee (MAC) in place. The MAC remit included clinical governance, reviewing practicing privileges of all consultants, reviewing key performance indicators and advising management.
- Both ethics and equal opportunities were on the mandatory training programme. Within the surgical

Surgery

division, 91% and 90% of staff had attended these sessions respectively. A ward manager informed us about an ethics helpline that staff could call anonymously if they needed to talk to someone.

Vision and strategy for this core service

- The hospital vision was 'striving for excellence'. The hospital endeavoured to achieve this through "the provision of a safe and efficient patient pathway; by anticipating the needs of our patients, relatives and consultants and by providing our staff with a resourced, supportive and open environment from which to deliver care". Not all staff we spoke with were able to reiterate the hospital vision.
- There was no clear vision for surgical services but staff were aware of their individual departments' vision and goals. Staff were able to tell us what their department strategy was and where they saw themselves within this strategy.
- Nursing staff informed us that values were discussed at their supervision and appraisal sessions and were embedded into practice.

Governance, risk management and quality measurement for this core service

- There was a defined governance and risk management structure from corporate provider level to hospital and department level. There was also a designated reporting structure for quality and risk management.
- There was a surgical services risk register in place. There were four open risks on the surgical services risk register at the time of the inspection and senior managers were aware of these risks.
- The hospital had a Risk Recording and Assessment policy in place that set out the expectations around what risks could be recorded on the register and how those risks would be assessed.
- The theatre user group, which included the theatre surgical services manager, consultant anaesthetist and theatre staff, met each quarter to review operational issues, funding opportunities and any staffing or equipment issues, as well as discussing methods to improve processes.
- The medicine management committee met quarterly and reports and data, such as medication errors and

timely discharges for each area were reviewed. The surgical services quality group also met monthly as well as the surgical wards quality group. All these groups fed into the patient safety and quality board that met each month and was led by the CEO.

Public and staff engagement

- HCA staff we spoke with said that they felt like their managers were very approachable. They could recall opportunities they were given to interact with members of the board and the executive team.
- Inpatient nurses we spoke with informed us that they felt very engaged. They explained that there were various opportunities throughout the year to engage with leadership.
- Patients were provided with a patient survey on admission to the wards. They were able to fill it in and post it to the head office. A patient engagement committee in place that met every month. Their responsibility was to ensure that the patient voice was being heard and practice evolved accordingly.
- There was a Patient Safety and Quality Board (PSQB) and a Patient Safety and Quality Group.
- Staff were invited to 'ENGAGE' sessions held every week. These sessions were open spaces where both clinical and non-clinical staff could come together to discuss various issues. Issues ranged from learning from incidents to FGM awareness and awareness of patient pathways. Junior nurses we spoke with said they found these sessions both interesting and informative.
- Senior nursing staff informed us that they receive newsletters and weekly emails from human resources telling them the different areas where money was being invested by the hospital.






Innovation, improvement and sustainability

- The surgical service was awaiting the arrival of software for their Da Vinci robot. The clinical applications for this software would mean real-time anatomy identification using near-infrared guidance. Fluorescence imaging would allow the surgeon to see and assess anatomy better than with the naked eye.
- The service had also purchased a technology that used a 3D-HD camera to optically map the brain. This enables the surgeon to use a minimally invasive stereoscopic

Surgery

(3D) camera for neurosurgical, ENT, and laparoscopy applications. This will provide improved depth perception for the surgeon and potentially better clinical outcomes and safer operations for the patient.

Critical care

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

Are critical care services safe?

Good 

Incidents

- Between April 2015 and October 2016 there were no never events in critical care services. A never event is a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level. During the same period staff reported 42 incidents that resulted in no or low harm and no serious incidents as defined by the hospital's incidence reporting policy. All of the incidents had been investigated by an appropriate member of staff and had a clear outcome with learning identified.
- Staff used an electronic system to submit incident reports that enabled them to be tracked and investigated. A senior member of staff took responsibility for investigating each incident depending on where it occurred and whether it resulted in harm or risk. Most clinical staff told us they felt incidents were fully investigated and said they usually received individual feedback. One nurse said, "The incident investigations are a collaborative process and it means we get feedback on practice and support to improve when needed." One doctor said, "There is no clear mechanism to find out about incidents across the hospital and no method for shared learning for doctors."
- Learning from incidents was shared with staff through cross-site meetings and a newsletter. This included a recent incident of an incorrect medicine dosage. Senior staff implemented changes to practices and policies

following learning from incidents. For example, more staff had been trained in advanced airway management and three members of staff were required to roll patients who needed a position change. A critical care nurse held a link post for incident investigation and acted as a liaison between the senior team and staff who experienced an adverse event.

- The medical governance committee and medical advisory committee reviewed every patient death in critical care. In addition, morbidity and mortality (M & M) meetings were held where a patient death was unexpected or where clinicians felt there was learning to be made. Some consultants said they felt M & M meetings were robust and consistent, with proactive engagement with coroners and the hospital legal team. However, outcomes from M & M meetings were not always shared with staff consistently or using a robust system. For example, one doctor told us they felt the hospital was "slow to respond" to learning from M & Ms and said, "I only find out what's happened if I go looking for it. There is no consistency in who receives this information or who acts on it." We looked at the M & M meeting minutes for four months and found learning to be identified in some cases and to be inconsistent in others. For example, one M & M review found that two RMOs, consultants and nurses did not identify a misplaced endotracheal tube. However, the learning outcome focused on temporary nursing staff and did not include how the findings would affect doctors. M & M meetings were restricted to critical care and did not routinely enable collaborative multidisciplinary working with other hospital teams.
- The multidisciplinary team had an awareness of incidents and were able to support investigations and

Critical care

recommendations. This team demonstrated an awareness of the duty of candour as well as the ability to ensure patients remained confident in the service. For example, following a minor incident that did not result in harm, the therapies team provided a patient with free hydrotherapy.

- At the time of our inspection the matron and a tissue viability nurse (TVN) was leading the investigation into a unit-acquired pressure ulcer. As an interim measure, the matron was reviewing communication standards between nurses and the TVN was preparing a new skin care checklist. Each patient was cared for on an air mattress, which reduced the risk of pressure ulcers.

Cleanliness, infection control and hygiene

- Between April 2015 and March 2016 there were no reported cases of hospital-acquired MRSA.
- Staff highlighted any patients with an infection control risk or who were cared for in isolation during a daily safety briefing. This included a reminder of the correct personal protective equipment to be used and of the need for stringent hand washing techniques.
- Clinicians demonstrated an awareness of the increased risk of infection by patients admitted from overseas.
- Staff audited compliance with hand hygiene protocols and with the ventilator associated pneumonia (VAP) care bundle. Between January 2016 and August 2016, the north unit achieved 98% compliance in hand hygiene the south unit achieved 96% compliance. Between March 2016 and August 2016, the north unit achieved 100% compliance with VAP care bundles and the south unit achieved 98% compliance with VAP care bundles.

Environment and equipment

- Each patient bedroom had a daily checklist that two members of staff used to check emergency equipment was functioning correctly. We looked at the records for each critical care treatment room for the month prior to our inspection and found records to be complete.
- Staff documented checks on resuscitation trollies and difficult airway equipment on a daily basis. We looked at the daily records for all critical care emergency equipment for the three months prior to our inspection and found them to be up to date with no gaps and

corrective action taken where necessary. There were a number of gaps in the recording of daily checks of the difficult airway bag in the south unit. This included six days without documented checks in August 2016 and five days in September 2016.

Medicines

- Drug charts were of a consistently good standard. This included a staff signature and date for each prescription, no missed doses and clearly documented allergies. There was evidence of regular reviews of medicines by a pharmacist.
- Controlled drugs (CDs) were stored and managed appropriately and met the standards of clinical guidance 46 of the National Institute of Health and Care Excellence. CDs were checked twice a day by two registered nurses. We looked at the records for the three months prior to our inspection and found two daily checks had been missed in this period and had been found and corrected by pharmacy checks. This meant the back-up system provided by the pharmacy team ensured the safe management of medicines.
- Medication documentation audits had resulted in improvements in practice. For example, the daily checklist for CD checks was changed to include a column to record the expiry date of drugs.
- Staff consistently recorded allergies in patient notes and these were confirmed during handovers.
- The critical care pharmacist adhered to the antimicrobial stewardship guidance of the Association for Professionals in Infection Control and Epidemiology. This meant the use of antibiotics was monitored to ensure prescriptions were appropriate and in the best interests of patients.
- Where a member of staff was involved in a medicine error, they took part in a reflective exercise to identify what might have contributed to the mistake. A matron then used a risk scoring system to identify if there was a risk the mistake could happen again and one-to-one support was provided to the member of staff to ensure their practice protected patients from harm.
- Consultants said they could request new drugs from pharmacy services if there was a clear evidence base for their use and risks were appropriately managed.

Critical care

Records

- Staff used an electronic system to record and monitor risk assessments and paper records for observations. Risk assessments were completed on admission for malnutrition and water low, falls, infection control, manual handling and pain. Observations were documented appropriately and consistently, including sedation scores and ventilator observations.
- A senior nurse was the project lead for the implementation of an electronic patient records system. They visited other hospitals operated by the provided to identify areas for learning and development and were working with senior clinicians to identify what they most needed from the new system.
- The critical care outreach team (CCOT) used a live electronic system to monitor patients across the hospital. This alerted them to patients whose condition was deteriorating and enabled them to respond rapidly.

Safeguarding

- All of the staff we spoke with were knowledgeable in the principles of safeguarding and the escalation process in place for urgent concerns about patient welfare. This included in multidisciplinary teams, who described the working environment as “without hierarchy”, which meant they could approach any senior member of staff if they had any safeguarding concerns.
- A safeguarding link nurse was in post in the unit who attended additional training and was able to provide colleagues with updates on best practice guidance. Although the unit did not treat patients under the age of 16, staff were trained in basic child safeguarding so they could ensure the welfare of young people who might visit relatives who were patients.
- Safeguarding training included recognition of female genital mutilation (FGM), neglect and abuse. The hospital had protocols for staff to follow in the event they suspected such instances and had access to expert support when needed.
- Staff were trained in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Guidance was available when staff needed advice in complex cases or when they needed to arrange a best interests assessment. This included access to social services and local crisis intervention teams.

Mandatory training

- The hospital provided a mandatory training package of 13 subjects, including infection control and manual handling. At the time of our inspection, 100% of critical care staff were up to date with mandatory training. This was better than the hospital’s minimum target of 80%.
- The infection control lead nurses provided staff training on sepsis management and the clinical services manager for surgery had updated the sepsis protocol used in critical care services.

Assessing and responding to patient risk

- Ward staff used the national early warning scores (NEWS) system to identify deteriorating patients. This triggered an escalation to the critical care outreach team (CCOT) and the RMO via the mobile electronic clinical monitoring system. This team initiated a review of each patient who triggered the system.
- Staff used a daily operational site meeting to review all patients seen by CCOT in addition to a daily ward safety briefing. Both meetings enabled the clinical team to review patients who had deteriorated or who required an elevated level of care and ensure their needs were met. This included a review of the use of the NEWS system by ward staff. We observed a safety briefing and found it was thorough and included identification of patients with a Deprivation of Liberty Safeguards (DoLS) authorisation in place, those at high risk of falls, patients with a pressure sore and patients on the mental capacity register.
- The nurse in charge sent a daily falls risk and infection control report to the senior clinician on site as part of a daily census procedure to ensure patients isolated with infections or at high risk of falls were adequately monitored.
- Patients with a tracheostomy had a named tracheostomy nurse or a named anaesthetist who managed their treatment and led a weekly specialist ward round.
- A critical care consultant was the infectious disease lead for the hospital. One doctor said, “This is a very risk-averse hospital. [The senior team] make sure they have policies and protocols in place as soon as they become aware of a new risk.”

Critical care

- The CCOT duty nurse visited every inpatient ward at the beginning of each shift to provide an immediate visual presence to nurse teams.
- The cardiac arrest team held twice daily resuscitation meetings in each unit to establish roles and responsibilities and to identify any deteriorating patients not seen on the previous shift.
- The CCOT team had developed a new policy on sepsis management as a result of an audit on the management of deteriorating patients. The policy was based on the national best practice standards of the sepsis 6 pathway and was provided for staff in the form of pocket cards.

Nursing staffing

- A matron at each unit led the nursing and healthcare assistant teams.
- Nurse staffing levels met the guidance the Intensive Care Society (ICS) core standards for intensive care units. This meant patients who received level 3 care had a nurse ratio of 1:1 and patients who received level 2 care had a nurse to patient ration of 1:2. A supernumerary nurse coordinator was always available.
- The matron or nurse in charge in each unit completed a twice-daily staffing review using a 'safer staffing' acuity tool to ensure the number of nurses available met national guidance. This ensured sufficient numbers of staff were available to ensure patient safety.
- Although nurse staffing levels always met the requirements of the unit, there was a consistent reliance on temporary agency staff to achieve this due to vacancies. This was noted on the risk register for critical care and included a number of risk control measures. This included a check by the senior nurse on shift of agency staff competency and an orientation and induction checklist to ensure they were aware of safety and emergency procedures. In addition, a hospital site coordinator acted as a liaison for clinical staff in managing agency nurses and the service had recruited 30 new registered nurses who were planned to begin work by the end of January 2017.
- Nurses could work between the north and south units depending on demands of the service and staffing levels. The north unit predominantly cared for cardiothoracic patients but nurses in the south unit did

not routinely have training in this area. The clinical services manager and matrons used daily staffing skill mix reviews to ensure any movement of staff between the units was appropriate based on needs of patients.

- Staff we spoke with described nurse staffing levels as their key challenge. One member of staff said, "We can have 15 nurses and healthcare assistants and only four will be permanent staff. The temporary staff we have are very good but 11 of them on a single shift is very challenging in terms of managing patients because we [permanent staff] spend a lot of time supporting them." The patient safety and quality group documented their concerns over the large numbers of temporary staff used and acknowledged that 30 new nurses would be joining the team before the end of the year, which would reduce the reliance on temporary staff.
- We looked at a sample of nurse staff rotas. During a four week period between September 2016 and October 2016 in the north unit, 39 permanent staff nurses covered shifts in comparison to 74 temporary staff. During the same period in the south unit, 30 permanent nurses were available in comparison to 97 temporary staff. This reflects the total number of staff used during the four week period.
- The senior team prioritised known bank staff who were airway trained and held a post-registration qualification in critical care to fill temporary staff shifts. Where agency nurses were used, they either a post-registration qualification in critical care or demonstrable proven experience in a critical care unit.
- Supervision and induction processes for agency nurses were not always evident. For example, during a handover a permanent member of staff reminded an agency nurse they needed to wear their ID at all times. However, we observed the same agency nurse in the unit without any visible ID shortly afterwards. Although the nurse in charge asked the nurse if they had worked in the unit before, there was no formal check of their knowledge of local procedures.
- Each nurse conducted a detailed bedside handover for shift changes. We observed the process and found it included a review of overnight observations and anaesthetist input as well as personal care needs

Critical care

including skin, eye and mouth care. Nurses also confirmed allergies were documented accurately and ensured the patient had access to their as-needed self-administered pain relief.

- Although the units were never under-staffed on a shift basis, low overall levels of staffing meant nurses were sometimes removed from training courses to ensure critical care services could operate safely. This meant patients were cared for appropriately but meant nurses did not always benefit from specialist training opportunities.
- Consultants spoke positively about the nursing team. One member of staff said, “The nurses are phenomenal. The senior nurses are not just sitting in an office; they work wherever they’re needed. The agency nurses we have are exceptionally well skilled. The nurses are all very competent in situational awareness – they know when a patient is about to deteriorate and they act appropriately.”
- CCOT nurses conducted a handover for patients who had deteriorated or triggered a referral for all patients irrespective of their resuscitation status.

Medical staffing

- Medical care was led by a team of four senior consultant intensivists accredited by the Faculty of Intensive Care Medicine (FICM). A consultant intensivist led the admission of each patient and conducted a full review within four hours. Consultant intensivist cover for critical care met the requirements of FICM and the ICS.
- A consultant led twice-daily ward rounds and there was evidence of this in patient notes.
- There was a dedicated intensive care unit (ITU) resident medical officer (RMO) and an ITU fellow in both the north and south units 24-hours, seven days a week. The RMO and fellow provided cover for new admissions to critical care and supported the outreach team in caring for deteriorating patients in the hospital. RMOs were also available in cardiac care, general surgery and oncology and provided specialist input when needed. A named consultant was available on-call at all times to provide support to the ITU RMO. A consultant said, “The RMOs are exceptionally good. They are all very senior and research active.”

- The medical team demonstrated a system of communication and collegiate working. For example, following the death of a patient at 2am, the on-call consultant and cardiologist met at 5am to review the death and to plan the repatriation of the patient to their home country.
- RMOs handed over to each other as well as to consultants and other clinicians at least daily.

Major incident planning

- All senior nurses were trained as fire marshals and were able to lead an evacuation or emergency situation including coordination with the control centre using radios available in the unit. Records from observed fire drills showed areas for improvement in how staff responded to an emergency and in how they managed the environment. For example, during two fire drills on the north unit, the hospital fire officer found fire doors to be wedged open and observed staff did not always correctly identify this during their sweep. Staff on this unit were provided with additional training to manage emergency situations effectively.
- Staff inconsistently documented fire escape checks on the south unit. For example, in September 2016 only two out of four weekly checks were documented and between June 2016 and August 2016 eight out of 13 checks were documented.
- All medical equipment had a secondary back up or emergency back-up power supply.
- The major incident and evacuation plan was displayed on each unit in staff areas and staff we spoke with were aware of the major incident plan and their responsibilities.

Are critical care services effective?

Good 

Evidence-based care and treatment

- Critical care contributed to the Intensive Care National Audit and Research Centre (ICNARC) case mix programme. This meant the effectiveness of services could be compared with national standards. An ICNARC

Critical care

link nurse and an audit link nurse were in post and acted as points of contact for staff who wished to conduct audits as well as to ensure the units responded to audit results.

- Critical care services participated in the hospital's clinical audit programme where audits were relevant to the service. This included a quarterly audit of risk assessments including venous thromboembolism, the use of the malnutrition universal screening tool, pain scoring and management and three infection control audits in addition to the units' hand hygiene and
- Critical care services had a local audit plan that included four distinct rolling audits, including the standard and timeliness of consultant-led reviews and pressure area assessment and documentation. In addition, therapies staff who worked in critical care participated in their own audit programme to assess and benchmark patient care. This included audits of interdisciplinary team notes and the use of effective rehabilitation care pathways.
- A new fracture prevention pathway had been developed by clinical staff as a strategy to prevent fractures in patients with reduced bone density. This incorporated a comprehensive, evidence-based assessment, management and monitoring plan including the use of vitamin D and calcium. A September 2016 audit found 90% compliance with the new protocol in relation to the completion of appropriate risk assessments and prescribing of calcium chew and alendronic acid. A senior sister was leading on an action plan to educate unit staff and the multidisciplinary team on the most effective use of the protocol, which they planned to re-audit in October 2016.
- A consultant intensivist had led the implementation of a new 'high impact' checklist to standardise the assessment practice of consultants and RMOs with level 3 patients. The checklist used the mnemonic 'FLATHUGGS BDD' to signpost staff to a checklist based on clinical evidence from the National Heart, Lung, and Blood Institute Acute Respiratory Distress Syndrome Clinical Trials Network. Patient notes were audited before and after the implementation of the checklist to track changes in the documentation of 11 key criteria, including feed and fluid balance goals, a VTE assessment and screening for delirium. Both audits indicated a high standard of documentation in relation to VTE documentation and the prescription of ulcer prophylaxis. Three areas improved significantly following the introduction of the checklist. For example, feed and fluid level balance goals were recorded for 71% of patients, which represented a 61% improvement and documentation relating to bowel movement and laxatives improved from 30% completion before the checklist to 100% after its introduction.
- Pathways for the treatment of oncology patients and those with neutropenic sepsis were in development with the support and input of ward staff.
- Policies were in place for the use of physical or chemical restraint in patients, including the use of soft mittens to prevent them causing injury by pulling out lines while receiving treatment. In cases of restraint, a matron reviewed the patient within 24 hours and the clinical services manager reviewed them within 72 hours. We saw examples of a restraint review form in use and found it completed in line with the requirements of the Mental Capacity Act (2005).
- The physiotherapy team had established a 'gold standard' of care for patients with a tracheostomy that exceeded the national benchmark of NICE interventional procedures guidance 462. This included managing fluid suctioning and weaning proactively and providing tracheostomy care in 100% humidity, 37 degrees Celsius environment that represented the latest published research.
- The physiotherapy team had worked with speech and language therapists to introduce an in-line speaking valve at an early stage once a patient's communication techniques were established. This meant they could begin early rehabilitation more effectively.
- The critical care outreach team (CCOT) had conducted an audit of the effective use of the national early warning scores (NEWS) system by ward staff when assessing deteriorating patients. This had resulted in new training for staff and the reintroduction of the NEWS system hospital-wide through a series of engagement seminars.
- The CCOT and RMO teams had completed an audit of the reasons they were called according to medical problem, such as renal or cardiac. The information from this audit was used to identify training needs amongst nurses.

Critical care

Pain relief

- Staff used the critical care pain observation tool (CPOT) to monitor patient's pain and provide timely analgesia. An audit of the use of CPOT in August 2016 and September 2016 found an improvement in the completion of documentation following staff training and targeted support from the practice development nurses.
- An acute pain team and consultant pain specialist was available Monday to Friday and a pain control nurse was available 24-hours, seven days a week.
- All of the patients we spoke with said their pain was well managed and staff acted quickly when they told them they were in pain. The monthly patient feedback questionnaire asked if pain had been managed and controlled. Between January 2016 and August 2016, an average of 75% of patients said they were happy with pain control.
- The unit met the core standards for pain management services in the UK.

Nutrition and hydration

- Dedicated dietician support was available seven days a week. A nurse assessed each patient for risk of malnutrition and dehydration within four hours of admission and a dietician provided a specialist review within 24 hours.
- Staff used 24-hour food and fluid charts and a food diary for patients with significant dietetic needs, including the malnutrition universal scoring tool.

Patient outcomes

- Critical care services were benchmarked against the national Intensive Care Society (ICS) core standards for intensive care and against other similar units within the provider's network. This included an assessment of the timeliness of consultant review and admission and discharge standards. The units met all 26 standards nationally and 25 of the 26 standards for the internal network.
- Critical care services provided care for patients who had an elective or planned admission as well as for emergencies that included multi-organ failure. Mortality rates were between 2.5% and 3%, which was significantly better than the national average.

- At the time of our inspection the hospital performed the same as or better than other hospitals operated by the provider in unit mortality, delayed discharges and out of hours discharges. For example, in the previous 12 months, there were no out of hours discharges to a ward and no discharges delayed over 24 hours. During the same period less than 0.5% of patients were delayed over 12 hours and the unplanned readmission rate was 2%.

Competent staff

- The nursing team exceeded the ICS standard that a minimum of 50% of nurse hold a post-registration qualification in critical care and an education plan was in place to enable the units to meet the provider's internal standard that a minimum of 70% of nurses have this qualification. This included an increase in the number of nurses supported to undertake the post-registration training.
- Two practice development nurses (PDNs) supported staff during induction and with training and professional development. This team identified the learning needs of individual staff and worked with colleagues in the critical care network to provide specialist training opportunities. PDNs also provided nurses with bedside teaching and competence assessments and helped solve gaps in skills in a 'no blame' culture.
- The medical advisory committee granted practising privileges for consultants using a registration and background check policy that enabled monthly oversight of workload and practice competency.
- In addition to mandatory training, staff undertook medical devices training, mentorship and specialist procedure training such as tracheal suctioning, tracheostomy care and the use of sliding sheets. Rates of training were consistently high and an average of 95% of staff were up to date with training in the use of 21 specific items of medical equipment. This included seven items of equipment in which 100% of staff were up to date with training. Staff spoke highly of their access to training and opportunities for professional development and nurses said they felt PDNs were "readily available" for support. This member of staff also offered bedside training to temporary staff.
- Each permanent member of staff performed a specialist link role, such as in diabetes or infection control. This

Critical care

meant each member of staff took the lead in their area of responsibility to attend training days and then deliver new information or practice guidance to colleagues. This system was reviewed on an annual basis and each member of staff had the opportunity to reflect on their progress and identify their training needs for the following year.

- To ensure nurse staffing levels were increased to meet the needs of the service, newly qualified nurses had been employed. New nurses were provided with a structured induction that included clinical competencies such as intravenous fluids management and corporate training. Specialised training in tracheostomy care, discharge planning, airway management and pain management were provided within a three month supervision period to ensure new nurses were adequately skilled. Newly qualified staff told us senior nurses “went out of their way” to ensure learning opportunities were maximised by allocating them to patients with conditions they needed more experience in managing.
- The physiotherapy team were supported to lead their own professional development, including completion of Masters-level study and attendance at international conferences.
- To help staff communicate with patients, the hospital offered a four-week language course in Arabic.
- The physiotherapy team identified maintaining competencies in treating patients with complex spinal injuries as a challenge as there could be long gaps between such patients. To address this, physiotherapists had attended a specialist centre for spinal care training and the CCOT lead had attended a spinal injury course. This meant staff could meet the needs of patients with a spinal injury when they were admitted at short notice.
- The physiotherapy team delivered annual rehabilitation training to all nursing staff. This was delivered with a registered nurse who could support the physiotherapists with nursing queries and who also conducted competency checks on nurses after the training.

- All CCOT nurses were trained in advanced life support. All resident medical officers held an up to date advanced life support certificate and all staff who worked in critical care had intermediate life support training.
- Every nurse was offered the opportunity to take a post-registration qualification in intensive care nursing. All nurses who were shift leaders had completed a post-registration qualification in intensive care nursing.

Multidisciplinary working

- A dedicated multidisciplinary (MDT) team worked with medical and nursing staff and led a programme of early rehabilitation that ensured patients received tailored, highly specialised care from an early stage after admission. This team included physiotherapists, a clinical psychologist, specialist dieticians, speech and language therapists (SaLT) and occupational therapists. Weekly MDT meetings reviewed patients against treatment goals they developed with the therapies team.
- A tracheostomy team and complex posture and seating team was staffed by specialists and provided patients with targeted support as part of their rehabilitation plan.
- The MDT team had access to medical devices and technology that represented the most recent practice in critical care. This included an innovative, highly specialised ‘Eye Gaze’ system that enabled patients to control computer software with eye movements and fibre-optic endoscopy for the evaluation of swallowing. The Eye Gaze system was specifically modified for a patient who could only communicate with their eyes. This enabled them to communicate with members of the MDT team and for them to work collaboratively in planning care. This enabled the patient to gain a level of independence and engagement in activities they had previously enjoyed, such as writing a blog.
- MDT working led to significant positive outcomes for patients. For example, one critically unwell patient was transferred from another hospital that was unable to meet their needs. Complex MDT involvement and planning, including obtaining a medical history through an interpretation service, resulted in the patient being successfully weaned from ventilation and making a full recovery.

Critical care

- The nurse-led CCOT team provided hospital-wide cover 24-hours, seven days a week. This team responded to patients who were deteriorating and liaised with consultants about emergency admissions to critical care. The CCOT team also provided support to ward staff in using early warning scores effectively. A consultant and medical RMO acted as points of contact for CCOT nurses and provided additional clinical support.
- Physiotherapists worked in all acute clinical areas of the hospital and those with a special interest in critical care had developed the dedicated service. This team predated the establishment of CCOT and had a long-term track record of meeting urgent 45 minute cardiac physiotherapy referrals. The team was available on-call with CCOT to provide urgent care for patients with complex respiratory needs.
- A daily MDT handover took place between nurses, pharmacy, physiotherapy, dieticians and SaLT. This was complemented by a weekly MDT ward round with consultants and a separate meeting between the MDT team to review patients with complex neurorehabilitation needs. During a weekly meeting staff considered each patient's individual social needs as well as their physical needs. For example, physiotherapists and occupational therapists considered devices to enable a patient with rapid-onset muscle weakness to access the internet. Staff also considered the causes of a patient's ongoing agitation from their different professional points of view and planned to obtain further pharmacy support in managing their confusion.
- The CCOT and physiotherapy teams worked together to ensure their skills were used most effectively to meet patient needs. For example, the CCOT team could provide specialist care for spinal patients and the physiotherapy team could lead on tracheostomy weaning plans.
- A consultant microbiologist was available daily and participated in the weekly MDT ward round. This member of staff was experienced in recognising organisms from the Middle East, where many patients came from.
- Clinical staff demonstrated the ability to work with colleagues from other services to ensure patients received the most appropriate care. For example, to

plan a constructive approach to care to meet the complex needs of a patient admitted from outside of the UK, consultant intensivists met with a general practitioner, cardiologist and surgeon from another hospital as well as with the patient's family. This approach resulted in a significant recovery for the patient; an outcome that was precluded in their home country.

Seven Day Working

- All services, including therapies and consultant intensivists, were available on a seven day basis.

Access to information

- All medical staff working in critical care had access to electronic and paper notes, observations and risk assessments. During a medical handover and ward round staff had access to results from blood chemistry, microbiology and radiology as well as to patients' treatment history before admission, including from overseas hospitals.
- Consultants and RMOs used a unified report system that enabled them to access historic patient health reports, test results and observations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff provided care and treatment in line with the hospital's consent policy. Where a patient was unable to provide consent, a best interest decision protocol was available. This enabled clinicians to provide care to meet medical need and included liaison with relatives or social services where appropriate.
- Clinical staff contributed to the hospital's capacity register, which was reviewed weekly by the Mental Capacity Act committee. This enabled staff to ensure patients with reduced mental capacity or who were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation were cared for appropriately.
- Senior staff spoke positively about nurse development in their understanding of mental capacity and DoLS. A matron said, "DoLS and our responsibilities around this are embedded in all our processes now. I've observed great conversations between staff when they've been assessing capacity, especially when someone has a fluctuating mental state."

Critical care

Are critical care services caring?

Good 

Compassionate care

- A previous patient in the unit returned with their family after they had recovered to thank staff for their compassion and told them they remembered the calming voices they heard even when unconscious on the unit.
- All staff in critical care had taken the hospital's dignity pledge and patients told us they felt treated with kindness, dignity and respect. One patient said, "Staff are very caring and I never wait very long when I call for them." Another patient spoke about the impact staff had on them when finding resources to help them communicate. They said, "Staff helped me get this computer and it changed my life. I can speak to them now."
- Critical care patients were encouraged to complete a survey to highlight positive experiences and areas in which the hospital could improve. Between January 2016 and August 2016, 95% of patients said they had full confidence in their nurses, said they were treated with courtesy and said nurses explained what they were doing before giving care.

Understanding and involvement of patients and those close to them

- Physiotherapists were able to initiate sensitive discussions around cost for self-funding patients to ensure they received the most effective care possible. This included discussions with service managers to identify novel funding opportunities and identifying potential discharge problems at the point of admission.
- During a bedside handover we saw nurses involved the patient in their discussion. The nurse taking over the shift introduced themselves and explained what was happening. They also checked the patient was happy with their personal care and made sure they had ordered breakfast. The nurse leaving the shift said goodbye to the patient and wished them the best for their planned discharge later the same day. After the

handover, the nurse explained the discharge plan to the patient and asked if they had any questions. This included a realistic estimate of discharge time and what would happen next in the procedure.

- Staff demonstrated a commitment to ensuring patient needs were met at all stages of treatment. This included providing treatment to keep a patient's airways open for them to discuss palliative care with their family. This was removed on the wishes of the patient, who staff involved in their plan alongside the palliative care doctor and oncology clinical nurse specialist. In the monthly patient survey, 93% of those treated between January 2016 and August 2016 said they felt involved in their care.
- Doctors and nurses had learned some basic phrases in Arabic and were able to use this during interaction with patients on ward rounds, which helped reduce anxiety and put patients at ease. Consultants and RMOs listened to patients during ward rounds and explained test results and treatment plans openly and in a way the patient could understand.
- The physiotherapy team had acted on feedback from patients with regards to transfers within the hospital. For example, patients had expressed anxiety about being moved between critical care units or to an inpatient ward. To address this, the patient's physiotherapist accompanied them during their move and made sure the staff receiving them understood their routine such as what time they liked to be rolled, how they preferred to be hoisted and what time their relatives liked to visit. This helped staff to understand each individual's needs and provided continuity of care.

Emotional support

- Patients had access to a neuro-psychologist and health psychologist to meet their mental health needs. This team also worked closely with therapies staff to ensure patient's emotional needs were met.
- A spiritual care coordinator provided emotional support to patients and relatives, including bereavement support. An end of life care team, including a lead consultant, was available 24-hours, seven days a week.

Are critical care services responsive?

Critical care

Good 

Service planning and delivery to meet the needs of local people

- Critical care staff had prepared a patient and relative's guide to the units. This was detailed and written in clear language that avoided medical jargon. It included details of medical and nursing cover and how relatives could arrange a family meeting. International newspapers and TV channels were available and the unit had internet access.
- The link nurse for diabetes was developing a sliding scale protocol policy for long-term level 3 patients. This would help staff to manage blood sugar levels in ventilated patients.
- Consultants participated in planning strategies to deal with emerging health threats. For example, the consultant team helped develop the guidelines and protocol for treating patients infected with the Ebola virus.
- The critical care outreach team offered an individualised service to elective patients to help reduce their fears and anxiety about their planned admission. For example, a nurse would meet the patient, explain the critical care environment and what to expect. They also offered the patient the chance to visit the unit and meet some of the staff.

Access and flow

- Between April 2015 and March 2016, critical care services reported an average bed occupancy rate of 78%.
- Consultants led discharge planning and identified exit strategies for patients when planning their admission. This meant if a patient could not be safely cared for at the hospital, consultants could recommend a more appropriate hospital.
- Consultants led patient admissions with support from resident medical officers (RMOs) and adhered to the hospital's exclusion criteria. This included a list of conditions for which the hospital was not resourced to safely treat, including certain mental health conditions such as psychosis or suicidal thoughts.

- Between April 2016 and June 2016, there were no non-clinical transfers from either the north or south unit. During the same period the, unplanned readmissions counted for 2% of all discharges, which was significantly better than the national average.
- Less than 0.5% of patients experienced an out of hours discharge or a discharge delayed between four hours and 12 hours. Less than 0.2% of patients experienced a discharge delay of over 24 hours.

Meeting people's individual needs

- Relatives and visitors had access to quiet rooms, rooms for private meetings and facilities for drinks and snacks.
- The physiotherapy team had actively sought greater patient involvement in their care through a change in the model of care they provided. This involved a transition from a solely medical model of care to a holistic model that enabled the physiotherapy, psychology and occupational therapy teams to work more closely with patients to plan their goals. As part of his strategy, the multidisciplinary team met each patient within seven days of admission to establish their non-medical care. This included getting to know each patient as an individual and identifying what was meaningful to them. Patients involved in this process told us they felt in control of their care plan and goals, which was a motivating factor in their recovery. The individualised, re-modelled approach to care and rehabilitation established by the multidisciplinary team had resulted in an increased level of engagement from patients. This included working with them to identify barriers to progress in the traditional medical approach of care. The critical care team had worked to meet the needs of a long-term patient with complex needs. For example, in addition to sourcing innovative communication technology, the team found the patient wanted to have access to films. To facilitate this, they planned to transfer the patient to the hospital's boardroom, where films could be shown on large-scale audio visual equipment. This was completed successfully and safely and led to future plans to consider how the patient could be supported to attend a cinema safely.
- Staff at all levels demonstrated an understanding of how to involve relatives in the care of those close to them. For example, when a female patient was

Critical care

emerging from an induced coma, the physiotherapy team asked their family if they would be more comfortable with a female physiotherapist to meet the patient's cultural needs. In addition, the team established the patient's favourite films and TV shows so they could prepare these ready for when the patient was able to stay awake.

- Staff used a risk assessment to record the actions of patients who presented with signs of delirium. This included an assessment by the consultant or RMO to identify causes of delirium to ensure the most appropriate course of action was taken.
- The multidisciplinary (MDT) team demonstrated a clear commitment to patient communication and interaction. This included investment in alternative and augmentative communication to help patients with physical or communication impairments to interact with staff or make their wishes known. This included an 'Eye Gaze' system that enabled a patient with very restricted physical and communicative capability to form messages to staff.
- The individualised, re-modelled approach to care and rehabilitation established by the MDT team had resulted in an increased level of engagement from patients. This included working with them to identify barriers to progress in the traditional medical approach of care. For example, in the previous model of therapy, a patient may need to sit out of bed for long periods of time despite this being very challenging for them. The new approach meant therapists worked closely with patients to find more effective ways to deliver rehabilitation that did not make them feel uncomfortable.
- The critical care team had worked to meet the needs of a long-term patient with complex needs. For example, in addition to sourcing innovative communication technology, the team found the patient wanted to have access to films. To facilitate this, they planned to transfer the patient to the hospital's boardroom, where films could be shown on large-scale audio visual equipment. This was completed successfully and safely and led to future plans to consider how the patient could be supported to attend a cinema safely.
- Staff had access to translation and interpretation services 24-hours, seven days a week including British Sign Language interpreters. An Arabic translator was available in the hospital and the physiotherapy team had their own dedicated Arabic translator.
- Patients were assessed by a neuro-psychologist or health psychologist within one week of admission. This took place with the multidisciplinary team who used the outcome to decide if the patient could be better supported in a rehabilitation setting or a setting with a psychologist and doctor.
- The neurology lead clinician and physiotherapy team conducted a weekly spasticity ward round to consider the most appropriate interventions for patients.
- Consultants had obtained an independent consultation from a specialist to assess the environment of a patient who had been in the unit for an extended period of time. This enabled staff to check they were able to meet the patient's complex needs.
- Staff demonstrated the ability to meet patient needs in urgent and distressing situations. For example, a bariatric patient suffered a fall in the north critical care unit. Clinical staff assembled 10 members of staff to safely lift the patient, secured a bariatric ambulance to transport them to the south unit for a computerised tomography (CT) scan and ensured they were back in their own bed within three hours.
- The critical care outreach team reviewed patients discharged from critical care to a ward within the first 24 hours and within 48 hours.
- Staff used 'care in progress' clips on bedside curtains to help maintain patient dignity and privacy.
- Staff had a good understanding of the communication needs of patients with a learning disability, including cultural differences and the use of pictures and visual aids to help identify when patients were in pain or needed to make a request.
- Long term patients were issued with a critical care diary, which was also available in Arabic. Staff had adapted the diary based on research with patients about the benefits they gained from them and staff ensured they wrote entries in language that avoided medical jargon.

Critical care

- On-site catering services were available 24-hours, seven days a week and patients had access to food that met their dietary, cultural and religious needs.
- Although there was no formal follow-up clinic, staff invited patients back after their rehabilitation programme to speak with the nurses and doctors who had cared for them and to visit the bed space they had stayed in.
- The practice development nurses and matrons planned in standardise working practices between the units to improve working practices and enable them to share a single workforce.

Governance, risk management and quality measurement

Learning from complaints and concerns

- The complaints procedure and complaints forms were readily available and senior nurses were available to talk to patients and relatives about concerns they had at any time. Between April 2016 and October 2016, there had been no formal complaints.
- In response to patient feedback about the noise in the unit, soft-close lids had been provided and staff kept telephone conversations to a minimum overnight. In addition, electronic key-finders had been installed to enable staff to locate medication cupboard keys without causing a noise disturbance. Patients had also raised the low temperature on the unit as a concern. In response, senior staff obtained a consultation for a new air system and obtained blade-free 'hospital friendly' heaters for safe use in the units.

Are critical care services well-led?

Good 

Vision and strategy for this this core service

- Staff had developed their own vision for critical care, which was displayed on each unit. This outlined their commitment to patient safety and dignified, compassionate care.
- Future medical plans for critical care included scoping the possibility of dialysis treatment in the level 2 south unit and the installation of water points to cater to long term renal patients.
- The south unit had six uncommissioned beds and the senior team included the future plans for the beds in the vision and strategy of the service. This including scoping exercises by senior clinicians for an increase in future specialist activity in line with patient demand.
- The critical care delivery group was a cross-site group within the provider's network that enabled staff to learn from incidents and share good practice through the use of a bulletin and visits. For example, when a critical care unit at one hospital obtained new equipment, staff took it to other units so colleagues could gain experience in its use.
- Multidisciplinary staff from critical care and cardiology met monthly as a patient safety and quality group. This group reviewed incidents, complaints, staff training needs and any other element of the service operation that affected service, such as items on the risk register. The minutes of meetings showed feedback from staff and patients was acted on and senior staff ensured issues raised by staff were resolved.
- The senior team managed a risk register for critical care and used this to identify risks to the service, patients or staff. At the time of our inspection, there were three active risks on the register. These related to a reliance on temporary nurse staffing, a risk of harm to patients in the units on a long-term basis as a result of sub-optimal bone density management and a variance in RMO practice in relation to taking bloods. Each risk had an appropriate person responsible for resolution and there was evidence progress was made safely and in line with patient needs. For example, a new service manager was tasked with ensuring each RMO received an induction that enabled them to perform blood tests to standardised hospital protocols. This had resulted in a reduced number of incidents and RMO competencies were monitored through clinical study days and clinical educators.
- Clinical staff described varied opinions of clinical risk governance structures. Nurses said they felt clinical risk was well managed from their point of view and they felt informed by senior staff of changes in the department. A doctor said they felt there was limited oversight of clinical risk. They told us, "The clinical governance

Critical care

process in this hospital is not functioning. I have never seen a clinical risk summary or had any contact from senior management about how they're addressing risks."

- The patient safety quality board had ratified a new bone density protocol for patients with a long critical care stay. The protocol enabled staff to perform early measurements of bone density and calcium, which reduced the risk of fractures. The corporate manual handling specialist had delivered training in the new protocol to all staff and the efficacy of the protocol was due to be audited in October 2016. This represented a sustained and robust approach to ensuring patients were protected from harm through the effective management of the risk register.
- The resuscitation committee met every three months and reviewed each cardiac arrest in critical care for opportunities for learning.

Leadership and culture of service

- The critical care, cardiology and acute admissions units' divisional structure was overseen by the clinical services manager, and supported by the chief nursing officer. A clinical services manager provided governance, risk management and quality oversight for both units and was supported by two matrons. Each matron had a dual role. The matron for the north unit was also responsible for the critical care outreach team and the matron for the south unit was also responsible for the acute admissions unit.
- Most of the staff we spoke with described a supportive and responsive leadership team that valued their contribution. For example, one nurse said, "This is the first time I can see myself progressing because of the support I have and opportunities for development."
- Supportive and motivational leadership was evident on the units. During a handover the nurse in charge encouraged staff to provide mutual support and checked everyone was happy with their allocation before the shift began.
- Staff described a flexible working environment in which they were encouraged to have a positive work-life balance along with their other commitments.

- A consultant said, "One of the best things about this hospital is the 'can-do' attitude of everyone. It doesn't matter if it's the CEO or a porter or a nurse, everyone is here to help each other and of course the patients."
- The matron at each site worked closely together as part of the local quality board and planned to rotate in clinical shifts between their respective units from December 2016. This would enable them to develop their skills in the different units.
- Senior clinicians spoke positively about the culture of critical care services. One consultant said, "We have a triangulation here of managers, medical staff and corporate staff who all work really well together."
- The matrons and clinical services manager interviewed nurses who left the service to identify any patterns or areas of concern that could help them to reduce the turnover of staff. They told us the most recent resignations had been as a result of changes in personal circumstances of the staff, who had no negative feedback about their time at the hospital. The senior team worked with existing and new nurses to ensure their shift pattern and responsibilities enabled them to achieve a positive work life balance. They also tried to identify any potential challenges in managing shifts during the interview process so that appropriate adjustments could be made to accommodate the member of staff.

Public and staff engagement

- Monthly unit meetings took place that involved all staff and included a focus on staff training and support needs.
- The matrons asked each member of staff on joining the unit what their personal and professional goals were and used this information to plan development and training. For example, one nurse had been supported to start their BSc in intensive care studies within six months of joining the team.
- The senior team conducted an exit interview with each member of staff who left the service as a strategy to identify any patterns in the causes of staff turnover. They had identified a reduction in activity in the north unit

Critical care

that caused some nursing staff to move to healthcare providers they felt could provide a greater case mix of patient care. In response, the hospital provided more specialist training for remaining staff.

- The matrons operated a monthly 'Excellence in Care Awards' programme that rewarded staff for team work based on votes from colleagues. This included recognition of the winner and a prize as a strategy to foster motivation and good working relationships.
- Matrons participated in the hospital's 'clinical Friday' strategy to encourage senior staff to work with their teams clinically rather than book meetings. Critical care matrons used this time to speak with each member of staff on shift and to complete environmental checks throughout the units. Matrons and senior nurses also used this time to complete peer reviews of areas they did not usually work in. This process was used to assess quality standards.






Innovation, improvement and sustainability

- Senior staff demonstrated a focus on continual development and service sustainability. For example, the physiotherapy team traditionally employed only experienced, senior therapists. However, following a successful trainee physiotherapist placement scheme, a junior member of staff was recruited after performing well. This was the first time the hospital had employed a junior therapist and senior staff provided a structured framework of support and development so they could practice safely and develop their skills. The matrons had recruited a newly qualified nurse directly after they

successfully completed a period as a student nurse at the service. This process had worked well and the senior team were establishing a recruitment protocol to recruit nurses in the same way in the future.

- The physiotherapy team had completed a feasibility study to reduce hypotension with the use of a robotic leg attached to a table. This was intended to address the needs of patients who experienced instability after being administered high levels of inotropes. The study was trialled with a patient in ITU, staff were asked for their feedback and staff presented the findings to colleagues in the hospital at a poster presentation.
- Staff had the freedom to identify self-development projects, such as a nurse who wanted to lead on the introduction of a new electronic patient records system to maintain their development.
- A CCOT nurse conducted sepsis research as part of their Masters programme and used this to develop the new sepsis pathway.
- The units relied on nurses from overseas to operate with safe staffing levels. Senior staff were aware this meant nurses could sometimes resign from their post to go home. As a strategy to retain nurses, the matrons offered a period in which nurses could change their decision to leave the unit without a new application process.
- The matrons developed strategies to retain band seven nurses by ensuring they were offered appropriate development opportunities. This included two funded Masters programmes each year and the opportunity to join the outreach team and lead on audit programmes

Outpatients and diagnostic imaging

Safe	Good 
Effective	Not sufficient evidence to rate 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients and diagnostic imaging services safe?

Good 

Incidents

- There were no Never Events reported within medical services. 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 type 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 occurrence for that incident to be categorised as a never event.
- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents. Incident reporting training was included in the staff induction programme, which all staff attended when they commenced employment at the hospital.
- Staff across the OPD and diagnostic services were able to identify and describe situations requiring completion of an incident form. Staff told us there was a good reporting culture and that they were encouraged to report 'near miss' situations in addition to incidents that had occurred.
- Outpatients and diagnostic imaging services (OPD) reported 144 clinical incidents and 25 non-clinical incidents between April 2015 and March 2016. The rate of clinical incidents was higher than the rate of other independent acute providers.
- There had been no Serious Incidents as defined by the hospital's incidence reporting policy reported in the previous 12 months.
- There had been no reported IR(ME)R incidents reported in the previous 12 months
- We looked at incident investigation reports, which included a detailed chronology of events, investigation and root cause analysis. There were recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the hospital.
- We saw nursing staff using sliding sheets in the MRI department which had resulted from radiology staff completing an incident report form following a 'near miss' incident.
- We saw learning from an incident involved the mis-labelling of a skin biopsy in the OPD. Nurses told us they now used an adapted version of the World Health Organisation (WHO) checklist to ensure procedures were followed to ensure correct patient labelling.
- Changes in radiology and OPD had occurred due to a patient fall. This included escorting patients in and out of the OPD when they did not have relatives with them.
- The hospital produced a quarterly clinical operating report. The report reviewed and monitored key performance indicators (KPI) on a quarterly basis such as mortality and incidents. We viewed the report for quarter one, January 2016 to April 2016 and saw incidents and learning was discussed.

Outpatients and diagnostic imaging

- Incidents and learning from incidents were discussed in monthly imaging radiation protection committee meetings. For example in nuclear medicine a patient had signed to confirm they were not pregnant, however it was noted when the scan started the patient was pregnant. We saw actions taken from this including patients signing a separate scan and pregnancy form that included an escalation process.
- Incidents were a standing item on the agenda of the daily hospital operational meeting, which occurred every weekday morning.
- 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.
- All staff we spoke with had good awareness of duty of candour requirements. Staff explained that patients would be informed if an incident occurred, given an apology and told an investigation would take place. Staff were able to give examples of incidents where the duty of candour requirements had been applied.
- The hospital had policies and procedures in place to manage infection prevention and control, which all staff had access to. We saw policies and processes for the management of waste and decontamination and staff followed them in practice
- Staff attending clinical areas adhered to "bare below the elbow" guidelines. We saw staff using alcohol hand gel before and after patient contact. However staff in the radiology department did not wash their hands with soap and water following contact with a patient with clostridium difficile (C. Diff).
- There were sufficient hand washing facilities including hand wash, antibacterial hand gel and moisturiser located in prominent locations around the departments.
- Compliance with good hand hygiene practice was checked through monthly audits. The hand hygiene audit was an observational audit undertaken by infection prevention control link practitioners. They observed instances of the WHO five moments of hand hygiene undertaken in clinical areas. Information provided demonstrated all areas of OPD, diagnostic imaging and the breast care unit were compliant against trust targets of over 90% between January 2016 to June 2016. The breast care unit achieved 100% compliance throughout this period.

Safety Thermometer

- The hospital did not use the NHS Safety Thermometer (a tool which measures harm to patients which may be associated with their care). However, the hospital had developed a dashboard which monitored patient safety relating to pressure ulcers, falls, catheters, urinary tract infections and venous thromboembolism.
- We saw dashboards for the OPD, diagnostic imaging and breast care unit. We saw that no falls had been reported in the previous four months.

Cleanliness, infection control and hygiene

- All of the clinical and waiting areas we visited were visibly clean and tidy.
- Data provided demonstrated 94% of staff had completed infection control training. This exceeded the hospital's minimum requirement of 90% of staff.
- Cleaning checklists were available in all OPD areas and were fully completed for the months of July 2016 and August 2016.

- In the breast care unit staff completed a daily cleaning schedule for the ultrasound room, mammogram room and clinical room. Cleaning schedules were signed with no omissions and green 'I am clean' stickers were dated, signed and applied to equipment.
- The hospital reported no incidents of MRSA or MSSA in the period April 2015 to March 2016. During the same period there were nine incidents of E-Coli and four incidents of hospital-acquired C.Diff.
- Some consulting and assessment rooms in the platinum medical centre (PMC) were carpeted. There was a blood trolley in a room that was carpeted and each consulting room had a couch for clinical examinations. This did not meet Department of Health guidelines that state carpet should not be used in clinical areas.
- Personal protective equipment, such as gloves and aprons, was readily available for staff in all clinical areas. The equipment helped to ensure safety and reduce risks of cross infection during procedures.

Environment and equipment

Outpatients and diagnostic imaging

- The outpatients department was well designed and maintained. Patient waiting areas were clean with sufficient seating for both patients and relatives. In the breast care unit there was less space and we saw patients and their relatives seated in cramped areas. There was an improvement plan to increase space and this had been considered and was part of the business plan.
- All items of equipment checked were labelled with the last service and review date and had a number to allow easy tracking if it needed servicing or maintenance. We saw examples of local registers listing equipment within each department. The hospital had robust arrangements for servicing and repairs of equipment. Staff told us the hospital was quick to respond when equipment needed servicing or replacing. For example there had been several updates of equipment within the radiology department.
- In the diagnostic imaging department, specialised personal protective equipment was available and used in radiation areas. We saw that staff wore personal radiation dose monitors.
- We saw audits completed every six months accessing safety compliance of all lead gowns and thyroid shields in the diagnostic imaging departments.
- All clinical staff we observed in the radiology and radiotherapy departments had a valid in-date radiation monitoring badge.
- Signs in the diagnostic imaging department identified when x-rays were being taken, with a warning not to enter the room.
- Radiology staff were able to demonstrate that procedures were in place for the safety testing of all diagnostic equipment on a daily, monthly and annual basis.
- Resuscitation equipment was located in each department on a trolley. The trolley was sealed with tamper-proof tags. We saw a daily check sheet that recorded the trolley had been checked to ensure equipment was available and in date.
- There was no separate waiting area for children in the OPD. However, nursing staff were able to demonstrate that all children were seen within 10 minutes of arrival to mitigate concerns that they were waiting with adult patients.
- Appropriate play areas with age appropriate toys were available on each OPD floor in the PMC.
- We saw fully completed quality assurance logs for the x-ray unit, CT scanner, magnetic resonance imaging (MRI) scanners and PET-CT scanner.
- Monthly environmental audits were completed in the OPD and diagnostic imaging departments with action plans completed. For example in September 2016 the environmental audit for the PMC demonstrated a 92% compliance with action plans including to add a clinical waste bin and to fix a crack in the wall.
- Adult and paediatric emergency grab bags were available on each floor. We saw daily checks occurred and daily logs were fully completed with no omissions.

Medicines

- Staff we spoke with were aware of the medicines management policies and the systems in place to monitor stock control and report medication errors.
- Medicines in the OPD were stored securely in locked cupboards. All medicines were found to be in date. There were no controlled drugs used in this area of the hospital.
- Contrast media and medicines were safely stored in the diagnostic imaging department. Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography. All medicine cupboards were locked and the keys held securely in the department, which staff had appropriate access to.
- Radiographers were authorised to work under patient group directions (PGD) to administer contrast media and other medicines required during diagnostic imaging processes. PGDs are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition.
- There was no medication used in the children's services. Staff confirmed that any children requiring pain relief would be seen at other hospitals operated by the same company.

Records

- There were two electronic patient record systems used within the OPD. Nurses and doctors used separate systems to record patient care and nurses transcribed relevant information onto the main system.

Outpatients and diagnostic imaging

- Nurses in the OPD department told us records were always available for scheduled appointments. Data provided demonstrated patients were only seen in the OPD if all medical records were available.
- We reviewed five sets of patient records, all of which contained details of past medical history, allergies, infection control, medicines and discharge planning.
- Records held by the hospital were stored securely off site by the medical records department. When records were in the outpatient department they were either held in the consulting/treatment room with the relevant practitioner or stored in securely behind the nurse's station.

Safeguarding

- Staff we spoke with were aware of how to access the safeguarding policies on the hospital's intranet. Nursing and allied health professional staff we spoke with were able to identify different types of abuse and were aware of how to escalate concerns.
- Adult safeguarding training was part of the hospital's mandatory training programme and 100% of staff in the OPD were up to date with this.
- According to the hospital policy, all staff involved in the care and treatment of children should receive level three safeguarding training. However, information provided to us demonstrated 80% of staff had completed level two training and we were unable to verify staff who had received level three training.
- There were laminated flow charts for staff, should they have a safeguarding concern, available in all clinical areas we visited. These included where to seek advice within the hospital and all relevant contact numbers. The posters demonstrated a clear escalation flow chart for both adult and child safeguarding.
- The nominated lead for safeguarding was the chief nursing officer and in their absence the clinical service manager for the hospital site. The provider also employed an organisational-level safeguarding lead and named doctor. There had not been any safeguarding concerns raised within OPD or diagnostic services in the 12 months prior to our inspection.
- There were designated level four trained department leads for both adult and child safeguarding. Staff demonstrated they were aware of who the leads were and we saw posters with contact details available throughout the departments and services.

- Nursing staff told us they had received recent training on female genital mutilation (FGM) awareness and were aware of how to be vigilant in relation their most at-risk patients. Staff had an understanding of the procedures to follow which included informing the gynaecology lead nurse and raising an immediate safeguarding alert.
- The hospital reported no safeguarding concerns to CQC for the period July 2015 to August 2016.

Mandatory training

- Mandatory training included health and safety, fire, manual handling practice, infection control, customer care and control. All staff were expected to complete life support training annually. Depending on their role staff completed training at either basic, intermediate or advanced level.
- Consultants completed their mandatory training at the NHS establishment they routinely worked at. They were required to provide evidence of completion of mandatory training to the hospital and medical advisory committee (MAC). The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced. We saw examples of emails to consultant reminding them to provide evidence within a certain time period to ensure the practicing privileges were not cancelled.
- Mandatory training compliance rates for the OPD and diagnostic imaging services demonstrated completion rates of 90% or above for all staff in mandatory training topics. In the breast unit the overall mandatory training compliance rate for all mandatory training topics was 82%, which was below the hospital target of 90%.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- Staff completed daily safety assurance checklists in each area we visited. Checklists prompted the nurse in charge to ensure there was safe staffing, emergency equipment was checked, fire exits were clear, emergency alarms were working and equipment was clean.
- In the therapies department all staff completed scenario-based training at least every six months to plan

Outpatients and diagnostic imaging

for a deteriorating patient in the hydrotherapy pool. Therapy staff we spoke with were confident describing the actions they would take if they needed to get a patient out the pool in an emergency.

- The x-ray department undertook patient safety questionnaires before commencing MRI scans. The purpose of the questionnaire was to ascertain if the patient had any metal objects in their body so the clinician could assess whether it was safe for them to have the scan. Staff also asked patients verbally whether they had any metal objects in their body.
- We observed the six point IR(ME)R check list completed prior to all imaging procedures.
- We saw large pregnancy radiation warning posters displayed with information in 10 different languages.
- Staff followed adapted WHO checklists to ensure the right patient received the correct radiological scan at the right time. Staff showed us examples of checklists that had been completed and these were audited regularly.
- WHO checklists were used for appropriate procedures within the radiology department. We saw WHO checklists completed for procedures such as peripherally inserted central catheter lines, central line insertions, lumbar punctures, epidurals, percutaneous nephrostomies and angioplasties. We saw audits on WHO checklist compliance completed weekly with a high compliance rate, including 96% for August 2016.

Nursing/AHP staffing

- Outpatient departments do not have set guidelines to follow on the number of nurses required to run safely. Senior nursing staff told us staffing was flexible depending on activity and that bank and agency staff were booked when required.
- There was variable use of bank and agency staff for inpatient nurses for the period July 2015 to August 2016. This meant the rates were mainly worse than the yearly average of other independent acute hospitals CQC holds this type of data for. However, there was low use of bank and agency staff in respect of health care assistants for the same period. The use of bank to agency ratio was 8.2 bank nurses to 1 agency nurse. This meant the majority of temporary staffing were utilised from the hospital bank service rather than nursing agencies.

- There were no agency health care assistants working in outpatient departments in the three months prior to our inspection.
- Consultants in OPD told us nurse staffing was not always adequate to provide support to their patients when the department was busy. Two consultants who regularly worked in the OPD told us more staff were needed to improve the service.
- The breast unit had only one mammographer, which meant if they were on annual leave or sick leave there would be no provision to provide mammography. An experienced bank mammographer had joined the team the week of the inspection who would be supporting clinics on Mondays and Tuesdays. We saw that mammographer staffing was appropriately listed on the department's risk register.
- There were two WTE nurses within the paediatric services with one vacant post which was advertised at the time of inspection. We were told that this was not a sufficient number of staff to ensure paediatric nursing cover for every child.
- Across the diagnostic imaging services we saw that there were two radiographer vacancies and in the OPD there were three nursing vacancies.
- The average sickness rates across the OPD and diagnostic imaging services was 1.57%, which was lower than the national average.

Medical staffing

- The hospital employed 907 medical staff working under practising privileges. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. We were not given information regarding the number of consultants who worked in the outpatients and diagnostic imaging departments.
- The hospital employed 9 resident medical officers (RMOs). RMOs are doctors of varying experience that are full time hospital employees. The RMO's provided medical cover in case of patients needed to be seen urgently due to a deteriorating condition.
- There was a thorough and robust system in place to ensure consultants with practicing privileges complied with their annual appraisal. We saw examples of consultants whose appraisal was due where the hospital sent reminders. Doctors told us practice would be withdrawn immediately if appraisals were not kept up to date.

Outpatients and diagnostic imaging

- There were sufficient consultants to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital OPD and administration team.

Major incident awareness and training

- The hospital had a business continuity management plan approved by the senior team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- This hospital major incident plan covered major incidents such as loss of electricity, loss of frontline systems for patient information, loss of information technology systems and internet access, loss of staffing and loss of water supply. The hospital was not a receiving hospital for a local major incident.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

Evidence-based care and treatment

- Care and treatment within outpatients (OPD) and diagnostic imaging departments was delivered in line with evidence based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute of Health and Clinical Excellence (NICE).
- We saw patient protocols and pathways in the breast unit reflected best practice and evidence based guidelines including The Royal College of Radiologists (RCR), The Royal College of Surgeons (RCS), NICE, national screening guidance and The British Association of Aesthetic Plastic Surgeons (BAAPS).
- A comprehensive audit programme in the radiology department included report turnaround times, World Health Organisation (WHO) checklist completion, image quality and request form completion.
- We saw monthly hand hygiene audits based on local and national guidelines which included the provider's hand hygiene policy, WHO guidance and epic 3 guidance.
- The radiation safety policy contained relevant and up to date information. The policy was reviewed every 2 years.

It took into consideration relevant legislation, regulations and guidance such as The Ionizing Radiations Regulations 1999; The Ionizing Radiation (Medical Exposure) Regulations 2000 (IRMER); Radioactive Substances Act Guidance issued by the Environment Agency; The Ionizing Radiation (Medical Exposure) Regulations (2000) Guidance and Good Practice issued by the Department of Health; and guidance published by the Health and Safety Executive.

- Radiotherapy pathways and prescription doses all followed professional body and NICE guidelines.
- Safety alerts were received by the diagnostic imaging manager. All relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings.
- We saw examples of evidence based care in the therapies department and staff had presented a range of new treatment initiatives at national and international conferences.
- We saw evidence that IR(ME)R audits were undertaken as required by the regulations and action was taken as a result.
- Audits of compliance regarding IRMER were completed for the radiology department and PET/CT centre. We saw evidence that IR(ME)R audits were undertaken and actions taken as a result of these.

Pain relief

- Resident medical officers were contactable via the hospital bleep system to assess patients and prescribe relevant medication in cases requiring urgent attention. If the patient's consultant was available more quickly they would assess the patient and provide necessary treatment.
- In the therapies unit there was no current pain management provision. Physiotherapists told us patients who needed pain management input would be seen at one of the provider's other hospitals..
- No medication was used in the OPD department for paediatric patients and. It was clear within the hospitals remit that no medications were used for paediatrics. Paediatric patients with acute pain were not seen and were referred to a sister hospital for treatment.

Patient outcomes

- The hospital in collaboration with others in the provider group published the Breast Quality Framework Report, which contained outcome data collected as a

Outpatients and diagnostic imaging

retrospective audit of breast cancer patients treated in the period of 2010 to 2014. The hospital was working collaboratively with Public Health England to collate and publish patient survival rates.

- Data provided demonstrated all diagnostic images were reported within 24 hours unless a specific consultant was requested by the patient and all images were quality checked before the patient left the department. This demonstrated compliance with the national guidelines for radiological reporting.
- Mammograms undertaken in the breast unit had a better than the national average PGMI (perfect, good, moderate, inadequate) score. PGMI is a widely used tool within Europe for quality evaluation and classifying mammograms. The purpose of the PGMI assessment is to monitor, achieve and maintain high quality images.
- Information provided demonstrated 100% of mammograms in the breast unit were double reported by consultants in line with breast screening guidance.
- Radiologists were working on analysis of 3T knee MRI to determine whether it provided additional detail to surgeons prior to surgery and therefore better patient outcomes. This was in the process of being submitted for publication.

Competent staff

- Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- Appraisal rates for the year April 2015 to March 2016 were 100% for nursing staff healthcare assistants and allied health care professionals, which included physiotherapists and radiography staff.
- Staff told us the induction process was comprehensive including department tours and introductions to heads of department and colleagues, which we confirmed by looking at records. Staff were supernumerary for a period during their induction.
- The registered manager and medical advisory committee followed a process to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The registered manager reviewed the competencies and skills biannually. This included review of outcomes, appraisal and revalidation.

- In diagnostic radiology all staff members were trained across every modality. This ensured that staff had the opportunity to expand their knowledge and skills across a broad range of services.
- We saw examples of detailed and comprehensive competency booklets in use within the radiology department. These included competencies for all modalities including MRI, CT, DSA and x-ray. We also saw detailed lists of all equipment where training was indicated.

Multidisciplinary working

- Multidisciplinary (MDT) working was evident throughout OPD and diagnostic imaging services. In the breast clinic we saw consultants, nurses, radiologists and psychologists all working together to coordinate a one stop shop clinic for their patients. MDT meetings were held regularly and a MDT coordinator had recently been recruited to organise these meetings
- Regular consultant-led MDT meetings were held to discuss patients based on their treatment area. We saw evidence of multiple MDT meetings that were held throughout the week and found them to be robust and to represent patients' best interests.

Seven-day services

- Seven day a week outpatient services were not provided. The OPD ran clinics Monday to Friday from 8am until 8pm and on Saturday from 8am until 2pm.
- The radiology department did not provide a seven day service. The diagnostic imaging department ran Monday to Friday from 8am until 8pm and on Saturdays from 8am until 3pm. However, an on-call service was provided seven days a week and on-call staff were available within 30 minutes from the hospital.
- The breast unit did not provide a seven day service. The breast unit was open Monday to Friday from 9am to 5pm except for Tuesday, when appointments were available from 1pm until 9pm..

Access to information

- The radiology department used a nationally recognised system to report and store patient images. The system was used across the hospital and allowed local and regional access to images for reporting.
- Staff in the radiology department told us radiology request forms were constantly modified to reflect changes in practice or lessons learnt from previous

Outpatients and diagnostic imaging

incidents. For example the addition of 'high falls risk' 'previous imaging checks' 'mental capacity' 'blood results' and source isolation' sections had recently been added.

- In the radiology department we saw radiology procedure patient information leaflets which were available in both English and Arabic. Staff told us they were able to provide these leaflets in other languages upon request.
- We saw patient information leaflets available in the OPD. These all referenced best practice guidelines and had clear review dates.
- Television screens in departments provided patients with a range of information including board members, dignity pledge and translation services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) guidance was covered in the mandatory safeguarding training. Staff demonstrated a good understanding of their responsibilities with regard to the MCA. and 100% of staff had completed MCA and DoLS training.
- The consent process for patients was well-structured, with written information provided before consent being given. Patients told us they received relevant information, both verbal and written, to make informed decisions about their care and treatment.
- We observed staff in the diagnostic imaging department obtaining consent from patients before starting care or treatment. We noted that staff explained the planned procedure and interacted well with the patient to obtain consent for example before for x-rays, outpatient procedures and physiotherapy treatments.

Are outpatients and diagnostic imaging services caring?

Good 

Compassionate care

- Staff took all possible steps to promote patients' dignity and they were given privacy at all times. All clinical activity was provided in individual consulting rooms and doors were always closed to maintain privacy and confidentiality.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- Patients who attend The Wellington Hospital are encouraged to complete a patient satisfaction survey. Data from this is collected by an external company and we saw monthly reports displayed in staff areas of each department.
- Departments had also created their own versions on patient feedback questionnaires. We saw these in the breast unit and also saw that the children's service had developed child friendly feedback questionnaires.
- We saw positive feedback comments from patients in staff areas. Comments included 'first class treatment by the full team', 'Staff are professional helpful and efficient', and 'fantastic service in every way'.
- In the breast unit a patient commented 'a very traumatic experience made bearable by support. Staff were compassionate, supportive and the information I was given was truly outstanding'.
- Patients we spoke with were overwhelmingly positive about the service. Patients told us they felt staff were "excellent" and that they are always polite and courteous.
- Friends and Family test scores for July and August demonstrated 100% of patients would recommend the services to a friend or family member.

Understanding and involvement of patients and those close to them

- Nurses and clinical support staff told us they had developed a dignity project where they reviewed the care philosophy and developed a 'commitment to care' in the form of a dignity pledge. The dignity pledge was launched on international nurse's day where staff signed the pledge which outlined their commitment to providing excellent care to every patient.
- Patients and their relatives were encouraged to be involved in decisions made about their care and treatment. We observed staff taking time to ensure that patients and relatives felt involved in the individual's treatment plan.

Outpatients and diagnostic imaging

- During our inspection, we saw there was a wide range of health promotion literature in waiting areas. In the breast care unit information packs were pre-prepared for patients to take home. Literature we sampled in the OPD, diagnostic imaging and breast care unit departments were up to date and referenced appropriate national guidance.
- In the OPD there was ample seating in the waiting area and access to tea and coffee. Reception desks were a sufficient distance away from waiting areas so patients could speak to receptionists and staff without their conversation being overheard.

Emotional support

- Data provided demonstrated 97% of patients said they were greeted promptly and courteously on arrival at the department.
- When we spoke to staff, it was clear they were passionate about caring for patients and that they put the patient's needs first, including their emotional needs. In the OPD nurses were available to comfort patients who had received bad news.
- The hospital provided emotional support to patients. Patient appointment times in the OPD were planned to allow sufficient time for explanation and reassurance. Staff said they liked working at the hospital because they had time to talk to patients, and try to relieve their anxieties.
- The breast cancer specialist nurses provided skilled clinical and emotional support for both patients and their families. We saw nurses offering patients opportunities to ask questions and time was given for staff to identify any emotional support needs for either the patient or their families.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by the hospital. In the breast unit there was a vast amount of information from multiple charities and agencies to assist patients.
- Staff in the breast unit were able to discuss in detail their patient population and demographics. Nurses were able to give clear examples of how they had adapted services to meet the needs of these groups of patients.
- Radiologists told us they gave lectures to local general practitioners and physiotherapists on when it was appropriate to request CT and MRI imaging for their patients.

Access and flow

- The consultants' secretaries arranged patient appointments with the outpatient reception team. They liaised with patients and gave them a choice of the day and time of their appointment.
- In the radiology department we saw patient lists where free appointments were kept available to ensure access to diagnostic imaging was available for all inpatients and outpatients who required this. We saw patient feedback that demonstrated patients had been offered these appointments.
- There was no formal system in place to inform patients if a clinic was running behind schedule in the OPD. Outpatient nursing staff told us they would advise patients as they arrived for their appointment if clinics were running late. Information regarding how long patients waited was not captured and therefore could not be audited to identify good or poor practice.
- We saw waiting time audits completed per clinician in the OPD. Results for July to August 2016 demonstrated the average waiting time to be between 10 to 15 minutes. Staff told us it was normal procedure to complete an incident form for all patients waiting over 20 minutes.
- In the radiology department detailed waiting time audits were performed. Audit results demonstrated 95% of patients in September 2016 were seen either before or at their appointment time.

Are outpatients and diagnostic imaging services responsive?

Good 

Service planning and delivery to meet the needs of local people

- The provider's international office managed all aspects of care of international patients. This service was designed to meet the needs of the large demographic of international patients the hospital received.
- Services were planned around the needs and demands of patients. Outpatient (OPD) clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.

Outpatients and diagnostic imaging

- Rapid access pathways were in place between the breast units and plastic surgeons for the provision of complex surgery.
- Audits on radiology reporting times demonstrated 92% of images were reported within 24 hours. Information demonstrated that the 8% which had not been reported on within 24 hours was due to specific consultants being requested by patients.
- The hospital did not monitor did not attend (DNA) rates for adults in the OPD. All children with a DNA status were followed up with a phone call.
- The hospital did not have cancer target monitoring or benchmarking for outpatients or diagnostic imaging.

Meeting people's individual needs

- Pre-assessment nurses in the OPD alerted the ward about patients living with dementia or a learning disability so they could organise the required support to meet the patient's individual needs.
- Staff used a hospital wide daily operational meeting to identify any patients in the hospital or coming into the hospital with additional needs that needed responding too.
- Nurses in the OPD told us the booking team would inform them of any patients requiring additional support prior to the patients' appointment to ensure everything was in place.
- In-house interpreters were available for patients who spoke Arabic although we did not see any posters advertising this service. Information provided by the hospital and senior members of the hospital team advised us a telephone interpretation service was available to interpret for other patients. However, in the OPD we spoke with three nurses who told us this was not available and who were unsure what they could do for a patient who turned up without an interpreter with any other language except Arabic.
- We saw all outpatients and their family members offered a food menu including sandwiches, wraps and hot and cold beverages free of charge whilst waiting for examinations and consultations.
- The chef catered for the needs of patients with specific dietary needs for religious, cultural or medical reasons. We saw examples of patient menus with varied food options available.
- The specialist breast care service provided patients with tailored advice, support and care from initial referral through to diagnosis and treatment of breast cancer,

which met both the physical and psychological needs of the patient. The unit offered a symptomatic and mammography service supported by a multidisciplinary team.

- Consultants discussed dates for surgery and treatment with patients at their outpatient appointment. Patients could choose to have their operation at a time suitable to them.
- Physiotherapy staff told us that rehabilitation treatment in the neurology rehabilitation centre was planned to meet the individual needs of each patient. We saw examples of rehabilitation plans that demonstrated this including hydrotherapy treatment scheduled at the end of the week to help the patient relax before the weekend.
- Radiology staff operated a daily outreach service. This involved radiographers visiting each floor to discuss any patients coming for diagnostic imaging that may lack mental capacity, be at high risk of falls or require special assistance. This was documented and filed in each viewing room to ensure all staff were aware of the patients.
- The diagnostic radiology department provided a 'trial' scan service where patients could come and lay on the scanning table and experience going in and out of the scanner before their actual appointment. This was offered free of charge and enabled patients to get a sense of the environment and ensured staff could provide necessary tailored support of the day of the patients scan.
- During an MRI scan the hospital was able to provide music or audio versions of the Bible and the Koran for patients to listen to whilst in the scanner. Patients were also able to bring their own music or audio.

Learning from complaints and concerns

- The hospital provided information about how to raise a concern or make a complaint in pre admission information and was also displayed in the hospital.
- Nursing staff told us they aimed to resolve concerns in a timely way to improve the patient experience and prevent a formal complaint.
- The hospital received 43 complaints in the period April 2015 to March 2016, three of which were referred to the Independent Healthcare Sector Adjudication Service (ISCAS). The number of complaints was less than other similar independent hospitals.

Outpatients and diagnostic imaging

- Staff were fully aware of the complaints process and told us the chief executive officer and the chief nursing officer took overall responsibility for complaints, supported by the patient experience manager.
- We saw examples from all departments where there had been learning from patient complaints and concerns. For example in the radiology department they had changed from slippers to non-slip socks and provided patients with scrub bottoms to cover their legs.
- The monthly complaints and patient experience committee was attended by senior management staff and used to discuss trends and issues highlighted in the patient satisfaction survey and specific complaints. We saw examples of improvements identified from the patient satisfaction survey, which included changes to catering services.
- Learning from complaints was cascaded via a monthly patient experience report. This report was discussed in divisional meetings at the patient safety quality board and at local meetings. We saw copies of ward meeting minutes where this had been discussed.
- Managers in the OPD, radiology and physiotherapy departments had clinical roles and were easily accessible. Staff reported good support and guidance from their managers. Managers were passionate about their teams and caring for their patients.
- Many staff had worked at the hospital for a long time and said it was a good organisation and hospital to work for. Staff spoke positively about the teamwork they experienced at the hospital. Staff said they felt respected and valued and senior staff and management encouraged them to complete further training and qualifications.
- All staff we spoke to were very positive about the chief executive officer and chief nursing officer and senior management team. Staff said senior managers were very visible on the wards and approachable. They operated an 'open door policy' and 'clinical Fridays' and encouraged staff to raise concerns directly with them.
- Staff said they worked well as a team and felt supported by their immediate managers who lead their departments well. Staff we spoke with across OPD and diagnostic imaging services told us the best thing about working in the hospital was the team work, many of whom told us it was like an extended family.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships with the management team. Consultants were complimentary about the nurses and allied health care staff telling us everyone worked together to achieve the best care possible for patients.
- There was a lead nurse for the outpatients' paediatric services. Consultants and nurses were complimentary about the improvements she had made for the paediatric patients attending the services. For example, we saw evidence of waiting time audits to ensure children were not waiting for longer than 15 minutes for their appointments.

Are outpatients and diagnostic imaging services well-led?

Good 

Leadership / culture of service

- An imaging manager led diagnostic imaging services in the inpatients department and outpatients department (OPD). He was supported by a clinical lead in nuclear imaging and a clinical lead in radiology. Superintendent radiographers were in post to supervise the day to day running of the departments.
- The breast unit was managed by a clinical nurse specialist who was also actively involved in daily clinics.
- The OPD was managed by the modern matron for outpatient and oncology who reported to the outpatient and oncology services manager. The day to day running of the department was the responsibility of the department managers.

Vision and strategy for this this core service

- We saw current and detailed strategic plans in place for each department we visited. For example the breast care team were working with the hospital marketing team, surgeons, radiologists and referrers to promote, develop and expand the service.

Outpatients and diagnostic imaging

- Staff had clear ambition for their services and were aware of the vision for the departments. In the diagnostic radiology department, AHP staff were clear and succinct in detailing the vision for the future. This included the on going upgrade of equipment, increasing the number of staff, providing optimal imaging across all sites and improving services by purchasing a biplane angiography machine to enable faster treatment.
- Staff were aware of the corporate provider's values of integrity, respect, equality, appreciation, compassion and honesty and reflected these values in the way they treated patients and their families.
- Staff could tell us about the hospital vision to aim to deliver the highest possible standard of patient care and were able to give examples of how their work contributed to this vision.
- We saw staff in each department had developed their own vision directly aligned to that of the hospital's overall vision. For example in the breast unit the vision was 'to provide comprehensive, state of the art care in the most supportive and patient centred environment.'

Governance, risk management and quality measurement for this core service

- There were defined governance and reporting structures in place and quality measurement was carried out via a 'ward to board' framework. There were several monthly meetings which reported on patient safety and performance directly into the hospital operations board. These included the patient safety quality group, patient safety quality board medical board and medical advisory committee .
- We saw monthly department meeting minutes with a standard agenda for each of the services and included incident learning, performance and improvements. Outcomes of department meetings were fed up to divisional clinical governance meetings.
- We saw examples of the quarterly clinical operation review report, which demonstrated incident trends, clinical coding, MDT compliance, staffing turnover, clinical key performance indicators and patient satisfaction with specific action plans to address areas of safety concern and under- performance.

- Each department had their own risk register, which fed into the main hospital risk register. We looked at risk registers in each department and saw that these were updated regularly.

Public and staff engagement

- We saw examples of improvements made after the staff opinions survey. For example, to improve communication we saw evidence that action had been taken that included a change in department meetings times and location to ensure a larger cross section of staff were able to attend and engage in discussion.
- Nursing and allied health professional staff told us the CEO and CNO held regular staff forums to communicate updates and developments to the hospital and departments. Staff told us this was also an opportunity to raise concerns or discuss improvement ideas.
- Patients were encouraged to complete department specific feedback questionnaires. We were shown examples of department specific questionnaires from each area of the hospital we visited including child friendly questionnaires for children. Improvements had been made in response to these questionnaires.

Innovation, improvement and sustainability

- We saw evidence of combining the use of CT scanning, PET scanning and nuclear medicine scanning to advance and refine the accuracy of muscular skeletal diagnosis. The hospital was one of the first to install this type of scanner in the UK and Europe. Work had been published in the journal of plastic reconstructive and aesthetic surgery. Due to this service the hospital had become the provider of an innovative service for the Royal National Orthopaedic Hospital, United Kingdom athletics and the English national cricket board.
- The hospital was starting functional MRI on patients in an unresponsive wakefulness state (vegetative state). This was being carried out at Cambridge University and Birmingham University. The hospital would be the first private hospital to offer the service.
- The MRI lead was one of the only magnetic resonance safety officers (MRSO's) in the UK. The hospital funded this training in the United States of America as it was not yet available in the UK. This promoted a culture of safety within the service.

Outpatients and diagnostic imaging

- A one stop nurse led urogynaecology service has been set up and provided a service for women seeking advice, investigations and conservative treatments for pelvic floor disorders. Conditions treated included stress incontinence, overactive bladder, mixed urinary incontinence
- Staff participated in Project World Class to maintain quality customer services.

Termination of pregnancy

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

Are termination of pregnancy services safe?

Incidents

- There were no “Never Events” reported within termination of pregnancy services (TOPS) between April 2015 and March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no incidents reported for termination of pregnancy services (TOPS) between April 2015 and March 2016. However, all staff we spoke with in both the 4th floor south ward and mezzanine theatres 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 unrelated to TOPS.
- Feedback and learning points from incidents were shared with staff across the service via email and during handovers and team meetings. The consultants shared learning from serious incidents via the medical advisory committee (MAC) meetings and shared minutes from these meetings with all consultants.

Duty of candour

- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They 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

health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Although there were no incidents that met duty of candour requirements relating to TOPS, nursing staff we spoke with were able to give us examples from other areas of their practice that demonstrated compliance.

Cleanliness, infection control and hygiene

- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. There hospital had employed a lead IPC nurse, who increased awareness of infection control issues and motivated staff to improve their practice.
- The mezzanine theatres and 4th floor south ward were clean, tidy and well organised. Personal protective equipment (PPE) was available for staff to use. The ward and theatre had antibacterial gel dispensers at the entrances and throughout.
- Disposable curtains were in use in recovery areas and these were all within date and clean. Green ‘I am clean’ stickers were in use throughout clinical areas to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- All nursing and medical staff in clinical areas we visited adhered to the hospital bare below the elbows (BBE) policy. We saw that staff used effective hand-washing techniques.
- Between April 2015 and March 2016, there were zero cases of MRSA. MRSA is a bacteria that can be present on the skin and can cause serious infection. In the same period, four cases of Clostridium difficile infection were reported. This is a bacterium that can infect the bowel and cause diarrhoea. It most commonly affects those people who have been recently treated with antibiotics.

Termination of pregnancy

- All patients were provided with single rooms with en-suite bathrooms. The single rooms ensured that they could screen patients on admission for MRSA and results would be returned within 24 hours.
- In theatres, patients were prepared for surgery in accordance with National Institute for Health and Care Excellence (NICE) guidelines. There were no surgical site infections (SSIs) relating to TOPS between April 2015 and March 2016.

Environment and equipment

- We saw that equipment used on the ward was clean and had been labelled by staff to indicate it was disinfected and ready to use. All portable equipment we checked had been recently serviced and labelled to indicate the next review date. Resuscitation equipment was available and tamper seals were in place. Emergency drugs were available and within the use by date. Nursing staff carried out daily checks to demonstrate that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items.
- A range of sterile, single use items were provided and decontamination of reusable items were carried out at a fully compliant decontamination unit.
- In the recovery area of mezzanine theatres, we found some equipment was not safety tested. Staff were aware that this equipment had not been serviced. This risk had been identified by the provider and an item was added to the corporate risk register in July 2016, relating to the provision of timely maintenance, servicing and follow-up of medical equipment.

Medicines

- We found that medicines were managed and stored appropriately. Staff kept medicines and intravenous (IV) fluids in locked cupboards or rooms. Medicines were accessed by staff using an electronic system. Each member of staff that was trained in medicine administration had a password that would allow them to access medicines using this system.
- On the ward there was pharmacist cover from 9am until 5.30pm on weekdays and between 9am and 12.30pm on weekends. Pharmacy services ran until 8pm to cover the outpatient department. After 8pm an on-call pharmacist

was available. They would usually attend the site for the handling of controlled drugs, but otherwise the site manager and resident medical officer (RMO) had access to medications out of hours.

- The service conducted regular audits to maintain high standards of medicines management and storage across all clinical areas. There was an up-to-date medicines management policy.

Records

- Information governance training was mandatory for all staff working at the hospital. Completion rates for staff within the surgical service stood at 88.8%.
- There was a combination of paper and electronic systems to store patient records. Paper records were stored within locked cabinets on the ward, and later scanned onto the electronic system. Electronic records were password protected.
- We reviewed 18 electronic sets of patient records and found that generally information was concise and clear. Consultations took place at another separately registered location and the patient was admitted with a clinic letter to the hospital, which detailed this discussion. The specialist nurse had introduced a checklist in July 2015 which indicated what referring doctors should include in their clinic letter. Any shortfalls were addressed with the individual consultant. We saw evidence that discussions of sexual health screening, psychological support and contraception in the original consultation were all more clearly documented after this time. We also saw evidence that pre-operative checks had been conducted on admission to the ward, in both nursing notes and the nursing checklist.

Safeguarding

- The hospital did not provide TOP to any patients under the age of 18 years. The safeguarding vulnerable adults intercollegiate document was currently being revised by NHS England at the time of inspection, so there were no recommended minimum levels of safeguarding training for professionals working with patients undergoing a TOP procedure who were over the age of 18.
- Safeguarding was part of the hospital's annual mandatory staff training. On the 4th floor south ward, 100% of gynaecology nurses had completed

Termination of pregnancy

safeguarding children level 1 and 2 training, compared to 90.9% of general surgery nursing staff. Both gynaecology nurses and general surgery nurses had completion rates of 100% for safeguarding vulnerable adults training. All appropriate senior staff had completed safeguarding children level 3 training.

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Both junior and senior staff had an awareness of issues such as domestic abuse and sexual exploitation. Consent prior to surgery was taken privately without partners present. Staff had access to the up-to-date trust safeguarding policy on the intranet. A paper copy was also held on the ward.
- The chief nursing officer (CNO) was the designated member of staff (safeguarding lead) responsible for acting upon adult or child safeguarding concerns locally, coordinating action within the treatment unit, escalating to the HCAUK corporate safeguarding lead as necessary, and liaising with other agencies. All staff we spoke with correctly identified the safeguarding lead.
- There was good awareness of female genital mutilation (FGM) amongst both junior and senior staff. We observed posters in staff rooms and nurses we spoke with could explain the escalation process for suspected FGM. The specialist nurse had provided training sessions to staff addressing FGM, the laws surrounding it, what to do when a patient presents with FGM and how to report it.

Mandatory training

- The mandatory training programme included: health & safety, ethics, fire training, infection control and manual handling. Mandatory training compliance rates for the surgical division varied between 86% and 94%.
- Senior nurses were responsible for ensuring that staff that they supervised were up-to-date with their mandatory training. Staff were sent an email every three weeks to remind them if any of their training was due to expire.

Assessing and responding to patient risk

- We saw evidence in clinic letters that all patients were assessed for their general fitness to proceed with a surgical termination. The assessment included obtaining a full medical and obstetric history,

measurement of vital signs, including blood pressure, pulse and temperature. An ultrasound scan confirming pregnancy dates, viability and multiple gestations was carried out in all cases. Further vital sign measurements were undertaken on admission to the ward.

- Patients were routinely assessed for risk of venous thromboembolism (VTE) on admission to the ward. We saw evidence in care records that this risk had been assessed for each patient. There was one case of VTE across the entire hospital between April 2015 to March 2016, though this was not related to TOPS.
- 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. These are safety steps staff are expected to follow prior to, during and after surgery, to check patient safety throughout their surgical pathway. This checklist was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. In addition, the hospital had recently introduced new pre and post procedure checklists, where checks were made by three different clinicians. We saw evidence in the patient records of that the WHO surgical safety checklist was implemented.
- There was a sepsis pathway in place which included treatment for possible neutropenia. This is a condition which affects the blood and can lead to increased susceptibility to infection. The service manager was working with key groups to adapt a new sepsis pathway.
- Post-procedure antibiotics were prescribed to reduce the risk of infection. All patients were tested for blood type and if necessary, offered an injection prior to discharge to prevent rhesus disease. Rhesus disease is a condition where antibodies in a pregnant woman's blood destroy her baby's blood cells. We saw evidence in all 18 records examined that this had been done.
- Basic life support training was part of the annual mandatory training programme. All staff on 4th floor south had completed both basic life support and intermediate life support training. The ward sister had completed advanced life support training.
- We saw that staff used the national early warning score (NEWS) tool to identify patients at risk of deterioration, or needing urgent review. The nurses documented the NEWS in the electronic patient record. For high warning

Termination of pregnancy

scores the electronic system would automatically send a warning to the outreach team who would then contact the nurses on the ward. We saw an example in one of the patient records where the outreach had attended the ward promptly in response to a raised NEWS and blood loss following a procedure. All patients who experienced complications from surgery would be cared by the outreach team or within departments in the hospital. There were no transfers of care to NHS providers.

- There was an initiative across the hospital called 'call, don't fall'. There was a poster in each patient room to encourage patients to call a nurse if they felt unsteady when trying to stand.
- A registered nurse monitored patients in recovery after their surgery and until they were fit for discharge. A systematic and regular assessment of the patient's condition was undertaken, which included recording their blood pressure and heart rate, as well as monitoring for pain during this period. We saw that patients were not discharged until they were assessed as fit for discharge by the nurse.
- All the wards had arrangements for 24 hour, seven days a week, resident medical officer (RMO) cover. All RMOs were required to have a current advanced life support certificate. As on-call staff were required to be able to attend the hospital within 30 minutes if required, the hospital provided off-site accommodation for RMOs covering these shifts. The RMO we spoke to confirmed he had seen patients who had undergone TOP post-procedure and would have no issue escalating post-operative concerns to the consultant.

Nursing staffing

- During the course of inspection, we saw the ward was staffed with enough nurses and healthcare assistants to keep patients safe. Staffing skill mix was reviewed twice daily against both patient numbers and patient acuity level. There was a team of five dedicated and speciality specific gynaecology nurses. Senior staff informed us that at least one of these staff would be on duty to care for any patient undergoing TOP. The rota was designed to ensure that one gynaecology nurse was on shift, both

day and night. A junior gynaecology nurse we spoke with confirmed that she had been allocated a TOP patient recently. The ward sister would care for this patient if no junior nurses were available.

- There were no shifts filled by agency staff who may be involved in caring for patients undergoing a TOP procedure in the last three months. Any agency staff were routinely buddied by a permanent member of staff, but any patient undergoing a TOP procedure would be reallocated to a specially trained member of staff. There were no registered nurse vacancies for TOPS ward staff.
- Between September 2015 and August 2016, the surgical nursing turnover rate was 25.1%. This was higher than the national average, compared to other similar independent health care providers. The nursing vacancy rate at the time of the inspection was 13.1%. In mezzanine theatres, there was currently one nursing vacancy, which was being recruited into. Senior staff told us that this was relatively easy to manage due to the decrease in current activity.

Medical staffing

- There were no medical doctors employed specifically for the management of patients undergoing TOP procedures. These were performed by consultant gynaecological surgeons and referrals were managed by consultant gynaecologists. None of these consultants were employed directly by the Wellington Hospital, but operated 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. The medical advisory committee (MAC) reviewed each application for practicing privileges and advised the hospital chief executive officer (CEO). Consultant anaesthetists were linked specifically to each surgeon and also operated under a practising privileges agreement.
- There was 24-hour cover available for surgeons out-of-hours. There was also an out-of-hours anaesthetic rota. The referring consultants were available for out-of-hours advice via telephone. Senior nurses told us no TOP procedures were carried during out-of-hours.

Major incident awareness and training

Termination of pregnancy

- The service had a contingency business plans 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. Within the surgical division, 84% of staff had received this training.

Are termination of pregnancy services effective?

Evidence-based care and treatment

- The medical advisory committee (MAC) reviewed patient outcomes and the renewal of practicing 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. A new policy relating specifically to TOPS had been introduced in September 2016. The policy relating to the sensitive disposal of pregnancy remains had been updated in July 2016. These were accessible through the trust intranet for all staff that had electronic access. Hard copies were also available on the ward. All policies sampled were up-to-date.
- The service complied with the Royal College of Anaesthetists recommended fasting time of six hours for food and two hours for clear fluids for surgical patients.
- The services surgical pathways were delivered in line with referenced national clinical guidance. Senior managers and nurses took an active role in the development of policies. For example, the sepsis policy incorporated the 'Sepsis 6' initiative and ensured that patients with suspected sepsis were treated within evidence-based recommendations.
- The service had a comprehensive audit programme. Aseptic and clean touch technique was audited 10 times per month in the ward environment. Venous thromboembolism (VTE) assessment rates, completion of falls risk assessments, pain scores, discharge times, and compliance with National Early Warning Score (NEWS), were all audited 20 times per calendar month. The assessment and management of neutropenic sepsis was audited quarterly.
- Sexual health screening was carried out by the referring consultant as part of the initial assessment if required. This consultation took place at a separately registered premises and so was not inspected as part of this process. Some patients opted for oral contraceptives at the original consultation and were provided with a prescription for these on discharge from the hospital. If patients consented to Long Acting Reversible methods (LARC) contraception, they were offered the devices at the same time as their treatment. Sexual health screening and advice was not currently a service the ward nurses provided. However, on discharge all patients are given an information leaflet detailing national agencies offering sexual health screening. Senior nurses told us that they were looking into the provision of condoms and had provided training on different contraceptive options to nurses who attended a recent study day.
- All patients were treated with prophylactic antibiotics to prevent infection in accordance with local and national guidelines.
- Patients were given verbal and written information on what to expect following a TOP procedure. If patients needed to contact the service for support after discharge, they were provided with contact details for the specialist nurse and the number of the ward. Patients were told that they could ring the ward at any time. Nursing staff on the ward provided 24-hour cover and had been trained in dealing with TOP. Nurses told us that they felt confident dealing with enquiries relating to post-procedure complications and would seek the advice of the resident medical officer (RMO), admitting consultant or specialist nurse, if necessary. Counselling was available to all patients before, during and after they had received treatment.
- If a patient requested a termination without general anaesthetic the referring consultant would refer to another provider in the first instance. The Wellington hospital only provided surgical terminations under general anaesthetic.

Pain relief

- Non-steroidal anti-inflammatory drugs (NSAIDs) were usually prescribed, in line with best practice, after treatment and were recorded in the patient's records.

Termination of pregnancy

The patient's level of pain was assessed regularly as part of their observation record. Appropriate actions were taken in relation to pain triggers to make patients more comfortable.

- Patients were given advice on discharge regarding the type of pain relief to take.

Patient outcomes

- There were no unplanned transfers or readmissions of patients undergoing TOP procedures between April 2015 and March 2016. The small number of patients admitted ensured that waiting times, complaints and any patients with complications, repeat terminations or failure rates were easy to monitor. One patient had been referred to the service after an unsuccessful early medical abortion from another provider, but no patients were readmitted following an unsuccessful termination or due to complications.
- The specialist nurse audited records of all TOP procedures to ensure that all Required Standard Operating Procedures (RSOPs) were met. This involved reviewing the checklist and the clinic letter from the referring consultant, as well as admission records. The audit aimed at improving compliance throughout the patient pathway and promoting best practice, even though consultation took place at a separately registered location. The service had introduced a checklist to ensure that all information required was included in the clinic letter and discussed in the consultation, prior to referral to the hospital. The last audit, covered between April 2015 and March 2016, indicated that only 44% of original consultations had discussed contraceptive advice. After the introduction of the checklist, improvements were evident in the records that we examined relating to contraceptive advice and medical history in the clinic letters from the original consultations. Other measures, such as number of patients who do not proceed to a termination following consultation, or the number of patients returning for follow-up, could not be audited by the hospital as these took place at another registered location.
- In the same audit, only 28% of patients were informed in the original consultation (that took place at another registered location) that their information would be shared with the Department of Health (DH) for statistical analysis via the HSA4 form. This question was later changed to incorporate that the information was

anonymised. HSA4 submission was not directly managed by the hospital as this was part of the role of admitting consultant. The hospital monitored submission by requesting email confirmation that the HSA4 was submitted or returned from the consultant's secretary.

- The hospital offered a female doctor for those patients who wished to be treated by one.

Competent staff

- The medical advisory committee (MAC) reviewed each application for practicing privileges and advised the hospital chief executive officer (CEO). The advisory function covered granting, renewal, restriction, suspension and withdrawal of practicing privileges. Consultant credentials were reviewed via a monthly report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials were provided. There was an annual review of practicing privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via Decision Making Group (DMG) and then the Corporate DMG if required.
- The majority of consultants (95%) were appraised through their NHS Trust. The remainder with no NHS affiliation were required to report to the Responsible Officer in the hospital. Records showed 100% completion rates of validation of registration for doctors working with practicing privileges.
- All of the nursing staff we spoke with 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. Records demonstrated that 100% of nurses caring for patients undergoing a TOP procedure had completed an annual appraisal.
- 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 run open sessions around what the process involved and how to collate portfolio evidence. A practice development team within the hospital were

Termination of pregnancy

able to support staff through revalidation and answer any other questions they might have. Since April 2016, 100% of nurses who underwent the revalidation process had completed this successfully.

- All operating department practitioners (ODPs) were required to complete a peri-operative assessment and competency booklet. This included competency checks on the use of different medical devices, caring for the patient in the anaesthetic room, maintaining the safety of a patient while undergoing surgery and handover in the post-anaesthetic care unit.
- All staff who offer counselling should be trained to diploma level (RSOP 14: Counselling). This was provided by an independent counsellor, who was trained in humanistic and integrative psychotherapy and was a member of UK Council for Psychotherapy (UKCP). They renewed their membership annually. We saw the most recent certificate.
- Nursing staff on the ward were required to attend the paediatric bereavement study day and the twice yearly women's study day. However, only 55% of staff on the ward had attended the women's study days in either April or September 2016. These included training on difficult conversation and communication. In the most recent study day, training on contraception was provided due to feedback from the previous session, which indicated that nursing staff wanted to be able to talk about this more confidently to patients who were admitted. The senior gynaecology nursing team also educated and supported junior staff and new starters through informal teaching sessions. Junior gynaecology nursing staff that we spoke to confirmed that they had attended the training and were booked in for further study days.

Multidisciplinary working

- There was a multidisciplinary team (MDT) meeting for pelvic floor and gynaecology patients. Any patients undergoing a TOP procedure would be discussed here if necessary, but this was usually not necessary as they were day cases.
- 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, such as escalation to the outreach

team or admitting consultant. Nurses were complimentary about the support they received from one another and the wider team. Follow-up appointments were managed separately to the service, by the referring consultant. Nursing staff gave patients an appointment card on discharge.

- The service did not have in-house pathology services and so had an agreement with HCA labs to provide laboratory work and some pathology results.

Seven-day services

- The surgical wards and theatres were open seven days a week. However, senior staff told us that TOPS were not currently scheduled at weekends, but could be if necessary. Patients could call the ward any time after discharge, 24 hours per day, seven days a week. Ward nurses then performed triage and gave advice.
- There was 24/7 RMO cover on the ward and consultant surgeons or consultant gynaecologists were available if their patient required urgent review. Only international patients undergoing a TOP procedure were required to stay overnight on the ward.
- On the ward there was pharmacist cover from 9am until 5.30pm on weekdays and between 9am and 12.30pm on weekends. Pharmacy services ran until 8pm to cover the outpatient department. After 8pm an on-call pharmacist was available.

Access to information

- There were sufficient computers available on all of the wards we visited, which gave staff access to trust information, protocols and policies. Paper copies of key policies were also available on the ward. There was a resource file with information specifically relating to TOPS for staff to reference. This included: a copy of their licence, the updated TOPS policy, the corporate safeguarding adults policy, copies of the both the consultant and nursing checklists, consent forms relating to sensitive disposal of foetal remains and surgery, patient information leaflets, RCN guidance on TOPS, and a copy of both a HSA1 form and a HSA4 form.
- Clinical staff told us they had access to current medical records and diagnostic results such as blood tests and imaging to support them to safely care for patients. Admission documents and assessments were available at least four hours before a patient's admission for a TOP procedure.

Termination of pregnancy

- A discharge letter was generated and two copies were given to the patient when they left the ward. This enabled them to give one copy of the letter to their GP to ensure that they were aware of the procedure and any post-operative treatment recommended. RSOP 3, which relates to post-procedure care, states that the patient's decision must be respected if they did not want their GP to be informed. Records indicated that this was the case. An audit conducted between April 2015 and March 2016 showed that 100% of patients undergoing a TOP procedure were given two copies of their discharge letter.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The consultation process for TOP took place at a separately registered location. The hospital ensured that all necessary documentation was completed before a referral for admission was accepted.
- There were systems in place to obtain consent from patients before carrying out a procedure, which we saw evidence of in patients' notes. The patient was given clear information relating to the risks of undergoing a surgical procedure under general anaesthetic, in order to be able to give informed consent. An audit conducted between April 2015 and March 2016 showed that 100% of patients undergoing a TOP procedure had a surgical consent form signed by patient with surgeon in their care record. Staff indicated that this consent was obtained privately with the patient, in the absence of any family members or partners. Any patients whose first language was not English was provided with an interpreter.
- Senior staff we spoke with told us vulnerable patients, with complex needs, such as a pre-existing mental health problem, would be referred to their GP or the NHS for treatment by the referring consultant. Although none of the staff we spoke to, or records we reviewed, indicated that a patient undergoing a TOP procedure lacked capacity, all were aware of their roles and responsibilities under the Mental Capacity Act 2005 (MCA). There was a weekly MCA meeting and grand round, which was attended by a variety of staff across the service. There was a transfer checklist for patients being admitted to the ward who lacked capacity. Senior

staff told us that any capacity issues would be discussed in handover. MCA training formed part of the mandatory training programme. Within the surgical division, 82% of staff had completed this training.

Are termination of pregnancy services caring?

Compassionate care

- There were no patients undergoing a TOP procedure at the time of inspection, so we were unable to speak to patients directly. However, the ward environment ensured privacy as there were only single occupancy rooms. Nursing staff demonstrated a good knowledge of maintaining patient dignity and knew how to make patients feel relaxed and comfortable before a procedure. Staff across the hospital had recently taken part in a project where they reviewed the care philosophy and developed a 'Commitment to Care' in the form of a dignity pledge.
- Although the service was unable to provide feedback directly relating to TOPS, all patients received a patient experience questionnaire upon admission and were encouraged to complete them. Data from the inpatient survey for 4th floor south was consistently good. Between March and August 2016, the overall quality of care was rated at between 95% and 100%. In the same period, quality of nursing care scored between 93% and 100%. Pain management varied between 94% and 100%. The discharge process was rated at between 86% and 100% satisfaction by patients.
- Patients undergoing a TOP procedure were provided with contact details of the specialist nurse, together with a 24-hour nursing telephone number. This number connected to the ward. All nursing staff we spoke to during inspection demonstrated a non-judgemental and supportive attitude when discussing caring for patients undergoing a TOP procedure.

Understanding and involvement of patients and those close to them

- The nursing checklist that staff had to complete prior to a patient undergoing a TOP procedure ensured that staff had given the patients the opportunity to raise concerns or doubts, and that they were happy to continue with

Termination of pregnancy

procedure. Nursing staff we spoke with told us if they felt a patient was unsure of treatment, they would advise them to seek counselling. Senior staff gave an example of a patient who was admitted for the procedure and advanced to the anaesthetic bay before she changed her mind. The patient was discharged without payment being required for any treatment.

- The updated TOPS policy stated that the patient's wishes in regards to their partner's involvement in care would be respected by the nursing team. This was confirmed to be the case by nursing staff that we spoke with during inspection.
- All patients were given impartial evidence-based information by nursing staff on discharge, both verbally and in writing. Nursing staff guided patients through information leaflets that covered emotional responses that may experience during and following a termination, potential side effects, complications, pain relief, clinical implications, contraceptive options and testing for sexually transmitted diseases. A separate leaflet was freely available on the ward, which detailed common sexually transmitted infections (STIs), reducing the risk of these and where to go for treatment and advice. In an audit conducted between April 2015 and March 2016, 89% records indicated that patients received an information leaflet relating to TOP.

Emotional support

- Records indicated that emotional support was offered to patients at the initial consultation and was available throughout their pathway of care. An independent counsellor, based off-site, was available by telephone at any time. They would see any patient that were unsure or anxious about a TOP procedure. Staff kept her contact details on business cards that they could give to patients should they wish to contact her directly. A leaflet entitled 'the benefits of counselling' was also freely available on the ward, which included an explanation of the process and details of other support agencies.
- A gynaecology clinical nurse specialist was available on the ward to offer patients and staff additional support. All ward nursing staff we spoke to, both in gynaecology and general surgery, demonstrated an awareness of the increased level of support a patient undergoing a TOP procedure may require. Junior nurses told us about a patient who had recently had a spontaneous

miscarriage on the ward and how they had worked with the specialist nurse to offer enhanced support to her and her partner. The independent counsellor would also support family members if necessary.

Are termination of pregnancy services responsive?

Service planning and delivery to meet the needs of local people

- The hospital was easily accessible by public transport. There was step-free access in the mezzanine theatre and wards. All inpatient rooms had step-free access to bathrooms.
- All of the TOP procedures that took place were elective. Patients were seen at a separately registered location for a consultation. The referring doctor then undertook the TOP procedure under a practising privileges agreement at the hospital. Admissions were staggered throughout the day in order to avoid busy times.

Access and flow

- Patients were referred to the hospital by one of three consultants. The hospital did not accept GP or self-referrals for TOP procedures. The consultant provided documented evidence of the initial assessment and the HSA1 form no less than four hours prior to admission to the hospital for the TOP procedure. The gynaecology team received this information to enable them to prepare for the patient and read all of their admission documentation. A bed meeting occurred at 10am each morning, in which any patient undergoing a TOP procedure was discussed and given priority.
- RSOP 11: Access to Timely Abortion Services indicates patients should be offered an appointment within five working days of referral and should be offered the abortion treatment within five working days of the decision to proceed. Records confirmed that no patients waited longer than 10 days from first appointment to having the procedure between April 2015 and March 2016. Senior staff told us that the small number of referrals for TOP procedures meant that a patient could be admitted immediately following a referral from a consultant where required.
- All patients residing in the UK were admitted for TOP as day surgery. Any international patients without a

Termination of pregnancy

permanent UK address were cared for overnight in the ward to ensure they were safe to be discharged. Patients were always discharged with a relative or friend to ensure their safety.

- All TOP procedures in the reporting period were early surgical terminations. However, there were appropriately trained staff in place and patient information available to those patients who may present for later surgical terminations.
- Delays in the surgical list were rare. Day surgery patient admissions were staggered throughout the day to ensure that patients weren't waiting for a long period following their pre-operative appointment.
- In the 12 months prior to inspection, the service had cancelled nine procedures for non-clinical reasons. None of these patients were undergoing a TOP procedure.
- No patients undergoing a TOP procedure had been transferred to another healthcare provider for further management in the 12 months prior to inspection.

Meeting people's individual needs

- The most commonly admitted patients were from the UK, Kuwait and Qatar. This meant that most of the patients admitted from outside the UK were Arabic speaking. We saw many signs and instructions in Arabic throughout the hospital. Translation services were readily available for those patients whose first language was not English. Staff were able to access an in house interpreting service, who could be bleeped or called to assist with communication. Staff could also contact the international office for advice. For patients from countries that the hospital did not have an interpreter for, the service would contact the embassy and ask them to provide an interpreter. Telephone interpretation services were also available.
- 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, vegetarian and vegan options.
- A female doctor could be provided if requested by the patient. Female staff members were present at all stages of the patient pathway.
- Leaflets and information were given to patients to inform them what to expect after treatment. This included the number of the ward to ring for 24-hour

telephone advice and the details of the independent counsellor. We saw examples in the records where patients had called the ward for advice following discharge, and were given appropriate advice.

- Senior staff we spoke with told us vulnerable patients, with complex needs, such as a pre-existing physical or mental health problem, would be referred to their GP or the NHS for treatment by the referring consultant.
- The Human Tissue Authority (HTA) published guidance in England, Wales, and Northern Ireland in March 2015 for practitioners to follow, regarding the handling of pregnancy remains following pregnancy loss or termination. The guidance states that should a woman prefer not to make a decision about disposal, she should be told of what method of disposal will be used. The woman's decision as to whether she wishes to discuss the options should be respected at all times, but she should be made aware that information is available to access. The hospital policy relating to the sensitive disposal of pregnancy remains was recently updated, in July 2016.
- Prior to the TOP procedure, the admitting nurse discussed the patient's wishes in relation to sensitive disposal of pregnancy remains. The patient was also given written information. A sensitive disposal consent form was then completed and signed by the patient and filed in the medical record. An audit conducted between April 2015 and March 2016 indicated that this had occurred in 89% of cases. We saw evidence of these forms and discussions in patient records. This happened in all cases after the nursing checklist that specified this should be discussed was introduced in September 2015.
- We saw the register that theatre staff were required to complete at the time of a TOP procedure and the place in which pregnancy remains were stored. These were kept in individual containers for three months after each procedure, in a locked storage unit. The service were currently sourcing tasteful packaging to enable patients to take any pregnancy remains away, should they wish. There were arrangements with a local undertakers to arrange cremation of pregnancy remains, if this was the patient's choice.

Learning from complaints and concerns

- There was an up-to-date corporate complaints policy available on the intranet. Patient information on how to

Termination of pregnancy

raise concerns or make a formal complaint was displayed in each room on the ward. Comment cards were also available, which patients were encouraged to use to share any feedback.

- All formal complaints were recorded promptly on the hospital reporting system, which was monitored via an internal database. The hospital aimed to acknowledge all formal complaints within 48 hours. A corporate target of 20 working days was set for a full response. In the 12 months prior to the inspection there were no complaints relating specifically to TOPS.
- The monthly complaints and patient experience committee (CPEC) was attended by senior managerial staff. Complaints and any learning points were discussed in the CPEC. Action plans arising from any complaints were shared with relevant staff via email, team meetings and divisional quality groups.
- The Chief Executive Officer (CEO) took overall responsibility for any complaints. They worked to resolve any complex issues with the Chief Nursing Officer (CNO), with support from the Patient Experience Manager.

Are termination of pregnancy services well-led?

Vision and strategy for this core service

- The hospital vision was 'striving for excellence'. The strategy to deliver this involved anticipating patient and staff needs through the provision of efficient care pathways and a supportive and open environment. The hospital hoped that high quality care would lead to business growth. All staff we spoke with were familiar with the vision and strategy. This hospital vision and values had been incorporated into the staff appraisal process.

Governance, risk management and quality measurement for this core service

- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful. The two doctors must then sign a form to indicate their agreement (HSA1 Form). It was hospital policy that a copy of a completed

HSA1 form must be provided by the referring consultant no less than four hours prior to the patient's admission. This provided nursing staff with the time to ensure that they were compliant with statutory regulations. All HSA1 forms were present in the records we reviewed and held the signatures of two registered medical practitioners. Senior nurses confirmed that these always arrived at least four hours before the patient's admission. An audit completed in September 2016 confirmed that the form was present and complete in all cases.

- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit demographical data following every termination (HSA4 form). Nursing staff told us that it was the responsibility of the admitting consultant to ensure that the HSA4 certificate was submitted within 14 days of the termination taking place. The consultant's secretary sent confirmation of this submission to the hospital via email.
- The site manager referred all inpatient deaths to the Clinical Service Manager for each division. All inpatient deaths were reported to the CQC through the usual formal process.
- Emergency terminations were not performed at the hospital and so there were no systems in place relating to HSA2 forms. These terminations would be referred to another provider in the first instance.
- The Abortion Act 1967 provides a right of conscientious objection which allows clinical staff to decline to participate in an abortion. The TOPS policy indicated that clinical staff should speak to the relevant manager if they wished to decline participation in a TOP procedure.
- There was a defined governance and risk management structure from corporate provider level to hospital and department level, designed to promote both upward and downward sharing of key information. There was also a designated reporting structure for quality and risk management.
- The surgical division had an up-to-date risk register that included mitigation of risk and action plans. Issues on the risk registers aligned to the concerns that staff identified during inspection. There were currently no risks relating to TOPS on the corporate or divisional risk register.
- There were several groups which dealt with governance and risk management across the hospital. The quarterly theatre user group, which included the theatre surgical

Termination of pregnancy

services manager, consultant anaesthetist and theatre staff, reviewed operational issues, funding opportunities and any staffing or equipment issues, as well as discussing methods to improve processes. The quarterly medicine management committee reviewed data relating to areas such as medication errors and discharge. The surgical services quality group and surgical wards quality group met on a monthly basis. All these groups fed into the monthly patient safety and quality board, which was chaired by the Chief Executive Officer (CEO).

- The medical advisory committee (MAC) oversaw clinical governance issues, key policies and guidance and monitored patient outcomes. It also renewed the practicing privileges of all consultants. The MAC reviewed each application relating to practicing privileges and advised the hospital CEO. Their advisory function covered the granting, renewal, restriction, suspension and withdrawal of practicing privileges. Consultant credentials were reviewed via a report provided to the CEO through the Centralised Credentialing and Registration Service (CCRS) based within the corporate office. If there were delays in receiving evidence of up-to-date documentation, the CEO suspended a consultant's privileges accordingly until credentials were provided. There was an annual review of practicing privileges, including scope of practice and activity. Any concerns, including those regarding consultant competency, were dealt with through the 'Responding to Concerns' policy via the hospital Decision Making Group (DMG) and then escalated to the Corporate DMG if required.

Leadership / culture of service

- Legislation requires that all non-NHS locations must display a certificate of approval for termination of pregnancy. The certificate is issued by the Department of Health. We saw the certificate of approval was on display in the staff room of the ward. An additional copy was kept in the TOPS resource folder for reference.
- RSOP 24 relates to the payment of fees and requires that patients are free from any fear of exploitation when accessing TOPS. As the consultation took place separately before referral to the hospital, payment for treatment was never requested before two certificates of opinion (HSA1 forms) had been completed.

- TOPS were not managed separately from other surgical services within the hospital. However, the gynaecology specialist nurse and gynaecology ward sister oversaw the audit and improvement of the patient experience in this area.
- There was a clear management structure within the ward and mezzanine theatre. The ward had permanent ward manager, who was supernumerary. The specialist nurse was also involved in the management of TOPS. Junior nursing staff described their ward manager and the specialist nurse as approachable and supportive, confirming that they were available at all times for advice and support.
- The senior divisional and executive teams were described as visible and proactive by nursing staff, who told us they felt supported and able to speak up if they had concerns. The executive team held various regular meetings with staff of all levels. The chief nurse undertook regular ward rounds and created a 'no meeting clinical Friday'. There were also 'ask the board' sessions and CEO open forums, open to staff of all levels to ask questions.
- Staff of all levels told us they were happy working at the hospital and felt they contributed to creating a positive work environment. All ward staff we spoke with were happy with the teamwork within the ward and felt everybody worked together to improve patient care.

Public and staff engagement

- Patients were provided with a patient survey on admission to the wards to gather their feedback. There was a patient safety and quality board (PSQB), which considered these survey results, amongst other measures, to improve patient experience across the hospital.
- Staff attended various ward and divisional meetings, as well as additional forums such as CEO open hours and 'ask the board' sessions. These meetings were designed to foster staff engagement, share information and drive forward improvement. Learning was shared via internal newsletters and emails.
- Staff were invited to attend weekly ENGAGE sessions. These sessions were open spaces where both clinical and non-clinical staff could come together to discuss various issues. Topics discussed ranged from medication management to the management of complex patients.

Termination of pregnancy

- A new excellence reward scheme was introduced in early 2016, which provided staff with the opportunity for individual recognition of achievement.

Outstanding practice and areas for improvement

Outstanding practice

Areas of outstanding practice are as follows:

- The neuro-rehabilitation unit exceeded in meeting patient's individual need with many examples. For instance; a variety of devices was available to assist patients with physical and communication impairments to express themselves. This included access to 'Eye Gaze' technology, which allowed patients to control computer software with their eyes. There were therapies group every day including ladies lunch, breakfast, upper limb, communication, making sense of it and exercise group. The unit was also awarded specialist international patient centre of the year in 2015 and maintains CARF accreditation (Commission on Accreditation of Rehabilitation Facilities).
- Staff had implemented an evidence-based fracture prevention pathway for patients who stayed in the unit on a long-term basis and for those with reduced bone density. This had been audited with a 90% compliance rate and a senior nurse was leading an education programme to further improve staff knowledge.

- Staff demonstrated an unwavering commitment to individualised care for patients with complex needs. This included the sourcing of innovative technology to enable a patient with significantly reduced motor ability to communicate using eye movements. Staff had also successfully moved the patient from the unit to the boardroom so they could watch a film on a large screen.
- The implementation of a new high impact care checklist had resulted in significantly improved, sustained risk assessment documentation.
- The physiotherapy team had developed a 'gold standard' of care that exceeded national NICE guidance. This included the managing of weaning protocols to reduce recovery time and an early rehabilitation programme with comprehensive multidisciplinary working across multiple specialty teams.

Areas for improvement

Action the provider SHOULD take to improve **Actions The Wellington Hospital SHOULD take to improve:**

- The medical services should improve the quality of the medical records documentation, particular documentation of MDT discussion in records, all entries should be clearly signed and dated and resuscitation forms to be completed in full.
- The hospital should ensure all doctors have access to a clinical risk management system that includes a robust morbidity and mortality review process and a process for accessing incident learning and outcomes.
- The hospital should ensure that when temporary staff are used, the skill mix is not diluted and nurses with a post-registration qualification in critical care nursing are prioritised.

- The hospital should ensure all clinical equipment kept in resuscitation trolleys are up to date.
- The hospital should ensure that all consultants and RMO's have access to the electronic observation notes.
- The hospital should ensure all relevant equipment is safety tested.
- The hospital should ensure all medical records are locked away.
- The hospital should ensure that all consultants adhere to the hospital bare below the elbows policy.
- The hospital should ensure that all equipment in theatres is safety tested and within use-by date.

Outstanding practice and areas for improvement

- The hospital should ensure that all staff working on the 4th floor south ward are encouraged and given time to attend additional training, such as the women's study days.
- The hospital should conduct regular audits to ensure that the introduction of the nursing and consultant

checklists have improved compliance with RSOPs, particularly in relation to patients being informed in the original consultation that their information will be shared with the Department of Health (DH) for statistical analysis via the HSA4 form.