The Hospital of St John & St Elizabeth

Quality Report

60 Grove End Road
St Johns Wood
London
NW8 9NH
Tel:02074374000
Website:www.hje.org.uk

Date of inspection visit: 18 & 19 October 2016, and 1 & 3 November 2016
Date of publication: 07/06/2017

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

The Hospital of St John and St Elizabeth is one of the UK's largest independent charitable hospitals, with any profits used to fund the on-site hospice, St John's, which offers free care to more than 3000 patients and their families every year. The hospital was founded in 1856 with a Roman Catholic affiliation and is a registered charity. The hospital has 73 beds and facilities, which include; five operating theatres, diagnostic imaging, a three-bed level two-care unit, outpatient department, and a walk-in urgent care centre. The hospice is located within the main hospital.

The hospital provides surgery, medical care, and outpatient and diagnostic services for children, young people, and adults.

We inspected surgery and medicine, which included endoscopy, and end of life care. We also inspected the outpatients and diagnostics services using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18, 19 October 2016, and unannounced visits to the hospital on 1 and 3 November 2016.

We did not inspect the GP service, which operates at this location, as this service is managed by another provider.

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

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

Services we rate

We rated this hospital as good overall.

Medical care services were rated as good because:

- There was an open culture of incident reporting in which staff were encouraged to highlight any concerns and report accidents without fear of blame. All of the staff we spoke with said they received feedback from incident investigations, which we saw were shared with the whole team.
- St Andrew's Ward (for medical care) had opened three months prior to our inspection and had established safe working practices, monitored through a clinical dashboard. During its initial three months, staff provided harm-free care in 98% to 100% of cases.
- Rates of mandatory training were good and all staff on St Andrew's Ward were up to date with the required safety training.
- Staff followed hospital infection control and hand hygiene practices and the endoscopy unit outsourced scope decontamination to another provider. This took place within an established service level agreement and meant the hospital could continue to offer safe endoscopy procedures.
- Staff were establishing an audit programme for St Andrew's Ward as well as a benchmarking exercise for the rehabilitation programme. Care for specific conditions was provided in accordance with the National Institute of Health and Care Excellence clinical guidance.
- Staff demonstrated adherence to the principles of the Mental Capacity Act (2005), and consent processes were embedded in all aspects of care.
- Staff were kind, caring, and compassionate in all of our observations. Patients told us staff were approachable and treated them well. Most patients said they felt involved in their care and understood their treatment plan.
- Patients were provided with facilities including ensuite bedrooms, TV access, and tablets with internet access. Relatives were able to stay overnight with their loved one if needed and had access to food and drink at all times.

Summary of findings

- Staff provided individualised support and advice to endoscopy patients before and after their procedure. This helped reduce the risk a procedure would be cancelled due to poor bowel preparation and meant patients could access help whenever they needed it.
- The hospital complaints procedure was readily available in all clinical areas and staff demonstrated the ability to support patients in resolving complaints. Medical care services had received no formal complaints in the six months prior to our inspection.
- There were clear clinical governance arrangements, which enabled the senior team to identify and manage risks to the service. Good governance systems meant clinical staff worked within established hospital protocols and met regularly to assess the quality and management of the service.
- Staff were involved in the development of St Andrew's Ward and the senior team engaged them with on-going consultation as the ward became more established.

However, we also found:

- Staff had not always documented daily safety checks on resuscitation equipment.

We found surgery required improvements with regard to safety because;

- The World Health Organisation (WHO) surgical safety checklist in use was not always completed according to national and local guidance.
- The recording of controlled drugs was not always to the required standard in the anaesthetic room and recovery area of the operating theatre department.
- Medicines were not always kept separately by product and were removed from the original packaging, and the guidance information.

However;

- There were sufficient numbers of suitably trained staff available to meet patients' needs. Staffing levels and skill mix were planned, implemented, and reviewed. Any staff shortages were responded to promptly to meet patients' needs. Effective handovers between shift changes ensured staff provided safe and appropriate care.
- Staff understood and fulfilled their responsibilities to raise concerns and report safety incidents and near misses. They understood their responsibilities in ensuring the duty of candour was applied. Mandatory safety training was provided to staff.
- Patient records were stored securely, were legible, and were mainly completed in accordance with best practice.
- All patients underwent a risk assessment to determine their individual risk of developing blood clots, pressure ulcers and falls. A National Early Warning Score (NEWS) tool was used to identify deteriorating patients, and was acted upon.
- Plans were in place and were tested to respond to emergencies.

We found overall the outpatients and diagnostic imaging department were good because:

- There were sufficient numbers of suitably skilled and experienced staff. They were supported to access safety training and other development opportunities in order to provide safe and response treatment and care.
- Prescribed medicines were managed safely. In outpatients, radiology medicines were stored in locked cupboards in the department. Lockable medicines fridges were subject to daily temperature checks, which were recorded.
- There was evidence treatment in outpatient's services was delivered in line with national guidance and best practice. Staff with specialist skills and knowledge supported their colleagues to provide advice or direct support in planning or implementing care to ensure patients received the treatment and care they needed. Teams made appropriate referrals on to specialised services to ensure patients' needs were met.
- We observed care provided by nursing, medical, and other clinical staff. Throughout the outpatient and diagnostic imaging departments, all staff were helpful and professional, putting patients and their relatives at ease.
- Staff told us the local leadership within outpatients was good. All managers were approachable, supportive and staff were proud of their service. Staff felt involved and were keen to improve systems and processes to ensure patients received the best care. Staff at all levels said managers were easily visible and accessible.

Summary of findings

- All the consultants we spoke with commented on the proactive and responsive style of leadership. Issues and concerns were promptly followed up and resolved and clinicians were involved and consulted about changes. Feedback was sought and responded to when considering changes or developments to services.
- Consultants spoke positively about the care and safety within the outpatient, radiology and diagnostics and urgent care departments.

However;

- Personal and confidential information was not always securely stored. For example, patient's personally identifiable information was kept in a communication book, which could be read by unauthorised people. We saw the lockable cupboard in outpatients was already full with box files leaving no room to put away additional paperwork
- Risk registers did not reflect all areas of concern. For example, managers were aware hand hygiene audits the hospital undertook had not included the outpatients department. They were aware some staff were not following the bare below the elbow policy. Therefore, risks to patients were not being managed.
- The audit programme was not sufficiently detailed to identify which audits would apply to the OPD.

We found good practice in relation to end of life care overall because;

- Staff were empowered to report incidents in a working culture, which valued their input and experience. Senior staff demonstrated thorough investigations and a root cause analysis of each incident and shared learning with all staff.
- Staff had acted upon an infection control audit that found 12 areas of urgent attention in July 2016 and August 2016. As a result an action plan was implemented and the hospice team made significant progress towards its completion.
- There had been a steady decrease in the number of preventable falls as a result of staff work to ensure harm-free care was provided.
- Medical care was consultant-led and there was provision for medical cover at an appropriate level of seniority 24-hours, seven days a week.
- The nursing team worked flexibly to meet the needs of patients, including increased cover when a patient needed a higher level of care.
- Hospice care was provided in line with London Cancer Alliance Palliative Adult Network guidance, according to the gold standards framework. This was benchmarked against national guidance from the National Institute of Health and Care Excellence.
- A rolling programme of audit contributed to quality monitoring and staff used the outcomes to improve care and treatment, including in the provision of effective and safe pharmacy services. Staff had used the results of audits to improve discharge planning and documentation and this was monitored on an ongoing basis.
- Multidisciplinary working was embedded in the service and patients were cared for by a range of professionals who co-ordinated care through a structured system of meetings and assessments.
- Hospice services performed consistently well in the Friends and Family Test and the most recent results, from July 2016 to September 2016, indicated 100% of respondents would recommend the service.
- The Hospice@Home service provided an individualised service to meet people's needs. In addition, staff tried to ensure people were able to die in their preferred location where possible. This was audited and there was a consistent approach to improve the resources available to staff to ensure this was achieved.
- Staff told us they felt well supported and had access to managers whenever they wanted. They also said they felt engaged with the running of the service and were able to contribute on a regular basis.
- The hospital encouraged staff and patient participation in research trials where these were deemed to be safe.
- Previous audits indicated good compliance with requirements of do not attempt cardiopulmonary resuscitation (DNACPR) documentation.

However, we also found:

- An audit identified the use of the malnutrition universal scoring tool as an area for improvement, which senior staff were planning to re-audit in

Summary of findings

November 2016. Although patients indicated some improvements in food in the hospital, a survey demonstrated they felt the choice available had been reduced.

Ted Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	We rated this service as good because it was safe, effective, caring, responsive and well-led. Staffing was managed jointly with surgery.
Surgery	Good 	Staffing was managed jointly with medical care. We rated this service as requires improvement for safety and good for effective, caring, responsive, and well-led.
End of life care	Good 	We rated this service as good as it was safe, effective, caring and responsive to people's needs, and was well-led.
Outpatients and diagnostic imaging	Good 	We rated this service as requires improvement for well-led. For safe, caring, and responsive we found this service was good. We did not rate the effectiveness of the service.

Summary of findings

Contents

Good

The Hospital of St John & Elizabeth

Services we looked at;
Medical care, Surgery, End of life care, and Outpatients and diagnostic imaging.

Summary of this inspection

Background to The Hospital of St John & St Elizabeth

The Hospital of St John & St Elizabeth was founded in 1856, as a community based charitable independent hospital. All profits fund their on-site hospice St Johns, which treats over 3000 patients each year without charge.

The Hospital of St John and St Elizabeth is a charitable private hospital based in central London. The hospital primarily serves the communities of Chelsea and Westminster, however also accepts patients from across London, the UK and overseas.

The hospital has had a registered manager in post since 2001.

Our inspection team

The team that inspected the service comprised a CQC inspector manager, Stella Franklin, and five other CQC inspectors. There were four specialist advisors with expertise in theatres, imaging, paediatric care, and end of life care.

Why we carried out this inspection

We carried out the inspection as part of planned schedule of independent hospital inspections.

How we carried out this inspection

We used our inspection methodology, including the key lines of enquiry in order to check if patients using the service received treatment and care in accordance with five areas related to safety, effectiveness, caring, responsiveness. We also checked if the service was well-led.

We inspected four core services at the hospital, which covered all the activity undertaken. These were, surgery, outpatients and imaging, medicine and end of life care.

We viewed a wide range of documents and data we requested from the provider. These included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital before our inspection, which enabled staff and patients to provide us with their views on our 'tell us about your care' comment cards. We received seven comments from patients. During our inspection, we reviewed 24 sets of patient records

We carried out an announced inspection between 18 and 19 October 2016 and unannounced inspections on 1 and 3 November 2016.

We interviewed the management team and spoke with a wide range of staff, including registered nurses, heath care assistants, medical staff, and radiographers totalling 58 staff. We also spoke with 16 patients who were using the hospital.

Summary of this inspection

Information about The Hospital of St John & St Elizabeth

The hospital had five inpatient wards and one day unit, a high dependency unit, a hospice day centre and outpatients department. They were registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Surgical procedures
- Treatment of disease, disorder, or injury
- Maternity and midwifery services

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected twice previously, and the most recent inspection took place in February 2014. At the time we found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016, there were 9,332 inpatient and day case episodes of care recorded at the hospital; of these 2% were NHS-funded and 98% funded by other means.
- 100% of all NHS-funded patients and 40% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 70,595 outpatient total attendances in the reporting period; of these 98% were other funded and 2% were NHS-funded.
- There were 464 doctors with practising privileges at the hospital, and 31% of these carried out over 100 or more procedures during July 2015 and June 2016. There were 131.9 Whole time-equivalent (WTE) registered nursing staff, 36.2 WTE healthcare assistants, and operating department practitioners and 339.6 WTE other hospital staff. The Accountable Officer for controlled drugs (CDs) was the deputy matron.
- The most common medical procedures between July 2015 and June 2016 were: diagnostic gastroscopy (261), diagnostic colonoscopy (104) and diagnostic oesophago-gastro-duodenoscopy (74). The most common surgical procedures during July 2015 and June 2016 performed were facet joint injection (1095), epidural injection (906), dorsal root ganglion block (696) and cataract surgery (336).

  Between July 2015 to June 2106 there were:

- No never events reported during this period. Never events are serious incidents that are wholly preventable and have the potential to cause serious harm or death.
- There were five serious incidents reported and 807 clinical incidents. Of these, 80% (645) incidents occurred in surgery and inpatients, and 7% (53) incidents occurred in other services.
- There were no incidences of hospital acquired meticillin-resistant Staphylococcus Aureus (MRSA), or incidences of hospital acquired meticillin-sensitive Staphylococcus Aureus (MSSA.)
- There were no incidences of hospital acquired Clostridium difficile (c.diff) and no incidences of hospital acquired E-Coli.
- The hospital received 135 complaints for the reporting period July 2015 to June 2016.

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Joint Advisory Group on GI endoscopy (JAGS) accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as requires improvement for surgery because:

For surgery:

- The World Health Organisation (WHO) surgical safety checklist in use was not always completed according to national and local guidance.
- The monitoring and recording of controlled drugs was not to the required standard in the anaesthetic and recovery area in the operating theatre. Controlled drugs audits were not sustained. Actions identified were not always acted upon in accordance with the audit plan.

However:

- Staff were valued and empowered to report incidents. Investigations and root cause analysis of each incident was shared to staff.
- The majority of staff were up to date with their mandatory training.
- Staff we spoke with were all aware of their responsibilities under duty of candour, which ensured patients and their relatives were informed of incidents that had affected their care and treatment and were given an apology.
- Staff used the national early warning scores (NEWS) system to monitor patients for deterioration and followed the correct pathway to ensure those patients were treated quickly.
- There was a robust system in place for granting and reviewing practising privileges of consultants and other medical practitioners'.
- We saw evidence that staff managed prescribed medications safely and there was a good system for medicine optimisation.
- There were sufficient nursing and other allied health care staff to deliver good care to patients.
- The hospital had a service contingency plan for staff to use in the event of any unplanned interruption to essential services.

Are services effective?

Good

We rated effective as good because:

- Patients' needs were assessed and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

Summary of this inspection

- Staff had access to policies on the hospital intranet, which enabled care and treatment to be provided in line with best practice guidelines. For example NICE CG50: Acutely ill patients: recognition of and response to acute illness in adults in hospital.
- Radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff to access. There was an assigned radiology protection adviser and a radiology protection supervisor for the hospital.
- Hospice care was provided in line with London Cancer Alliance Palliative Adult Network guidance. Palliative care clinical nurse specialists provided care based on the gold standards framework.
- Patient's pain was managed well by staff across the hospital. We saw documented evidence in nursing care plans that pain scores were assessed and documented at regular intervals.
- The hospital provided induction, learning development and appraisals for all staff and staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent and records we viewed showed staff adopted a consistent approach.
- Staff completed 'Do not attempt cardiopulmonary resuscitation' DNACPR documentation in line with Resuscitation Council (UK) guidance, including an assessment of mental capacity.

Are services caring?

Good

We rated caring as good because:

- Feedback from patients and those close to them was consistently positive about the way staff treated and cared for them.
- Patients felt supported and treated with dignity and respect, and were involved in planning their treatment and care.
- Patients understood their care, treatment and condition, prior to treatment. Patients were communicated with and received information in a timely way, and in a way that they could understand.
- There were appropriate arrangements to support and meet the emotional needs of patients and those close to them and staff.
- Patients were enabled to manage their own health and care when they can and to maintain their independence.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- Access to services was timely and took account of patient needs including those with urgent needs.
- Care and treatment was coordinated with other services and providers.
- Cancellations were monitored and were managed appropriately.
- Complaints and concerns were responded to in a timely way and listened to. Improvements to the quality of service had been made in response to patient feedback and concerns.
- The hospital offered proactive, personalised care to meet the needs of adults and children that attended the hospital.
- Translation services were available for patients who did not have English as a first language and they were used occasionally.

Are services well-led?

Good

We rated well-led as requires improvement because:

- Improve structures to monitor the governance and risk management systems. A more robust system of audit needs to be in place to ensure improvements are identified and acted upon quickly particularly in relation to cross infection procedures within outpatients and theatre and medicine management within theatres.
- Ensure risk registers reflect all areas of concern. For example, managers were aware hand hygiene audits the hospital undertook had not included the outpatients department and this was not reflected on their risk register. Therefore, risks to patients were not being managed.

However:

- The hospital had a clear vision to deliver high quality care and promote good outcomes for patients.
- There were strategy and supporting business plans that staff were aware of, which reflected the vision and values, and these were regularly monitored.
- All of the staff we spoke with in the hospice described a positive and supportive working environment. One member of staff said, “I’ve felt very welcomed since I came to work here. Everyone looks out for each other and it feels like I belong here.”
- A number of staff within the inpatient services had been recognised and received individual and departmental hospital awards for their valuable contributions to patient care.
- There was a statement of the hospitals values, based on quality and safety which was understood by staff.

Summary of this inspection

- People's views and concerns were encouraged, heard and acted on. Information on patient experience was reported and reviewed alongside other performance data.
- Leaders encouraged co-operative, supportive relationships among staff so that they felt respected, valued and supported.

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	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Good

Medical care

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

Are medical care services safe?

Good

We rated safe as good because;

Incidents

- Staff used an electronic incident recording system to report incidents. Senior staff discussed incidents during a monthly clinical governance meeting and identified any potential changes to practice or policy as a result of incident investigations. Every member of staff, regardless of role or seniority had access to the reporting system, and said they felt supported by the senior team to submit issues and concerns as part of a 'no blame' culture.
- When a mistake was made, this was shared openly with the patient involved and their relatives when appropriate as part of the hospital's requirements under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- A dedicated falls group reviewed all patient falls and conducted a root cause analysis of each incident. The senior member of staff in each area was responsible for falls prevention management and the falls group provided support to them in prevention training and incident investigation. Falls investigations adhered to quality standard 86 of the National Institute of Health and Care Excellence (NICE) in relation to adequate assessment and future prevention.
- Patients on St Andrew's Ward were admitted after a stroke for rehabilitation and intensive physiotherapy, and were often at high risk of falls. In response staff completed detailed risk assessments and therapies staff were trained in managing falls risk when using specialist rehabilitative moving and handling equipment.
- The resuscitation team audited all cardiac arrests and the medical advisory committee maintained oversight of each patient death. This process replaced the more common approach of a morbidity and mortality meeting because most patient deaths were expected at the time of admission.
- There was a total of seven patient falls for the period of June 2015 to July 2016. In September 2015 an inpatient falls audit was conducted. Following this audit a more specific falls prevention process measures audit was conducted in October 2016. Actions that followed from the audit included the introduction of a
- The hospital policy related to falls risk management was updated in October 2016. Prior to this the new falls leaflet, falls care plan, revised falls risk assessment (based on the patient's risk factors present and absence - rather than a numerical value to determine risk of falls) was devised. Training was rolled out simultaneously to the policy. In 2016, this was implemented as part of the mandatory clinical manual handling training.

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

- A performance dashboard measured harm-free care in clinical areas in relation to the avoidance of pressure ulcers, venous thromboembolism (VTE), patient falls and urinary tract infections. St Andrew Ward was opened in July 2016 and the data available was for the

months of July to September 2016. Whilst there was no overall target set for the ward, we reviewed information which indicated scores of harm-free care of 100% for July and September, and 98% for August.

- In the same period there were no reported instances of harm in the endoscopy unit. Where harm was noted, this related to one fall with low harm in September 2016, six incomplete VTE assessments in July 2016 and four patients admitted with grade two pressure ulcers during the whole period.

Cleanliness, infection control and hygiene

- Staff provided printed information to patients, their relatives and visitors about the risks associated with meticillin resistant Staphylococcus Aureus (MRSA). This included a simple description of the bacteria, how it is spread and what people could do to reduce the risk. The leaflet also explained why staff wore extra personal protective equipment when caring for someone with MRSA. In the reporting period July 2015 to June 2016, there were no reported instances of MRSA or Clostridium Difficile infection in medical care services.
- Side rooms in St Andrew's Ward were equipped to accommodate patients who presented an infection risk to others and staff used discreet notices to advise visitors to follow enhanced infection control guidance. This protected patient's dignity as well as their infection risk.
- Staff we observed on St Andrew's Ward and in the endoscopy unit followed good infection control practices in line with the hand hygiene and 'bare below the elbows' policy. We observed staff use antibacterial hand gel, hand washing facilities and personal protective equipment appropriately, such as when preparing medication and before and after patient contact.
- During our inspection an external ambulance service collected a patient for transfer from St Andrew's Ward. The ambulance crew did not adhere to local infection control or bare below the elbows guidance. For example, they did not wash or gel their hands when entering or leaving clinical areas and wore long-sleeved clothing. Although staff on the ward adhered to very good infection control practice themselves, they did not challenge the ambulance crew. We spoke with the deputy matron about this who said they would discuss with the nursing and medical team strategies to confidently challenge poor infection control practice amongst visitors.
- Many of the corridors of the hospital were carpeted and staff transferred sick patients through these areas, such as when taking them for a scan or diagnostic test. This presented an elevated risk of infection or contamination if blood or other bodily fluids were spilled on the carpet. Senior staff recognised the risks associated with this and said they had recently provided biohazard spill kits in all carpeted areas that were readily accessible. However, we did not see any of these kits on display or signposted in carpeted areas of the hospital we looked at.

Environment and equipment

- Clinical areas had resuscitation equipment and difficult airway kits. The hospital standard was that a member of staff completed and documented a check of each set of equipment on a daily basis. We looked at the documentation records of the resuscitation trolley in St Andrew's Ward. A member of staff had documented a safety check on most days but in the previous four weeks there were three gaps in reporting. This meant checking procedures did not meet the requirements of the hospital's resuscitation equipment policy.
- The endoscopy unit had one treatment room and there were facilities to perform procedures under heavy sedation. The theatre manager had been responsive to safety concerns around the decontamination and processing of endoscopes in the unit. To address these, the process had been outsourced to an NHS specialist site with no delays or negative impact on the service and the unit's consistent safety record had been maintained. Staff tracked scopes electronically and the decontamination process had a 12 hour turnaround.
- A chemical spill station was provided in the endoscopy unit and staff checked this regularly.
- All but one sharps bin on St Andrew Ward was safely maintained with a closed aperture and first date of use noted. One sharps bin in the medicine room had a used needle pointing out of the aperture, which presented a needle stick injury risk to staff and did not comply with hospital policy on the safe management of hazardous material.

- Each patient bedroom in St Andrew's Ward had a hoist system and the central corridor had a ceiling-mounted hoist for the whole length of it. This meant patients could be safely moved for therapy sessions, when they wanted to spend time in a different environment or when they needed to be transferred.

Medicines

- A central pharmacy managed medicine stocks in medical services and a medicine management committee provided safety and governance oversight.
- The drugs and therapeutics committee and a medication safety group monitored all incidents relating to medication errors and provided investigative support as well as practice and competency support to staff.
- Medicines were stored securely and access was restricted to clinical staff with the appropriate competencies to administer them. Controlled drugs were stored and documented in accordance with national legislation and appropriately-qualified staff administered them according to a documented checklist. This included a requirement that two members of staff check and sign for every dose.
- Staff maintained a temperature record of the medicines storage room and medicines fridge to ensure they were stored within the manufacturer's recommended temperature range. We looked at records for the previous two months and found temperatures had been safely maintained and corrective action taken where an increase was noted.
- Clinicians demonstrated appropriate action when a patient was admitted with a supply of an unlicensed medicine. An unlicensed medicine is one that is used outside of the terms of its UK license or a medicine that has no UK license. The physician on duty stored the medicine safely and contacted the admitting and prescribing doctor to discuss it and ensure the medicine was charted accurately on the patient's drug chart. This meant clinical staff followed the best practice prescribing guidance of the General Medical Council.
- Since the hospital's antibiotic prescribing guidelines had been updated in May 2016, the drugs and therapeutics committee had initiated an antimicrobial stewardship. This is a professional programme aimed at reducing antimicrobial resistance in line with guidance from the Association for Professionals in Infection Control and Epidemiology.

Records

- Nurses completed a number of risk assessments for patients on admission to St Andrew's Ward, including for falls, pressure sores, malnutrition and dehydration and venous thromboembolism. The ward manager recognised areas for improvement in nursing documentation after considering how the existing paperwork met patient needs during the ward's first three months of operation. As such they collaborated with colleagues to create a new template, which the ward team were asked to provide feedback on.
- We looked at eight records and found they were completed legibly and to the standards of the General Medical Council's 2013 guidance on keeping records. This included staff titles and signatures that enabled them to be traced in case of a query.
- Multidisciplinary team notes were of a high standard, detailed, legible and followed NHS Professional's 2016 record keeping clinical guidance. This included detailed evidence of social, therapeutic and clinical interventions.

Safeguarding

- Safeguarding reports, incidents and alerts were audited to ensure staff appropriately identified triggers and took action to ensure people were protected from avoidable harm. Support for safeguarding concerns was provided through an agreement with the local authority and a social worker was based in the hospital to ratify safeguarding decisions.
- All staff held child safeguarding and adult safeguarding training levels one and two.
- Staff at all levels of responsibility we spoke with had a clear understanding of the safety systems and processes to help them recognise and escalate situations that had potential to case people harm.

Mandatory training

- The hospital had a mandatory training policy that required staff to undertake up to 23 specific modules of training depending on their role. A number of training sessions were common to all staff as part of their

induction, including complaints handling, incident reporting, fire awareness, information governance and conflict resolution. All of the staff on St Andrew's Ward were up to date with their mandatory training.

- Resident medical officers (RMOs) usually undertook mandatory training in the NHS and the medical advisory team at this hospital tracked this to ensure they were up to date in core modules such as safeguarding, infection control and moving and handling.
- Life support training was mandatory for all staff and the level provided depended on their role and responsibilities. For example, all staff had basic life support training and all clinical staff had intermediate life support training. RMOs and night sisters had advanced life support training. Training information was confirmed by looking at staff records.

Assessing and responding to patient risk

- Staff used the national early warning scores (NEWS) system to monitor patients for deterioration. If a patient's condition deteriorated and they could not be safely treated on site, a consultant used an unplanned transfer out protocol to transfer the patient to a hospital they could be safely cared for. Transfers were consultant-led and used a specialist ambulance service.
- An intensive care clinical fellow and RMO were always available on site and responded to patients who were deteriorating. Overnight a night sister also provided this support and conducted regular checks on patients whose NEWS score was elevating. There was a high dependency unit on site that could care for patients, including those who needed airway support, in the event of an emergency.
- Procedures carried out in the endoscopy unit adhered to the British Society of Gastroenterology quality and safety indicators. We viewed the hospitals endoscopy operational policy. This gave clear guidelines ranging from guidance on the management structure, patient care policy and adverse events policy and referral guidelines.
- Most medical admissions were elective or planned, which meant consultant cover was provided in line with the patient's known or predicted medical needs. RMOs and senior nurses we spoke with said all of the consultants that cared for patients were easy to contact in the event an urgent situation arose.
- A transfer protocol was in place in the event the hospital could not safely provide care or treatment for a rapidly deteriorating or acutely unwell patient. This could involve a transfer to a nearby intensive care unit or an accident and emergency department. The deputy matron audited all transfers for safe practice.

Nursing staffing

- The medical inpatient ward had opened in July 2016 with an established minimum nurse staffing level plan based on the predicted acuity and needs of patients. As such staffing levels were still under review to ensure the team could operate the ward safely. At the time of our inspection a team of eight staff nurses, led by a ward manager, provided care on the ward and a further four staff nurses had been recruited.
- The established staffing level was a senior nurse co-ordinator, four staff nurses and two healthcare assistants (HCAs) between 7.30am and 7.30pm seven days a week. Overnight, two staff nurses and two HCAs were on duty. The duty manager used a safer care nursing tool twice daily to identify high-level dependency on the ward and to provide additional nurses or HCAs in response.
- We observed a nurse-led handover with an external ambulance crew who arrived to transfer a sick patient. The nurse demonstrated exemplary attention to detail when focusing on patient safety and ensured the ambulance crew, ward manager and RMO in attendance were happy with the detail and information given.
- Three nurses were dedicated to the endoscopy unit and had completed the gastrointestinal endoscopy for nurses ('gin') programme accredited by the Joint Endoscopy Group on GI Education and the Royal College of Physicians.
- A night sister was available between 8pm and 8am and acted as a single point of contact site manager for ward-based staff. This member of staff was supernumerary to nursing teams and provided responsive support to clinical areas when called in addition to visiting each ward individually at least once per shift.
- The nursing team on St Andrew's Ward conducted a twice daily handover of patients. Handovers were

attended by the ward manager and HCAs and included a detailed review of each patient, including their clinical needs and risks, nutrition and hydration status and social needs.

Medical staffing

- A team of six resident medical officers (RMOs) provided medical cover 24-hours, seven days a week on 12 hour shifts. Each RMO was research active and represented a minimum grade of an intensivist FY2 or were on a PhD pathway. Staff we spoke with at all levels were positive about the standard of care and support of the RMO team and said they were responsive to calls for assistance on the ward. RMOs worked according to an established service level agreement with the hospital. This meant they would always be involved in the investigation of incidents that occurred during their shift and available to speak with other physicians regarding patients they had made decisions about.
- Consultant care was scheduled in advance during admission planning and consultants visited their patients at intervals depending on their needs. Treatment in the endoscopy unit was consultant-led.
- Between 8pm and 8am, two on-call physicians were available in addition to the RMO on site. An on-call stroke rota enabled staff to gain immediate support for acute stroke patients and a named physician was always on-call for patients who experienced an acute myocardial infarction. An intensive care fellow was always on site overnight and provided medical support for patients who were deteriorating.
- A lead physician was responsible for care and treatment on the endoscopy unit and the medical advisory committee ensured each consultant worked within current practising privileges.
- A robust system was in place to granting and reviewing the practising privileges of consultants and other medical practitioners. This included checking each person's General Medical Council licence to practice and evidence of appraisal and revalidation.

Emergency awareness and training

- All staff had undertaken fire risk and evacuation training prior to the opening of St Andrew's Ward. This included using fire zones for a progressive horizontal evacuation and the use of evacuation lifts, which operated with a secondary power supply.
- The director of governance and risk was working to align disaster recovery and business continuity policies with the NHS England Business Continuity Management Framework. Staff training was planned for after the hospital's policy and strategy were updated and ratified by the senior executive team.
- St Andrew's ward and the endoscopy unit complied with the NHS England standard for emergency preparedness, resilience and response.

Are medical care services effective?

Good

We rated effective as good because;

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

- A clinical practice group ensured clinical assessment; treatment and care met the best practice guidance of the National Institute of Health and Care Excellence (NICE) for specific conditions. For example, policies had been developed that met NICE clinical guidance 169 on the prevention, detection and management of acute kidney injury and on clinical guidance NG 51 on the recognition, diagnosis and early management of sepsis. This included an appropriate screening tool and treatment pathway.
- Staff completed falls risk assessments and avoidance strategies based on clinical guidance 161 of NICE in relation to reducing the risk and incidence of falls. In addition, staff completed risk assessments for venous thromboembolism (VTE) and prescribed prophylaxis in accordance with NICE quality standard three.
- Audit programmes were in place on a hospital-wide and departmental basis. Staff on St Andrew's Ward were considering audits specific to them for the near future as their priority since July 2016 had been the smooth initial operation of the ward as a new dedicated entity within the hospital.
- Governance leads were planning to audit the stroke rehabilitation pathway to benchmark it against national

standards. This followed an initial piloting period to ensure the rehabilitation programme could safely and effectively meet the needs of patients who were cared for after a stroke.

Pain relief (medical care specific only)

- St Andrew's Ward met the Core Standards for Pain Management Services in the UK (2005) from the Faculty of Pain Medicine. This meant staff assessed pain on admission and reviewed this at regular intervals. It also meant patients had access to appropriate pain medication.
- Patients in St Andrew's Ward told us they felt staff managed their pain well. We saw documented evidence in nursing care plans that pain scores were assessed and documented at regular intervals.
- Pain relief and sedation were available in the endoscopy unit and were administered by trained staff using established protocols.

Nutrition and hydration

- A dietitian was available in St Andrew's Ward to review new patients and provide on-going monitoring and support. This included risk assessments for malnutrition and dehydration and nutrition planning as part of a rehabilitation plan.

Patient outcomes (medical care specific only)

- St Andrew's Ward had not been in operation long enough to contribute to any national benchmarking quality audits. However, treatment and care was provided in line with hospital and corporate quality and clinical governance standards and protocols. This included for admission and discharge planning and condition management.
- The clinical team reported positive outcomes for patients admitted to St Andrew's Ward following a stroke. This included four to six therapy sessions per day, seven days a week from dedicated physiotherapists and occupational therapists. Senior staff said patients admitted with major left or right sided weakness usually walked out with significant mobility because of the intensive therapy provided.
- Between January 2016 and October 2016, there was one unplanned transfer out of general medical care services. This was on the request of a consultant for an urgent cardiac intervention and followed hospital transfer protocol.

Competent staff

- The drugs and therapeutic committee and medication safety committee assessed all staff responsible for the administration of medication for their clinical competency. This included adherence to policies and the standard operating procedure for controlled drugs.
- Prior to the opening of St Andrew's Ward, staff had undertaken a number of training modules and competency assessments delivered by specialists. This ensured the team were ready to meet the needs of patients when it opened. This training included swallowing support delivered by the speech and language therapy team, care of deteriorating patients delivered by an intensive care unit fellow as well as moving and handling and fire drill training. A cardiac team had also completed unannounced simulation training with staff to assess knowledge and understanding of how to treat a person experiencing a cardiac arrest.
- Resident medical officers (RMOs) received clinical supervision in their NHS posts and consultants at this hospital provided opportunistic bedside teaching sessions to help RMOs develop their clinical competencies.

Multidisciplinary working

- A multidisciplinary team provided care for medical patients, including those with complex needs and comorbidities. This included dietitian's, speech and language therapists, occupational therapists, physiotherapists and a tissue viability nurse. Staff also worked with external professionals as part of patient's care, including ophthalmology services.
- Palliative care clinical nurse specialists and palliative care consultants worked with the stroke and medical teams to contribute to care and treatment plans. This team could also arrange for patients to die in their preferred place through collaborative working with other clinicians.

Good

Medical care

- The stroke rehabilitation pathway was delivered by an experienced multidisciplinary team and there was evidence of on-going, consistent co-ordination between various professionals to ensure care and treatment was clinically appropriate, holistic and individualised.

Seven-day services

- The stroke rehabilitation service on St Andrew's Ward operated seven days a week, with daily physiotherapy cover.
- RMO and intensive care fellow cover was provided to ward staff seven days a week.
- Pharmacy services were available seven days a week, between 8am and 8pm Monday to Friday and 9am to 6pm at weekends.
- The on-call theatre team provided a 24 hour 7 days a week out of hours service for those patients requiring access to the endoscopy suite.

Access to information (medical care only)

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way, including risk assessments, care plans and diagnostic and test results.
- When patients were transferred or referred to other services, staff ensured information relating to their on-going care was made readily available.
- Co-ordination between hospital services and multidisciplinary teams met NICE quality statement 15 in relation to providing co-ordinated care. This meant discharge summaries included the reason for admission, investigations and diagnostic results, details of the rehabilitation plan and community information such as dietary or social needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff obtained and recorded consent for endoscopy procedures during the initial booking process and just before the procedure. This gave patients the opportunity to ask any last minute questions. Endoscopy staff completed cross-checks on consent documentation to ensure no patients underwent procedures without this in place.
- An appropriate clinician documented a mental capacity assessment of each patient admitted to St Andrew's Ward as well as a record of consent to medical treatment.
- Staff undertook Mental Capacity Act (2005) training and demonstrated a good understanding of the principles and requirements of this. The ward manager and an RMO we spoke with demonstrated a clear understanding of how the Deprivation of Liberty Safeguards might affect patients under their care and were aware of application procedures.

Are medical care services caring?

Good

We rated caring as good because;

Compassionate care

- St Andrew's Ward contributed to the hospital's patient survey by encouraging patients and relatives to complete feedback forms. The ward had not yet been in operation long enough for an analysis and review of feedback.
- Six patients we spoke with said they were happy with the kindness and approachability of all staff they had come into contact with. One patient said they felt their care and support from the physiotherapist "really stands out" because of their determination and encouragement. Another patient said they had received very personalised care from nurses and felt they were treated as an individual.
- We observed care during our inspection and saw in all cases staff were kind and compassionate, including in their interactions with relatives. For example, staff used personalised communication when speaking with each person because they had taken the time to get to know them. This meant they knew if patients wanted to be spoken to informally or formally and how they preferred to be addressed.

Understanding and involvement of patients and those close to them

- Nurses maintained consistency of care between shifts by aiming to look after patients they had previously met and spent time with. We asked six patients about this

who said they felt staff took the time to get to know them. One patient said they felt their treatment and care plan was unclear and they felt there could be more frequent updates from staff. Another patient said they were happy with information from the medical team although they said, "I do think they [doctor] tells me about what he's going to do rather than asking me and discussing it."

- We observed staff talking with patients and explaining what they were doing during care and treatment procedures. This included during personal care and medicine administration. For example, a nurse reminded a patient what their medicine was for and encouraged them to take it.
- The multidisciplinary therapies team in St Andrew's Ward worked closely with patients and their relatives to develop rehabilitation plans, which met their medical, physical and social needs. For example, therapies staff helped patients to set goals important to them, such as returning to a sports team or returning to work.

Emotional support

- A spiritual and religious steering group was available in the hospital and represented and developed services and policies for patient wellbeing.
- Staff were able to organise emotional support for patients through counselling and psychology services and the multidisciplinary team on St Andrew's Ward included a dedicated neuropsychologist. This member of staff provided targeted psychological support to patients on the stroke rehabilitation programme.

Are medical care services responsive?

Good

We rated responsive as good because;

Service planning and delivery to meet the needs of local people

- The admissions service sent patients a preparation pack in advance of their endoscopy procedure to ensure they arrived able to undergo their planned procedure. This helped to reduce the number of unnecessary cancellations. Patients also had direct line access to an endoscopy nurse before and after their procedure to answer questions.
- Individual bedrooms on St Andrew's Ward had been designed to ensure patients were comfortable and maximised the use of natural light. Each room had a digital interactive TV and a tablet with internet connection. The ward had a glass-enclosed visitor's room that provided a quiet space for patients and their relatives although this room was used for equipment storage at the time of our inspection.
- Each inpatient bedroom was en-suite and the shower room could be used as a wet room for patients with reduced mobility.
- Relatives and carers were able to stay overnight with patients in St Andrew's Ward and there were drink and snack facilities as well as showers on the ward for them. Catering was available on-demand 24-hours, seven days a week.

Access and flow

- Most patients on St Andrew's Ward were admitted on a planned basis by a named consultant with specialty competence in the relevant medical area. Patients could be transferred from another hospital inpatient ward or admitted from an accident and emergency ward with appropriate admissions planning and clinical oversight.
- Patients had access to on-site diagnostics and investigations, including scanning and x-rays, seven days a week.
- The multidisciplinary team worked together to ensure the stroke rehabilitation programme was implemented immediately after admission for patients who had experienced a stroke.
- Consultants contacted each patient's GP on the day of discharge with an appropriate follow-up care plan and details of on-going rehabilitation. We saw examples of this and found them to be detailed and timely.
- Endoscopy procedures were usually carried out as part of a planned surgical investigation and the unit did not normally provide emergency procedures.

Good

Medical care

Meeting people's individual needs

- The endoscopy recovery area included private changing rooms, shower facilities and a private room for meetings and discussions with relatives and staff.
- Staff provided a range of signposting information to patients and relatives, which helped them access the specialist advice and services. This included organisations that provided respite care, a guide to personal care and wellbeing after a diagnosis of deep vein thrombosis, how to manage visual inattention after stroke and guides from the Stroke Association on coping with depression and fatigue after stroke.
- Staff from The Alzheimer's Society had visited St Andrew's Ward as part of a review of the hospital environment. As a result the ward manager was planning a number of aesthetic changes to make the ward more welcoming and calming for patients with Alzheimer's disease or dementia. This included scoping the possibility of dedicated bedrooms for those living with dementia.
- Nurses demonstrated a good understanding of how to meet patient's individual needs during a handover we observed on St Andrew's Ward. This included a discussion of how to support a patient who had a restless night and a reminder for staff to ensure one patient wore their hearing aids so they could communicate more readily.
- Catering services were available on site 24-hours, seven days a week and could provide individualised menus for each patient to meet advice from the dietitian. Culturally or religiously-appropriate food was also available, including halal and kosher food.
- Snacks and drinks were available to patients in the recovery area after an endoscopic procedure to help them recover gently from sedation.
- A neuropsychologist was available to provide psychological support and assessments and also ensured patients had the necessary support in place for after they were discharged.

Learning from complaints and concerns

- There were six complaints related to medical care within the reporting period of July 2015 to June 2016. These related to a variety of reasons, which included unhappiness with the environment of the room and loss of personal property. The hospital monitored complaints to identify if any particular trends were re-occurring.
- There had been no formal complaints about care and treatment on St Andrew's Ward since the unit opened in July 2016 and no complaints regarding the endoscopy unit in the six months prior to our inspection.
- The hospital had an overarching complaints procedure and this was readily available on St Andrew's Ward. A dedicated ward clerk was available on the ward five days a week and could provide patients or relatives with additional information on the complaints procedure and the ward manager was empowered to resolve clinical issues.

Are medical care services well-led?

Good

We rated well-led as good because;

Vision and strategy for this this core service (for this core service)

- St Andrew's Ward had been in operation since July 2016 and the senior team continued to ensure staffing and safe practice were embedded in the unit. In addition, improvements to nursing documentation were in development and staff planned to develop the rehabilitation programme as the ward became more established.
- The endoscopy unit had a vacancy for a team leader and the theatres manager's immediate strategy was to recruit this role before considering the future of the unit. In the interim period the theatre manager covered this role and nurses we spoke with said this had worked well.

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

- A director of governance and a risk governance lead were responsible for risk management and clinical governance in medical services. This included oversight of risk registers, which were used to identify specific

risks to services or departments. There were no current risks to St Andrew's Ward that were not already reflected on the corporate risk register which related to all inpatient areas.

- A matron and deputy matron were responsible for the nursing care and treatment on St Andrew's ward and also held oversight of resident medical officers working on the unit, along with the medical director.
- A theatre manager and team leader were responsible for governance and risk management on the endoscopy unit, including management of the department's risk register. There were three key risks on the register and there was evidence of progress in resolving them. For example, an information governance risk had been identified because it was difficult for staff to maintain privacy and confidentiality at the nurse station. The risk had been mitigated with the provision of new systems to manage documents. The theatre manager also identified that the recovery area did not afford patients with full privacy and was preparing a scoping exercise to explore the possibility of soundproofing recovery cubicles.

Leadership and culture of service

- A ward manager led care on St Andrew's Ward and the theatres manager led care and treatment on the endoscopy unit.
- Staff at all levels spoke highly of the working environment and their working relationships with colleagues. One doctor told us, "This is a delightful place to work, staff are happy to ask for help and to be asked at the same time.It's the same with consultants, they are very supportive."
- Staff on St Andrew's Ward and other clinical staff across the hospital spoke positively of the support they received from the deputy matron and matron. One nurse said, "They [matrons] do a walkabout of the whole hospital every shift. They're very visible and nothing is too much trouble. I really believe I have developed here so well because of their support and encouragement."
- The sickness rates for nurses working in inpatient departments were similar to or below the average of other independent acute hospitals in the reporting period (Jul 15 to Jun 16).
- The sickness rates for health care assistants working in inpatient departments were below the average of other independent acute hospitals in the same period.

Public and staff engagement

- During a nurse handover on St Andrew's Ward we observed good engagement and involvement between staff nurses, the nurse in charge and the ward manager. For example, nurses were clearly empowered to challenge each other on best practice and worked together to ensure they were allocated to patients based on their experience, clinical competency and skill set. This meant patients were cared for by the most appropriate nurse and enabled the team to influence their own professional development.
- Senior staff involved everyone who worked on St Andrew's Ward in its development. This included asking staff to contribute to a pilot of new care plan documentation and ensuring all staff had the opportunity to raise concerns, opportunities for improvement and highlight good practice during monthly team meetings.

Innovation, improvement and sustainability

- Four staff nurses had recently been recruited to join the team on St Andrew's Ward as it continued to be established as a core hospital service. This was part of the senior team's initial strategy to ensure this was a sustainable ward with a well-defined but adaptable stroke rehabilitation service.

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because;

Incidents

- Incidents were reported via an electronic reporting system. Staff we spoke with knew how to report incidents and understood the need to report them promptly. Staff working at all levels correctly described the types of situations they would report. Staff told us they received feedback at staff meetings and through bulletins so that improvements were made. We saw this had happened in relation to medicines errors, for example.
- Between July 2015 and June 2016, 645 (80%) of the 807 reported clinical incidents in the hospital had occurred within the surgical or inpatients service. This meant the rate of clinical incidents in the surgical service in the reporting period was around 1% higher than that of other independent acute hospitals. This could have been an indication of higher levels of reporting, and should not be seen as a negative indicator.
- Between July 2015 and June 2016 39 (42%) out of 93 non-clinical incidents reported in the hospital (42%) occurred in the surgical or inpatients service. This meant the rate of non-clinical incidents in surgery within the reporting period was similar or lower than the rate of other independent hospitals.
- There were no reported never events between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event 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.
- There were seven (less than 1%) self-reported serious incidents in the reporting period. All of these had been investigated and lessons learned had been circulated to all relevant staff. Following an incident which required a surgical patient being transferred to other services the hospital had introduced a new policy and procedure to enable efficient management of adult patients experiencing massive blood loss. Plans were in place to test the policy through a simulation exercise at least once a year.
- Staff told us where pressure ulcers were identified, these would be reported as an incident, and were subject to review and root cause analysis. We saw where this happened. Any actions required would be implemented, and relevant information shared through the hospital's governance processes. An example of action taken following reports of pressure ulcers was the review of equipment and the purchase of new beds and mattresses.
- The duty of candour is a regulatory duty that rates openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were provided with training in the duty of candour as part of the hospital's induction process.

- Staff we spoke with were all aware of their responsibilities under duty of candour, which ensured patients and their relatives were informed of incidents that had affected their care and treatment and were given an apology.
- Minutes of clinical governance meetings demonstrated that compliance with duty of candour was followed when responding to patients and/or their relatives when investigating incidents.

Safety thermometer

- New types of performance dashboards were developed within the inpatient areas in the reporting period. The dashboard included information around key performance indicators (KPI) related to patient safety. We looked at data for the period January 2016 to September 2016 where information was reported about pressure ulcers, patient falls, urinary tract infections where an indwelling catheter was in use, and venous thromboembolism (VTE). Harm free care was reported as 100% St Elizabeth Ward. St Joseph's ward reported a range of 82% to 92.5%, and 99.75% for theatres. Patient numbers were small in the sample size as well as actual incidents, the majority of which were attributed to falls.
- In October 2016 a specific falls prevention process measures audit was conducted and actions were taken as a result. A task and implementation falls group was introduced to revise risk assessment, care plan, falls leaflets, training plan and handover sheet so the care plan continued to be completed and actioned at each shift. At the time of our inspection we were unable to see the results of these actions as they had just been implemented.
- New equipment such as inflatable bed mattresses had been introduced to help alleviate falls.
- There were no reported cases of meticillin-resistant Staphylococcus Aureus (MRSA), meticillin sensitive Staphylococcus Aureus (MSSA), or E coli within the reporting period. There were four reported cases of Clostridium difficile (C.Diff). These were investigated through hospital governance processes. None of the cases were hospital acquired and no cross infection was found.
- The hospital participated in the surveillance and monthly reporting of alert organisms to Public Health England. There were 10 surgical site infections reported between July 2015 and June 2016. The rate of infections during upper gastrointestinal and colorectal and cranial procedures was higher than the rate of other independent acute hospitals we hold this data for.
- The rate of infections during orthopaedic and trauma, spinal, breast and urological procedures was similar to or lower than the rate of other independent acute hospitals we hold this data for.
- There were no surgical site infections resulting from primary knee arthroplasty (joint surgery), revision knee arthroplasty, primary hip arthroplasty, revision hip arthroplasty, gynaecological or vascular procedures.
- All surgical site infections had been investigated and no common trends or concerns had been identified.
- There were no reports of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) in the reporting period. All patients within the surgical service should be risk assessed for VTE. We saw this was the case in all of the patient records we looked at. VTE audit was conducted on a monthly basis with results being discussed at department meetings and reported through clinical governance processes. There were two months within the reporting period which showed there was less than the 95% target with screening.

Cleanliness, infection control and hygiene

- There were policies and procedures, which enabled staff to prevent and control hospital associated infections. Clinical staff and clinical support staff we spoke with all understood their responsibilities in minimising the risks of infection.
- There were two nominated staff who took the lead for infection prevention and control (IPC), one of whom was a consultant microbiologist, and one a nurse.
- The lead IPC nurse role was outlined in their job description. However there was no evidence that this was reviewed on a regular basis and it referred to outdated organisations and pay structures. Following our inspection the service provided evidence that the lead nurse for IPC had undertaken university training (Level 6 Surveillance, Prevention and management of Infection in 2010.
- An IPC committee met every quarter and was chaired by the consultant microbiologist.
- Cleanliness of the inpatients areas was in accordance with local and national policy and was visibly clean and tidy. However, cleanliness within the operating theatre

department did not always meet national or local standards. During our inspection we saw dust on floors, surfaces and equipment within the operating theatre department in theatre one, anaesthetic room one and recovery area. Cleaning schedules, checklists and the use of 'I am clean' labels were not always used in accordance with local or national policy, such as The Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance. We brought this to the immediate attention of the theatre manager and saw during our unannounced inspection corrective action had been taken including the replacement of dirty and rusty trolleys, cleaning of equipment and surfaces and the introduction and completion of a revised cleaning schedule and checklist.

- Staff showed us there were separate clean and dirty utility areas in the operating theatre to ensure the risk of infection transmission was minimised. However the clean and dirty areas were not clearly labelled or defined, which could lead to confusion. In addition the corridor areas did not distinguish between clean and dirty zones. We brought this to the attention of the manager, and saw during our follow up visit that laminated signs had since been put in place, and these clearly indicated the clean and dirty utility areas. For example, areas labelled sterile instrument store, theatre two scrub area and pharmacy cupboard.
- We asked staff and managers for cleaning schedules in the operating theatre department. These were not readily available at the time of our announced inspection. At the unannounced inspection incomplete schedules were shown to us as well as a new schedule, which showed who was responsible for cleaning, what equipment and work surfaces had been cleaned and how often. It was planned that a new practice of the carrying out random spot checks of the theatre environment to ensure staff have cleaned properly will be introduced.
- Infection control audits for theatres were conducted every six months by the IPC lead and other staff members. The audit covered each theatre and anaesthetic room and reviewed areas such as furnishings/fabrics, walls, work surfaces clean, floors clean, hand basins clean. Action plans were attached to each area covered but had not been completed. The expected compliance rate was 80%. In August 2016 the results in anaesthetic room one were 78%. The main problem was damage to the infrastructure. This was not resolved at the time of our announced inspection.
- Hand hygiene and bare below the elbows audits were conducted monthly in the inpatient areas and high dependency unit (HDU) and recovery. Observation of 20 staff working at all levels was included. The audits did not have a target completion rate; therefore it was not clear whether they achieved the organisation's compliance rate.
- Data we viewed from April 2016 to June 2016, indicated St Joseph's ward achieved above 90% compliance for the hand hygiene audits and on average 90% for bare below the elbows audits.
- St Francis ward showed an average score of 90% for bare below the elbows audits and average score of 70% for hand hygiene. St Elizabeth Ward achieved an average of 90% compliance for both hand hygiene and bare below the elbows.
- HDU achieved 90% compliance target for April 2016 and May 2016 and 70% for June 2016. The recovery area achieved 90% compliance for hand hygiene for April and May 2016 and 75% for June 2016. We were told hand hygiene audits and bare below the elbow audits were not conducted in other areas of the operating theatre department.
- Results of the audits were communicated through the hospital's governance processes on a quarterly basis. We were told staff who were non-compliant were provided with individual feedback by the person conducting the audit.
- The skirting board in anaesthetic room one within the operating theatre department had become detached from the wall. This increased the risk of cross infection as cleaning could be compromised. On our unannounced visit we saw this had been fixed.
- A trolley used to store instruments in anaesthetic room one was rusty and had four dirty and dusty wheels which meant there was a risk of cross infection. Staff were unable to confirm when it was last cleaned as there was no available checklist. We brought this to the attention of the theatre manager who was able to show at the unannounced visit that the trolley had been replaced.
- In theatre one, we saw lights held out of the way with a crepe bandage, and diathermy pads used as draft excluders on a door. We also saw a fire extinguisher

stored loose on the floor that was not secured in a proper holder. Paper notebooks that could not be cleaned were tied to trolleys. None of these issues were still happening at the time of our unannounced visit.
- Hand sanitisers were available for use at entrances to the wards, clinical areas, and patient bedrooms and bathrooms. However in the majority of areas there were no instructions or information that would encourage their use and we did not observe patients or visitors being asked to use them by staff.
- There were no racks to store bedpans in the dirty utility area in St Elizabeth Ward. Bedpans were stored on shelving which did not meet national recommendations. This had been identified as a risk on the risk register, and a new replacement bed pan rack had been ordered and delivered. However, at the time of our inspection an essential part was missing that delayed installation, and therefore it had not been fitted and the risk remained unresolved.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff used this when delivering care. We saw that staff adhered to the 'bare below the elbows' policy in clinical areas.
- We observed clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen. We saw staff complied with these arrangements.
- We saw sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps containers were dated and signed when brought into use.
- We were told that there were IPC link staff in each department and they met on alternate months. Hand wash audits were said to be completed by the link staff. Equipment and environmental audits were said to be completed every six months, and audit of sharps quarterly. If compliance was less than 75% the audit would be repeated the following month.

Environment and equipment

- The inpatient areas participated in Patient Led Audit Clinical Environment (PLACE). In 2015 the audit team consisted of four members from the local health watchdog along with the deputy matron, infection prevention and control nurse and the estates and facilities manager.
- The hospital scored above 90% in all the five domains audited in the PLACE audit (Cleanliness, Food, Privacy Dignity and Well Being, Condition Appearance and Maintenance and Dementia).
- There was a member of the estates team on-site 24 hours a day, 365 days a year to ensure any problems within estates or equipment issues were dealt with immediately.
- The inpatient areas were visibly clean and tidy with corridors free of non-essential items to allow ease of access especially in emergency situations, for example: transporting of resuscitation equipment to patient rooms.
- All consumables we checked were in date.
- A check to ensure the correct functioning of anaesthetic equipment is essential to patient safety. Routine checks of anaesthetic equipment were undertaken in accordance with recognised guidance by the Association of Anaesthetists of Great Britain and Ireland (AAGBI), 'Checking Anaesthetic Equipment' 2012 guidance. We observed checks were generally completed and recorded. However, we saw six occasions where the checks on anaesthetic equipment had not been signed for between June 2016 and August 2016 in anaesthetic room and 11 occasions where the anaesthetic machine checks had not been signed for in the recovery area.
- Records for planned preventative maintenance were kept and were up to date.
- Equipment to assist people with their mobility was available for use in the inpatient and operating theatre departments.
- Both the ward and operating theatres had appropriate arrangements for managing waste. Waste was correctly disposed of, segregated and labelled. For example containers were available for the disposal of sharp medical instruments.

Medicines

- All clinical staff we spoke with were clear about the arrangements in place for safely managing medicines, including controlled drugs (CDs). CDs are medicines which require additional security. The arrangements were set out in policies and procedures for ordering, recording, storing, dispensing, administering and disposing of medicines.
- An on-site pharmacy service was provided for hospital inpatients and outpatients between 8am and 8pm

Monday to Sunday. This was located in a recently refurbished dedicated pharmacy which was spacious, clean and with all the required security arrangements. Access to the pharmacy during opening hours was by pharmacy staff only. Out of hours there were on call pharmacists available 24 hours.

- Medicines storage in the surgery service was generally secure and in accordance with manufacturers' guidance. However, in the operating theatre department there was a large medicines storage cupboard that contained oral medicines, intravenous infusions and medicines for injection which was outside (higher) the required temperature range. This meant not all medicines were stored in accordance with manufacturers' instructions. We brought this to the immediate attention of the theatre manager and chief pharmacist. We were told that a larger storage room had been identified to ensure appropriate storage of medicines and had been put in use the day before our inspection. We were also told an air conditioning system had been placed on order prior to our announced inspection. However, during the first day of the inspection the air conditioning was not yet installed. A mobile air conditioner was put in place within two hours of our observation and remained in place to ensure the room was maintained at the correct temperature. As a result the temperature was reduced to the required range. During our unannounced follow up inspection we saw this remained the case. We saw this situation was reported on the hospitals' electronic incident reporting system and lessons learned were shared with staff during a staff meeting.
- In anaesthetic room one we found four ampoules of different medicines in a medicines storage cupboard in the anaesthetic room. These were not stored in their original packaging and had been placed in one medicines tray together. Staff told us the medicines would be used to manage anaphylaxis; however there was no indication of this as there was no packaging and the tray containing the ampoules was not labelled. None of the medicines had any supporting literature or product information. We brought this to the immediate attention of the theatre manager who took corrective action.
- We checked the records and completed random reconciliation checks of controlled drugs in the inpatient areas, pharmacy and operating theatre department. Generally these were all correct and recorded in accordance with the required procedures. However, we observed incomplete CD documentation in the operating theatre department controlled drugs registers in recovery and anaesthetic room. For example there were 37 entries in the theatre CD register where the time of the administration of CDs had not been recorded. In addition, we saw 40 entries in the CD register which did not distinguish between whether CDs had been supplied, administered or destroyed medicines administered and two dosages that had been written in error without the proper procedures for deletion followed. We brought this to the immediate attention of the theatre manager and the accountable officer for controlled drugs (the deputy matron), who provided us with an explanation and assurance there had been no discrepancies in the CD stock, and took corrective action by reminding staff of their responsibilities.
- Medicines safety thermometer monitoring information was provided to us for the inpatient wards. The results for October 2016 indicated on St Elizabeth Ward that there were no omission of medicines, and a 100% compliance with recording an allergy status. There was no equivalent data for the operating theatre department.
- There were specific procedures for other named staff to gain emergency access to the pharmacy out of hours, with the resident medical officer (RMO) and duty manager holding separate keys to ensure single access was not possible. There were appropriate security controls in place to monitor when the pharmacy had been accessed and the stock item removed.
- Medicines were contained in clearly labelled locked cupboards allowing enabling staff to quickly locate the item required.
- There was a separate cupboard containing a supply of pre packed medicines when prescribed for patients to take home (TTOs).
- We observed medicines were administered safely and correctly.
- There was a key safe containing a set of pharmacy keys should the need arise for staff to access the pharmacy out of hours. There were appropriate security controls to monitor when the pharmacy had been accessed and the stock item removed.
- The management of medicines was audited, for example the number of occasions prescribed medicines were omitted and the correct storage and management

of controlled drugs. CD audit results for August 2016 indicated the majority of areas achieved the required level of compliance. Areas where the target was not met were identified on an associated action plan, along with the planned date for re-audit.

- We saw a draft report of a reconciliation of medicines audit conducted in September 2016 had been carried out in accordance with NICE ng5 Medicines Optimisation. The sample included inpatients staying 3 days or more in the month of July 2016. Three areas scored compliance greater than 80%, including having a name, signature, date, time on the medicines administration record (99%), pharmacist verifying the medicines prescribed, (83%), and information from admission having been transcribed onto the drug chart by the RMO (86%). However, 17% had a drug omitted on the drug chart from the list collected at admission, and only 4% of patient records contained an entry to explain the omission or change to the prescription. A further 6% of the sampled records had change in the dose of the medicine. None of these incidents resulted in patient harm. The errors had been reported as clinical incidents and actions such as re assessment of staff competencies completed.
- An audit of intravenous (IV) antibiotic prescribing was completed in August 2016. The results indicated low compliance, for example 67% of the sampled patients (5) had an indication for the IV prescription documented in their clinical records. Only 33% had followed the hospital antibiotic prescribing guidelines. 11% had a stop or review date on the chart or in the record. 22% had IV antibiotics for longer than five days. It was recommended the audit be repeated in October 2106 across a five day period, as the sample had been small.

Records

- The hospital used system for recording patient care and treatment. A complete set of all aspects of patient care and treatment were kept on site including a record of the initial consultation and treatment provided by the admitting consultant.
- Administrative staff were employed to effectively manage the records to ensure patient records were available on site for clinic appointments and inpatient or day care admissions. Staff we spoke with told us the records management was good and could not recall recent examples of any missing notes.
- We saw surgical registers were maintained in each operating theatre to record procedures which were undertaken, names of surgeon and support staff, the time each patient entered and left theatre, the patient's name and identifier, details of implants and details of untoward events.
- Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results and treatment and care provided.
- The care pathways used included risk assessments such as risk of falls and mobility, which were found to have been correctly completed and reviewed as required.
- Some patient records were kept at the bedside, such as care plans and fluid balance charts. These were found to have been completed and up to date.
- We reviewed eight sets of patient records. These were formatted in a standard layout to allow ease of access to relevant information.
- Operating theatre records were completed and included the World Health Organisation (WHO) surgical safety checklist. The stages of the checklist were: team brief, sign in, time out, sign out and debrief.
- Patient records were stored securely in the surgical wards and operating theatre to ensure confidentiality.
- Once records were no longer required after patient discharge they were stored on site in a secure records office prior to being archived off site. Prior to filing, records were checked for completeness and to ensure all records within the file were secure.
- Administrative staff were employed to effectively manage the records to ensure patient records were available as required, for example to ensure files were available on site for clinic appointments or following a patient re admission.
- We viewed the surgical consent record audit of October 2016. Ten sets of records were audited to check consent had been recorded correctly. The contents of the consent form were checked. There was 100% compliance for, the patients name, procedure undertaken, risks involved, benefits of the treatment recorded. There was 50% compliance in the legibility of the consultant's handwriting and 80% compliance in recording the name of the consultant. We saw action plans were made for the consent policy to be recirculated to the relevant consultants and a reinforced message for legible handwriting. A re-audit was to be taken for the month of November 2016.

Good

Surgery

Safeguarding

- There had been no safeguarding concerns in the surgical service reported to the CQC in the reporting period July 2015 to June 2016.
- Staff completed training about safe guarding at the required level and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- Nursing, medical and other clinical staff could name safe guarding leads for adults and children who were level three trained. We spoke with members of staff who could not recall any recent safeguarding concerns but were able to describe how they would act upon and escalate any concerns, including, for example, if a patient may need to be restrained. We saw guidelines for reporting and escalating concerns displayed in the inpatient and operating theatre departments.

Mandatory training

- The staff training requirements determined by the organisation as being mandatory, the frequency of attendance, and responsibilities of those involved were set out in a local policy.
- Staff told us they were required to complete mandatory training to provide safe care. This was completed either through instructor led attendance, induction briefings or through e-learning that was in line with national guidelines, core skills training framework and the hospital'. Staff described a range of topics included in their training such as moving and handling, safeguarding information governance and infection prevention and control.
- All mandatory training was scheduled and monitored by managers and documented as part of the annual staff appraisal process. Individual records were maintained for all staff with an alert system to remind staff of when they were due to attend a course. Departmental training attendance levels were monitored and reviewed at clinical governance meetings. Heads of departments were encouraged to support staff to attend sessions to ensure compliance. Staff we spoke with were consistently positive about the priority given to this.
- We saw the rates of mandatory training compliance for theatres. Figures showed us theatre registered nurses were averaging 80% for completion of training for all core subjects. Theatre health care assistants (HCA) and operation department practitioners (ODP) were meeting their targets for most core subjects, except for health and safety at work and moving and handling and slips and trips, where the average rate was 70%.The RMOs were asked to produce their mandatory training records when they were recruited and asked to produce a new certificate when they expired. The hospital funded their mandatory training.

Assessing and responding to patient risk

- A pre-admission assessment was completed for all patients prior to their admission to hospital for surgery or treatment. Patients were either pre assessed at the hospital or by telephone.
- In the last 12 months the percentage of patients risk-assessed for venous thromboembolism VTE was 95%. We saw this was completed in all of the patient records we looked at. There were no cases of hospital acquired venous thrombosis and pulmonary embolism within the reporting period
- Patients assessed for treatment as a day case signed a document to say they understood the advice provided which included they must not eat and drink for a specified time pre operatively and should not drive post operatively.
- Staff explained that during pre-assessment they recorded base line observations such as temperature and blood pressure checked the patient understands of the treatment they were being admitted for, discussed discharge arrangements, and completed a range of risk assessments such as risk of falls and pressure ulcers. During the pre-admission appointment any particular individual needs were identified and recorded such as dietary or mobility needs.
- We saw patients with known allergies wore an allergy bracelet which acted as an alert to any staff providing care or treatment. In all of the patient records we looked at we saw allergies were recorded and acted upon.
- A management of adult sepsis policy was introduced in June 2016. This encompassed a screening tool and care bundles to manage the risk.
- A national early warning system (NEWS) was used to identify the deteriorating condition of patients. This system alerted nursing staff to escalate, any patient whose routine vital signs fell out of safe parameters. We reviewed nine patient records and saw these had been correctly completed in all cases. Audits of NEWS records were completed in October 2016 for 30 patients covering three wards. The results showed the compliance was above 90%.

- There was a level two high dependency unit with three beds, used for patients who required closer monitoring post-surgery.
- The World Health Organisation (WHO) surgical safety checklist was used. We observed checks as they were carried out. During our inspection we saw a case where this was not in accordance with the required procedures as the checklist was completed prior to the patient's admission to the operating theatre department rather than at the time of the check. Staff we spoke with told us this happened from time to time. We brought this to the attention of the departmental manager and were told corrective action was taken by reminding all staff of the process.
- An unannounced audit of the use of WHO safety checks was undertaken every six months. The audit included observation and a review of a random selection of ten sets of patient notes (ten consultants). The WHO Safer Surgery Audit Report, July 2016 demonstrated that a team briefing and team debriefing occurred in 90% of cases, sign in was completed in 70% of cases, and a clear announcement of the safety check was completed in 60% of cases. The anaesthetist was present for less than 50% of sign in procedures. Documentation was completed at the time for only 30% of the sample. Learning points from the audit were shared with relevant staff at staff meetings and the clinical audit group meeting.The latest audit (conducted in August 2016 and reported in September 2016) demonstrated overall improvements in the WHO Safer Surgery process from the July 2016 report.
- There were 16 unplanned transfers in the reporting period. The transfers related to patients who required specialist treatment not provided by the hospital, in particular to those needing level 3 intensive therapy unit care. Staff we spoke with told us there were no formal arrangements for patients to be transferred to the local NHS hospital if the patient required specialist or critical care. However,the provider told us they had no incidence of a patient requiring Level 3 care being delayed due to inability to transfer to the NHS.
- There were appropriate arrangements for ensuring blood required for elective surgery was available when required, and for obtaining blood in an emergency. There was access to the minimum requirement of two units of emergency supplies of O Rhesus negative blood. The blood fridge temperature and stock were checked and recorded daily.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients within the hospital. They needed to be available to attend within an appropriate timescale according to the level of risk of medical or surgical emergency. This included making suitable arrangements with another approved practitioner to provide cover in the event they were not available, for example whilst on holiday.
- If a patient became unwell after treatment, there were arrangements for the patient to be seen promptly by a doctor (RMO and or Intensive Care Fellow) and if necessary reassessed by the admitting consultant or anaesthetist where required.
- The operating theatre team held daily briefing sessions known as safety huddles, which we observed in action. These meetings were used for example, to check if all ordered equipment had been received, staffing arrangements and allocated responsibilities were understood, and staff were aware of any changes to operating lists and if staff had any concerns.
- If changes to an operating list had to be made there was a process understood by the bookings administrators, and operating theatre and ward staff. Once a change had been agreed with the consultant the original list was destroyed and a revised list was issued to relevant departments. This process was used to ensure all staff worked to the same list to ensure patient safety.

Nursing staffing

- The service offered elective surgery, which is surgery that is scheduled in advance, and does not involve a medical emergency. This meant the number of staff required on any particular day could be calculated and booked in advance.
- In the inpatients and day care services a staffing tool was used that was endorsed by the national institute for health and care excellence (NICE) and based on the analysis of the acuity and dependency of patients. In the operating theatre department staffing levels were based on guidance from the Association for Perioperative Practice (AfPP). From this the number of nurses, operating department practitioners and health care assistants (HCA) required for each shift was calculated.

- During our inspection we saw the planned staffing numbers were met for each department. Staff we spoke with confirmed this normally happened and duty rotas we looked at confirmed this. Changes to rotas were clearly recorded to ensure accuracy.
- We looked at data which showed the use of bank and agency nurses working in inpatient departments was higher than the average of other independent acute hospitals in the reporting period. Figures for May and June 2016 revealed reduced bank and agency usage, due to a positive recruitment programme. At the time of the inspection this trend had continued.
- The use of bank and agency staff in the operating theatre department was similar to or lower than the average of other acute independent hospitals we hold this type of data for. There were no agency nurses, operating department practitioners or health care assistants working in the in the operating theatre department in the last three months of the reporting period.
- Contracted staff worked flexible hours to cover the rota and gaps were met by a separate team of bank and agency staff familiar with the hospital and team.
- Agency staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. Agency staff were provided with an induction programme when new to the service which included access to and the location of emergency equipment and fire exits. Records of signed completed induction programmes were maintained by managers and were shown to us on request.
- Managers explained they aimed to keep agency use to a minimum and tended to use bank staff at weekends when the occupancy and dependency levels were lower. We reviewed staffing rotas and these reflected the explanation provided.
- Administrative assistants were employed in the operating theatre department and inpatient areas to support clinical staff to concentrate on patient care.
- A senior nurse or theatre co-ordinator was allocated to be in charge of each shift to oversee the running of the department(s).
- Within the HDU patients received at least 1:1 or 2:1 care.

Surgical staffing

- Patient care was consultant led. The hospital practising privileges agreement required that the consultant visit inpatients admitted under their care at least daily or more frequently according to clinical need or at the request of the Resident Medical Officer (RMO) and other clinical staff. Out of hours emergency cover was provided on site by the RMO and an ITU Fellow.
- The RMO explained they made a routine visit to operating theatre each evening to check progress of patients and were kept informed of any potential issues that may require their attention. They confirmed they were never asked to assist with surgical procedures in the operating department.
- Nursing staff and the RMO found the consultants to be supportive and responsive when they had contacted them for advice.
- The hospital had a Medical Advisory Committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practise.
- The MAC periodically reviewed existing practising privileges to ensure continued compliance with the practising privilege agreement and advised the hospital about continuation of practising privileges. If there was non-compliance with practising privileges, the Medical Director would suspend the consultant's privileges so that they were not able to practice at the hospital until all the required information had been given
- If the consultant wished to use external staff as a first assistant for surgery the protocol required adequate notice is provided to allow time for all identity, fitness to practise and competency checks to be made to ensure patient safety.

Major incident awareness and training

- The hospital had a service contingency plan for staff to use in the event of any unplanned interruption to essential services.
- There was a robust team structure and pathway for staff to respond to serious incidents and crisis situations. The team was led by the crisis management team (CMT), who were responsible for the overall coordination of the incident providing strategic guidance for the response of the incident.
- Underneath the CMT were the emergency response team (ERT) who were responsible for the 'on the ground' co-ordination of the emergency and acted as the 'eyes and ears' at the scene and reported to the CMT.

- There were departmental recovery teams who co-ordinated and actioned the necessary tasks to implement the recovery strategies required to respond to the incident.
- We viewed the cardiology, respiratory and autonomic medicine 'dealing with a serious incident 'roles and responsibilities. Clear definitions and pathways for staff to follow in the event of a crisis were listed.
- There was a hospital resuscitation team with a lead co-ordinator. The team met at each shift change when emergency bleeps were issued to designated staff, and each team member's roles and responsibilities were clarified. We observed this happened during our visit.
- There was no formal service level agreement with any particular NHS hospital trust to accept patients in the event of an emergency situation in the locality.

Are surgery services effective?

Good

We rated effective as good because;

Evidence-based care and treatment

- The surgical service had a schedule of internal and external audits performed throughout the year For example : infection prevention and control, the national comparative audit of blood transfusion : 2015 audit of patient blood management in scheduled surgery; and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Sepsis study. A framework showed how the results were reviewed and disseminated at hospital governance and MAC meetings, and cascaded to clinical departments.
- Policies and standard operating procedures were kept up to date and referenced in accordance with the hospital clinical governance processes. These were based on guidance from such as national institute of health and care excellence (NICE), World Health Organisation (WHO) and the royal colleges. Staff were informed of new guidance as it became available through a monthly hospital bulletin.
- We saw systems to ensure staff had access to policies on the hospital intranet, and these enabled care and treatment to be provided in line with best practice guidelines. For example NICE CG50: Acutely ill patients: recognition of and response to acute illness in adults in hospital.
- There had been higher numbers of patients returning to theatre in order to manage post-operative complications. Further, there had been higher than expected unplanned patient re-admissions within 28 days of discharge in the reporting period. The hospital reviewed these patient outcomes and had not identified any concerning contributory factors.

Pain relief

- The surgical pathway prompted staff to assess and record if pain was being managed effectively. This was commenced in the pre-assessment clinic where actions to deal with pain management were discussed. All of the patient records we looked at showed this was happening.
- Patient controlled analgesia (PCA) equipment was available and staff felt they had sufficient quantities and skills to meet the needs of the patients at any one time.
- Patients told us nursing and medical staff were responsive to their requests for pain relief and monitored the effectiveness of medicines provided. Records we looked at confirmed this happened.

Nutrition and hydration

- Staff told us they were notified in advance of a patient's admission of specific dietary needs or allergies such as an allergy to nuts and checked patients completed menus on a daily basis to ensure the correct diet was provided.
- Nursing staff completed an assessment of patient's nutritional status and their needs as part of their initial assessment. Two dietitian's worked within the service under Licence to Attend. Staff found them accessible and approachable, and were satisfied with the service.
- Staff described the pre-operative fasting guidelines used for adults. These were aligned with the recommendations of the Royal College of Anaesthetists (RCOA).
- We saw in all of the patient records we looked at that nausea and vomiting were assessed and recorded in patient notes and that intravenous fluids were prescribed and recorded as appropriate.
- Patients knew when they could and should not eat and drink pre and post operatively.

- We saw that patients had access to hot drinks and snacks at all times if required.

Patient outcomes

- There was a higher number than expected of unplanned re-admissions (58 patients), within 28 days of discharge in the reporting period. These related to a mixture of urology, general surgery, bleeding, pain and orthopaedic reasons. For each readmission the hospital was able to provide an explanation and reason why the patient was readmitted.
- The infection prevention and control senior nurse was asked to review patients to see if any causes for the high readmission rate could be identified. They looked at the patients' records, theatre usage and antimicrobial use and found no commonalties or trends which may have caused readmission rates. A reduction of unplanned admissions was reported in quarter four of the reporting period. However, the hospital could not provide a reason for the reduction.
- There were 16 cases of unplanned transfers of an inpatient to another hospital in the reporting period. The assessed rate was not high when compared to other independent acute hospitals which submitted performance data to the CQC.
- There had been a higher number (23 patients) who had an unplanned return to the operating theatre in the reporting period. Fourteen were for evacuation of haematoma and bleeding. The haematomas were mainly plastic surgery cases, but the bleeding was across all specialties with no trends identified. The remaining unplanned returns related to various issues across all specialities, again no trends or causes for concern were identified.
- There were no unexpected deaths in the surgical division for the reporting period. We saw from minutes of the Hospital Management Board (HMB) operations meeting and MAC committee meeting dated June 2016, the matter of patient mortality reviews had been discussed. It was agreed that consultants would complete a mortality review form for acute patient deaths. However because there had been no surgical acute patient deaths in the time period requested, a completed form was not available at the time of our inspection.
- From April 2016 the service took part in Patient Reported Outcome Measures (PROMS) such as the use of EuroQol-5D and EQ Vas index for hip replacement therapy and groin hernia repair. These measures are based on descriptive information relating to five areas; mobility, self-care, usual activities, pain or discomfort and anxiety or depression. Minutes reviewed confirmed clinical outcomes had been discussed at the Hospital Management Board and Medical Advisory Committee meetings.

Competent staff

- The hospital provided induction, learning development and appraisals for all staff. These arrangements were supported by the HMB and a full time clinical educator. All the staff we spoke with were satisfied with the learning opportunities they were offered, and were given time to complete them. Where professional revalidation was a requirement, for example for doctors and nurses, staff had successfully completed the process and felt supported by managers.
- We asked to see evidence of appraisal rates and were shown all theatre and ward staff had received an appraisal in the year 2016, with most having been conducted in February and March 2016.
- We reviewed five consultant files, which included two consultant radiologists. These files contained evidence of fitness to practise, appraisals, safety training undertaken at their substantive NHS hospital, GMC registration, and professional indemnity cover. We also saw evidence that the RMOs had received an appraisal and supervision.
- We saw records of completed inductions for agency staff.
- At the time of our inspection 54% of registered theatre nurses had completed paediatric immediate life support training, even though children were not inpatients of the hospital. All registered practitioners had completed intermediate life support (ILS) training. Non registered practitioners had completed basic life support (BLS) training as part of mandatory training.
- Staff received training about how to use NEWS and calculate the patient score. This ensured they were able to effectively respond to the needs of a deteriorating patient.
- Nursing staff had completed competencies in various areas such as medicine administration, surgical scrub techniques and orthopaedic care.

Good

Surgery

- There was a process for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations. We viewed six records which showed all registration, certification and training was in date.
- The role of the MAC included ensuring the consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for a consultant to carry out specified procedures.
- Consultants were required to apply to undertake a new technique or procedure not undertaken previously by them at the hospital. The introduction of the new technique or procedure had to have the support of the MAC, which took national specialist guidance into account, such as that of the National Institute for Health and Care Excellence (NICE). The consultant was also required to produce documentary evidence that they were properly trained and accredited in the undertaking of that procedure. Administrative and operating theatre staff were aware of this requirement and gave examples where bookings for planned treatment were queried.
- Practising privileges for consultants were reviewed annually by the medical director the MAC. As well as ensuring that GMC and MDU memberships were up to date, the review included all aspects of a consultants' performance, including a review of their annual appraisal, volume and scope of activity, plus any related incidents, complaints or performance issues.

Multidisciplinary working

- Medical and nursing staff reported good working arrangements and relationships with local NHS and independent hospitals.
- We observed effective team working and communication among management, administrative, clinical, nursing and ancillary staff throughout our inspection.
- On the day of discharge letters were sent to the patient's general practitioner (GP) with details of the treatment provided, follow up arrangements and medicines prescribed and provided.

Seven-day services

- The service provided elective surgery with lists planned in advance six days a week.
- Consultants were on call 24 hours a day seven days a week for patients in their care.
- On -site 24 hour RMO and intensivist cover provided clinical support to patients, consultant and other staff.
- The hospital had 24 hour on call arrangements for imaging, pathology, pharmacy and physiotherapy services if required. Staff and patients we spoke with were satisfied with the accessibility and service provided.
- There was also an on-site or on call engineer available 24 hours a day.

Access to information

- There were arrangements to ensure staff had necessary information to deliver effective care.
- Staff had access to patient records of those patients treated within recent months should a patient be readmitted. There were arrangements to ensure staff had access to NHS notes for patients receiving treatment commissioned by the NHS. This meant when a patient was admitted for surgery clinicians had all the necessary information such as test results available.
- Staff were able to demonstrate how they could access policies and protocols via the hospital intranet.
- Each staff member had an email account to receive notifications and hospital bulletins.
- Copies of minutes of all meetings relevant to staff were provided and accessible.
- Minutes of meetings of the Medical Advisory Committee (MAC) were available for consultants with practising privileges to ensure they were aware of items discussed and agreed actions.
- Staff had access to files in the relevant department offices such as information about Control of Substances Hazardous to Health (COSHH) and safety alerts relevant to their working environment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date consent policy that staff were familiar with.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people including those who lacked capacity to consent to their care and treatment.
- The mandatory safeguarding training provided included information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) to ensure all

relevant staff were competent to meet patient needs and protect their rights where required. Staff we spoke with were able to correctly describe the processes in place.
- We looked at nine sets of patient notes and saw consent forms were fully completed, signed and dated by the consultant and patient in accordance with the required policies and procedures. The forms identified the planned treatment, and the associated risks and benefits and intent of treatment.

Are surgery services caring?

Good

We rated caring as good because;

Compassionate care

- We observed consistently positive interactions between nurses, doctors, allied health professionals and patients. Staff responded immediately to call bells and patient requests for assistance.
- Staff knocked on doors before entering patients' bedrooms and introduced themselves. Patients told us they felt safe and cared for and that they valued the frequent checks by staff.
- Gowns were provided when patients walked to the operating theatre to ensure their dignity was protected. Once patients were taken to the recovery area curtains were used to ensure their privacy.
- Patients spoke positively about the caring approach of operating theatre department and inpatient services staff. One patient told us: 'The staff are wonderful and caring. They are very attentive and my pain is managed well. A wonderful experience'. Another patient said: 'The staff are kind and caring; I have been kept well informed. I would definitely come here again'.
- We viewed seven comment cards we provided the service prior to our inspection. Such comments received from patients included 'exceptionally good care in every respect'.

Understanding and involvement of patients and those close to them

- Patients were orientated to their accommodation by staff to help them become familiar with the environment and services available.
- We saw all patients were allocated a named nurse on admission who managed the assessment process and supported the patient during their initial pre and post-operative period.
- Patients told us they felt well-informed and able to ask staff questions if they were unsure of anything.
- We saw staff allowed patients sufficient time to ask questions. Patients felt most of their questions had been answered during the pre-admission process and where the planned discharge date was discussed.
- Patients we spoke with understood what to do if they felt unwell during their hospital stay and following discharge home.
- We saw that upon discharge patients were given a copy of the letters sent to their GP outlining the treatment provided and the discharge plan, including information about any prescribed medicines to take home and follow up appointment arrangements.

Emotional support

- Pre-admission and inpatient assessments included consideration of patients' emotional well -being.
- Patients felt staff had time to listen and provided reassurance if they had any concerns.
- Patients told us they generally made direct contact with their own religious ministers if required. There was a list of chaplains for staff to contact to enable patients different spiritual needs to be met when required.

Are surgery services responsive?

Good

We rated responsive as good because;

Service planning and delivery to meet the needs of local people

- The booking system for admission to the hospital was conducive to patient needs, as where possible patients could select times and dates to suit their needs.
- Five operating theatres were available for elective surgery from 8am until 8pm Monday to Friday, and by arrangement until 8pm Saturday. A team were on call to provide 24 hour cover for emergencies outside of these times.
- Operating theatre lists for elective surgery were planned with the operating theatre manager, consultant, and bookings team to ensure the patient's safety and other

individual needs were considered before each patient was scheduled on to the list. Surgical lists were also arranged to ensure there was efficient utilisation of available operating time and resources.
- Consideration of patients' age, gender and type of operation and equipment required were also taken into account.
- Surgeons were provided with allocated operating theatre times in advance to allow prior planning of patients and operating theatre activity. The operating theatre managers explained when approving schedules checks were also made to ensure availability of other services such as imaging services.

Access and flow

- All patients were assessed to determine whether they were safe for surgery and unnecessary cancellations were avoided where possible.
- Staff began planning the patient's discharge during the pre-admission process where they gained an understanding of the patient's specific home circumstances and likely care needs.
- There were five reported incidents of cancelled operations due to non-clinical reasons in the last 12 months. These had all been rescheduled to meet the patient's needs. Unutilised or cancelled sessions were identified on the theatre timetable as available for other procedures.
- For the period January 2016 to September 2016 there was a total of 23 patients returned to theatre (RTT). There was a mixture of returns for all specialities. The majority of surgeons did not have more than one patient RTT. For those few surgeons that had more than one RTT the hospital had monitored the reasons and found no cause for concern.

Meeting people's individual needs

- On St Elizabeth Ward 12 out of 18 patient bathrooms had baths. The ward manager explained rooms appropriate to patients' needs were carefully planned and allocated as the majority of patients were admitted for orthopaedic treatment and were unable to use a bath post operatively. The hospital management board advised of planned refurbishment with the provision of showers and that meanwhile patients were assisted to another empty bathroom.
- An interpreting service for patients who did not speak English as their first language was available and staff knew how to access it. However; staff told us this was not required very often.
- Patients' individual needs such as specific dietary requirements, or a need for specialist nursing care such as dementia care were assessed and identified prior to the patient's admission.
- Patients who used the day care service who were assessed as not being fit for discharge after their procedure would be transferred to the inpatient ward for overnight care if required. If this occurred it was recorded as an incident to help identify trends.
- Patients' discharge plans took account of their individual needs, circumstances, on-going care arrangements and expected outcomes.
- Patients were discharged at an appropriate time and when all necessary care arrangements were in place.
- Throughout the hospital we saw information for patients about the services offered and how to access them. Patient areas of the hospital were accessible to people who had problems with mobility.
- Patients told us they were given detailed verbal explanations about their planned treatment, in addition to written information. The hospital website also contained a range of procedure specific information which included information about various procedures, what to expect post operatively and how the patient could aid their own recovery. We also saw a range of procedure specific discharge instructions provided.
- The hospitals patient led assessments of the care environment (PLACE) scores were lower than the England average for, organisational food and ward food.

Learning from complaints and concerns

- There were 15 complaints received in the period of July 2015 to June 2016. The complaints related to a variety of concerns ranging from nursing care, housekeeping and delayed admission as no bed was available.
- One patient complaint that managers told us about related to discomfort and distress caused to a surgical patient after their bed was accidentally banged into the wall by staff. This was investigated. Corrective action included informing the relevant line manager as well as the moving and handling officer who used the complaint as an example during mandatory training.

- All complaints were investigated and responded to within 20 days. Responses were discussed with relevant staff through governance processes, multidisciplinary team meetings, and at departmental team meetings.
- Patients and those close to them knew how to access information and who to ask for assistance with raising a complaint or concern. Information was provided to patients in their hospital admission pack and in leaflets at reception desks.
- Staff we spoke with understood the hospital's complaints procedure and had completed relevant training. They aimed to address concerns at the point of service delivery wherever possible, and provided examples of where this happened. They told us where they were unable to achieve this, the matter would be escalated to the duty manager, deputy manager or matron who would visit or call the patient to help resolve the issue.

Are surgery services well-led?

Good

We rated well-led as good because;

Vision and strategy for this core service

- The vision for the hospital was stated in the Strategic Plan. Staff were aware and familiar with the vision of the service which was communicated through team meetings and appraisal. Business plans were under development for their relative departments.
- Staff told us they felt they had an influence over the overall development of services and were encouraged to contribute their ideas to improve the service.
- The recent changes to the management team meant it had not had time to fully establish its strategy; however, the HMB felt they had made significant progress on this. The team had recognised the need to review its position in relation to the shorter terms strategic aims going into 2017, and the longer term strategy for 2019. To this end the team held an away day facilitated by a strategist. The subsequent strategy had been developed and presented to the Finance Committee for relevant approval.
- The Board and Trustees had approved the strategy and this was currently in draft form, prior to issuing to the heads of department. We noted there were 18 programmes of work which were underpinned by the values of compassion, excellence, responsibility, charity and innovation. The values were clearly displayed throughout the service.
- The hospital's values were incorporated into the appraisal process and staff understood the aim to improve quality and surgical activity.

Governance, risk management and quality measurement for this core service

- The clinical governance (CG) committee met monthly. Departmental managers attended the governance meetings and were responsible for cascading information back to their colleagues. The CG committee considered a range of complaints, incidents, health and safety issues and patient satisfaction. In addition, local audits, patient safety and care were included to monitor whether actions were completed by target dates.
- Issues around the incomplete documentation of controlled drugs had been identified as part of quality measurement CD audits in May and June 2016. Included wards, HDU, Endoscopy, theatres 1,4 & 5, and recovery. Whilst there were aspects of CD management which scored 100%, there were low levels of compliance related to documentation in the CD register, with rates of compliance scored between 11% and 30%.
  Four recommendations were made and an action plan was developed. Two of the four actions were completed and two remained as on-going, as they related to reinforcing messages regarding documentation with staff. The issues had been discussed at the theatre staff meeting in August 2016; however, some of the issues were unresolved in the operating theatre department at the time of our inspection, for example incomplete documentation.
- As part of the governance processes an audit on the safe and secure handling of medicines was completed in May 2016 across all the hospital services. Report findings included areas of non-compliance, for example: lack of security, medicines policy knowledge, medicines storage, and fridge temperature control. An action plan had been developed and time scales stated, as well as lessons learned. We were provided with evidence demonstrating an action plan had been developed, and this indicated where issues had been resolved or were on-going.

- Infection control was part of the clinical governance framework. The hospital Matron was the designated director of infection prevention and control accountable to the chief executive and the board.
- An externally commissioned Infection Prevention and Control (IPC) report was undertaken in July and August 2016. The report identified gaps in some of the IPC governance in the reporting period: for example that an annual IPC report had not been published, and IPC audits were not up to date in all areas. An action plan had been drawn up and work was in progress, however some of the issues could only be addressed through the New Hospital Development programme.
- Infection control risks were not always reported at relevant meetings. It had been identified the consultant microbiologist did not normally attend MAC meetings, and would be invited to do so in the future.
- A quality committee had recently been established and we saw the draft terms and reference for this group. The aim was to meet on a quarterly basis as a means of strengthening the governance arrangements. Further arrangements had been actioned as a means of strengthening the governance arrangements. For example, an external advisor had been supporting the service with regard to infection prevention and control within the service.
- The Medical Advisory Committee (MAC) met quarterly attended by a group of consultants who held practising privileges and represented colleagues from each speciality service at The Hospital of St John and St Elizabeth. Its terms specified membership, quorum and responsibilities - which included regulatory compliance, practising privileges, quality assurance and proposed new clinical services and techniques.
- The chair of the MAC had recently changed, with the outgoing chair moving to a role of trustee board membership. The new chair had not yet chaired an MAC meeting. We were told the chair had regular engagement with the CEO, and had oversight of the MAC agenda in advance, as well as reviewing meeting minutes. In addition the chair would review all 'Decimal' correspondence, which was sent out to all consultants on a quarterly basis. This communication was sent out in place of MAC minutes, which sometimes contained sensitive information, and as a result could not be shared with everyone. We viewed a number of examples of the 'Decimal' communication, which were detailed and informative, including MAC highlights.
- Weekly meetings took place between the CEO, medical director, matron, and director of governance to review incidents, practising privileges applicants, and fitness to practice investigations.
- There was a clinical audit plan in place. A rating system was used to indicate progress. A red rating signified where' audit production has stopped'. They rated 12 audits red within the reporting period, which included nine relating to medicines management and pharmacy. Work was in progress towards completion of the audits.
- Incidents were reviewed to identify trends and reported through the hospital clinical governance processes. There were requirements to use a standard agenda at governance and risk meetings, and ensure sub committees provided reports, such as from the medicines management, resuscitation and infection control committees.
- We spoke with staff and departmental managers about their local risk registers. These had been introduced recently and were described as work in progress and not yet fully embedded. However, managers were able to correctly describe their top risks, and said staff contributed to the register. Staff were less certain about the new arrangements. Prior to our visit, the September 2016 risk register did not include the risk of medicines being stored outside of the correct temperature in the operating theatre department. Managers said these would be added.
- Dates of identification of risks and actions were not recorded or completed in a timely manner, in particular in relation to medicines issues, infection prevention and control and environmental issues in the operating theatre department. However staff told us there had been significant improvements since the recent appointment of a new estates manager and we saw evidence of maintenance and replacement equipment.

Leadership / culture of service

- A board of trustees oversees the hospital management board (HMB).
- We were informed that 60% of the hospital management board had changed since December 2015. The CEO told us HMB had not had time to fully establish its strategy but had made significant progress towards this.

Good

Surgery

- There was a zero tolerance towards harassment or discrimination, underpinned by HR policies, upholding the right of staff to work in an environment free of abuse.
- Staff generally found the senior managers to be visible and approachable. Staff told us how they felt supported by managers, were encouraged to raise any concerns, and were listened to.
- Sickness rates for nurses working in the operating theatre department were similar to or below the average of other independent hospitals in the reporting period, and for operating department practitioners and health care assistants working in the operating theatre department lower than the average.
- Sickness rates for nurses working in the inpatient departments were similar to or below the average of other independent acute hospitals in the reporting period, and for health care assistants working in inpatient departments were below the average of other independent hospitals.
- The vacancy rates for operating department practitioners, health care assistants and nurses in the operating theatre department, and for nurses and health care assistants in the inpatient areas were all lower than these staff groups in other independent hospitals.
- The rate of staff turnover for theatre nurses was above the average of other independent providers, and for operating department practitioners and health care assistants in theatre it was below average. Inpatient nurse and healthcare assistant was above the average turnover. However, many nurses and administrative staff we spoke with had been working in the service for over 10 years and all spoke positively of the organisation.
- Managers and directors felt involved and were consulted regarding any proposed organisational changes. We were advised there were staff representatives appointed for some roles, for example, if there was any consultation work taking place prior to a change in work related activities.

Public and staff engagement

- The service sought feedback from patients, whether they were funded privately or by the NHS, via a written survey. The Friends and Family test (FFT) included questions about the quality of the service and whether the patient would recommend it to their friends and family. Feedback was consolidated into a monthly report.
- The Friends and Family survey results for the period April to September 2016, which had a response rate of above 61% showed 85% satisfaction with the quality of care for all types of patient (NHS or insured/self -pay).
- An in-patient satisfaction survey was managed by an independent company. Over 80% of respondents to the inpatient survey rated the quality of care provided as excellent.
- A staff survey conducted by an external company showed a significant improvement from the previous survey, carried out in 2013. Staff satisfaction rated highly. Almost 78% of respondents indicated they were well supported by managers, and almost 70% felt appreciated by the hospital leadership. Just over 78% responded that the managers praised good work.
- The CEO told us they had started weekly workshops recently, which were held either as a breakfast or afternoon session. These sessions were used to share information and would be continuing going forward on a monthly basis. They expected to communicate information for example, about key performance indicator results, and changes in policy.
- We spoke with the lead for human resources and operations who told us about the current position with respect to workforce race equality standards. A baseline assessment of the workforce had been completed, which was shared with us. This included the whole workforce and took into account protected characteristics, and was then compared with some of the NHS data. The report, which was presented to the board identified gaps in the data, and as a result of this more work was planned for January 2017. An action plan had been developed to support this, in conjunction with the new IT system.

Innovation, improvement and sustainability

- Staff were recognised for their contributions to patient care through the hospital's 'magic moments' award scheme. We saw information which demonstrated a number of staff within the surgical services had been recognised and received individual awards for their valuable contributions to patient care. In July 2016 departmental awards had been presented to St Elizabeth Ward, nominated by a patient for their

dedication and compassion. St Francis ward had also been commended Information about such awards was also provided, along with other information about staff and the hospital in the 'Heartbeat' newsletter.

- The hospital had created an off-site patient contact centre. This was developed with the aim of providing a rapid and responsive service to members of the public providing information about particular consultant services, specialities, clinic sessions and operating days. The phone was expected to be answered within two rings, and staff would respond directly. The centre linked directly with various surgical specialities, such as gynaecology, hois, knees and hernia, which meant specific information could be provided in a timely way
- A GP symposium was held in the previous year, with over 440 GPs in attendance, where consultants presented a topic related to their speciality.
- A new hospital development is commencing in April 2017 which will include seven operating theatres and a day care unit, refurbishment of all wards, an admission suite, a new HDU/ITU and imaging department.

Good

End of life care

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

Are end of life care services safe?

Good

We rated safe as good because;

Incidents

- Staff used an electronic incident recording system to report incidents and said they felt they were supported to do so by the senior team. For example, one member of staff said, "If I report an incident a senior member of staff investigates it and discusses it with me. It's a very supportive approach, I've never felt 'told off' or under pressure for reporting something."
- Senior staff discussed incidents during a monthly clinical governance meeting and identified any potential changes to practice or policy as a result of incident investigations. A detailed 'lessons learned' report was produced monthly and used to identify strategies for risk reduction. For example, after an incident involving an abusive patient, the ward manager provided staff with up to date guidance on the managing conflict policy. Ward managers subsequently discussed incidents relevant to their area of work in departmental meetings. We attended a clinical governance meeting and spoke with the hospice director about a decrease in the number of incidents reported by staff. He said this was due to the team successfully addressing previous incidents and avoiding recurrences.
- There was evidence of improved practice as a result of incident reporting. For example, the discharge policy was amended following an incident with a discharge letter. This gave responsibility for accurate letters to a registrar and ensured information was copied to each patient's GP and their district nurse.
- Between July 2016 and September 2016, staff reported 38 incidents in the hospice inpatient unit and three incidents in the hospice day centre. Incidents relating to medication, the implementation of care or ongoing review accounted for 53% of incidents.
- A dedicated falls group reviewed all patient falls and conducted a root cause analysis of each fall. The senior member of staff in each area was responsible for falls prevention management and the falls group provided support to them in prevention training and incident investigation. Falls investigation adhered to quality standard 86 of the National Institute of Health and Care Excellence in relation to adequate assessment and future prevention.
- Staff used a weekly multidisciplinary meeting in the hospice inpatient unit to review any patient deaths as part of a morbidity and mortality discussion.
- We viewed the outcome of an investigation into the development of a grade three unit-acquired pressure ulcer incident in the inpatient hospice. The investigation included strategy meeting minutes to discuss the incident attended by six members of staff including the tissue viability nurse. The investigation showed root cause analysis, lessons learned, and actions taken, such as providing additional and on-going training to nurses and introducing a care bundle and documented pathway that adhered to the 'SSKIN' standards of NHS England and the British Association for Parenteral and Enteral Nutrition.
- We viewed the outcome of an investigation into the incorrect dose of a controlled drug administered to a patient in the inpatient hospice. The root cause analysis was thorough and a review of the timeline of events led to a number of changes in practice and policy. This

included more intensive staff training, a change to the hospital medicines management policy and increased oversight of prescribing and administration by the medical team.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. The hospice inpatient unit used this tool to assess patient safety and outcomes. We saw evidence the safety thermometer data was being routinely used to improve the quality of care, such as the number of 'harm free days'. Between January 2016 and September 2016, 100% of care was harm-free with a small number of patients being treated for pressure ulcers acquired before being admitted to the hospice.

Mandatory training

- The hospital had a mandatory training policy that required staff to undertake up to 23 specific modules of training depending on their role. A number of training sessions were common to all staff as part of their induction, including complaints handling, incident reporting, fire awareness, information governance and conflict resolution.
- Life support training was mandatory for all staff and the level provided depended on their role and responsibilities. For example, all staff had basic life support training and all clinical staff had intermediate life support training. Resident medical officers (RMOs) and night sisters had advanced life support training.

Cleanliness, infection control and hygiene

- A monthly infection control audit took place amongst a sample of 20 patient contacts to assess staff hand washing technique and their compliance with the hospitals 'bare below the elbow' policy. Between July 2016 and September 2016, average compliance with hand hygiene practice was 97% and average compliance with the 'bare below the elbows policy' was 90%. The infection control audit nurse immediately intervened with any staff observed who did not follow infection control practice.
- The mortuary viewing room was clean but was being used to store a patient's personal belongings. We spoke with a senior nurse who said this was a temporary measure and the items would be removed soon, which was saw was the case. The hospital bed used for viewing had a green 'I'm clean' tag attached. Staff consistently used this system for all cleaning to indicate when an item had been disinfected and could be safely used.
- Housekeeping staff cleaned fridges after each transfer out and porters provided a cross-check to ensure the clean was thorough.
- An infection control nurse adviser conducted an infection prevention and control hygiene audit over three days in July 2016 and August 2016, including an inspection of hospice facilities. The audit highlighted 12 areas with a 'high' or 'urgent' need for improvement. The hospice manager worked with colleagues in housekeeping and estates to address the issues and make immediate improvements where possible. For example, the audit found high-level dust on the tops of paintings, which were subsequently cleaned by housekeeping staff. In addition, receptionist's chairs were found to be torn and stained, which presented an infection control risk. The reception manager was preparing a replacement plan for chairs with an easy-to-wash design. In addition, the decision was made to discard all of the plastic bedpans as there was no method to properly disinfect them. They were replaced with disposable papier-mâché items. At the time of our inspection all of the areas identified by the audit had been rectified with the exception of a kitchen fan and flooring in the Lymphoma clinic room. These had also been replaced by the time of our unannounced visits in early November.
- In the reporting period July 2015 to June 2016, there were no reported instances of meticillin-resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile infection.

Environment and equipment

- Waste management and disposal procedures in the hospice units followed national best practice guidance, including in the handling of biohazardous waste.
- Syringe pumps were stored and used in line with manufacturer and NHS guidance.

- The mortuary had storage available for 12 bodies in three fridges. One fridge was capable of accommodating larger bodies. The fridge temperatures were checked and recorded daily by the porters and any problems reported to the estates manager.

Medicines

- A central pharmacy managed medicine stocks in medical services and a medicine management committee provided safety and governance oversight.
- Medication errors and incidents were discussed in a monthly risk and governance meeting and there was evidence of improved practice as a result. For example, after a patient was discharged with an incorrect medication dose in their discharge letter, a lead consultant for palliative care contacted each doctor individually with a reminder of the discharge policy. Between July 2016 and September 2016, staff reported 14 incidents relating to incorrect administration, prescription, handling or storage of medication. In response an independent pharmacist had completed objective structured clinical examinations (OSCEs) with all relevant staff, including competency assessments in medicines management, controlled drugs and syringe drivers. In addition, the prescription chart template had been redesigned to reduce the risk of recording errors.
- We spoke with a member of staff who had experienced a medication error. They said they had been well supported after this and given the opportunity to reflect on their practice to identify areas for improvement.

Records

- Staff used an electronic patient tracking system to document risks to patients wherever they were cared for in the hospital or hospice. This document was detailed and included guidance on mobility as well as where patients had increased falls risks for certain activities. Where patients could mobilise with assistance, it was noted how many staff were needed to assist.
- Nurses completed a care plan on admission for each patient. This included risk assessments for falls, moving and handling and skin integrity, which were repeated weekly or more regularly if patients were at high risk. Risk assessments for all nine inpatients at the time of our inspection were dated and signed by an assessor.
- Patient records were completed, stored and organised in line with the hospital clinical record keeping policy. Each care plan had a signature sheet preface staff were required to sign after they had read the document. This was evidence staff providing care understood the patient's needs, medical and social assessments. However, in one care plan for a patient who had been admitted for over two months, only one member of staff had signed the sheet. One patient's care plan was missing risk assessments for a four week period. This was because staff had started a new volume of notes for the patient, which meant some information was not immediately available. We spoke with the ward manager about this who was able to show us how they could be easily accessed. This meant records were kept in a way that provided staff with rapid access to contemporaneous notes.
- For all the records we viewed we saw falls risks assessments were in place for each patient.
- Clinical record keeping, nursing assessment and care plan audits had taken place to assess quality against the standards of the Royal College of Physicians General Record Keeping Standards and the Nursing and Midwifery Council Record Keeping Standards. The latest results related to the reporting period March 2016 to June 2016 and reflected a significant deterioration of standards in documentation. This included a reduction of 21% in the number of entries that were timed and a reduction of 56% in the number of entries that had a legible, printed staff designation. In response the senior hospice team provided staff with improved training and education. The audit found very good standards of discharge planning and documentation.
- Staff completed DNACPR documentation in line with Resuscitation Council (UK) guidance, including an assessment of mental capacity. We looked at five DNACPR forms and found them all to be signed by an appropriate doctor. On one form staff had not indicated if the patient had a welfare attorney or if they had a valid advance refusal in place. This was an exception to the otherwise consistent standards of documentation. An advance refusal is a decision patients can make to refuse a specific type of treatment in advance. The doctor also noted the person did not have mental capacity to make the DNACPR decision and referred to a previous conversation with a relative over the decision instead of seeking a new assessment to confirm the situation.
- A record keeping audit took place between March 2016 and June 2016 and found 100% compliance with DNACPR documentation. Our findings therefore

suggested a possible lapse in quality control processes since then. However, this audit found full compliance with consent and mental capacity documentation, both of which were of a good standard during our inspection.
- Multidisciplinary team (MDT) notes and clinical notes were stored using two different systems. For example, an MDT co-ordinator summarised discussions after each MDT meeting but these were not always checked by a clinician and doctors and nurses used paper records in the inpatient unit. However, the MDT action plan was added to the inpatient handover sheet so that all staff had timely access to the notes.

Safeguarding

- The hospital had an overarching safeguarding policy that applied to each department. Staff we spoke with had good knowledge of this, and some staff demonstrated how they had used it in practice, including when liaising with the hospital safeguarding lead and local authority services.
- Staff adhered to patient's wishes and the requirements of lasting powers of attorney when handling sensitive patient information and monitoring access to hospice and hospital areas. For instance, where a family had a safeguarding concern about a relative of a patient, staff included discreet details on the electronic patient record system to ensure staff did not grant access to them.
- Following an incident investigation into a pressure sore, the hospice adopted a new protocol to inform referrals of patients with pressure damage. This meant care would subsequently be provided in line with an established assessment and risk management pathway.
- On the hospice inpatient ward, 95% of staff had up to date adult safeguarding training levels one and two and 20% of staff had up to date child safeguarding training levels one and two. The ward manager had escalated the need for additional training dates to the deputy matron to increase the number of staff with up to date training.

Assessing and responding to patient risk

- Patients in the last days of life were cared for according to a ratified policy that took into account their personal and cultural wishes as well as that of those close to them where appropriate. This included regular reviews of medication, pain relief, personal care and mouth care.

Nurse staffing

- A ward manager led a team of four band six sisters, 14 band five staff nurses and 10 healthcare assistants (HCAs) in the hospice inpatient unit. There were three posts vacant for staff nurses and two posts vacant for HCAs. A multidisciplinary nurse coordinator, a practice development nurse and a referral and discharge nurse worked full time in the service.
- Nurse staffing levels in the inpatient hospice were flexible based on patient needs. For example, if a patient's level of risk for falls increased, the hospice provided one to one nursing care. Between April 2016 and September 2016, nurses employed permanently by the hospice staffed 71% of planned nursing shifts. Agency and bank nurses filled shifts where changes in a patient's condition or an unscheduled admission meant enhanced one-to-one care was needed.
- A night sister was available between 7pm and 7am and acted as a single point of contact site manager for ward-based staff. This member of staff was supernumerary to nursing teams and provided responsive support to clinical areas when called in addition to visiting each ward individually at least once per shift.

Medical staffing

- Two consultants in palliative medicine led care in the inpatient hospice and community and day care services and cover was provided on a 1.6 whole time equivalent (WTE) basis. An additional 0.8WTE consultant post was available and was advertised for recruitment. Consultant cover was provided Monday to Friday from 8am to 8pm. Out of hours and at weekends, a consultant was available on an on-call basis.
- A registrar and junior doctor provided medical support seven days a week between 8am and 8pm and a GP trainee worked in the hospice two days per week.
- Between 8pm and 8am, an RMO provided on-site medical cover and two on-call physicians were also available.
- On one date in September 2016, non-urgent patient admissions to the hospice were restricted due to non-availability of staff. This occurred through a mixture of annual leave and doctors attending training off-site. This situation was added to the hospice risk register with a view to recruiting an additional junior doctor in 2017.

Good

End of life care

- A morning handover meeting was used to discuss all new referrals amongst the inpatient unit team, including the medical team, referrals and discharge nurse, coordinating nurse and therapies staff.
- RMOs handed over to each other twice daily with a review of patients in the hospice. This included consideration of any cultural or religious needs in relation to the end of life and death certificate. This helped RMOs ensure they could follow patient's wishes.

Emergency awareness and training

- The director of governance and risk was working to align disaster recovery and business continuity policies within the NHS England Business Continuity Management Framework. Staff training was planned for after the hospital's policy and strategy was updated and ratified by the senior executive team.
- Staff had fire training for their usual area of work, including the principles of firefighting and evacuation. A named fire warden was in post for the hospice areas and all staff we spoke with knew who they were and what the process was in an emergency.
- Hospice units complied with the NHS England standard for emergency preparedness, resilience and response.

Are end of life care services effective?

Good

We rated effective as good because;

Evidence-based care and treatment

- Hospice care was provided in line with London Cancer Alliance Palliative Adult Network guidance. Palliative care clinical nurse specialists provided care based on the gold standards framework. Palliative care standards followed guidance 31 of the National Institute of Health and Care Excellence (NICE) in relation to the care of dying adults in the last days of life.
- Staff completed falls risk assessments and avoidance strategies based on clinical guidance 161 of NICE in relation to reducing the risk and incidence of falls.
- A new mortuary policy had been ratified but a risk and governance meeting highlighted this had not been made available to staff through the intranet. This also indicated a need for additional training for porters in mortuary procedures.
- An audit committee met monthly to review the progress of audits within the hospice programme. In the period July 2016 to September 2016, staff completed five audits to benchmark and assess service and practice against legislation, best practice guidance, and internal policies. For example, hospice day services were audited against the Hospice UK Audit guidelines to benchmark against existing standards to identify areas for improvement. A care of deceased patients audit was used to ensure compliance with local pharmacy medication standards and a controlled drugs audit checked management met the requirements of the Misuse of Drugs Regulations (2001) and the Controlled Drugs (Supervision of Management and Use) Regulations (2006).
- The hospice audit programme for October 2016 to December 2016 consisted of seven audits to ensure ongoing quality assurance and benchmarking. This included an audit of the monitoring of venous thromboembolism to ensure this was conducted in line with National Institute of Health and Care Excellence clinical guidance as well as audits of clinical falls and the management of pressure ulcers.
- Pharmacy services conducted a bi-annual audit of missed medicine doses and the documentation of allergies. The latest available results were from March 2016 and indicated 100% of patients in the hospice audit sample had allergies documented. In addition, staff had accurately documented omission codes for all missed medicine doses. This meant patients were protected from the avoidable harm because practice followed evidence-based standards.

Pain relief

- Nurses completed a pain risk assessment and score for each patient on admission, which was reviewed at intervals depending on the patient's level of need.
- A quarterly survey measured how patients felt their pain and symptom relief was measured. Results were consistently good, with 95% of patients between November 2015 and September 2016 indicating satisfaction with this.

Nutrition and hydration

- Staff used the malnutrition universal scoring tool (MUST) to monitor patient food and fluid intake and to protect them from the risks associated with malnutrition and dehydration. However, in two of three patient records

we looked at, the MUST was either incomplete or missing. We spoke with the ward manager about this who told us MUST assessments had been identified as an area for improvement by the nutrition and hydration steering group. A new standard operating procedure was being prepared and education sessions had been provided for staff. The steering group was due to re-audit the completion of MUST documentation in November 2016.

Patient outcomes

- Staff ensured bodies were not kept in the mortuary longer than the recommended time after death and within the two week maximum allowed by the hospital policy. Between April 2016 and September 2016, no referrals were made to Public Health Funerals.
- The deputy matron reviewed each patient transfer to ensure it was in their best interest and ensure staff had followed the transfer protocol effectively and safely.

Competent staff

- All nurses and healthcare assistants who joined hospice services completed an introduction to palliative care course. This included training on how to improve system control, communication skills and guidance on how staff can look after their own welfare.
- A palliative care practice development nurse had recently been appointed and led an education and professional development programme.
- The senior leadership team actively encouraged staff to undertake additional training and qualifications. For example, all band six nurses either had or were about to complete a degree in palliative care and a band seven nurse was about to begin a degree programme. Staff had also undertaken specialist training in the management of chronic obstructive pulmonary disease.
- Hospice staff had an annual appraisal that enabled them to discuss their work and identify training needs. All staff who had been in post for over 12 months had completed an appraisal. Senior staff encouraged them to set objectives for the coming year, such as to complete the care certificate for healthcare assistants.
- The drugs and therapeutic committee and medication safety committee assessed all staff responsible for the administration of medication for their clinical competency and adherence to policies and the standard operating procedure for controlled drugs.
- In response to risks identified in the hospice, specialist training had been provided or was planned for late 2016 for staff in medicines management, pressure ulcer prevention, moving and handling and clinical record keeping.
- Palliative care ambulance crew were trained in the use of oxygen on board and had completed first aid and basic life support training. This team was due to undertake a communication course in the near future.
- All HCAs either held or were undertaking the nationally-accredited care certificate. This meant their practice was benchmarked against established quality and training standards.
- Porters were responsible for moving bodies from the hospice or ward to the mortuary using a special body transport trolley. All porters were trained by a supervisor and were checked throughout the year as they undertook the task.

Multidisciplinary working

- The service used an electronic palliative care co-ordination system to enable staff to track patients on a palliative care pathway wherever they were cared for in the hospital. This system included medical and social information on each patient and helped staff to co-ordinate their care effectively across multi-professional teams. For example, where a patient's wish was to move from the hospital to a hospice nearer their home, staff contacted the hospice to begin planning this.
- A daily multidisciplinary team (MDT) meeting in the hospice day unit was used to identify patients who had been admitted and who were known to the day service as well as new patients, discharges, referrals and patients who were taking part in a research trial. We observed one meeting and saw it included an MDT co-ordinator, a therapies assistant, the day services clinical manager, a staff nurse, a palliative care consultant, a community services manager and a social worker. The team discussed each patient in depth and with a holistic approach that enabled them to plan complex individualised care.

Good

End of life care

- We observed a weekly MDT meeting in the hospice inpatient unit. This was well-attended by a range of professionals including both palliative care consultants, a registrar, physiotherapist, social worker, nurses, therapies assistant, chaplain, discharge nurse and pharmacist.
- Staff had access to an alcohol service psychiatrist who provided on-demand targeted support with the medical and nursing teams for patients living with the effects of alcoholism, including the psychological support needed for Korsakoff dementia.
- A dietitian provided a dedicated weekly visit to St John's Hospice and completed dietetic assessments and reviewed related policies.
- Documentation of multidisciplinary care was of a very high standard, with each discipline clearly defined and extensive evidence of multi-professional working and treatment planning.
- Palliative care clinical nurse specialists met with GPs in the local area to coordinate care for patients in line with the gold standards framework.
- Specialist care and review was provided in hospice services for a range of long-term conditions and co-morbidities, including heart disease, respiratory failure, HIV and cancer.

Seven day services

- Consultant cover was provided Monday to Friday from 8am to 6pm with an on-call service available outside of these hours. The hospice was undertaking recruitment for a dedicated specialist palliative care weekend doctor.
- Pharmacy services were available seven days a week, between 8am and 8pm Monday to Friday and 9am to 6pm at weekends.

Access to information

- Discharge summaries, included the do not attempt cardiopulmonary resuscitation (DNACPR) status of each patient, were sent to each patient's GP on their day of discharge. This included information on their reasons for admission, investigations and diagnostics undertaken and a rehabilitation plan if appropriate.
- Palliative care consultants liaised directly with GPs to co-ordinate follow-up care after discharge where needed.

Consent, Mental Capacity Act and DoLS

- Senior staff demonstrated good awareness of their responsibilities in relation to the Deprivation of Liberty Safeguards (DoLS) and ensured the use of this legislation was in patient's best interests. For example, a referral was made for a DoLS authorisation to protect a patient who was very agitated during the terminal phase of their illness.
- We observed a very high standard of consideration of a patient's needs in relation to the Mental Capacity Act (MCA) (2005) and DoLS during an MDT meeting. This included considering changes to the patient's care plan as a result of fluctuating capacity and behaviour.
- Staff used soft knitted posey mittens to prevent patients scratching themselves and pulling out intravenous lines. Mittens were used only following a risk assessment and mental capacity assessment and staff monitored the patient's condition to enable them to remove the mittens if it was safe to do so.
- Hospice staff had been provided with enhanced DoLS and MCA training and advanced care planning training following an audit of practices in the unit.

Are end of life care services caring?

Good

We rated caring as good because;

Compassionate care

- Staff ensured that after a patient died, their possessions and valuables were stored safely and returned to a person nominated by the patient. They also ensured patient's wishes about organ donation were acted on promptly, including immediate contact with specialist organ donation teams and providers.
- The quarterly patient survey included a recommendation question based on the NHS Friends and Family Test. In the period July 2016 to September 2016, 100% of respondents said they would recommend the unit. This was better than the year to date average from November 2015 to September 2016 of 93%.
- Between July 2016 and September 2016, the patient survey indicated improvements in the scoring of 10 of the 17 measures used to assess how patient's felt about their care. For example, 100% of respondents said they were happy with how hospice staff communicated with

them, compared to an annual average of 90%. In addition, 100% of patients said they felt staff treated them with dignity and respect, which was better than the annual average of 95%.

- As part of our inspection we asked the hospital to make comment cards available to patients and their relatives to tell us about their experiences. One respondent wrote, "Our [relative] was admitted to St John's Hospice a week ago. It was a very sudden deterioration in his condition and we were unprepared. But the care, attention and support we received from the admin staff, doctors, nurses and kitchen staff has supported us to provide the very best ending we could for him. He died today and I cannot think of anywhere else we would rather have been at this time." Another person wrote, "We came to St John's at very short notice. We were very shocked and traumatised. Everyone has taken incredible care of us and of [my relative]. [They] died this afternoon and we couldn't have been better supported. He was taken care of as if he was a family member."
- Arrangements for the transfer of bodies from the hospice or a ward to the mortuary ensured dignity and respect were maintained and nurses and porters worked together to ensure appropriate documentation was completed before and after transfers. We spoke with a porter supervisor who told us collections were arranged for before or after normal hospital hours to minimise distress for other patients. If bodies needed to be moved during the day, staff were able to obscure doors with screens and extra staff were always on hand to facilitate the movement.
- One patient told us, "Frankly without the care of the staff I doubt I would have made a recovery."

Understanding and involvement of patients and those close to them

- Staff offered to help patients complete a family tree during their time in hospice care. This helped to stimulate patients, provided psychological support and helped staff to understand their family situation.
- Staff used the quarterly patient survey to assess how well patients felt involved in their care and treatment. In the period July 2016 to September 2016, 82% of patients said they had been involved in decisions about their care and treatment as much as they wanted to be. This was similar to the annual average of 85%. In the same period, 80% of patients reported they had been given enough information to make decisions about their future care. This was better than the annual average of 77%.
- One relative said, "The staff are very caring, the doctors speak to us about the treatment and care and are mindful of the fact that [patient] does not want to know the details too much. Housekeeping staff always offer me drinks and snacks as they go around the ward, even those who don't know me."

Emotional support

- Care plans demonstrated good levels of attentive, emotional care. For example, a member of staff had documented in one patient's care plan that their mood was being negatively affected because they wanted to collect some personal possessions from home. To help improve the patient's mood, staff arranged for a home visit the following day so the patient could collect some belongings.
- Staff completed comprehensive emotional support assessments of patients. This helped them to build relationships with patients and understand what was most important to them. For example, where patients received a terminal diagnosis, staff documented their conversations to identify if they needed targeted psychological support. In addition, each patient had a spiritual assessment to help make sure staff understood their beliefs and could provide care that respected these.
- In the period July 2016 to September 2016, 73% of patients who completed the quarterly survey said they felt staff recognised and addressed their emotional and psychological needs. In addition, 82% of patients said staff recognised and addressed their religious or spiritual needs.
- During a weekly multidisciplinary team meeting we observed staff had a good understanding of the spiritual and emotional needs of each patient, including recognition of any family issues.
- A spiritual and religious steering group worked with the hospital chaplain to ensure patients had access to care that met their emotional and holistic needs beyond physical treatment.
- The chaplain led a twice yearly 'light up a life' service for bereaved families and welcomed people from all faiths.
- A team of volunteers worked in hospice services and provided one-to-one support to patients as well as

Good

End of life care

facilitating activities with them. Volunteers completed a thorough vetting process, including through the Disclosure and Barring Service, and were supervised at all times when with patients.

- Two art therapists visited the hospice weekly and provided structured activities support to patients.

Are end of life care services responsive?

Good

We rated responsive as good because;

Service planning and delivery to meet the needs of local people

- Staff used an electronic patient administration system to record patient priorities for their preferred place of death. In the period February 2016 to September 2016, 85% of patients were able to die in their preferred location. During a weekly multidisciplinary team meeting we observed staff had a good understanding of each patient's preferred place of care and preferred place of death. Staff used a personalised patient care plan to ensure they understand each patient's needs and wishes in their last days of life, in line with the hospitals care of the dying patient policy.
- Two palliative care ambulances were available with three dedicated crew for patient transfers, admissions, visits home and as part of the Hospice at Home service. This service facilitated rapid discharge for patients with a community package of care who wanted to leave the hospice for their own home.
- The Hospice@Home team provided structured support for the last two weeks of life and were particularly responsive in arranging for patients to die at home when this was their wish.
- Staff changed a rolling trolley for a hospital bed in the mortuary as they felt it was a more sensitive way to present a body to relatives.
- Patient accommodation on the hospice inpatient unit was provided in private ensuite rooms.
- Provisions were made for visitors and relatives. This included facilities for relatives to stay overnight with patients in the inpatient hospice and day hospice patients often brought family, friends and carers with them.

Meeting people's individual needs

- Staff included personal requests in their handovers and multidisciplinary review meetings of patients. For example, where a patient requested a specific daily newspaper, this was noted in handover documents.
- Healthcare assistants were trained to provide escort support to patients who wanted a home visit or to attend a day centre.
- Staff took time to ask patients about their personal and social needs. For example, a nurse asked one patient what they wanted to do that they couldn't because they were in the hospice. When the patient said they would rather be spending time with their sister, staff set up a telephone call for the patient. The hospice team were empowered to provide an individualised, responsive service to patients and could organise weddings on-site as well as order special birthday cakes from the catering department.
- Each patient had a 'what matters to me' board by their bedside and could use this to express what was important to them.
- An on-site chapel was available 24-hours for patients to use for religious purposes or quiet reflection. Staff also enabled hospice patients to take part in activities such as alternative therapies, crafts and art.
- Access to the chapel was up a flight of steps and an electric stair-climbing wheelchair was provided to ensure patients with reduced mobility could access this. The chapel was available for patients, relatives and visitors of all faiths.
- Patients had access to a garden, which had been previously designed and displayed at a nationally recognised garden event.
- The quarterly patient survey asked questions about the choice and quality of food and demonstrated variable results. In the period July 2016 to September 2016, 92% of patients said they were happy with the quality of the food. This was better than the year to date average result of 85%. The percentage of patients who said they were happy with the choice of food between July 2016 and September 2016 decreased from the year to date average of 75% to 67%. To improve this, staff ensured volunteers who were responsible for managing menus were aware of the additional options that were always available.

Good

End of life care

Access and flow

- In the period April 2015 to September 2016, 27% of patients died in the hospice and 21% of patients were discharged home. Other patients either died in hospital or in the care of relatives.
- Following an incident that resulted in a delayed discharge of 24 hours, the ward manager or multidisciplinary team nurse representative allocated specific tasks to a named nurse and ensured discharge nurses followed a prescribed checklist during the discharge process. All hospice staff were scheduled to attend discharge planning training.
- A discharge co-ordinator was present in the weekly multidisciplinary team meeting in the hospice inpatient unit. Discharge planning involved input from all staff who provided care to the patient.
- The hospice inpatient unit planned to admit patients between 9am and 5pm Monday to Friday and could accept emergency admissions from the community at weekends.
- The hospice day unit was open four days per week and was used for multidisciplinary meetings and specific patient clinics one day per week.

Learning from complaints and concerns

- Hospice services received no formal complaints between April 2016 and September 2016. Changes had been made to services following complaints before this period. This included improving communication training for nurses and healthcare assistants and improving drug charts for doctors.
- The hospital's complaints leaflet was widely available in all areas, including on digital information screens and their website. Staff at all levels of responsibility were trained to respond to verbal complaints from patients, relatives and visitors. For example, if a junior member of staff received a verbal complaint, they offered the person involved the complaints procedure leaflet, attempted to resolve minor issues there and then and let the nurse in charge know about the situation.
- A quarterly survey asked patients if they had been given information about how to raise concerns about their care. In the period July 2016 to September 2016, 77% of patients said they had been given this information, which was better than the year to date average result of 65%.

Are end of life care services well-led?

Good

We rated well-led as good because;

Vision and strategy

- Staff in end of life care services felt involved in the vision and strategy of the provider as a whole and said they felt supported to contribute to and develop their service.
- The end of life care service had an immediate strategy to reduce turnover of staff and ensure the team was stable and could contribute to long-term development.

Governance, risk management and quality measurement

- The hospice director held overall responsibility for palliative care services and was supported by the inpatient unit service manager, the day services clinical manager and two palliative care consultants.
- The board of directors led an overarching quality assurance framework that involved a number of groups responsible for safety and risk management in the hospice and end of life care services. This included a blood transfusion group, point of care committee, infection prevention and control group and a medication safety committee. A dedicated clinical governance quality committee led clinical policy and clinical audit groups.
- Clinical governance meetings were well attended by multidisciplinary clinical and non-clinical staff. We observed one meeting and saw the hospital director, a secretary, two consultants, the therapies lead, a referral and discharge nurse, a ward manager, the day hospice manager, a community services manager and the infection control multidisciplinary co-ordinator attended.
- Senior staff maintained a risk register that was used to monitor significant risks to the service, its patients and staff. They discussed each item during monthly clinical governance meetings although work to resolve risks was ongoing continually. For example, one risk included a need for an additional palliative care consultant but an attempt to recruit had resulted in no applications. Staff used a monthly clinical governance meeting to review

recruitment strategies and whether the risk to the service was escalating. There was evidence of an effective review process in place for the risk register, such as a reorganisation to provide more storage space for essential equipment.

- A hospice risk register was used to review and update risks to the service, its patients and staff on a quarterly basis. A named lead held responsibility for each risk and identified progress and action during a monthly governance and risk meeting. Where risks could not be fully resolved and remained on the risk register, they were added to the hospital audit programme to monitor patient safety. A risk policy group monitored risks specific to the hospice and supported staff to manage these within the scope of the service. Where they found a risk to be on-going or escalating, this was escalated from the hospice risk register to the corporate risk register.
- There was good evidence of multi-professional involvement and co-ordination across governance structures. For example, the hospice clinical lead was part of the medical advisory committee, which meant they could ensure clinical practice and staffing was maintained. In addition palliative care consultants attended drugs and therapeutic committee meetings to contribute to medication policy changes and incident investigations.
- There was evidence of improvements to the service as a result of medical advisory committee meetings. For example, it was identified the drug chart risk assessment tool in the hospice did not meet national standards. As such a new risk assessment tool was introduced that ensured compliance.

Leadership of service

- All of the staff we spoke with described a supportive and coherent leadership structure and we saw evidence of this in practice during our observations and time in the hospice areas. Staff told us they had access to psychology support services on request and this was provided without question or pressure. One member of staff said, "I have time to properly care for my patients and to spend time with them. We have a great ward manager and they've been very flexible with my hours when I needed to get a better work life balance."
- The deputy matron conducted a daily walk around of all medical areas to provide support to staff and a visual senior presence.

Culture within the service

- All of the staff we spoke with in the hospice described a positive and supportive working environment. One member of staff said, "I've felt very welcomed since I came to work here. Everyone looks out for each other and it feels like I belong here."

Public and staff engagement

- A user involvement forum and volunteers contributed to the development of the patient survey tool and encouraged more patients to contribute, resulting in a 37% completion rate in the period July 2016 to September 2016.

Innovation, improvement and sustainability

- In the 12 months prior to our inspection, staff turnover in the hospice inpatient unit was 32% and staff turnover in day services was 25%.
- A dietitian trained volunteers in the hospice as part of a three-monthly rolling programme.
- The palliative care ambulance crew were due to begin their first patient survey imminently and would use the results to improve the service.
- The hospital encouraged staff and patient participation in research trials where these were deemed to be safe. This included the participation of hospice patients in the CanACT trial to explore using a new type of treatment to improve mental, social and physical health during cancer treatment.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because;

Incidents

- There was a system for reporting and recording significant events. In the 12 months prior to our inspection there had been no reported never events for the outpatient or diagnostic imaging department. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.
- Between July 2015 and June 2016, there had been 12 non-clinical incidents within outpatient and diagnostic services.
- In radiology and diagnostics lessons learnt were shared through different routes including discussion at the imaging speciality group meeting held quarterly. Minutes from these meetings were sent to all radiologists via e-mail and a hard copy was available in the department.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Staff were aware of actions they should take when a 'reportable patient safety incident' occurred and assured us they were open and transparent. They were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most nursing staff we spoke with were clear what duty of candour meant for them in their role. Managers accurately explained what responsibilities they had under duty of candour.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons learnt were shared and action was taken to improve safety in the practice.

Cleanliness, infection control and hygiene

- All nursing staff in the clinical area were wearing appropriate uniforms, which complied with the hospital's "bare below the elbow" policy to allow for appropriate hand washing and prevent infections.
- Several staff told us hand hygiene audits had not been carried out for consultants. Despite this, we were provided with audit results for the period August and September 2016, which indicated the inclusion of consultants in the monitoring of compliance. We saw when it was identified they were not following correct protocol they had been challenged by staff and their response had been recorded. For example, removing a wrist watch.
- Information from staff regarding the hand hygiene audits indicated observations were made of individual staff on several occasions. When we reviewed the audit

results and discussed these with staff, we were concerned that the number of individuals included in the audit was small. Therefore this was not necessarily representative of a robust audit.

- Staff also told us they had observed consultants not following hospital policy on infection control. We observed two consultants who were not adhering to the arms bare below elbow policy. Managers told us nursing staff were encouraged to speak with consultants directly if they observed the policy not being followed and staff confirmed this.
- Following our visit managers told us they had introduced more robust arrangements to monitor "bare below the elbow" and hand hygiene standards for all employed staff and consultants practising at the hospital. They had introduced a "planned audit schedule" to ensure infection control procedures were followed by all staff in outpatients departments.
- The infection control link nurse, took responsibility for monitoring the hospital policy on hand washing and training staff in the outpatient department. They had recently taken on this additional role and confirmed audit processes to ensure compliance of hand hygiene within outpatients was not yet established. Hand hygiene audits carried out by the hospital did not include the outpatients department. This information was contrary to the evidence we were provided with following our inspection visit.
- The hospital had introduced nursing staff competency checklists. These were in the process of being implemented for all nursing staff and they included observation of hand hygiene techniques. We saw records of two staff who had been signed off as competent and found they were appropriately completed.
- We saw regular hand hygiene audits from the imaging department, which confirmed staff were compliant with legislation.
- Nursing staff told us they had completed mandatory training in infection prevention and control training. We saw 86% of registered nurses in the OPD had completed this training, and 100% of the healthcare assistants had completed it.
- The hospital maintained standards of cleanliness and hygiene and we observed the hospital to be clean and tidy. Clinical areas appeared clean and checks were in place to monitor cleanliness. Spillage and cleaning products were available to staff.
- Staff were employed in housekeeping services to monitor the cleanliness of toilets and general outpatient areas, and an external provider managed cleaning schedules within the hospital. Cleaning staff completed daily cleaning checklists to confirm which areas had been cleaned.
- Personal protective equipment, such as aprons and gloves were available. Hand-washing facilities were available in each clinical room. Staff across the outpatient services were observed to be using personal protective equipment appropriately. And in line with:Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE.
- We observed hand sanitisers were easily accessible to staff and patients and others visiting the hospital. They were routinely placed near an exit or entrance to the area, encouraging people to sanitise their hands. Hand gel was available in all clinical areas, however we observed there were no information in waiting areas and other communal areas advising patients to use hand gels.
- Domestic, clinical and hazardous waste and materials were managed in line with current legislation and guidance.
- There were systems for the segregation and correct disposal of waste materials such as x- ray solutions and sharp items. Sharps containers for the safe disposal of used needles were available in each clinical area. These were dated and were not overfilled**.** This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Environment and equipment

- Equipment we looked at was visibly clean and stored appropriately. All clean equipment had "I am clean" stickers or notes attached.
- The curtains in use within the consulting and treatment rooms were disposable and found to be in date.

Good

Outpatients and diagnostic imaging

- The examination couches observed within the consulting rooms were wipeable and stocked with blue disposable towels. This meant the couch could be easily cleaned between each patient.
- The hospitals electrical maintenance team were responsible for annual safety testing. The equipment we looked at all had an up to date safety test and appeared in good condition.
- The assessment, revision, and renewal of imaging services that are provided is considered good practice by the United Kingdom accreditation service (UKAS, 2013). The equipment in the diagnostic imaging department was on a capital replacement programme, with the computerised tomography (CT) scanner unit due to be replaced in the next financial year.
- The provider had an appointed radiation protection supervisor (RPS) and a radiation protection adviser (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. They provided an independent annual audit of the imaging services.
- The annual radiation protection audit in October 2015 commented that "radiology equipment was maintained to a very high standard", with a "comprehensive preventative maintenance programme and regular servicing". This ensured they met the health and safety executive guidance note PM77 on the recommended standards for diagnostic x-ray imaging systems.
- Resuscitation trolleys in outpatients were checked on a daily basis. All those we checked were well maintained with relevant medication in date. Resuscitation trolleys were available throughout outpatients and radiology and were checked and maintained ready for use in an emergency.
- Equipment used in the diagnostic imaging department had been checked regularly and serviced in line with published guidance. The provider had protocols to ensure safe operation of visible and invisible beams generated by lasers and radiation equipment.

Medicines

- We saw evidence the staff managed prescribed medications safely. In outpatients, radiology medicines were securely stored in locked cupboards. Lockable fridges were used, and these had daily temperature checks. This meant the department followed the appropriate guidance on the safe handling and storage of medication.
- Medication training was provided by the hospital and competency frameworks ensured staff were compliant with hospital policy.
- Emergency medication and emergency equipment was available on resuscitation trolleys.These were recorded as being checked daily. Emergency drugs were checked and in date.
- The hospital had its own pharmacy where patient prescriptions could be dispensed. The chief pharmacist reported to the director of operations and was an independent prescriber. This meant they were able to prescribe medications for any condition within their clinical competence.
- The radiology department used patient group directions (PGD's) for contrast media and bowel preparation (examination of the large bowel). PGD is a legal mechanism that allows named registered healthcare professionals to supply and/or administer medicines to groups of patients that fit the criteria laid out in the PGD. These are written instructions for the supply or administration of medicines to groups of patients. We found these were all in date, signed off and competency assessments had been completed for radiographers to demonstrate their understanding.

Records

- Private Healthcare differs from the NHS in that a patient contracts directly with a named consultant for their care rather than with the Hospital. When patients attend the outpatient department, the attendance is arranged between the patient and consultant based on the patient's preferences and the consultant's availability, with the consultant paying the hospital for the time using their facilities.
- Patients may see the consultant at one location for a first appointment, a second location for a follow up and a third location for inpatient care. In order to maintain a contemporaneous patient record it was essential for the consultant to maintain a comprehensive record of care provided. These records remained the property of the consultant who were data controllers in their own right.

Good

Outpatients and diagnostic imaging

- The hospital maintained clinical OPD records, which stated what treatment the patient had whilst onsite, as was documented via the prescription chart, minor treatment record form, dressing form and green surgical book.
- If the initial outpatient consultation leads to an inpatient admission the consultant had to provide a referral letter with clinical information as part of the booking form. If the patient has been an inpatient and was attending the outpatient department any existing medical notes were pulled for the consultant to review at clinic.
- Clinical records were a combination of electronic and paper records. Some consultants held their own patient records offsite to bring to the hospital. Other consultants held patient notes via their own practice software which was held securely on a cloud (remote) database accessible from the outpatient consulting rooms. Some consultants stored records onsite and used the hospital notes system to record and store patient information. As a result patients could have more than one set of notes held independently on consultant's records systems.
- Although the hospital did not monitor records availability for the outpatients department, patient care records generated in outpatients such as wound care and treatment information were kept within the department and were easily accessible.
- We saw patient's personally identifiable information was kept in the nurse's diary and a communication book that were both left out on the nurse's station.The nurse station was not always manned, and therefore information may have been at risk of being seen by non-authorised personnel. One member of staff said it needed to be left out so staff could write in it, as some clinics finished late in the evening and was used by nursing and administration staff to leave messages. The communication book had over 15 pages of individual patient's personal information either attached or loose in different pages going back to March 2016. There was one set of notes waiting to be collected from the previous week in the book. Several staff told us the communication book was not locked away at night as they had limited lockable storage. We saw the lockable cupboard was already full with box files leaving no room to put away additional paperwork.
- Paper records, currently in use in the outpatient department were stored securely behind the reception desk. Electronic records were available only to authorised people.
- Computers and computer systems used by hospital staff were password protected. Individual login details were used by members of staff including those who worked part-time.

Safeguarding

- We reviewed the latest available training information from radiology and diagnostics and it was not possible to identify the level of safeguarding training each individual had undertaken. However, we were provided with a training matrix, which indicated safeguarding children level three training was required to be completed every 18 months. The records indicated all staff were within the time scale for this, with training either completed this year or planned for later in 2016 or during 2017. Safeguarding adults at levels two and three was to be completed three yearly and all but one staff member was up to date with this or had a session planned.
- Nursing staff we spoke with told us they had completed training in safeguarding adults and children. We saw training records that confirmed all nursing staff in the outpatients department had completed safeguarding adults and safeguarding children training.
- We were given examples where staff had reported concerns using the safeguarding process, which indicated staff, were aware of their roles and responsibilities. They also knew how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- Safeguarding training was included as part of the mandatory training package and staff told us they knew where to find information should they need to. Information about how to report safeguarding concerns and safeguarding adult's information was available in outpatient clinics.
- We saw there were safeguarding policies and clear procedures to follow if staff had concerns. Safeguarding policies were updated through tri-borough meetings and included recommendations form the Royal College of Nursing (RCN) intercollegiate guidance.

Good

Outpatients and diagnostic imaging

- There were five paediatric staff trained to safeguarding level four within the hospital. Staff undertook three hours of paediatric safeguarding training every 18 months. Paediatric staff working in phlebotomy, and physiotherapy were trained to level three safeguarding children.
- An external company provided safeguarding adults training for level one and two as well as e-learning. A tri-borough level three safeguarding course was provided for all paediatric staff.
- The paediatric nursing team were available seven days a week either onsite or on-call at weekends. This service was supported by consultant paediatrician. All consultants seeing a child (up to the age of 18) were trained to safeguarding level three.
- All general nursing staff working in the OPD were trained to safeguarding level three as were the radiography staff. This was to ensure any child who had the potential to be 'at risk' was picked up immediately upon entering the service.

Mandatory training

- Staff within the outpatient and diagnostic imaging service had access to mandatory training in issues such as infection control, moving and handling, and safeguarding. This training was to be completed at various intervals. For example, two-yearly training in IPC for clinical staff, and three-years for non-clinical staff. Information governance was to be completed as an e-learning module yearly. Moving and handling for clinical staff was expected to be completed yearly.
- The training records provided to us showed the majority of staff in diagnostics had completed their mandatory safety training. We saw pre-planned dates for training in subjects set up for 2017.
- We did not have access to mandatory training dates for the administrative staff who worked in the outpatients and diagnostic imaging service but staff we spoke with told us they received regular training.

Assessing and responding to patient risk

- There were systems to prioritise urgent and routine new referrals and send appointments as required to patients.
- There was a rapid access urgent care service that referred directly onto specialist consultant's services when required.
- The Ionising Radiation (Medical Exposure) Regulation (IR (ME) R 2000) requires doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data had been collected and analysed for examinations performed with a view to establishing Local Diagnostic Reference Levels (LDRLs) and comparing against National Diagnostic Reference Levels (NDRLs). We reviewed the patient dosimetry report for February 2016, which did not identify any issues or concerns.
- Processes were established within outpatients to manage patients who deteriorated or became unwell within the department. There was an emergency response team within the hospital who could be summoned rapidly.
- A transfer protocol was available in the event the hospital could not safely provide care or treatment for a rapidly deteriorating or acutely unwell patient. This could involve a transfer to a nearby intensive care unit or an accident and emergency department. The deputy matron audited all transfers for safe practice.
- The "Breast Unit" had been accredited, and part of the accreditation agreement, all breast unit surgeons were required to fulfil the British association of surgical oncology (BASO) guidelines when treating patients with breast disease. This is used by surgeons working in the screening programme, and concentrates on the screening process up to the point of diagnosis. Surgeons use the guidelines to audit their own activity.
- We saw the world health organisation (WHO) safety checklist was completed before ultrasound guided injections.

Nursing and Radiology staffing

- All staff confirmed there were sufficient nursing staff to deliver care safely within outpatients and we observed this to be the case. The deputy matron told us no shifts had been unsafely staffed, and we saw staff rotas that confirmed this.
- When paediatric clinics were being held they were staffed by paediatric nurses. Staff told us they used suitably qualified agency staff on a regular basis who knew the hospital to cover paediatric clinics. They were in the process of recruiting an additional permanent paediatric nurse to cover outpatient's clinics and reduce agency use.

Good

Outpatients and diagnostic imaging

- Information provided by the hospital showed between July 2015 and June 2016, the use of bank and agency nurses and health care assistants in outpatient departments was higher than the average of other independent acute hospitals. Outpatient's nurses told us they used two or three agency staff most days and had a pool of regular agency staff who knew the hospital.
- Between July 2015 and June 2016, the rate of outpatient nurse turnover was higher than the average when compared to other independent acute hospitals.
- The rate of sickness for nurses working in outpatient departments was similar to or better than the average of other independent acute providers. The rate of sickness for outpatient health care assistants was better than the average of other independent acute providers in the same period.
- There were arrangements for planning and monitoring the number of staff and skill mix of staff to meet patient's needs. There was a rota system in use for all the different staffing groups to ensure enough staff were on duty.

Medical staffing

- There were 290 consultants that had been granted practising privileges, all of whom had been undertaking work at the hospital for over 12 months. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. This right is subject to various checks on for example; their professional qualifications, registration, appraisals, revalidation, and fitness to practice declaration.
- Consultants covered their own OPD clinics on a sessional arrangement, many having set days and times for consultations.
- The hospital had a Resident Medical Officer (RMO) on site 24 hours a day, seven days a week to support the clinical team in the event of emergencies or with patients requiring additional medical support.
- The diagnostic imaging department had more than 30 radiologists with practising privileges.
- The individual specialties arranged medical cover for their clinics where required. This was managed by individual clinicians, who agreed the structure of the clinics and patient numbers.

Emergency awareness and training

- The hospital had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.
- There were business continuity plans to ensure the delivery of the service was maintained.
- All staff had access to annual fire training and nursing staff explained the evacuation procedure for outpatient's clinics. Managers in outpatients assured us all nursing staff were up to date with annual fire training, and the training matrix provided to us indicated the sessions attended and planned dates of future training. Similarly information related to radiology and diagnostic staff showed the status of training was up to date for all clinical staff.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate the effectiveness of outpatient's services;

We found:

Evidence-based care and treatment

- Patients' needs were assessed and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example, protocols were followed with regard to national guidance for radiology examinations such as orthopaedic x-rays.
- Staff were kept up to date with changes in practice. They had access to guidelines from NICE and used this information to deliver care and treatment, which met patient's needs. For example, staff received National Patient Safety Alerts and alerts from the Medicines and Healthcare products Regulatory Authority. This meant they had accurate and up to date information confirming that best practice guidance was being used to improve care and treatment and patient's outcomes.
- There was access to specialist investigations such as magnetic resonance imaging (MRI) or a computerised

tomography (CT) scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body whilst a CT scan uses X-rays and a computer to create detailed images of the inside of the body.

- Radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff to access. There was an assigned radiology protection adviser and a radiology protection supervisor for the hospital.
- The Ionising Radiation (Medical Exposure) Regulation (IR (MER) (2000) required doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data had been collected and analysed for examinations and this information was reviewed in monthly quality meetings.The hospital had standard operating procedures available. For example, for MRS safety screening and acute kidney injury.
- A radiation safety survey had been completed in 2016 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). Staff showed good awareness of radiation protection requirements. We saw evidence through audits that radiation exposure was monitored.

Pain relief

- Patient attending diagnostics for prescribed treatment received ultrasound guided injections used to ease pain and reduce swelling and inflammation in soft tissues. This was for conditions such as tendons, tennis elbow or plantar fasciitis.
- Standardised pain assessment tools were not used in the OPD, therefore patient records did not contain information to indicate an assessment of pain.
- Pain relief could be prescribed within the outpatient's department and then dispensed by the pharmacy department.
- Doctors could refer patients requiring additional pain management to the pain management consultant. The outpatients department did not provide specific pain management clinics.

Patient outcomes

- The hospital did not gather data related to patients outcomes, nor participate in local and national audits which would allow them to benchmark patient's clinical outcomes for the outpatients department.
- The hospital did not participate in imaging accreditation schemes or improving quality in physiological services scheme. The Imaging Services Accreditation Scheme (ISAS) is a patient-focused assessment and accreditation programme designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff in safe environments.
- The physiotherapy services at the hospital were provided by an external company, which we did not inspect.

Competent staff

- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- There was a two day corporate induction programme for all newly appointed staff. It covered a mixture of governance organisational expectations and culture combined with statutory and mandatory awareness. Mandatory training topics included safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Managers told us all staff received an induction. Radiographers employed by the hospital told us they had a comprehensive induction. We spoke with three staff who confirmed they had received an induction.
- During our visit to the diagnostics department, we found some new staff had not yet been signed off by the RPS as competent, as the RPS was on extended annual leave at the time. We were told staff in probation were not generally added to the operator list until their probation was successfully completed. At the time of inspection, at least four radiographers were in probation or had recently ended their probation. In the absence of the RPS, signing off competence the clinical director would assume this role. The RPA was contacted and agreed to change the local rules so deputies could complete the assessments. Evidence of the actions taken was provided to us.

Good

Outpatients and diagnostic imaging

- In outpatients, radiology and diagnostics, we saw evidence of a competency and induction folder for new and agency staff. As a result, staff could integrate safely and efficiently into the workforce
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Most staff had received an appraisal within the last 12 months.
- The hospital had robust processes to ensure all new clinical and nursing staff had verified references and training and skills competency were checked on recruitment.
- Managers told us there was good availability of training opportunities and staff were actively encouraged to develop their skills and learning. Three nursing staff gave us examples where they had been supported and actively encouraged to improve their skills and knowledge. For example; a health care assistant had been encouraged to develop additional skills and nurses were encouraged to develop leadership skills to enable them to take on additional responsibilities. Managers encouraged staff to develop their skills and responsibilities if they wanted to.

Multidisciplinary working

- Information held on the hospitals own patient record system needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessments, care plans, medical records and investigation and test results.
- The hospital staff shared relevant information with other services in a timely way, for example when referring patients to other services.
- There was a strong multidisciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the department. Staff reported they worked well as a team.
- The "Breast Unit" had a multidisciplinary team of consultant breast surgeons, radiologists, plastic surgeons, pathologists and mamographers. The unit had a hospital Macmillan breast care sister and nurses who were committed to providing the highest quality breast care.

Seven-day services

- The outpatients department was open six days a week, Monday to Friday 8am to 8pm and Saturday 8am to 1pm.
- Radiology and diagnostics services were available seven days a week, 8am to 8pm. An on call service was available after 8 pm. There was access to specialist investigations such as MRI and CT scans or to a radiologist to interpret scans out of hours. Plain film and CT services were available out of hours for emergencies for in- patients and theatres.
- Patients that had symptoms they were worried about had access to a private self-pay, walk- in, urgent care centre "casualty first". This was open seven days a week between 8 am and 8 pm.
- An on-site pharmacy service was available for outpatients between 8am and 8pm, seven days a week. There were specified arrangements for staff to gain emergency access to the pharmacy out-of-hours.
- On-call clinicians were available seven days a week to support clinical decision making.

Access to information

- Staff generally had the information they needed to deliver effective care and treatment to people who used services. For example, access to policies, procedures and professional guidance.
- Clinic information and patient notes were accessible to relevant staff.
- Consultants were responsible for the outpatient records for their private patients and some consultants stored these off site. Where their medical secretary was employed by the provider then records could be stored on site.
- Consultants holding practising privileges with the hospital were required to be registered as independent data controllers with the Information Commissioner's Office, the provider did not monitor if they complied with this requirement.
- We saw letters regarding the outcome of an appointment were sent to a GP and other health professionals when appropriate and patients were sent a copy of the correspondence.

Good

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed radiographers following the hospital policy on consent to ensure that patient consent was gained for each scan or procedure.We compared the practice we saw with the Society and College of Radiographers' recommendations and saw the department's practice was in line with professional guidance.
- Staff told us doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic. Patients told us they had been asked for consent before their procedures. We viewed three records that confirmed this.
- Mental capacity act training was delivered by an external tri-borough trainer. Some nursing staff we spoke with had completed Mental Capacity Act (2005) and dementia training and described the process of how they would ascertain if a patient lacked capacity to consent. However not all clinical staff we spoke with had received this training at the time, although sessions were available going forward.
- Consultants told us they rarely came in to contact with patients who lacked capacity due to the nature of their respective specialities but were aware of their responsibilities and the hospital processes for this.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because;

Compassionate care

- The hospital identified patients who may be in need of extra support. For example: patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet.
- We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments, all staff were helpful and professional, putting patients and their relatives at ease.
- All outpatients departments had suitable rooms for private consultations. Patients were admitted into individual rooms so they could discuss their procedure or treatment in privately.
- There was a child friendly waiting area that was separate from the adult waiting area, and contained suitable toys for children to play with.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Patients said most staff were helpful, professional, polite, and kind. One relative gave an example about her relative where the consultant had "put them at ease, was empathetic and treated them with respect". They felt the nurses also treated their relative with "great dignity".
- We observed clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.
- Patients could request a chaperone to accompany them during their consultation and information on how to access this service was displayed in consultation rooms. Chaperones were available for male and female patients if required

Understanding and involvement of patients and those close to them

- Staff introduced themselves and we observed consultants introduce themselves and shake patient's hands when they were called in for their appointment slot.
- We observed interaction of staff with patients which demonstrated an understanding approach. Staff gave information in a manner which was respectful and responded to the needs of individuals.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Good

Outpatients and diagnostic imaging

- Information about costs of treatment and care was available to patients at the initial contact with the service and as required thereafter.

Emotional support

- Throughout our visit, we observed staff giving reassurance to patients both over the telephone and in person.
- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations
- Written information was available to direct carers to the various avenues of support available to them.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because;

Service planning and delivery to meet the needs of local people

- There were service led agreement's (SLA) for the hospital to undertake treatment of NHS patients within set specialties agreed between the hospital and the Local NHS trust. This showed collaborative working to reduce patient waiting times and improve access to treatment.
- A range of clinics were provided at the service. For example, orthopaedics, plastic surgery and dermatology.
- There was a specialist stroke unit, equipped to provide initial care and treatment for stroke patients and on-going rehabilitation as part of the recovery process following a stroke.
- There was an established paediatric OPD service at the hospital, staffed by qualified paediatricians and paediatric nurses. They provided specialist outpatient paediatric healthcare services to children from birth to age16 years.

Access and flow

- On arrival, patients reported to the main reception where they would then be directed to the outpatients or diagnostic imaging departments. The relevant receptionist at the front of department would then book them in via an online system and direct them to the waiting area or clinic room and we observed patients easily finding their way to their destination. There was sufficient space and flexibility for the number of patients being treated at the time of inspection.
- Approximately 50% of patients seen in the ear nose and throat (ENT) clinic were referred from local NHS hospital for surgery.
- Waiting times for appointments were variable, and most patients were seen within 15 minutes. However nursing staff told us patients could wait longer when clinics were busy. We observed that nursing staff kept patients updated on waiting times.
- The hospital collected waiting times information. Their target for adult patients was 20 minutes and paediatric patients 15 minutes. Between January and September 2016, 59% of adult patients were seen within 20 minutes of arrival and 35% within 20-60 minutes of arrival. 49% of paediatric patients were seen within 15 minutes of arrival and 50% within 20 to 60 minutes.

Meeting people's individual needs

- We observed that seating in the outpatient's area did not cater for patients that required different seat heights, for example patients with orthopaedic conditions. Managers told us they had identified they required additional seating and were waiting for them to be delivered. Whilst there were no specific chairs in the outpatient waiting area for bariatric patients, chairs could be provided without arms that could be utilised for this purpose.
- Patient leaflets were available in the outpatient reception area covering a range of conditions and treatment options. Nursing staff told us they were not available in large print or other languages. Staff commented that it would be useful to think about for the future and they had never been asked for leaflets in alternative formats. There was no information to advise patients where they could obtain such information.
- The hospital could be accessed by those who had a physical disability as there was a lift available to all floors, and a ramp at the front entrance of the hospital. Staff could arrange porter assistance for patients travelling alone or who may need more help.

Good

Outpatients and diagnostic imaging

- Relatives were able to stay with patients at all times, if required.
- Chaperones were available if required. Notices were clearly visible throughout outpatients and radiology and diagnostics informing patients of this option. Medical staff said they documented in patients notes when chaperones were used.
- Staff in urgent care services told us they frequently used chaperones to ensure examinations for male and female patients were appropriately managed.
- The hospital website gave clear information on what patients could expect when using outpatients and radiology and diagnostic services.
- Staff told us translation services were available for patients who did not have English as a first language and they were used occasionally.

Learning from complaints and concerns

- The hospital had a system for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for independent hospitals in England and there were designated staff who handled all complaints in the hospital.
- Between July 2015 to June 2016 six complaints were received by the service relating to different reasons ranging from consultant care, reception care and cancelled clinics.
- Department specific complaints were discussed within teams. Complaint themes were also discussed with department managers at hospital leadership team meetings. Managers and staff told us feedback on any trends or themes about complaints would be provided if it was relevant to each department.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because;

Vision and strategy for this this core service

- The hospital had a clear vision to deliver high quality care and promote good outcomes for patients.
- There were strategy and supporting business plans that staff were aware of, which reflected the vision and values, and these were regularly monitored.

Governance, risk management and quality measurement

- Governance frameworks were effective in supporting the delivery of the strategy and good quality care in the OPD and diagnostic services.
- Risks identified from audits, such as IPC findings were acted upon. However, risks related to non-compliance with infection control procedures in the OPD were not included on the risk register. Further, risk-meeting minutes where infection control policy and processes were discussed did not identify the lack of hand hygiene and bare below the elbow audit information in outpatients as a risk. Managers were not monitoring whether all staff were compliant with the infection control policy and processes.
- We looked at the outpatients risk registers from March 2016 and noted they did not state a date when a risk had been identified and put on the register. Therefore there was no audit trail to follow or timescale to see how long risks had been on the register. For example, in February 2016 one risk identified “gaps in written clinical policies” that were awaiting ratification. An update in June 2016, stated the “policy needed discussion in a policy meeting” and the third quarter 2016 risk register had the same comment. There had been no progress documented for over nine months. We saw similar timescales with other risks where there had been no recorded progress.
- However, when we followed this up, we were informed work to improve the Risk Register had been in progress during 2016, with a relaunch of the Risk Register Template in August 2016. The new template, which allowed for better identification of changes in risks, included a date of when a risk was entered on the risk register. This had been approved by the Risk Management Committee in August 2016. At the time of inspection the departmental risk registers were transitioning to the new template and not all departments had completed this transition. A new sub group had been established to manage OPD policies.
- There were structures to maintain clinical governance and risk management. For example, a monthly medical

advisory committee (MAC) and risk governance meetings. These tracked various performance systems including statutory and mandatory training, appraisal rates, complaints and response times, medical records (held at the hospital) performance audits and quality and safety meetings.

- We saw minutes which confirmed staff in diagnostic imaging had monthly imaging clinical governance meetings in which they discussed learning from incidents and complaints, policies, clinical issues and trust information.

Leadership and culture of service

- Outpatients was led by the outpatient's sisters and patient services manager. They reported to the deputy matron and matron and director of operations and chief executive.
- Staff told us that local leadership within outpatients was good. All managers were approachable, supportive and staff were proud of their service. Staff felt involved and were keen to improve systems and processes to ensure patients received the best care.
- Staff and managers at all levels said line managers and senior managers at executive level were visible and accessible. All radiology and diagnostics and outpatient managers had an open door policy for staff.
- Consultants spoke positively about the hospital's care and safety within the outpatient, radiology and diagnostics departments. Staff told us patient safety and care was the highest priority for the hospital.
- All the consultants we spoke with commented on the proactive and responsive management style of leadership. Issues and concerns were promptly followed up and resolved and clinicians were involved and consulted about changes. Feedback was sought and responded to when considering changes or developments to services.
- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments.
- Staff in outpatients and radiology services told us they worked well together. There was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different departments.
- Throughout the inspection, all staff were welcoming and willing to speak with us. Staff in outpatients and radiology and diagnostics departments spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team.

Public and staff engagement

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

Innovation, improvement and sustainability

- There were no particular innovative practices currently in development within the department. The services provided were sustainable with the existing arrangements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Improve the monitoring of staff adherence to best practice with respect to patient record completion, with particular focus on WHO safety checks and risk assessments.
- Enhance the monitoring of controlled drugs and recording of these.
- Consider how records can be stored more appropriately to minimise risks of unauthorised access.
- The provider should ensure that patient leaflets are available in other formats, such as large font or Braille, and other language.
- Consider how it may make easy to read information leaflets and information available when required.
- Review the audit programme so that it clarifies the area or department in which the audit will be undertaken.
- Continue to develop the risk register so the content reflects all risks, the mitigations to those risks and updates on the progress or actions.
- Building maintenance concerns are responded to in an effective and timely way to prevent health and safety hazards on the premises, and to improve the environment for patients and staff.
- Consider gathering data related to patients outcomes, and the participation in local and national audits of clinical outcomes for the outpatients department.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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