

Benenden Hospital

Quality Report

Goddard's Green Road
Benenden
Kent
TN17 4AX
Tel:01580 240333
Website: www.benendenhospital.org.uk

Date of inspection visit: 16 January 2017 to
17 January 2017
Date of publication: 11/05/2017

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

Ratings

Overall rating for this location

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Letter from the Chief Inspector of Hospitals

Benenden Hospital is operated by The Benenden Hospital Trust. The hospital has 32 beds, three operating theatres, an imaging department and outpatient and diagnostic facilities.

The services provided by the hospital are surgery, endoscopy, outpatients and diagnostic imaging. We inspected these three core services using our comprehensive inspection methodology. We carried out the announced part of the inspection on 16th and 17th of January 2017 along with an unannounced visit to the hospital on 24th January 2017.

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

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

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

We rated this hospital as outstanding overall.

- The service planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation. The service monitored this to ensure consistency of practice and staffing levels and skill mix were reviewed to ensure patients were safe.
- Staff were suitably qualified and had the skills they needed to carry out their roles effectively and in line with best practice.
- Staff from different disciplines worked together to meet the needs of patients who used the service and treated people with dignity, respect and kindness. There was strong collaboration and support across all staff groups and a common focus on improving the quality of care and the vision and values were well embedded amongst staff.
- The hospital had consistently high levels of constructive engagement with staff at all levels. Leaders listened to staff and valued their input. The hospital demonstrated a strong commitment to staff wellbeing.
- Hospital data showed 100% of staff had an up-to-date appraisal at the time of our visit. The service supported relevant staff through the process of revalidation, and 100% of relevant medical and nursing staff had up-to-date revalidation.
- There were high levels of staff satisfaction across all staff groups and staff were proud of the organisation as a place to work and spoke highly of the culture.
- Patients had comprehensive assessments of their needs including clinical needs, wellbeing, and nutrition and hydration needs.
- The hospital had the facilities to meet patient's individual needs. This included patients living with dementia, patients with learning disabilities and bariatric patients and expected outcomes were identified with regularly reviewed and updated care and treatment plans.
- Medical records were maintained accurately and securely in line with the Data Protection Act 1998 and medicines were stored in locked cupboards and administration was in line with relevant legislation.

Summary of findings

- There were appropriate arrangements for unplanned returns to theatre, with 24 hours a day, seven day a week on-call availability.
- The endoscopy services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. The service was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is the quality improvement and assessment tool for the GI endoscopy service.
- The hospital had a comprehensive audit programme in place to monitor services and identify areas for improvement and outcomes for patients were similar to, or better than, other acute hospitals in England.
- The hospital had a good track record on safety. Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The hospital took appropriate action to detect, control and prevent the spread of infections and infection prevention and control practices were in line with national guidelines. Areas we visited were visibly clean, tidy and fit for purpose.
- The service assessed monitored and managed risks to children and young people who used services on a day-to-day basis. These included signs of deteriorating health, medical emergencies and emotional wellbeing.
- The hospital responded to complaints by providing meaningful written responses to all complainants. The service shared learning from complaints with relevant staff to help drive improvement. The hospital tried to respond immediately to verbal feedback to avoid the need for escalation to a formal complaint. As a result, the number of complaints had reduced significantly.
- Patients and their loved ones were included to be partners in their care and the overall feedback from people who used the service and those who are close to them was positive about the way staff treated people.

We found areas of outstanding practice:

- The hospital's commitment to staff wellbeing and their "Investors in People Silver Award".
- The hospital's work in enhanced recovery pathways to reduce the length of hospital stay for orthopaedic patients.
- The hospital was a finalist in the national award for innovations in anaesthetics in 2016. Innovations in this area included use of a multi-purpose anaesthetic breathing system which recycled anaesthetic gases and reduced pollution in theatres.
- We identified the infection prevention and control leadership of the hospital and staffs commitment was an area of outstanding practice, with staff inspired to provide a good service to patients.

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

- There were intermittent problems with the controlled access mechanisms on the doors into the theatre department. This created a risk of inappropriate access into theatres.
- The hospital did not stagger admission times for surgery. This meant patients at the end of an operating list waited a long time between admission and surgery when they could have been at home.
- The scheduling of operating lists according to consultant availability meant some day surgery patients were not fit for discharge on the day of surgery. As a result, the hospital frequently converted day case patients to overnight stays.
- Privacy and dignity could not be guaranteed in the mixed sex waiting area outside of the changing area for patients awaiting procedures.



Summary of findings

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Outstanding 	<p>Medical care services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.</p> <p>We rated this service as outstanding because it was good for safe, effective and responsive, and outstanding for caring and well led.</p>
Surgery	Outstanding 	<p>Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.</p> <p>Staffing was managed jointly with medical care.</p> <p>We rated this service as outstanding because it was good for safe, effective and responsive, and outstanding for caring and well-led.</p>
Outpatients and diagnostic imaging	Outstanding 	<p>Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.</p> <p>We rated outpatient and diagnostic imaging as outstanding because it was good for safe and caring, and outstanding for responsive and well led.</p>

Summary of findings

Contents

Summary of this inspection	Page
Background to Benenden Hospital	8
Our inspection team	8
Information about Benenden Hospital	8
The five questions we ask about services and what we found	11
<hr/>	
Detailed findings from this inspection	
Overview of ratings	17
Outstanding practice	79
Areas for improvement	79
<hr/>	

Outstanding



Benenden Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Benenden Hospital

Benenden Hospital is operated by The Benenden Hospital Trust. The hospital opened in 1907 as a sanatorium providing treatment for Tuberculosis sufferers, the hospital adapted through time to become an independent hospital. It is a private hospital in Benenden, Kent. The hospital primarily serves the communities of the Kent and Medway areas. It also accepts patient referrals from outside this area.

Jane Abbott has been the registered manager since 21st December 2010.

The hospital has one ambulatory care unit, an eye unit, theatres and an outpatient and diagnostic imaging department and is registered to provide the following regulated activities:

- Diagnostic and screening procedures.

- Nursing Care.
- Surgical procedures.
- Treatment of disease, disorder or injury.

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 three times, and the most recent inspection took place in March 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

We carried out the announced part of the inspection on 16th and 17th of January 2017 along with an unannounced visit to the hospital on 24th January 2017.

Our inspection team

The inspection team was led by, Elaine Biddle, Inspection Manager, Care Quality Commission. The team included other CQC inspectors, and specialist advisors with expertise in surgery, medicine, paediatrics and radiology.

Information about Benenden Hospital

Surgical services at Benenden Hospital cover a range of specialties including orthopaedics, gynaecology, ophthalmology (eye surgery) and general surgery. The hospital only provides surgery for adults aged 18 and over and does not operate on children.

In October 2015 – September 2016, there were 8,169 visits to theatre. The most common operation in this period was cataract removal. There were 1,934 cataract procedures, which represented 23.7% of surgical activity. The second most common procedure was varicose vein removal (884 operations), followed by knee arthroscopy (549 procedures). Arthroscopy is a type of keyhole surgery used to diagnose and treat problems with joints.

The hospital provides surgery to members of Benenden Healthcare Society, self-funding patients, private insured

patients and NHS-funded patients. Benenden Healthcare Society members pay £9.10 each month for membership, which allows them to receive treatment at the hospital on a discretionary basis. The NHS funded 67% of inpatient procedures in October 2015 – September 2016.

As part of the first phase of the hospital's redevelopment, a new theatre suite, ward (Bensan Ward) and ambulatory care unit (ACU) opened in 2016. The theatre suite has three operating theatres, eight recovery bays and three anaesthetic rooms. Two of the operating theatres have laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination).

There were 1,611 inpatients and 7,326 day case patients recorded at the hospital between October 2015 and September 2016. Both overnight and day case patients

Summary of this inspection

recover from surgery on Bensen Ward. The ward has an inpatient area, with 14 single ensuite bedrooms for patients staying overnight. Two of the rooms have facilities for bariatric patients. There is a day case area at the opposite end of the ward. This contains six single ensuite rooms and six twin rooms each containing two trolleys. Patients recovering from day case surgery stay in this part of the ward. Patients staying in the twin rooms have access to single-sex, communal bathrooms.

The ACU has eight recovery beds and six reclining chairs. Ambulatory care is surgery on an outpatient basis without admission onto a ward. The service carries out minor procedures such as varicose vein treatment and spinal injections to treat back pain. Ambulatory care patients spend a short time in a single-sex recovery area after their procedure before discharge home.

The eye unit has a treatment room with a treatment chair for eye surgery under local anaesthetic. There is a private room containing chairs for patients to sit with their relatives and recover after their procedure before going home. The eye department does not perform any refractive eye surgery (laser vision correction).

Outpatient services at Benenden Hospital cover a wide range of specialities, including cardiology, dermatology, ear, nose and throat, gastroenterology, general medicine, general surgery, gynaecology, neurology, orthopaedics, rheumatology, spinal services, varicose vein services and ophthalmology.

The diagnostic and imaging department carried out x-rays and ultrasound scans. An external provider provided more complex tests such as MRI and CT scans on certain days of the week at The Benenden Hospital site. These services were not included in this inspection.

From October 2015 to September 2016, there were 46,129 outpatient total attendances, of these 24% (10,910) were NHS funded and 76% (35,219) were other funded.

The outpatient department runs clinics from 8.30am to 7pm, Monday to Friday. Saturday clinics were provided between 8.30am and 5pm. The diagnostic imaging department run clinics between 8am and 7pm, Monday to Friday, and Saturday between 8am and 2pm. Provides a 24-hour a day, seven day a week service for urgent requests.

There are 24 consulting rooms, including seven specialist rooms, such as for gynaecology procedures, in the outpatient department.

The imaging department consisted of one x-ray rooms, an ultra sound room, and an ultrasound scan room. The physiotherapy department had with two rooms with couches, and a small gym area.

During the inspection, we visited all clinical areas including outpatient department, diagnostic imaging department, physiotherapy, and pharmacy, theatres, ward areas and the eye unit during our inspection. During our inspection, we spoke with 42 members of staff including consultants, medical staff, operating department practitioners, nurses, allied health professionals, radiographers, physiotherapists, clinical support workers, administrators and managers and the executive team. We spoke with 15 patients and six patients' relatives. We reviewed nine sets of patient records and a variety of hospital data including meeting minutes, policies and procedures, staff training records, audits and performance data. We also received 40 comment cards with feedback from patients.

As of 1 October 2016, the service employed 16.7 whole-time equivalent (WTE) theatre nurses. There were four WTE theatre nurses vacancies. This meant the nursing vacancy rate for theatres was 19%.The service filled vacant shifts using bank and agency staff.

There were 12.7 WTE operating department practitioners (ODPs) and healthcare assistants (HCAs) in theatres. There were 5.2 WTE posts vacant for OPDs and HCAs in theatres. This gave a vacancy rate of 29%.

The ward had 31.1 WTE staff in post, which met the budgeted compliment of staff.

The eye unit had two WTE nursing vacancies. The hospital used specialist ophthalmic bank nurses to fill vacant shifts while they recruited new staff.

There was 8.4 whole time equivalent (WTE) outpatient registered nursing staff and 10.9 WTE clinical support workers (CSW) for outpatients. The outpatient department had a ratio of nurse to CSW of 1 to 1.3.

There were 1.8 WTE posts vacant for outpatient registered nurses given a vacancy rate of 18%. For CSWs, there were 0.21 WTE posts vacant giving a vacancy rate of 2%.

Summary of this inspection

116 doctors worked at the hospital under practising privileges. 2 regular resident medical officer (RMO) worked on a one week on, one week off working pattern. The accountable officer for controlled drugs (CDs) was Claire Harley.

Track record on safety

- No Never Events in the reporting period (Oct 2015 to Sep 2016).
- 771 Clinical incidents of no harm, 0 low harm, 0 moderate harm, 0 severe harm, 0 death
- No serious injuries
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- No incidences of hospital acquired E-coli
- CQC received no complaints in the reporting period (Oct 2015 to Sep 2016).
- The hospital received 19 complaints in the reporting period (Oct 2015 to Sep 2016). None of which have been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) 100% VTE screening rates in the reporting period (Oct 2015 to Sep 2016).

- Seven incidents of hospital acquired VTE or PE in the reporting period (Oct 2015 to Sep 2016).
- There have been no safeguarding concerns reported to CQC in the reporting period (Oct 2015 to Sep 2016).

Services provided at the hospital under service level agreement:

- Angiography
- Electroencephalogram (EEG)
- Nuclear medicine
- Pathology
- Clinical and or non-clinical waste removal
- Interpreting services
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Occupational health
- MRI/CT scanner
- Transfer of patients for critical care support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as good because:

- The service planned, implemented and reviewed staffing levels and skill mix to keep patients safe.
- The service had a good track record on safety. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The service took appropriate action to detect, control and prevent the spread of infections.
- There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Staff understood the principles of duty of candour regulations, were confident in applying the practical elements of the legislation.
- Patients were cared for in a visibly clean environment that was well maintained.
- There were adequate supplies of appropriate equipment that was properly maintained to deliver care and treatment and staff were competent in its use.
- There was good medicines storage, management and administration. There were systems that ensured patient's medicines were given safely, on-time and according to the consultant prescription. Medicines were stored securely as per national guidelines.
- We found there were systems to identify patients whose condition may be deteriorating to allow early intervention.
- There were sufficient numbers of medical, nursing and diagnostic staff to deliver care safely. Patient risk was assessed and responded to. There was a major incident plan in place, and a recent exercise had been undertaken.
- Staff were aware of their responsibilities with regard to the protection of people in vulnerable circumstances. All staff had received appropriate training in adult safeguarding.
- Records were stored safely, up to date, legible, and were available for staff. Emergency equipment was in place. Medicines were well managed within the department.
- The environments were visibly clean.

However:

Good



Summary of this inspection

- Privacy and dignity could not be guaranteed in the mixed sex waiting area in outpatients outside of the changing area for patients awaiting procedures.
- Staff did not consistently print names with a legible signature in patient records in line with guidance issued by the professional regulatory bodies for doctors and nurses.
- There were inconsistencies in the suitable number of staff receiving training at the appropriate level for safeguarding children and vulnerable adults.
- There were intermittent problems with the controlled access mechanisms on the doors into the theatre department. This created a risk of inappropriate access into theatres.

Are services effective?

We rated effective as good because:

- The service planned and delivered care and treatment in line with current evidence-based guidance, standards, best practice and legislation, including National Institute for Health and Care Excellent (NICE) guidance. The service monitored this to ensure consistency of practice with formal systems in place for collecting comparative data regarding patient outcomes.
- Outcomes for patients were similar to, or better than, other acute hospitals in England.
- Patients had comprehensive assessments of their needs. These included consideration of clinical needs, wellbeing, and nutrition and hydration needs. The expected outcomes were identified and staff regularly reviewed and updated care and treatment plans.
- Staff were suitably qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Patients were cared for by staff who had undergone specialist training for the role and who had their competency reviewed.
- The service supported staff with supervision and appraisal. Hospital data showed 100% of staff had an up-to-date appraisal at the time of our visit and the hospital supported them through the Nursing and Midwifery Council's (NMC) revalidation process. All of relevant medical and nursing staff had up-to-date revalidation.
- There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills and knowledge to do their job. Staff from different disciplines worked together to meet the needs of patients who used the service.
- The hospital had an on-going, comprehensive audit programme which monitored areas for improvement regularly.

Good



Summary of this inspection

- Staff worked with other healthcare professionals in and out of the hospital to provide services for patients.
- Patients provided informed, written consent before commencing their treatment. Where patients lacked capacity to make decisions, staff were able to explain what steps to take to ensure relevant legal requirements were met.
- Patients had access to appropriate nutrition and hydration.
- Patients and their relatives we spoke with were pleased with the care they had received.

Are services caring?

We rated caring as outstanding because:

- The hospital allocated the time necessary for nursing staff to build positive relationships with patients and their families. This enabled the nurses to provide reassurance, information and support to patients and families.
- Overall feedback from people who used the service and those who are close to them was positive about the way staff treated people. Patient's surveys and assessments reflected the friendly, kind and caring patient centred ethos.
- Staff encouraged patients and their loved ones to be partners in their care.
- Staff respected people's privacy and confidentiality at all times.
- Staff provided sensitive, caring and individualised personal care to patients. Staff supported patients to cope emotionally with their care and treatment as needed.
- Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and with respect.
- Patients felt well informed and involved in their procedures and care, including their care after discharge. Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- Interactions between staff and patients were welcoming, caring and supportive.

Outstanding



Are services responsive?

We rated responsive as outstanding because:

- Services were planned and delivered to meet the needs of the local population.
- The hospital responded appropriately and had the facilities to meet patient's individual needs. This included patients living with dementia, patients with learning disabilities and bariatric patients.

Outstanding



Summary of this inspection

- The hospital completed the first phase of an extensive redevelopment in 2016, which included new theatres, a new ward and a new ambulatory care unit. Staff and patients we spoke with were very positive about the new building.
- The hospital responded to complaints by providing meaningful written responses to all complainants. The hospital shared learning from complaints with relevant staff to help drive improvement. The hospital tried to respond immediately to verbal feedback to avoid the need for escalation to a formal complaint. As a result, the number of complaints had reduced significantly.
- There were systems to ensure that patient complaints and other feedback was investigated, reviewed and appropriate changes made to improve treatment of care and the experience of patients and their supporters.
- There were appropriate arrangements for unplanned returns to theatre, with 24 hours a day, seven days a week on-call availability.
- Services operated at times that allowed patients to access care and treatment when they needed it.
- There were a variety of mechanisms to provide psychological support to patients and their supporters. This range of service meant that each patient could access a service that was relevant to their particular needs. For example those whose first language was not English, or support for people living with dementia or learning disabilities.
- Patients could choose appointments that suited them.
- Patients were kept informed of any disruption to their care or treatment.
- Patients did not experience long waiting times to see their chosen consultant.

However:

- The hospital did not stagger admission times for surgery. This meant patients at the end of an operating list waited a long time between admission and surgery when they could have been at home.
- The scheduling of operating lists according to consultant availability meant some day surgery patients were not fit for discharge on the day of surgery. As a result, the hospital frequently converted day case patients to overnight stays.

Are services well-led?

We rated well-led as outstanding because:

- Leaders drove continuous improvement and organisational growth.

Outstanding



Summary of this inspection

- There was clear and highly visible leadership provided by senior management and within the departments. Staff spoke positively of their managers, who told us they were visible and approachable, and told us the senior management team had an 'open door' approach, and visited departments daily.
- The vision and values were well embedded amongst staff.
- The hospital's vision was embedded in the departments and staff embraced the values in the work they undertook.
- There were high levels of staff satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The hospital had consistently high levels of constructive engagement with staff at all levels. Leaders listened to staff and valued their input. The hospital demonstrated a strong commitment to staff wellbeing.
- The hospital had robust governance arrangements. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- Governance processes were evident at departmental, hospital and corporate level. This allowed for monitoring of the service and learning from incidents, complaints and results of audits
- The hospital had a risk register and was reviewed at the governance committee meetings.
- We saw strong collaboration and support across all staff groups and a common focus on improving the quality of care.
- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve services.
- Leaders actively encouraged staff to raise concerns. There was a culture of openness, and all staff we spoke to could describe their responsibilities relating to Duty of Candour.
- The management structure at the hospital meant there were clear lines of leadership and accountability. The senior management team were highly visible and accessible across the hospital. Staff described an open culture and said managers were approachable at all times.
- Staff had a good understanding of the vision for the development of their services.
- We saw staff were focused on providing the best service for all patients, and were proud to work at the hospital
- Staff spoke highly about their departmental managers and the support they provided to them and patients. All staff said managers supported them to report concerns and their managers would act on them. They told us their managers regularly updated them on issues that affected the separate departments and the whole hospital.

Summary of this inspection

- Projects such as the productive outpatients were in place to provide data on performance and improve teamwork.

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	Outstanding 	Good	Outstanding 	Outstanding 
Surgery	Good	Good	Outstanding 	Good	Outstanding 	Outstanding 
Outpatients and diagnostic imaging	Good	N/A	Good	Outstanding 	Outstanding 	Outstanding 
Overall	Good	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 

Notes

Medical care

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

Are medical care services safe?

Good 

We rated safe as good

Incidents

- No never events related to medical care services were reported by the hospital in the period October 2015 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital reported no serious incidents or deaths in the period October 2015 to September 2016.
- The hospital had an incident reporting policy which encouraged openness, the reporting of all incidents and descriptions of the levels of incidents. An electronic incident reporting system was used and staff demonstrated a good understanding of how to use the system. Feedback from incidents was discussed at departmental meetings and minutes of meetings confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn.
- Staff were able to give us examples of incidents that had been reported. For example, the allegation by a patient that money was missing led to a full investigation by hospital staff and police involvement. Lessons learned from the incident instigated a review of information

given before admission to the hospital and patients were reminded about the safety of valuables and this was achieved with reviewing the content of preadmission leaflets.

- Two Hundred and thirty six incidents were reported between January and December 2016 in medical care services. Of these, staff reported 25 as a near miss, 47 resulting in harm and 164 resulting in no harm. The high numbers of no harm incidents reported suggested a good reporting culture.
- Incidents were investigated by the management team. The majority of incidents related to clinical complications (124) and 96 to day case conversions. Conversions to inpatients were reported as incidents and were due to social, geographical or clinical reasons. Other incidents reported included infection control (33) and slips, trips and falls (11). These were then reported locally to departmental teams, the hospital executive, the medical advisory committee (MAC), the local clinical commissioning group and other relevant organisations as required.
- The dissemination of information regarding incidents and lessons learned was through electronic communications and staff meetings. We also reviewed a sample of hospital wide clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This 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



Medical care

support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken.

- We saw operational staff understood their responsibilities with regard to the duty of candour legislation and we found the responsible manager ensured that the duty was considered and met when investigating safety incidents.
- Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)
- The hospital monitored patient safety to enable them to measure, assess and analyse any incidents of harm. This data formed one of the hospital's key performance indicators (KPI's), a measurable value to demonstrate how the hospital achieved its safety objectives. The KPI's were documented in the integrated performance report. These were regularly monitored and reported to individual teams, consultant groups and key committees.
- The individual patient care pathways captured key data such as falls, urinary tract infections in patients with a catheter, venous thromboembolism (VTE) and pressure ulcers. Data showed between October 2015 and September 2016, no pressure ulcers were reported, six falls and three urinary tract infections were reported. We saw the hospital had achieved 100% VTE screening rates during the same reporting period.
- There was a policy in place describing the management of sepsis which was compliant with National Institute for Health and Care Excellence (NICE) guideline NG51 (sepsis: recognition, diagnosis and early management). Staff had attended scenario based training. Staff we spoke with were able to describe the prompt action to be taken in this event.
- We saw the infection prevention and control strategy and annual plan 2016-2018. The hospital had an infection prevention and control (IPC) team who fed into the integrated governance group and the Medical Advisory Committee (MAC) and met every three months. We saw the minutes of the meetings held in July and October 2016. Items discussed, but not limited to, included infections, needle stick injuries, audits, antibiotic usage and review of policies.
- The ambulatory care unit (ACU) and Bensen ward had an infection control champion known as 'link practitioners'. The link practitioner was central to disseminating infection control education, support to their local multidisciplinary team and provided a direct link with the IPC team. The link practitioners met every three months and we saw the minutes of the meetings held in April and July 2016. All areas of IPC were discussed. We saw in the July meeting the introduction of infection control information pack had been initiated for all new staff. The link practitioners were able to describe how they informed staff of updates through the departments email system and verbally.
- Cleaning audits were carried out in clinical areas monthly using the NHS 49 point checklist and the target was 90%. The checklist provides a comparative framework within which hospitals and trusts in England can set out details for providing cleaning services and assessing 'technical' cleanliness. We saw between January and April 2016, the day case ward scored an average 92%, inpatient ward 91%, and endoscopy 96%. The data for the audits performed between May and September 2016 showed improvement after the completion of the first stage of refurbishment. The inpatient ward scored 95%, day case ward 97%, and endoscopy 96%.
- Each head of department was provided with the results of the audits and the housekeeper allocated to that area was informed of failures to be rectified. Any failure which constituted a risk would be rectified immediately and all other failures (for example black marks on floors or bins) would be completed within 24 hours. Any area that fell below the agreed benchmark was closely monitored and spot check audits were completed to ensure all failures were rectified and standards maintained.
- Staff rota's showed at least one member of housekeeping staff was working on Bensen ward at all

Cleanliness, infection control and hygiene

- There were no incidences of E-Coli, MRSA and MSSA bloodstream infections or cases of C.difficile related diarrhoea reported in the period October 2015 to September 2016 at the hospital.
- All the areas we visited in the medical care services were visibly clean and tidy and there were good infection control practices in place.



Medical care

times during the day. We saw there were cleaning schedules for individual treatment rooms and toilets, which were fully completed. Housekeeping staff showed us their cleaning schedules which clearly set out the tasks to be performed and their frequency. They were required to sign when each task was completed and their supervisor checked their work.

- The endoscopy suite in the ACU had separate clean and dirty utility areas for the preparation and cleaning of equipment which minimised the risks of infection to patients. Staff transported dirty endoscopes from the treatment area to the dirty area in a covered, solid walled, leak proof container. This was in line with the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope reprocessing Units, QPSD-D-005-2.2.
- In the endoscopy department, we saw adequate systems to ensure that endoscopes were safely decontaminated. Documentary evidence showed that the use of scopes was tracked and the use of a specific endoscope was linked to each procedure. Staff we spoke with could explain the correct decontamination process. Scopes were stored safely in a drying cabinet for up to three days. There were processes in place to ensure staff reprocessed scopes at the appropriate time.
- All staff received infection control training as part of induction and this was repeated yearly. We saw mandatory training records which showed us by December 2016, 98% inpatients staff and all staff in the ACU had completed infection control training. The trust target was 95%.
- Hand hygiene audits were completed across the hospital for all staff on a monthly basis. A target of 100% was required. The audit included technique used, observations with patients at point of care and the use of World Health Organisation (WHO) guidelines for hand hygiene standards. We saw the September 2016 audit showed 86% medical staff, 96% registered staff and 100% non-registered staff were compliant. Areas of non-compliance related to the hand hygiene dress code. Two registered staff were wearing inappropriate jewellery and another was wearing a cardigan. We saw areas of non-compliance were raised immediately with the relevant member of staff concerned and training given.
- During the inspection we saw staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the WHO guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information was displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks. Sanitising hand gel was readily available throughout all areas.
- Personal protective equipment was available for all staff and we observed staff use it appropriately.
- Disinfectant wipes were available in clinical areas. Equipment which was shared between patients, for example commodes and observation equipment, was cleaned with these between each patient use. We saw staff apply 'I'm clean' labels on equipment. This indicated equipment was clean and ready for use. All the equipment we looked at was visibly clean.
- Disposable curtains were used in all ward areas, dates on them indicated they had been changed within six months in accordance with industry standards and hospital policy.
- Waste in the wards and clinical areas were separated and in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- The hospital commissioned an outside company to audit sharps safety in April 2016. This was to raise sharps awareness, assess practice and provide advice on compliance and current legislation. The target was 95%. We saw the results of the audit which showed the day care ward was 100% compliant. Garland ward (inpatients) scored 94% as it had some sharps boxes incorrectly assembled and unlabelled.
- Sharps bins were available in treatment and clinical areas where sharps were used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure



Medical care

containers and instructions for safe disposal of medical sharps close to the work area. The labels on sharps bins had been fully completed which ensured traceability of each container.

- The environment and clinical practice infection control audits for August 2016, for the ACU and Bensan ward showed overall compliant. The audit highlighted the ACU did not have infection control patient information leaflets displayed and Bensan ward had fabric chairs which were not compliant with national standards. The audits had an action plan with a named person responsible to rectify, target date for completion and action completed date. We saw the outcome showed the ACU had completed the required action and we saw there were leaflets for patient use. The replacement of the fabric chairs on Bensan ward was ongoing.
- During the inspection we saw all seating used within the patient areas was covered in a material that was impermeable, easy to clean and compatible with detergents and disinfectants. This was in line with HBN 00-09 section 3.133 for furnishings.
- The ACU and Bensan ward did not have carpets in clinical rooms. The flooring was seamless and smooth, slip resistant, easily cleaned and appropriately wear-resistant. This was in line with HBN 00-09: Infection control in the built environment, 3.109.

Environment and equipment

- Emergency equipment was located on Bensan ward and ACU. The resuscitation trolleys contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We saw the trolleys were secure and fully stocked and ready for immediate use. All equipment needed was available, as indicated by an equipment list. All consumables were in date. There was a system for checking these daily and we saw the fully completed records of checks. Staff checked the trolley in the ACU on the days the department was open. The records clearly stated 'not in use' on the days the unit was not open.
- Equipment service records indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw electrical testing stickers on equipment, which indicated the equipment was safe to use.

- Managers assessed staff to ensure competency before they used any medical devices, for example We saw examples of competency assessments in staff records, which were kept in ward areas.
- Equipment used for near-patient testing (an investigation taken at the time of the consultation with instant availability of results) was stored in the clean utility room on Bensan ward. Equipment included a blood gas analyser and testers for international normalized ratio (INR), blood glucose, and haemoglobin (red blood cells). All equipment was operational and we saw the records which showed they were quality controlled.
- Staff reported no problems with equipment and felt they had enough equipment to run the service. We were told there were no issues around securing the necessary equipment for individual patients, for example pressure relieving mattresses and commodes. The mattresses used by the hospital were fit for purpose and provided protection from infection and pressure damage.
- The endoscopy lead told us the number and size of endoscopes met the needs of the service. We saw a variety of scopes available to perform a variety of examinations. Equipment was maintained by an external contractor and we saw the equipment was labelled to show it had been maintained at the required frequencies. We saw competency certificates in endoscopy which indicated staff were competent in a variety of procedures and in the decontamination of equipment.
- Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.

Medicines

- The hospital had a medicines management policy. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of medicines.
- The hospital had a separate policy for the management for controlled drugs (CD's) and intravenous (IV) administration. IV therapy is the infusion of liquid



Medical care

substances directly into a vein and CD's are medicines that are liable for misuse and have additional legal requirements regarding their storage, prescription and administration.

- The hospital had a named controlled drugs (CD's) accountable officer. CD's were kept securely and stored in suitable cupboards with records maintained. The CD cupboards were locked, with restricted access and were bolted to the wall. Controlled drugs to be administered were checked by two members of staff. Spot checks on balances during the inspection showed contents of the cupboards matched the registers.
 - We saw the controlled drug audit performed between April and June 2016 and between July and September 2016 for endoscopy and Bensen ward. The endoscopy department had the correct balance of stock and all documentation was completed correctly. However, in Bensen ward the audit highlighted there were gaps in the correct documentation as cancellations and alterations were made by staff. The pharmacy team provided individualised training to ward staff to rectify this.
 - Medicine management was part of mandatory training for all clinical staff. This was part of induction and then updated every three years by e-learning. Training records showed us by December 2016, all inpatient and ACU staff were up-to-date with this training. The trust target was 95%.
 - Staff had access to up to date copies of the British National Formulary (BNF, a pharmaceutical reference book). Additionally, the hospital had devised its own medicines formulary which indicated the medicines held at the hospital, where they were located and what they were approved for. This assisted access for urgent medicines out of hours. The formulary was divided into different subject headings and included, but not limited to pain, respiratory, gynaecology, urology and unlicensed medicines.
 - We saw the audit of prescription charts and missed doses for March 2016 was on a selection of inpatients prescription charts randomly reviewed over a course of the previous three months. The audit assessed the quality of record keeping and found all to be compliant.
- We checked six prescription charts during the inspection. The prescriptions we looked at met legal requirements and were legible, signed and contained information about people's allergies.
- Medicines were stored securely to minimise unauthorised access. We saw medicine cupboards, fridges and trolleys were locked. Doors to medicine rooms had a key pad lock and only authorised staff had access. Doors were secure and locked. Bedside medicines storage containers for patients own medicines were also locked. Each authorised member of staff was issued with their own key which was personalised to the individual. This meant staff could only access areas as dictated by their key. Additionally the system allowed authorised staff access to medicine cupboards and enabled the organisation to review access to cupboards if required.
 - Medicines trolleys and fridges were clean and tidy. We found all the items stored were within date and there was a system of expiry date checks by pharmacy.
 - Security and safety of medicines was audited every three months. In March 2016, endoscopy was 100% compliant. Non-compliance was found in the day case ward regarding staff not regularly recording ambient and fridge temperatures and action taken when irregularities found. Additionally, the inpatient ward had liquid medicine which had been opened and used without the opening date being documented on the container (expiry is one month from opening due to risk of contamination). The audits in June and September 2016, found all areas were 100% compliant.
 - Staff monitored and recorded the minimum and maximum temperatures of the medicine refrigerator and room temperatures where medicines and products were stored in Bensen ward and the ACU. We saw records which indicated this was done daily and clearly marked. This meant medicines were kept in optimal conditions. The records in the ACU clearly stated 'not in use' on the days the unit was not open.
 - On Bensen ward there was suction and piped oxygen in every patient room. We saw records showing staff checked the oxygen and suction equipment daily.
 - The pharmacy department visited Bensen ward areas daily, Monday to Friday. They checked all medicine charts to ensure safe and effective use of medicines.



Medical care

Additionally the department organised the medicines given to patients on discharge from a hospital stay (TTA's). These were kept in a separate locked cupboard, restocked twice a day by pharmacy and dispensed by nurses on discharge.

Records

- No patients were seen without their relevant medical records in the three months before the inspection.
- We saw patient records were stored in locked trolleys and kept securely at the staff stations, which were in constant sight of staff. This maintained security and prevented unauthorised access of patient records.
- Staff on the endoscopy unit kept full scope-tracking and traceability records. These indicated each stage of the decontamination process. We saw the audit scope log book was completed and up to date. The service audited these records and we saw results of these audits, which indicated all stages of the process were completed. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- We saw the record keeping audit completed in October 2016. This was to ensure staff complied with the requirements of the standards for clinical record keeping policy and protocol in relation to auditing patient records. The audit consisted of 233 sets of notes which were selected at random from the health record library for the period July to December 2015. The audit showed three areas of concern which were: accountability and identification, legibility and accuracy of entries and patient detail capture and use of abbreviations. For example, in the nursing care pathways there were documented signature lists with authors identified in block capitals, initials and by designation. However in the medical section of the notes this was not the case and signatures were illegible, there was no designation or identification through the use of block capitals. The action plan of the audit showed by December 2016 consultant staff were to be made aware of the identified failings in the standards of clinical record keeping and staff training. This was part of clinical team meetings to remind staff of their responsibilities. The action plan stated there was to be a monthly audit to start in January 2017.

- We looked at six sets of patient records which were multi-disciplinary and we saw doctors, nurses and therapists contributed to a single unified document. The records were well maintained and easy to navigate. They were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. All were completed with appropriate assessments, signatures, allergies noted and all observations were documented and dated. The notes we saw had evidence of medicine reconciliation by the pharmacy team. However, in four records we saw the signatures of clinical staff were often not legible and names had not been printed.
- Mandatory training records showed us by December 2016, 98% inpatient staff and all staff in ACU had completed information governance training. The trust target was 95

Safeguarding

- See the Surgery section for main findings.
- The hospital had a safeguarding policy, 2016 which incorporated adults and children and these were accessible to staff. Safeguarding training was mandatory for all staff and achieved either face to face or by e-learning. Training for both adults and children was at induction and then every three years. We saw mandatory training records which showed us by December 2016, 93% inpatients staff and 90% staff in the ACU had completed level 2 safeguarding children training. All inpatients staff and 90% ACU staff had completed safeguarding vulnerable adults level 2 training. The trust target was 95%.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was.

Mandatory training

- We saw the training records for staff (excluding medical staff) for mandatory training. We spoke with managers who monitored the completion of mandatory training



Medical care

for their teams. We saw they had electronic systems, which recorded the training that was required, and its completion dates. Managers described how they used the system to ensure staff remained up to date.

- The training programme was comprehensive and contained all the training subjects that would be expected. For example, safeguarding adults and children, conflict resolution, informed consent, health and safety. Much of the training was available as on-line learning packages. No staff we spoke with described difficulties accessing these electronic training packages.
- The target for mandatory training set by the hospital was 95%. Overall 99% of inpatient staff and 94% of ACU staff had completed mandatory training by December 2016.

Assessing and responding to patient risk

- We looked at the records of medical inpatients and saw a range of risk assessments were used which used nationally recognised and validated tools. These included assessments for risk of pressure damage (Waterlow), falls and visual infusion phlebitis (VIP) score for monitoring infusion sites. We saw these assessments were reviewed as required by the hospitals care pathways.
- The hospital's anticoagulation policy stated every patient admitted must be assessed for venous thromboembolism (VTE) risk. We saw the risks of VTE were assessed for each patient and appropriate prophylactic measures were in place as a result of this, for example the use of anti-coagulant medication when required.
- Guidance from NICE CG50 Acutely Ill Patients in Hospital, recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. The hospital used the National Early Warning System (NEWS) and we saw this was routinely used for inpatients where appropriate.
- We found patients physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 Acutely Ill Patients in Hospital. We watched observations being taken and noted the technique used to monitor their condition. We checked observation charts and saw physiological parameters were conducted at appropriate frequencies.
- There was adequate resuscitation equipment and it was easily accessible. Staff knew where they were located.
- All staff received training in basic life support and anaphylaxis. Immediate life support training was for all registered staff and non-registered staff completed basic life support. This face to face training was part of induction and staff attended an update every year. We saw mandatory training records which showed us by December 2016, all appropriate staff had completed immediate life support in the inpatients and ACU areas. Basic life support training had been completed by all inpatient staff and 67% of staff in ACU.
- Medical cover was provided by the resident medical officer (RMO) 24 hours a day seven days a week. The RMO was selected on their experience to enable them to manage and respond to risks relating to the wide mix of patients at the hospital.
- An official on call rota was available for support out of hours. The rota was collected from reception every day and consisted of contact details for the RMO and a senior manager.
- The inpatient rooms on Bensen ward had access to a nurse call system which was directed straight to nurse's handsets. When the system was activated an audible alarm was not heard by all and this indicated other patients were not disturbed during the night and rest periods. The system was used to alert staff when a patient required assistance, an emergency call and a cardiac arrest call. This meant all staff on the ward were aware when a patient required assistance and were able to respond in a timely manner. The handsets were also used as a mobile telephone to enable nurses to communicate with each other.
- The hospital had a service-level agreement (SLA) with a local NHS hospital. This enabled them to transfer any patients who became unwell and needed critical care support.
- Bensen ward had 'sepsis six' kits, the name given to a bundle of medical therapies designed to reduce the



Medical care

mortality of patients with sepsis. The 'sepsis six' consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis.

Nursing staffing

- There was sufficient staff with the qualifications, skills and experience to meet the needs of patients. Staffing rotas showed there was always registered staff available in each department.
- Clinical staff were supported by other members of staff including health care assistants, porters, housekeepers and administrative staff. Staff we spoke with told us they considered there was sufficient nursing staff to meet the needs of patients. Patients echoed this view and told us any requests for help or care were responded to promptly.
- The hospital employed 24.8 Whole Time Equivalent (WTE) registered nurses and 13.5 WTE health care assistants (HCA's) in the day case and inpatient department.
- The use of bank and agency nurses in the inpatient departments was lower than the average of other independent acute hospitals CQC hold data for between October 2015 and June 2016. There was no use of bank and agency health care assistants in the departments in the same reporting period. Staff told us the usage of agency nurses was higher at night and these were regular agency nurses.
- The ACU employed 11.46 WTE nurses and had a vacancy for 16 hours each week. We saw the unit used 2.4 WTE agency nurses each week who were regular agency nurses and all were familiar with the department.

Medical staffing

- The medical staffing arrangements are reported on under the surgery service within this report.

Emergency awareness and training

- The medical staffing arrangements are reported on under the surgery service within this report.
- We saw mandatory training records which showed us by December 2016, 98% inpatients staff and 100% ACU staff had completed fire safety training. The trust target was 95%.

Are medical care services effective?

Good



We rated effective as good.

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

- Relevant and current evidence based guidance, standards, best practice and legislation were used to develop how services, care and treatment were delivered. Including; National Institute for Health and Care Excellence (NICE) guidance CG161: falls in older people assessing risk and prevention, QS24: nutrition support in adults, QS3: venous thromboembolism (VTE) in adults reducing the risk in hospital, QS66: intravenous (IV) in adults in hospital therapy and QS90: urinary tract infections (UTI) in adults and NG51: sepsis: recognition, diagnosis and early management. NICE guidance was reviewed at clinical governance meetings and if relevant, discussed with clinicians to ensure best practice.
- We reviewed a range of clinical policies and found that all expected topics related to relevant and current evidence based practice and legislation. Staff were able to access national and local guidelines through the internal computer system. This was readily available to all staff. Staff demonstrated how they could access the system to look for current hospital guidelines. We noted there were appropriate links in place to access national guidelines if needed.
- Patient records we reviewed showed the care patients received was consistent with NICE guidelines and protocols in use at the hospital.
- We saw an alert system that could be quickly cascaded through the hospital to ensure people were working within the national framework for the Medicines and Healthcare Products Regulatory Agency (MHRA). This is responsible for ensuring that medicines and medical devices work and are acceptably safe.
- Endoscopy procedures were completed in line with professional guidance, for example NICE safe sedation practice and British Society of Gastroenterology.



Medical care

- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation at the time of inspection. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. We saw minutes of meetings which were held every other month to discuss the progress of the application and this was led by a gastroenterologist. We saw the department had met level B of their application by April 2016 (level 'A' item on the GRS is seen as aspirational and best practice measures).
- The hospital had an equality and diversity strategy and plan to ensure there was no discrimination against patients when making care and treatment decisions. The strategy encompassed the nine protected characteristics of the Equality Act 2010, for example age, disability and sexual orientation.

Pain relief (medical care specific only)

- We saw effective pain control was an integral part of the delivery of care. Pain scores were documented on the NEWS charts in patient's records and managed accordingly. Patients had regular assessments for pain and appropriate medication was given frequently and as required.
- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). There were guidelines for prescribing using NICE guidance, for example opioids (a strong pain killer).
- None of the patients we spoke with required pain relief at the time of our inspection. Staff told us they would escalate any concerns around pain relief to the Resident Medical Officer (RMO).
- We saw the results of the audit conducted in October 2016 to collect information regarding the incidence of postoperative pain and nausea (POPV) and vomiting of gynaecological patients in the first 24 hours when on the ward. The pain results did not reach the suggested target of no or mild pain in more than 95% of patients. However, the audit showed the incidence of POPV reached the target of less than 20%. Recommendations from the audit included an increased sample size of the audit, different surgical procedures and review of the type and method of recording relevant questions.

Nutrition and hydration

- We saw risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a nutritional screen assessment tool MUST (Malnutrition Universal Screening Tool) which identified patients who were at risk of poor nutrition or dehydration. This was part of the pressure ulcer prevention policy to identify those patients who were at risk.
- We found patients and those supporting them had access to hot and cold drinks at all times. We saw drinks machines were available in waiting areas and we noted inpatients always had a drink within reach.
- We saw fluid intake was monitored using fluid balance charts. This included the administration of intravenous fluids if prescribed, when oral fluids were started and the patient commenced their diet.
- The hospital had a dietician who provided nutritional support and expertise to bariatric patients before and after surgery. The dietician also provided additional support and advice for other patients.

Patient outcomes (medical care specific only)

- The hospital had a robust audit programme and we saw the audit schedule for 2016. Audits for the day case and inpatient wards included National Early Warning System (NEWS), admissions and discharge lounge function and use, patient satisfaction and infection control and hygiene. Audits for the ambulatory care unit included comfort, consent, completion rates, JAG audit census and patient satisfaction.
- The care pathway used ensured key data was captured in relation to patient outcomes which assisted the departments to define audits to measure efficacy of care. We saw audits were completed and reported to the departments, the clinical governance committee and clinical effectiveness meetings. Trends were identified and action plans created to improve the service to patients. This was communicated back to the clinical departments for their action.
- The hospital reviewed patient satisfaction feedback, incidents and complaints, activity data and staff surveys. This enabled them to monitor patient outcomes to enable them to benchmark against similar services and improve people's outcomes.



Medical care

Competent staff

- See the Surgery section for main findings.
- Staff in the medical care service had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff's professional registrations were due and to ensure they were renewed. These were demonstrated to us.
- The hospital provided training courses for staff to promote career and personal development. This included diploma and degree modules, National Vocational Qualification (NVQ) training and management skills. Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- The mandatory training programme included training for essential professional development for clinical skills and knowledge. Subjects covered included medical devices, intravenous administration and allergy protocol. Data showed us the majority of registered staff across the hospital had achieved the 95% target in all subjects.
- Sepsis training was part of induction and staff attended an update every year. Sepsis arises when the body's response to an infection damages its own tissues and organs. It can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly. We saw 98% of registered staff had attended the training by October 2016. Staff we spoke with were able to describe the prompt action to be taken in this event.
- Scenario training was provided for staff every three months in different areas of the hospital with different subjects, for example sepsis training and this was last completed in December 2016. We saw and staff told us about the training schedule for the training day which was booked for two days after the inspection. The subject of the training was the use of the oxygen machines to be used for bariatric (extremely obese) patients.

- We saw the hospital received assurances from the agency used for nursing staff. This included training, qualifications, disclosure and barring service (DBS) check, immigration status, professional registration and details of induction.
- Data showed all staff had received an appraisal in the year January to December 2016. All staff we spoke with told us they had received an annual appraisal. They told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with the NMC.
- We observed nursing handovers on Bengan ward took place at 7.30am, 1pm and 7.30pm every day. Nurses used handover sheets to provide written information on each patient including allergies, relevant safety information such as pressure area care and any significant medical history. This ensured an effective, accurate and patient centred approach to care.
- Agency staff who worked in the ACU were regular staff that were familiar with the department. Staff showed us documentary evidence of agency staff inductions and formal competencies assessments.

Multidisciplinary working

- See the Surgery section for main findings.
- Staff told us they worked well as a team in their departments and all other areas of the hospital. We saw a strong multi-disciplinary approach across all the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the departments.

Access to information (medical care only)

- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system. This is medical imaging technology which provides economical storage and convenient access to images from multiple machine types.
- Staff in medical care services could access a shared drive on the computer where policies and hospital wide information was stored. Staff demonstrated this to us.
- Some medical staff were provided with an NHS email addresses for confidential transfer of patient data relating to all NHS contracts.



Medical care

- We saw ward based handover sheets for staff to reference. Staff regularly updated these, which contained current and accurate information about patients' needs, treatment plans, risks and their management. We attended a handover meeting and found there was adequate communication of patient's on-going needs and of any risks to their well-being.
- Staff sent discharge summaries to GPs on discharge from hospital which we observed.
- Endoscopy patients received a letter on discharge. This included the reason for the procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. A copy of this letter was sent to the patients GP and a copy was kept at the hospital in the patients' medical records. This meant there was a continuity of service and all medical teams were kept informed.

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

- The hospital had a policy for consent to examination or treatment. The policy demonstrated the process for obtaining consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits. We saw signed consent forms in six medical records which showed patients had consented to treatment in line with the hospital's policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- Informed consent was part of mandatory training for all clinical staff. We saw training records which showed us by December 2016, all inpatient staff and 90% staff in ACU had completed informed consent training. The trust target was 95%.
- The hospital had policies for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policies gave guidance on the local policies, practice and procedures to be followed by hospital staff when working with individuals who may lack mental capacity or are or may become deprived of their liberty. Staff had access to flowcharts to prompt them of the process.
- All clinical staff received training in MCA and DoLS as part of their induction and then as identified on their

personal development record. Training records showed us by December 2016, 98% inpatient staff and 90% ACU staff had completed the training. This was worse than the 95% target. However, we saw clear guidance available to all staff as part of the hospital's 'Informed consent policy'.

- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests.

Are medical care services caring?

Outstanding



We rated caring as outstanding.

Compassionate care

- See the Surgery section for main findings.
- We saw staff treating patients in a kind and considerate manner. Patients and their friends and family told us staff always treated them with dignity and respect.
- Staff maintained patients' privacy and dignity. We saw staff knock and wait before entering patient's rooms in all areas of the hospital. We observed staff were kind and patient in their approach.
- Patients told us, and we observed, call-bells were left within reach of patients and were answered promptly and staff responded promptly to requests for assistance.
- All patients were asked to complete a satisfaction questionnaire that incorporated questions of all aspects of their care and experience. The hospital measured national survey information, for example the Friends and Family Test (FFT), and used all patient feedback to guide investment plans, treatments offered and the overall patient experience.
- Data was submitted to the FFT for NHS patients only. The hospital's FFT scores were variable between April and September 2016 with an average score of 97%. Response rates were better than the national average of NHS patients across the same period with an average of 51%.



Medical care

- We spoke with six patients and five of their family and friends during our visit who were positive about the hospital and care received. One patient told us “I cannot fault the hospital” and “everybody is lovely”.
- During the inspection we asked patients to complete feedback forms to describe their experience at the hospital. We collected four completed cards relevant to Bensen ward and the ambulatory care unit. The cards were all positive about the hospital and included comments “the staff were brilliant, I couldn’t have asked for more” and “a lovely hospital and lovely staff”.

Understanding and involvement of patients and those close to them

- See the Surgery section for main findings.
- We observed staff discussed treatments with patients in a kind and considerate manner. The patients and their relatives we spoke with told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. They felt they had time to ask questions and that their questions were answered in a way they could understand.
- We observed staff introducing themselves to patients and their relatives.

Emotional support

- See the Surgery section for main findings.
- Patients reported they felt able to discuss their emotional state with staff if required.
- Staff showed us how they could access counselling services and other psychological support for a patient if it was needed.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance.

Are medical care services responsive?

Good



We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital had arrangements and collaboration with Clinical Commissioning Groups (CCGs) and the local NHS acute trusts. This ensured people had choices about where they received treatment but also that waiting was kept to a minimum. This meant the local population had choice as to where they could receive their care and treatment and the provider was focussed on their needs.
- Patients told us they had been offered a choice of times and dates for their appointments.
- The endoscopy unit was open Monday to Friday. The hospital provided endoscopy services to both NHS and privately funded patients.
- Inpatient wards had single rooms with separate shower and toilet facilities. The hospital provided complimentary toiletries for each patient. There were televisions available and internet connections in each room for patients to use.
- Visitors of inpatients on Bensen ward were welcome between 11am and 1.30pm and between 3pm and 8pm every day. Outside of these hours visiting was by agreement with the nursing staff.
- The restaurant was accessible to all. We saw cold and hot drinks were available in all waiting areas we visited.
- The hospital had lounges and gardens for patients and visitors use.
- The hospital had a volunteer programme. We spoke with volunteers who offered a guiding service, reception and general information for patients and visitors.

Access and flow

- See the Surgery section for main findings on referral to treatment times.
- The discharge process was nurse led and started at time of admission. We saw the care pathways used directed staff to consider all aspects of discharge planning for inpatients. We saw all sections had been completed which meant patients were protected from the risks associated with poorly planned discharge from the hospital.



Medical care

- Nurses on the wards would refer to the community teams if a patient required additional assistance when they returned home. For example, medication and wound care. Inpatients were provided with a discharge summary to pass to their GP.
- The GP's of endoscopy patients were sent a copy of the discharge letter on the same day as the procedure.
- Data showed 82% of patients were day cases in 2016. The average length of stay for inpatients was two nights.
- The hospital monitored incidents of day case conversions. We saw the information was collected monthly as part of the governance process to monitor as part of key performance indicators (KPI's). The hospital reported 96 incidents between January and December 2016 of patients admitted as a day case and required an overnight stay due to clinical complications. These were reported on the incident reporting system. Each incident was described, categorised, result, action taken and investigation and lessons learned if appropriate. All incidents were reported as no harm except for one incident which was rated as a near miss. The investigation of the near miss highlighted the complication caused should have been identified on admission. The lessons learned showed all staff to look comprehensively at pre-admission records.
- Literature was available to help patients understand their care, treatment and general health issues. We saw a variety of health-education literature and leaflets in the reception area. Some of this information was general in nature while some was specific to certain conditions.
- We did not see any leaflets in any other languages apart from English. However, staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database.
- Staff could tell us how they would access translation services for people who needed them. We were provided with two examples from 2016 when patients were provided with face to face translators. The hospital had access to a telephone interpreter service for a consultation and individual interpreters who would follow the patient through the journey of admission, consent, accompany to surgery, and were available in the recovery room and on ward.
- Patients who were living with a learning disability or dementia were identified by staff when the referral was received. Staff told us if applicable, the appropriate individualised care and support was provided, for example appointments to accommodate individual needs. Bensen ward had facilities for family and friends to stay with the patient if required.

Meeting people's individual needs

- All staff received equality and diversity training as part of induction and then every three years by e-learning. We saw mandatory training records which showed us by December 2016, all staff in inpatients and in the Ambulatory care Unit (ACU) had completed equality and diversity training.
- The endoscopy suite in the ACU had separate male and female changing and recovery areas to maintain patient's dignity.
- The physiotherapy team saw patients on Bensen ward twice a day, seven days a week. They did not see patients between 1.30pm and 3pm as this was protected rest time for the patients.
- Hotel service assistants on the ward discussed the menu with patients and collected their choices. Patients had the opportunity to order meals that were not on the menu. Cultural and therapeutic diets were available, for example, gluten-free, Kosher or Hal-al.
- All staff received dementia awareness training as part of induction and then every three years by e-learning. We saw mandatory training records which showed us by December 2016, 98% inpatients staff and all staff in the ACU had completed dementia awareness training. The trust target was 95%.
- The hospital had started an initiative in December 2016 to ensure the hospital was dementia friendly. This had involved an awareness campaign and recruiting dementia champions for each department.
- The hospital had allocated disabled parking bays and disabled toilets to accommodate patients living with a mobility disability. The hospital had several wheelchairs available for patients to use if required.

Learning from complaints and concerns

- The hospital recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were



Medical care

not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. All staff were encouraged and empowered to identify and address any concerns or issues while the patient was still in the hospital.

- The responsibility for all complaints rested with the hospital director who would decide which head of department and/or consultants needed to be involved in the investigation. Matrons, managers and service leads had delegated responsibility for the management of complaints arising in their areas of responsibility and were responsible for updating the clinical governance committee on issues raised.
- We saw complaints and compliments were formally discussed at the clinical governance meetings and department meetings as appropriate. This reviewed patient satisfaction data, complaint trends, onwards action as appropriate and areas for continuous improvements for the patient experience.
- The hospital's complaints policy set out the relevant timeframes associated with the various parts of the complaint response process. The patient experience and governance lead triaged all written complaints received and directed for appropriate management. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage the complainant would be given the information of who to take the complaint to if they remained unhappy with the outcome. Private patients were signposted to an independent adjudicator and NHS patients treated at the hospital, to the NHS Ombudsman.
- During the complaint investigation the process was monitored to ensure timescales were adhered to and responses provided within 20 working days. If a response was not able to be provided within this timeframe a holding letter was sent so they were kept fully informed of the progress of their complaint. All complaints information was retained within a paper file, with copies retained electronically and also stored in the hospital information management system.
- We saw there were three formal complaints made by patients for medical care services between April and September 2016. One related to lack of information

received on discharge, another the mismanagement of post-surgical pain and the third related to poor nursing care and the patient felt they were not treated with dignity or compassion. For all three complaints we saw the hospital had responded within the required time frame by letter and a representative from the hospital had met with the patient. All three complaints were resolved and showed lessons learnt from the hospital. Individual members of staff affected were provided with extra training where appropriate. We saw the complaints were discussed at ward meetings.

Are medical care services well-led?

Outstanding



We rated well-led as outstanding.

Leadership and culture of service

- Staff in ambulatory care unit (ACU) and Bensen ward reported to the matron for wards and ACU. The matron reported to the director of patient services who sat on the hospital's executive committee.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of medical care services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Any changes made were communicated through team meetings, newsletters and emails. We saw examples of newsletters on notice boards.
- Staff told us the hospital was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.
- The rate of sickness for inpatient nurses and health care assistants (HCA's) was lower than the average of other independent acute hospitals CQC hold data for between October 2015 and September 2016. There were no unfilled shifts reported in the last three months of the reporting period.



Medical care

- The rate of inpatient nurse vacancies was 2.38 whole time equivalent (WTE) giving a vacancy rate of 9%. There were no vacancies for HCA's in the department.
- The turnover rate for inpatient nurses was 7% between October 2015 and September 2016. This was a decrease of 4% from the previous reporting period. The turnover rate for HCA's was 7% in the previous and current reporting period.
- In January 2016, the hospital introduced an employee assistance programme. This was designed to improve the wellbeing of staff offering them support, guidance and advice. Staff had unlimited access to 24 hour support and advice line to talk in confidence on any issue causing concern including anxiety, stress, depression, grievance and harassment. Staff we spoke told us they were aware of the service.

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

- See the Surgery section for main findings.
- We were told the mission of the hospital was to be a leading provider of high quality healthcare services which improved patient's health. The strategic aims were to maintain a robust business that was capable of generating a reasonable surplus in order to invest in the achievement of their purpose.
- We saw and were told the hospital aimed to invest in staff to provide appropriate training and development to support practice. Additionally, they aimed to engage with stake holders and work together to provide an increase in knowledge and an improved service to patients.

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

- The service governance processes were the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- We saw the minutes of staff meetings for the inpatient wards. These were held every two months and we saw the agenda for the next meeting 23 January 2017. We saw key staff attended and the agenda items covered all the main areas of concerns, and actions were identified

to individuals. We saw the meetings followed a standard template with standing items to be discussed at every meeting, for example audit results, patient pathways and staff training.

- The managers of the inpatient ward and ACU were proactive in their understanding of the risks that could affect medical care services. We saw a separate risk register which included a list of 22 risks which were clearly identified and mitigating actions were related. The risk register was linked to the incident reporting system. Risks listed included the security of medical records, the use of the lift, sharps and access and use of balconies. Each of the 22 risk had separate risk assessments and further relevant information. For example, a patient or their adult family or friend who wished to access the balcony a separate form was to be completed and the risks involved explained.
- The minutes and actions from the clinical governance, Medical Advisory Committee (MAC), health and safety, infection prevention meetings were reported to the medical care service managers. The information was cascaded to the wider team through departmental meetings and staff briefings.
- A structured audit programme supported the hospital to ensure patient safety was at the forefront of service provision. Actions were monitored locally and within sub-committees and clinical governance meetings. These ensured lessons could be learnt and actions had been completed.

Public and staff engagement

- We saw posters in patient areas asking if patients had comments, compliments or a concern they were speak to the matron, ward sister or staff nurse and these people were identified on the posters. Additionally, information of how to give feedback was provided in leaflets and available on the hospital's website.
- Feedback from patients enabled the hospital to run 'spotlight' experience events which looked at highlighted issues of care. These typically ran for one month and recent topics included site development, nursing care and doctors.
- Patient feedback cards were obtained and specifically asked about pain relief, patient needs and trust in staff



Medical care

and we saw feedback was consistently over 90%. Additionally we saw a survey was undertaken by catering department on a regular basis to obtain patients feedback regarding the menu offered.






- We saw information displaying the results of patient surveys and what patients thought about the care they received on the ward. The information was updated each month with patients' comments about their experience in hospital which included what the hospital was doing well and where they could do better, under the title 'you said, we did'. This meant the hospital was listening to patient feedback and act on suggestions and concerns to improve services. For example, staff on Bengan ward told us a patient had provided feedback about the position of the shaving plug and the mirror in the shower rooms. This had resulted in specific shaving mirrors being fitted to assist patients with their personal care.
- Staff told us they were engaged in the changes occurring at the hospital and senior managers consulted them about the changes, asking their opinion.

- The results of the staff survey completed in December 2015 showed a response rate was 49% which was comparable with the response rates from previous staff surveys. The results showed 85% of staff agreed Benenden was a fair employer and 91% felt part of a happy and healthy workforce.
- The hospital encouraged social interaction for staff through a range of events organised specific to the hospital. This included charitable initiatives to encourage staff engagement in a social context, for example the awareness campaign 'sock it to sepsis'.

Innovation, improvement and sustainability

- Innovation, leadership and excellence were recognised at the annual staff awards. The awards were called 'Best of Benenden' and a HCA on Bengan ward received an award for leading and inspiring others.
- The management structure of hospital meant individual members were familiar with all aspects of the business. Decisions taken at board level could immediately be implemented as actions and were allocated to those present and systematically followed up.

Surgery

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

Are surgery services safe?

Good 

We rated safe as good.

Incidents

- Between October 2015 and September 2016, the hospital reported no never events. Never Events are a type of serious incident that are wholly preventable, where 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.
- Between October 2015 and September 2016, there were 503 clinical incidents and 84 non-clinical incidents relating to surgery or inpatients. In the same period, there were 771 clinical incidents across the hospital. Hospital data showed 99.1% of incidents were low harm or no harm. This demonstrated the positive incident reporting culture we observed.
- The hospital used an electronic system for reporting incidents. Staff could describe the process for reporting incidents, and gave examples of times they had done this. All staff we spoke to had confidence in the incident reporting process.
- The hospital had effective systems to ensure staff learned from incidents to improve patient safety. Heads of department, such as the theatre manager or ward manager, investigated incidents. The clinical governance committee (CGC) reviewed more significant incidents and any trends in incident reporting, such as returns to theatre and readmissions. We saw evidence of

CGC meeting minutes, which reflected this. The service also escalated some incidents to the medical advisory committee (MAC) and the senior management team meetings for review. Again, meeting minutes provided evidence of this.

- Staff told us they received feedback with any learning from incidents at ward or theatre meetings. We saw copies of theatre and ward meeting minutes, which reflected this. Staff were able to give us examples of changes to practice following incident learning. This included introducing bladder scans before discharge for day surgery patients following an incident where a patient had urinary retention. Urinary retention is the sudden inability to pass urine, and occasionally happens after surgery. It is usually painful and requires urgent treatment with a catheter.
- Staff we spoke with were aware of the duty of candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support. Staff knew what DoC meant and gave us examples of incidents which triggered DoC, such as drug errors. Staff could describe their responsibilities relating to DoC.
- The hospital did not carry out mortality and morbidity review meetings as a matter of course. This was in part due to the acuity level of patients treated and the consequent low numbers of patients that would fall into these categories. For example, the hospital had no patient deaths between October 2015 and September



Surgery

2016; therefore, mortality meetings were not applicable. However, the hospital could review mortality and morbidity through their multidisciplinary clinical governance committee should the need arise.

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

- Hospital data showed no surgical inpatients acquired a pressure ulcer between October 2015 and September 2016. In the same period, three patients had a catheter-associated urinary tract infection (CAUTI) and six patients had a fall. Data showed the harm-free care rates were 100% for pressure ulcers, 99.97% for catheter-associated UTIs and 99.94% for falls.
- The service reported seven cases of acquired venous thromboembolism (VTE) or pulmonary embolism (blood clots in veins) in October 2015 to September 2016. The hospital fully investigated each case using root cause analysis (RCA). We saw copies of RCAs for the last four cases of VTE. All RCAs showed staff calculated the risk of VTE correctly and gave appropriate prophylaxis, such as anti-embolism stockings, in accordance with the hospital's "anticoagulation policy". All RCAs showed the VTEs could not have been prevented. However, one RCA identified the need for staff to recognise and escalate early signs of VTE more quickly. Nursing staff received feedback around this at a ward meeting. The hospital's clinical skills facilitator also added learning from this incident into immediate life support training.

Cleanliness, infection control and hygiene

- All clinical areas were visibly clean and tidy. We saw "I am clean stickers" on equipment to provide staff with assurance that equipment was cleaned and ready to use. The hospital had an external infection control environmental audit in August 2016. The external auditor found an "excellent" standard of domestic cleaning throughout the ward and other departments, including theatres. The report also stated, "The cleaning of equipment undertaken by nursing staff was of a high standard, reflecting good compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance".
- We saw copies of daily, weekly and monthly cleaning schedules in theatres. The hospital carried out monthly

cleaning audits. Audit results for 2016 showed theatres, ward areas and other clinical areas consistently exceeded the 90% hospital target every month in January to December 2016. The average cleaning scores for 2016 were 95% for ward areas, 93% for theatres and 93% for other clinical areas. This demonstrated the hospital had assurance around cleanliness.

- The hospital carried out quarterly mattress, pillow and duvet audits. These confirmed the hospital condemned any stained or damaged mattresses, pillows or duvets. The hospital's policy was to discard any duvet in use for more than one year, or earlier if there was any damage or staining. We saw that mattresses on the ward had covers that could be wiped to allow effective cleaning. We randomly checked the mattress, pillows and duvet on an inpatient bed on Bensen Ward and saw that they were visibly clean.
- The hospital's annual IPC report for 2016 detailed activities to ensure the hospital met the requirements of the Department of Health: Code of Practice on the prevention and control of infections and related guidance. This programme of work was mapped to the compliance criteria within the code of practice and included systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment, ensure appropriate use of antimicrobials and ensure all staff were fully involved in the process of preventing and controlling infection.
- All staff we met were bare below the elbows to allow effective handwashing. Alcohol hand sanitiser and clinical wash hand basins were available in all clinical areas. All clinical wash hand basins, including those in patient bedrooms on Bensen Ward, were compliant with the Department of Health's Health Building Note 00-09. We saw staff wash their hands and use hand gel appropriately, for example before and after patient contact. This was in line with the world health organisation's (WHO) "Five moments for hand hygiene".
- Monthly hand hygiene audits showed the theatre department consistently achieved 100% compliance with hand hygiene policy in January to September 2016. This meant all theatre staff cleaned their hands appropriately in line with the WHO's "Five moments for hand hygiene". Hand hygiene audits also assessed hand



Surgery

washing technique and dress code such as “bare below the elbows”. This meant the audits measured the effectiveness, as well as the frequency, of hand washing and cleaning.

- In the same period, the eye department scored between 93% and 100% on hand hygiene audits. Ward staff scored between 84% and 100%. However, ophthalmology achieved 100% compliance in five out of nine months during this period. Ward staff achieved 100% compliance in four out of nine months. The infection prevention and control (IPC) link nurse for each area fed back to departmental managers with any areas of non-compliance for action. This meant the hospital could be confident staff cleaned their hands in line with hospital policy, and that staff challenged non-compliant behaviour.
- All theatre staff dressed appropriately in scrub suits and designated theatre shoes. Staff were not permitted into any clinical areas within the theatre department in outdoor clothing. We saw a sign on the internal doors within theatres reminding staff of the need to wear theatre clothes in these areas. Staff either changed clothes or wore a clean gown over their theatre clothes if they needed to visit other areas within the hospital. We saw that all staff followed this policy.
- We saw appropriate personal protective equipment (PPE), such as gloves and aprons, available in all clinical areas. We saw staff using PPE appropriately, for example, when cleaning patient rooms.
- The hospital had an onsite sterile services department (SSD) for the sterilisation of instruments. The service offered a four-hour turnaround time on instruments, and a fast-track service if theatres needed particular items more urgently. The SSD used an electronic traceability system to enable the tracking and tracing of instruments for quality assurance purposes. Staff told us they had used the tracking system to carry out “look back exercises”, for example, following an infection. This allowed the service to establish which individual instruments were used on which patients, and when. The SSD was working towards achieving external accreditation in 2018.
- The SSD had a “two door system” to ensure dirty instruments did not contaminate clean areas. Dirty instruments went into washers through one door and came out of a second door into the “clean” room. There were no personnel doors between “clean” and “dirty” areas. This meant staff could not move inappropriately between these areas. We saw that all staff in SSD wore appropriate theatre clothing including sterile gowns; and PPE such as eye protection.
- In all clinical areas we visited, we saw the correct segregation of clinical and non-clinical waste into different coloured bags. We saw that staff had correctly assembled, dated and labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks. These practices were in line with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste
- The hospital reported no infections of MRSA or methicillin-sensitive Staphylococcus aureus (MSSA) in October 2015 – September 2016. There were no reported cases of Escherichia coli or Clostridium difficile (C. diff) in the same period.
- At the pre-operative assessment stage, staff screened high-risk patients for Meticillin-resistant Staphylococcus aureus (MRSA), such as orthopaedic surgery, those who had been in hospital previously and patients who had previously tested positive for the bacteria. This was in line with Department of Health: Implementation of modified admission MRSA screening guidance for the NHS (2014).
- We saw evidence of MRSA screening in five patient records we reviewed. However, one patient’s negative MRSA result was more than one year old. The patient was unable to attend for re-screening before their operation. However, we saw evidence in the notes that this patient’s operation took place at the end of the operating list. This gave theatre staff sufficient time to carry out a deep clean of the operating theatre before the next day’s list. After surgery, the patient had a single ensuite room on Bensan Ward. This would minimise the risk of potential transfer of MRSA to other patients.
- The hospital took part in the Public Health England (PHE) surgical site infection surveillance service (SSISS). This allowed the hospital to benchmark its infection



Surgery

rates against other hospitals and identify areas for improvement. The hospital supplied surgical site infection (SSI) data to PHE on hip replacements and knee replacements.

- As part of the SSISS, the hospital sent out post-operative questionnaires to patients. This helped them identify more patients who developed an SSI after discharge. For example, patients who contacted their GP rather than the hospital for diagnosis and treatment of an SSI.
- The hospital's PHE SSI report for October 2015 to June 2016 showed 0.5% of patients developed an SSI following hip replacement during this period. This was better than the average infection rate of 1.2% for other hospitals that sent patient questionnaires during the same period.
- In October 2015 to June 2016, 1.8% of patients developed an SSI following knee replacement. This was about the same as the average infection rate of 1.9% for other hospitals that sent patient questionnaires during this period.
- In total, the hospital reported 46 surgical site infections in October 2015 to September 2016. The rates of infections following primary knee arthroplasty, gynaecology, upper gastro-intestinal and colorectal, urological and vascular procedures were worse than the rates for other independent acute hospitals we hold data for.
- However, we saw that the hospital reported all suspected wound infections, even if microbiology tests confirmed there was no microbial growth. The reporting of all unconfirmed SSIs allowed the hospital to follow-up all cases and monitor any trends. This reflected the positive incident reporting culture we saw during our inspection. We reviewed SSI incident investigations and saw that there were no deep infections. All infections were superficial and resolved following antibiotic treatment.

Environment and equipment

- We checked two resuscitation trolleys, one in theatres and one on Bensen Ward. On both trolleys, all equipment and drugs were within their use-by dates.

We also saw checklists for both trolleys showing evidence staff checked the trolleys daily. This provided assurances emergency equipment was safe and fit for purpose.

- We checked the anaesthetic machine in Anaesthetic Room Two and saw a logbook showing evidence of daily checking with no gaps. This was in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. Records showed staff changed the machine's tubing weekly to maintain its function.
- We checked the difficult airway trolley in theatres and saw a logbook showing evidence of daily checking. We saw theatres stocked the trolley in line with equipment referenced in the 2015 "Difficult Airway Society guidelines for unanticipated difficult intubation in adults". Staff maintained a list of equipment expiry dates, and we saw evidence staff replaced consumables before they expired. We saw that all equipment on the trolley was within its manufacturer-recommended expiry date. We observed that staff confirmed the location of the difficult airway trolley during a team brief. This was important to ensure any new or agency staff knew where to find the trolley quickly in an emergency.
- The hospital maintained an asset register with details of equipment servicing. The estates department checked the register every Monday morning and allocated servicing jobs to the team. We checked the register and saw the hospital serviced all equipment within the recommended periods. We also saw completed worksheets, which provided evidence estates staff had serviced equipment. We checked three items on Bensen Ward and three in theatres and saw evidence of recent servicing and electrical safety testing. These processes meant the hospital had assurances around the function and safety of hospital equipment.
- We saw the theatre implant register. This contained batch numbers for all orthopaedic implants such as prosthetic hip and knee joints. We saw that the register was up-to-date and complete with all implants used since July 2016. This allowed traceability of orthopaedic implants should any problems arise with a particular batch.
- On Bensen Ward, we saw sufficient equipment to maximise patients' independence while they recovered



Surgery

from orthopaedic surgery. This included walking frames, crutches, wheelchairs and raised toilet seats. We also saw the ward had one hoist. We spoke with a nurse, who felt one hoist was sufficient to meet patients' needs. This was because very few patients stayed on the ward that needed to use a hoist

- The hospital had appropriate equipment for bariatric patients, including beds, shower chairs and wheelchairs. Staff knew the maximum weights for different pieces of bariatric equipment to enable patients to use equipment safely. The hospital maintained bariatric equipment as part of the estates department's servicing schedule.
- There was uncontrolled access into the theatre department at the time of our visit. This was because the swipe-card access system had broken, allowing the doors to open freely. The theatre manager told us there had been intermittent problems with the access since the new theatres opened in May 2016. This affected the doors into the theatre department, the pharmacy door within theatres and the doors between theatres and Bensan Ward. However, the estates department were working to fix the problem. We saw that the doors between Bensan Ward and theatres self-locked when we returned for our unannounced visit. The pharmacy door also self-locked. However, there were still intermittent problems with the doors from reception into the theatre department. We saw that these doors opened freely during our unannounced visit, although the theatre manager told us the locking mechanism worked earlier that week.

Medicines

- We checked controlled drugs (CDs) in the theatre recovery area, Anaesthetic Room Two, and on Bensan Ward. Controlled drugs are medicines liable for misuse that require special management. We saw the CD cupboards were locked in all three areas. Only authorised staff could access CDs using individual electronic keys. The electronic key system logged which staff had accessed the CD cupboard to allow traceability. We checked the CD registers in all three areas and found two members of staff had signed for all controlled drugs. This was in line with national

standards for medicines management. We randomly checked the stock level of two CDs on Bensan Ward and in recovery. We saw the correct quantities in stock according to the stock list, and that all were in-date.

- The theatre department reported a CD discrepancy in November 2016. Staff discovered there was no record of receipt of a CD in Theatre Three. The theatre manager and a matron fully investigated the incident and the pharmacy department carried out an audit. Theatres subsequently changed their practices, and recovery staff ordered all CDs for theatres. Previously, different areas of the theatre department ordered their own CDs. We saw the "Theatre CD Record Book", which provided a register of all stock items. We saw that staff completed the book in line with pharmacy policies. We also saw records of medicines destroyed, supplied and administered. We also saw records showing staff checked stock levels at each shift change. These processes had prevented any further CD discrepancies and provided the hospital with assurances around the management of CDs.
- We checked the drugs fridges in Anaesthetic Room Two and Bensan Ward. We saw that fridge temperatures in both areas were within the expected ranges. We saw records in both areas, which showed staff had checked the fridge temperatures daily. All temperatures recorded were within the expected ranges, and there were no gaps on the checklist. This provided assurances the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety.
- Medical gases were secured to the wall and stored safely in theatres. On Bensan Ward, there was suction and piped oxygen in every patient room. We saw recordings showing staff checked the oxygen and suction daily.
- The RMO prescribed medicines for patients to take-out (TTO). TTO medicines are medicines given to patient on discharge from hospital stay. The pharmacy team reviewed TTO prescriptions daily to provide oversight. We saw that nurses counselled patients on TTO drugs at discharge.
- Drug allergies were clearly documented in five sets of patient records we reviewed, and also on their drug charts. Patients with drug allergies wore an additional red wristband to alert staff of their allergy status.



Surgery

- The hospital prescribed and administered antibiotic prophylaxis in line with its “Antibiotic policy”. A microbiologist from a nearby NHS trust attended IPC meetings to give advice on antibiotic prescribing. The hospital had an antimicrobial stewardship programme, with each antibiotic prescribed on the ward recorded and monitored for indication, appropriateness and frequency. This meant the hospital used antibiotics appropriately in line with relevant national guidance. This included the National Institute for Health and Care Excellence (NICE) NG15 Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use.
- We saw that there were no specific blue medicines disposal bins in theatres. Instead, staff discarded unused medicines into sharps disposal bins. However, the sharps bins contained solidifying agents. These solidified liquid drugs, making them unusable and preventing unauthorised use. Following our visit, the service purchased designated bins for the disposal of non-hazardous healthcare medicines for incineration. At our unannounced inspection we saw the bins in the theatre department. The theatre manager was awaiting delivery of appropriate brackets to secure the bins before the department started using them.

Records

- We reviewed five patient records and saw evidence of clear documentation, with no loose records. Staff had signed and dated all entries. This was in-line with guidance from the General Medical Council. All five patients had care plans that identified all their care needs. We saw staff had fully completed all five care plans.
- On Bensen Ward, staff stored notes securely in lockable cupboards at the nurses’ stations. This prevented unauthorised access to confidential patient data. After discharge, the hospital held patient records in its secure health records office. This allowed hospital staff to easily access patient records, for example following readmission, to assist with clinical decision-making. We saw that operation notes were integrated into patients’ hospital records in line with best practice guidance.
- Secretaries told us consultants with practicing privileges did not take any records off-site. This was in-line with the hospital’s “Management of Health Records and

Clinical Information” policy. The policy stated staff could only transfer photocopies of patient records if a patient subsequently received treatment at a different hospital. In these cases, staff kept the original set of records on-site. This ensured the hospital retained a complete set of records for all patients.

- All patients attended for a pre-operative assessment in advance of surgery. Staff completed a comprehensive pre-assessment record on a standard form. We saw completed pre-assessment records in all five sets of notes we reviewed.

Safeguarding

- Hospital data showed 98% of nursing and midwifery registered staff, 95% of allied health professionals, 98% of non-registered clinical staff and 100% of non-clinical staff had up-to-date safeguarding vulnerable adults level two training at the time of our visit. This was about the same as the hospital target of 95%. This meant the hospital had assurances staff had the correct level of training to identify adult safeguarding concerns.
- Hospital data showed the following levels of safeguarding children level two children at the time of our visit: Nursing and midwifery registered staff-95%; Allied health professionals- 94%, and non-registered clinical staff- 93%. This was an appropriate level of training in line with the national intercollegiate guidance, “Working Together to Safeguard Children” (2014) because the hospital did not provide surgery for children under the age of 18.
- Staff could identify the safeguarding lead and described how to report safeguarding concerns. We saw a poster on Bensen Ward describing safeguarding reporting processes. This served to remind staff of the correct reporting processes.
- Hospital data showed the safeguarding lead for adults had safeguarding vulnerable adults level three training. The safeguarding children’s lead had safeguarding children level three training. This was appropriate in line with national guidance.
- The safeguarding lead told us they felt staff knew the process for raising potential safeguarding concerns in the hospital, and gave us an example times they had done this. The hospital did not report any safeguarding



Surgery

concerns to the local safeguarding authority between October 2015 and September 2016. The safeguarding lead told us they felt very confident staff knew how to identify and report safeguarding concerns.

- The safeguarding lead attended regional safeguarding meetings every three months with other local healthcare providers. This allowed them to share learning from other organisations. The safeguarding lead shared any relevant learning from these meetings at matrons meetings.
- Female genital mutilation (FGM) identification and reporting was incorporated into safeguarding adults level two training in autumn 2016. We saw evidence of the online mandatory training course, which showed FGM was included.

Mandatory training (if this is the main core service report all information on the ward(s) here.

- Hospital data showed the following rates of mandatory training at the time of our inspection: SSD- 99.1%; Ambulatory Care Unit- 92.3%; Bensen Ward- 91.5% and Theatres- 85.9%. With the exception of SSD, mandatory training rates were slightly worse than the hospital target of 95%.
- There was a combination of online and face-to-face training. The hospital's mandatory training programme included the following modules: conflict resolution, equality and diversity, fire safety, health and safety, manual handling and infection control.

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

- We reviewed five sets of patient notes on Bensen Ward, and saw evidence of thorough pre-assessment for surgery in all five files. This included risk assessments for falls, pressure ulcers, IPC and general anaesthetic. These assessments were vital to assess a patient's suitability for surgery and to enable staff to make any necessary adjustments to ensure safe care. For example, staff told us they allocated patients at increased risk of falls to bedrooms closest to the nurses' station where possible.
- The hospital's "Anaesthetic department guidelines for elective surgery at Benenden Hospital" (reviewed July 2016) set out clear exclusion criteria. This included

patients with haemophilia and patients with biventricular pacemakers. This was to ensure the safety of patients having surgery because the hospital did not have facilities for planned critical care post-surgery.

- The hospital did not have any level two or three critical care beds. To mitigate this risk, the hospital operated on patients pre-assessed as grade one or two under The American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma. The hospital occasionally accepted grade three patients (patients with severe systemic disease that is not incapacitating). However, the hospital assessed patients on an individual basis and only accepted individual grade three patients following further pre-assessment with a consultant anaesthetist and consultant surgeon.
- Any patients highlighted to be at increased anaesthetic risk during pre-assessment had a further anaesthetic assessment with a consultant anaesthetist. Staff documented all assessments in the patient's records. We saw that the theatre team discussed a patient with increased anaesthetic risk during a team brief. The anaesthetist told staff what they were doing to mitigate the risk, and all staff confirmed awareness of the location of the difficult airway trolley.
- We saw evidence in patients' notes that the service routinely checked the pregnancy status of all female patients of childbearing age before elective surgery. Staff checked pregnancy status using a urine pregnancy test with the patient's consent. Theatre staff were aware of the hospital's policy to test all women aged up to 60. They told us they would not proceed with surgery without documentation of a negative urine pregnancy test. This was in line with NICE guideline NG45: "Routine preoperative tests for elective surgery".
- Data showed the hospital risk-assessed 100% of patients for VTE in October 2015 – September 2016. However, we reviewed five patient records and saw staff had recorded the risk of VTE, but not completed all steps of the VTE assessment, in two out of the five records. This meant the hospital might not have had assurances staff always assessed the risk of VTE correctly.



Surgery

- We observed theatre staff carrying out the World Health Organisation (WHO) Surgical Safety Checklist for two patients. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief. We saw that staff fully completed and electronically documented all the required checks.
- We saw that the service used a specific WHO checklist for cataract surgery. This ensured staff checked the most important safety factors relating to this procedure.
- The service audited staff compliance with the WHO checklist and calculated the percentage compliance each month. We saw the results for October – December 2016. Theatres scored 100% compliance with all areas assessed in October 2016. The department scored 80% in both November and December 2016. The theatre manager explained that the service introduced observational audits in November 2016. Previously, the service audited compliance against the WHO checklist by checking patient notes retrospectively rather than physically observing staff carrying out the checklist. The theatre manager felt the observational audits were more reliable at identifying non-compliance. Audit results detailed the reasons for non-compliance. The theatre manager or another senior manager of the theatre team addressed any areas of non-compliance with staff to help improve performance.
- The service used the National Early Warning System (NEWS) track and trigger flow charts. NEWS is a simple scoring system of physiological measurements (for example, blood pressure and pulse) for patient monitoring. This allowed staff to identify deteriorating patients and provide them with additional support. We reviewed five patients' NEWS charts. We saw staff had completed all five charts fully and calculated NEWS scores correctly. We saw evidence of escalation when clinically indicated in line with the NEWS guidance. However, NEWS chart audits for January – December 2016 showed variable compliance with NEWS chart completions. Audit results showed staff completed between 10% and 40% of charts incorrectly during this period. We saw that staff received feedback on NEWS charts at ward meetings to help improve performance.
- The hospital had a service-level agreement (SLA) with a local NHS hospital. This enabled them to transfer any patients who became unwell after surgery and needed critical care support. Staff told us a patient transferred to the local NHS hospital by ambulance two weeks before our visit following a heart attack before surgery. The theatre manager told us staff worked well as a team to care for the patient before transfer. Hospital data showed there were six further cases of unplanned transfer of an inpatient to another hospital between October 2015 and September 2016. Incident investigations showed all patients made a good recovery following transfer and one patient transferred back to Benenden Hospital when they were well enough.
- The hospital did not have a high-dependency unit. However, staff told us they cared for any deteriorating patients in the two larger patient rooms on Bensan Ward. The ward routinely used these rooms for bariatric patients but could use them for patients who needed additional support before transfer. This was because these rooms had more space, as well as mobile monitoring equipment that could transfer with the patient in an ambulance.
- Bensan Ward had “Sepsis Six” kits containing all the components needed for the diagnosis and treatment of sepsis. We saw sepsis guidance available to staff in all three anaesthetic rooms. Bensan Ward had a patient who developed sepsis in 2016. Staff recognised sepsis and responded promptly, administering intravenous antibiotics within 15 minutes.
- The hospital had an SLA for the supply of blood for transfusion. During our visit, we saw staff regularly reviewed the haemoglobin levels of a patient with anaemia and had cross-matched blood available in case the patient's condition deteriorated.
- Staff told us any patients who developed complications following discharge could contact the nurses on Bensan Ward any time, day or night. We saw a copy of the discharge pack given to patients, and this included a 24-hour contact number direct to the ward. We also saw a nurse give this information to a patient she discharged.

Nursing and support staffing



Surgery

- The theatre department staffed operating lists in accordance with The Association for Perioperative Practice (AfPP) guidelines. Hospital data showed there were no unfilled shifts in theatres between July to September 2016. During our visit, we reviewed planned staffing rotas, as well as records showing the actual number of staff on each shift in December 2016. These showed staffing levels met AfPP guidelines on all shifts.
- As of 1 October 2016, the service employed 16.7 whole-time equivalent (WTE) theatre nurses. There were four WTE theatre nurses vacancies. This meant the nursing vacancy rate for theatres was 19%.
- The service filled vacant shifts using bank and agency staff. The use of bank and agency nurses in theatre departments ranged from 4% to 8% from October 2015 to June 2016. This was better than the average rate for other independent acute hospitals we hold this type of data during the same period.
- There were 12.7 WTE operating department practitioners (ODPs) and healthcare assistants (HCAs) in theatres. There were 5.2 WTE posts vacant for ODPs and HCAs in theatres. This gave a vacancy rate of 29%.
- The use of bank and agency ODPs and health care assistants in theatre departments ranged from 0% - 3.5% in October 2015 – June 2016. This was better than the average rate for other independent acute hospitals we hold this type of data for during this period.
- Bensen Ward used staffing ratios of one trained nurse to seven patients, and one HCA to five patients. Staff and patients we spoke with felt the staffing levels were appropriate to meet patients' needs. The ward reviewed the ratios if they had higher acuity patients on the ward, or patients with additional needs. We saw that the actual staffing numbers met the planned levels on all shifts during our visit.
- Bensen Ward had an external staffing review in September 2016. At this time, the ward had 31.1 WTE staff in post, which met the establishment. Following the review, the hospital increased the proposed establishment by 2.8 WTE registered nurses and 1.9 WTE HCAs. This meant there were 4.7 WTE vacancies. The service filled one of the nursing vacancies before our inspection. The week before our visit, the service

interviewed and successfully recruited two full-time HCAs. Once the HCAs were in post following recruitment checks, this would bring the vacancy rate on the ward down to one WTE registered nurse.

- At the time of our visit, the eye unit had two WTE nursing vacancies. The hospital used specialist ophthalmic bank nurses to fill vacant shifts while they recruited new staff.
- We observed nursing handovers on Bensen Ward. Each patient had a named nurse, who handed over patients in their care to the new nurse coming on shift. Handovers took place at every shift change. Handovers were effective and nurses handed over important safety information such as pressure area risks. This allowed for continuity of safe care. Nurses used handover sheets to provide written information on each patient including allergies and any significant medical history. This ensured staff handed over all relevant information.

Medical staffing

- The hospital's resident medical officers (RMOs) provided medical cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care.
- As part of their practicing privileges agreement, consultants had to be available on-call 24 hours a day whenever they had an inpatient under their care in the hospital. Staff told us consultants attended promptly to review patients where there were clinical concerns.
- The hospital had an anaesthetist on-call rota outside of core theatre hours. This ensured 24 hour availability of anaesthetic cover should a return to surgery become necessary.
- The RMO conducted twice-daily ward rounds at 9am and 10pm to ensure patients were safe. The RMO also told us they visited Bensen Ward in between those times to review patients, usually between four and six times daily.
- As part of their practicing privileges agreement, consultants were required to review surgical inpatients at least once daily during their hospital stay. Staff on the ward confirmed consultants reviewed patients under their care at least once daily.



Surgery

- The RMOs carried out a formal handover. However, we did not see this as there was no change over during our visit

Emergency awareness and training

- We saw the hospital's business continuity plan, which covered emergencies and disasters. The business continuity plan set out clear roles for key personnel, including the incident advisor and incident coordinator. We spoke to the incident advisor, who was able to describe their role and responsibilities in supporting the incident coordinator (a senior executive).
- A manager described a simulated desktop exercise for generator failure that they completed in October 2016. The exercise tested the relevant telephone numbers, staff knowledge and staff response times. The manager said the exercise gave them confidence staff would know what to do if this situation arose. The manager told us the hospital held four major incident exercises in the past year. This was in line with the business continuity policy, which stated key staff should attend at least one simulation exercise every two years.
- The hospital had two back-up generators that covered all areas of the hospital, including theatres. Estates staff ran a weekly test where they ran the generator for five minutes. Staff also ran a monthly full-load test, where they turned the mains power off and ran the generators for two hours. We saw records showing evidence of weekly and monthly testing. We also saw servicing records, which provided evidence of three-monthly generator servicing in line with the hospital's generator servicing contract. Generator testing and servicing records provided the hospital with assurances that the generator would provide back-up power and enable services to continue in the event of a power failure.
- The hospital tested the fire alarms weekly and we saw that they tested the alarms during our visit. Nominated fire wardens and fire marshals completed annual face-to-face training to ensure their knowledge in this area was current. Hospital data showed 100% of fire marshals held up-to-date training at the time of our visit. The data showed 97% of relevant nursing and midwifery-registered staff held up-to-date fire warden

training. However, only 50% of relevant non-registered clinical staff and 41% of non-clinical staff held up-to-date fire warden training. This meant that not all fire wardens had up-to-date training in this role.

Are surgery services effective?

Good



We rated effective as good.

Evidence-based care and treatment

- We reviewed policies and procedures relating to surgery. All policies we saw were within their review dates and referenced relevant national guidance. This included National Institute for Health and Care Excellence (NICE) and the Association for Perioperative Practice (AfPP). Staff could access policies and procedures electronically through the hospital intranet and knew how to do this.
- The service audited staff compliance with trust policies in several areas and reported the results monthly. For example, we saw monthly WHO surgical safety checklist, NEWS and mental capacity assessment audits. We saw staff meeting minutes, which demonstrated staff received feedback on local audit results and areas for improvement.
- Theatres had yearly external audits from the AfPP. We saw the most recent AfPP audit (dated November 2016). The audit measured evidence-based care against AfPP guidance including "Standards and Recommendations for Safe Perioperative Practice" (2016) and "The Perioperative Audit Tool" (2014). The report demonstrated the department had achieved its objectives from the 2015 audit. These included clear leadership of all operating lists and consistency of practice in the counting of needles, swabs and instruments. The 2016 report also noted the department had improved its governance of controlled drugs. However, it made a further recommendation for agency staff to have further induction around medicines management policies. Independent audits such as these allowed the department to identify areas for continuous improvement and gave the hospital assurances around evidence-based practice.



Surgery

- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, we saw evidence of antibiotic assessment in five sets of patient notes, along with prescription (or non-prescription) or prophylactic antibiotics in line with the guidance.
- We reviewed five patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient's health post-surgery. Staff had completed all three observation charts in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
- Patient notes showed pre-assessment nurses performed pre-operative tests such as electrocardiogram for patients with pre-existing heart conditions. This is in line with NICE guideline NCG45: Routine preoperative tests for elective surgery.
- In theatres, we saw a surgeon monitoring the pain levels for a patient who had spinal anaesthesia. The surgeon regularly checked that the patient's pain was well controlled before continuing with the operation.
- There was no dedicated pain team at the hospital. However, consultant anaesthetists with an interest in pain relief gave advice on pain management.

Nutrition and hydration

Pain relief

- The service used a numerical pain assessment scale to monitor patients' pain levels. During routine observations, staff asked patients to rate their pain between one and 10 (one meaning no pain and 10 being extreme pain). We saw pain scores recorded in all five sets of notes we reviewed.
- All patients we spoke with said their pain was well controlled. One patient told us they had not experienced any pain after their operation. Another patient told us staff responded promptly when they needed additional pain relief.
- The hospital's "day surgery customer feedback" results for November and December 2016 showed 98.5% of patients felt staff definitely did all they could to control their pain. The remaining 1.5% of patients said staff did everything they could to some extent. In January 2017, 97.8% of patients felt staff did everything they could to control their pain. The remaining 2.2% said staff did everything they could to some extent. This meant staff responded to control all patients' pain following day surgery.
- The service followed the Royal College of Anaesthetists guidance on fasting prior to surgery. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Administrative staff sent admission letters to pre-operative patients before surgery, which included information on fasting times. Patients having operations in the afternoon could have an early breakfast on the day of surgery. This was in line with best practice. We saw that staff asked patients to confirm the time they last ate and drank before surgery. This ensured the service complied with the Royal College of Anaesthetists guidelines.
- The service measured patients' body mass index (BMI) at pre-assessment. If a patient had a very low or high BMI, staff discussed additional nutritional needs. Staff on Bensen Ward gave us an example of a patient with a BMI of 17 who had parenteral nutrition. Parenteral nutrition is a method of intravenous feeding for patients who are unable to obtain sufficient nutrition from the food they eat. We reviewed the notes of a patient who reported difficulties swallowing at pre-assessment. The service subsequently ensured appropriate foods were available for the patient.
- The service audited post-operative nausea and vomiting following major gynaecology surgery in January 2016. We saw the audit results, which showed only 2% of patients experienced severe nausea and vomiting 24 hours after surgery. Twelve per cent of patients reported nausea or vomiting at some point within the first 24 hours after surgery. This was better than the hospital's 20% target based on published research. We saw a patient who had an anti-emetic (medicine to prevent vomiting) before surgery following vomiting after a previous operation. These observations showed the hospital managed post-operative nausea and vomiting effectively.



Surgery

- The hospital had a dietician who provided nutritional support and expertise to bariatric patients before and after surgery. The dietician also provided additional support and advice for other surgical patients.
- For patients who needed to lose weight before surgery, the service signposted them to weight loss clinics within the hospital's catchment area to help them. Research has shown patients find it easier to lose weight with appropriate medical support.

Patient outcomes

- The hospital participated in the National Joint Registry (NJR) for hip and knee replacements. The most recent published data at the time of our inspection related to NHS-funded patients treated in April 2014 – March 2015. The NJR published this data in February 2016. NJR data showed seven patients who had hip replacement needed a revision (a further operation) within one year of surgery. The rate of hip replacement revisions within one year of surgery was 1.44%. This was similar to the national average of 0.75% for all hospitals who submitted data to the NJR. The hospital's hip replacement revision rate at three years was 2.39% (five patients out of 209 linkable cases). This was similar to the NJR average of 1.6%. At five years post-surgery, the hospital's hip replacement revision rate was 3.23% (one patient out of 31 linkable cases). This was similar to the NJR national average of 2.62%. Benchmarking data showed the hospital's standardised revision rate for hip surgery was within the expected range.
- NJR data for April 2014 – March 2015 showed 0% of patients had a knee replacement revision within one year of surgery. In this period, there were 673 linkable cases. This was better than the NJR national average of 0.48%. The knee replacement revision rate at three years was 0.99% (three patients out of 302 linkable cases). This was better than the NJR national average of 1.83%. At five years post-surgery, the hospital's knee replacement revision rate was 0%. There were 39 linkable cases in the same period. This was better than the NJR national average of 2.64%. Benchmarking data showed the hospital's standardised revision rate for knee surgery was within the expected range.
- The hospital provided data to national Patient Reportable Outcomes Measures (PROMS). PROMS used patient questionnaires to assess the quality of care and outcome measures following surgery. The hospital provided PROMS data from two areas: primary hip replacement and primary knee replacement.
- PROMS data for April 2014 to March 2015 showed 100% of patients reported that their health had improved following knee replacement according to the Oxford knee score. This was the most recent available data at the time of our inspection, with the 2015-16 data not due for publication until May 2017. The adjusted health gain in relation to the Oxford knee score was 19.0, which was better than the England average of 16.1. There were 38 knee replacement procedures included in the data during this period.
- PROMS data for April 2014 to March 2015 showed 100% of patients reported that their health had improved following hip replacement according to the Oxford hip score. However, there were only 28 procedures at the hospital included in the data. This meant the hospital's performance was not eligible for benchmarking against the England average. It was necessary to submit data for at least 30 procedures for national comparison.
- The hospital reported six cases of unplanned transfer of an inpatient to another hospital between October 2015 and September 2016. The rate of unplanned transfers was not high when compared to other independent acute hospitals that submitted performance data to CQC. We saw that the hospital investigated all unplanned transfers appropriately. We reviewed all six unplanned transfers and saw that there were no common themes. All patients made a good recovery following transfer.
- The hospital reported two cases of unplanned readmission within 28 days of discharge between October 2015 and September 2016. The rate of unplanned readmissions was not high when compared to other independent acute hospitals that submitted performance data to CQC. We reviewed the two unplanned readmissions and saw that the reason for one was post-operative pain. The other involved the transfer of a patient who previously transferred to an NHS hospital for high-dependency care back to Benenden Hospital to continue their recovery.
- The hospital reported four cases of unplanned return to the operating theatre between July 2015 and June 2016.



Surgery

We reviewed the incident investigations, which showed the reasons for three of the returns to theatre were post-operative complications. In the fourth case, the patient had suspected post-operative internal bleeding based on a very low haemoglobin result. Haemoglobin is the red pigment in blood cells, and very low levels may indicate post-operative bleeding. However, in theatre, staff found there was no internal bleeding. Laboratory results showed staff had made a blood sampling error, which give a false result. The service learned from this incident and provided further training to staff to prevent a recurrence.

- Two of the four returns to theatre happened outside of normal theatre operating hours. Incident investigations showed the theatre on-call processes worked effectively. All four patients who returned to theatre had an uneventful recovery.
- The theatre department had a comprehensive annual audit programme to measure performance. We saw the audit schedule, which included areas such as anaesthetics and pain management.
- The hospital started a subscription with the Private Healthcare Information Network (PHIN) in 2014. PHIN allows independent hospitals to share performance data in accordance with legal requirements regulated by the Competition Markets Authority. The hospital submitted their 2015 data for non-NHS funded patients to third party contractor for inclusion in PHIN before the September 2016 deadline. The hospital told us they were making changes to their patient feedback questionnaires and changes to their PROMS processes to meet the PHIN submission requirements for 2017.

Competent staff

- Hospital data showed 100% of nurses, ODPs and HCAs treating surgical patients had a performance appraisal in 2016. This meant the service reviewed staff performance and held assurances around the competencies of all staff.
- Hospital data showed 51 doctors with practicing privileges treated surgical inpatients. Of these, 48 (94.1%) carried out 10 or more episodes of care between October 2015 and September 2016. The remaining three doctors (5.9%) carried out between one and nine episodes of care during the same period. Doctors with practicing privileges therefore worked at the hospital regularly. This meant they were more likely to be familiar with the hospital's environment, staff, policies and ways of working.
- The hospital's medical advisory committee (MAC) reviewed applications for practicing privileges and advised the medical director of individual consultants' eligibility. The hospital only granted practicing privileges to consultants who had held a substantive consultant post in the NHS within the past five years. This was in line with the hospital's "Practicing Privileges Policy for Consultant Medical Practitioners" (dated October 2016). Consultants who did not meet this requirement may be awarded practicing privileges if they could "demonstrate experience of independent practice over a sustained period applicable to working in the independent sector" in line with the practicing privileges policy. The hospital did not award practicing privileges for any procedures outside a consultant's normal scope of practice in line with its practicing privileges policy. These processes demonstrated the hospital only awarded practicing privileges to consultants who demonstrated appropriate competencies.
- The MAC reviewed consultants' practicing privileges every three years in line with the "Practicing Privileges Policy for Consultant Medical Practitioners". Any consultants without a current NHS contract had an annual review. The hospital reviewed a comprehensive range of data in line with the GMC guidance, "Good Medical Practice" (2013). This included individual performance data and evidence of continuing professional development (CPD). We saw evidence in
- Hospital data showed 100% of inpatient nurses, theatre nurses and ODPs had up-to-date professional revalidation. Staff we spoke to told us the hospital supported them with the process of revalidation. Data also showed 100% of doctors with practicing privileges had up-to-date professional revalidation. This meant the hospital had assurances that all registered staff treating surgical patients met the practicing requirements of the relevant professional body.



Surgery

MAC minutes that showed the MAC took action to ensure all consultants submitted the required evidence to continue practicing at the hospital. This included evidence of current medical indemnity insurance.

- Hospital data showed the hospital suspended one consultant's practicing privileges between October 2015 and September 2016. This demonstrated the hospital took action when consultants did not provide evidence of meeting the required standards of practice.
- The hospital's clinical governance committee reviewed monthly key performance data for individual consultants. This included returns to theatre, surgical site infections and transfers to other acute hospitals with critical care facilities. The hospital also held performance data for individual orthopaedic surgeons, which it submitted to the NJR. The NJR also allowed consultant outcome comparisons on a national scale. This allowed the hospital to monitor and compare outcomes between consultants and take action if an individual's performance deteriorated.
- The hospital employed its own staff to carry out the first assistant's role during surgery. Consultant surgeons never brought in first assistants from outside the hospital. The role of the surgical first assistant was to provide continuous assistance to the surgeon throughout an operation. We reviewed the training records for two surgical care practitioners (SCPS) who acted as surgical first assistants as part of their roles. In both records, we saw a completed competency framework providing evidence of the required competencies for this role. This meant the hospital had assurances around the competencies of staff that performed first assistant duties.
- The clinical skills facilitator ran a sepsis scenario-based training exercise for staff. This exercise identified some learning for staff around the temperature range for patients with sepsis. The service gave feedback to staff to improve sepsis recognition. The matron felt staff training in this area helped staff recognise and respond to sepsis quickly when a patient developed sepsis in 2016.

- The clinical skills facilitator provided a range of scenario-based training exercises for staff, including resuscitation. Staff told us they found the exercises useful and the training helped them keep their clinical skills up-to-date.

Multidisciplinary working

- The hospital had a daily, multidisciplinary "10 at 10" meeting. The 10-minute meeting, held daily at 10am, allowed staff to discuss any immediate issues including staffing and incidents. The hospital's director of patient services chaired the meeting we observed, which around 30 staff attended. We saw effective multidisciplinary communication and representation from areas including theatres, ward, sterile services department, diagnostic imaging, porters and pharmacy.
- Entries in the medical records we reviewed demonstrated a range of professional input into patients' care. This included physiotherapy and pharmacy. Staff we spoke with reported positive multidisciplinary working relationships with colleagues.
- The service did not discharge any patients late at night. To avoid late discharges, the service converted any day case patients not fit for discharge by early evening to an overnight stay. Evidence in the patient notes we reviewed showed the service assessed a patient's anticipated post-discharge needs at pre-assessment. This allowed the service time to ensure appropriate support was in place, including any mobility equipment needed for the recovery period, before a patient went home after their operation. We saw that the service involved patients' relatives and carers in discharge planning. The service ensured patients had someone to help care for them at home in the immediate recovery period where necessary.

Seven-day services

- Physiotherapists treated orthopaedic patients recovering from surgery twice daily on the ward. The physiotherapy team provided seven-day cover. This meant patients recovering from surgery at the weekends had the same access to physiotherapy services as recovering during the week.
- The diagnostic imaging department provided a 24-hour, seven days a week service for urgent ultrasound or X-ray imaging requests to aid clinical decision-making.



Surgery

However, the hospital did not have in-house MRI or CT scanners. A mobile MRI and CT clinic visited the hospital, but not at weekends. This meant there was no seven-day access to MRI or CT services. However, MRI and CT scanning facilities were coming back into the hospital as part of the new building works in 2017. A matron told us the absence of weekend MRI or CT facilities had never caused any problems for patients.

- The hospital's "Practicing Privileges Policy for Consultant Medical Practitioners" required consultants to review all patients on the ward at least once daily. Staff on Bensan Ward told us all consultants reviewed patients daily, including at weekends, in line with the policy.
- The pharmacy opening hours were Monday – Friday, 9am – 5pm. We saw the hospital had policies to ensure patients could access medicines outside these hours. For medicines to take out (TTO), the RMO wrote prescriptions. Nurses on Bensan Ward gave the prescribed medicines to patients from the TTO cupboard.
- For inpatients needing medicines not stocked on the ward, the registered manager and senior nurse on duty had access to the hospital pharmacy. The RMO could subsequently dispense medicines from the hospital pharmacy, with the senior nurse on duty providing a second check to ensure correct dispensing. The hospital did not have any service level agreements (SLAs) for pharmacy support. However, staff could access advice on an informal basis from a nearby NHS hospital if needed.

Access to information

- Staff could access local policies and procedures electronically, and all staff we spoke to knew how to do this. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.
- The hospital held integrated patient records on-site. As well as keeping confidential patient data safe, this ensured timely access to all the information needed for patient care. We reviewed five sets of notes for surgical patients. All five contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results and care plans.

- We observed a discharge on Bensan Ward and saw staff gave the patient comprehensive written and verbal information about their ongoing care. This included wound care, follow-up appointments, counselling on TTO medicines and VTE advice. This helped patients understand how to care for themselves and recognise any post-operative complications while they continued recovering at home.
- The hospital provided discharge letters for patients' GPs. We saw that discharge letters included all relevant information to allow continuity of care in the patient's community. This included operation details, prescribed medications and wound care. Discharge letters contained details of the treating consultant so that the patient's GP could contact them if needed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed seven consent forms for surgery. On all seven forms, we saw consultants had documented the risks and benefits of surgery, in line with GMC guidance. In six out of the seven forms, we saw patients and consultants signed consent forms before the day of surgery. This was in line with guidance from the Royal College of Surgeons (RCS) "Good Surgical Practice 2014", which states staff should "Obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision". Patients and consultants then provided an additional signature on the day of surgery to confirm their consent to proceed in line with best practice guidance.
- However, one patient had signed their consent form for the first time on the day of surgery. This was not in line with the RCS "Good Surgical Practice 2014". We discussed this case with a matron, who told us the patient transferred their care from another hospital. The hospital subsequently fitted in their operation at short notice, and the consultant did not have an opportunity to obtain consent in advance of the day. The matron told us this was an unusual situation. Following our feedback, they told us they would monitor patients who transferred from another hospital more closely as part of the theatre department's consent audits.
- The hospital used a "consent form four- statement of healthcare professional for adults who are unable to



Surgery

consent to investigation or treatment". This documented the best interests' decision-making of staff for patients who lacked capacity in accordance with the Mental Capacity Act 2005. A nurse on Bensan Ward gave us an example of a time a consultant completed a consent form four to document a best interests decision to catheterise a patient who had urinary retention post-surgery. The nurse told us staff discussed the best interests' decision with the patients' family and kept them informed in line with best practice guidance.

- New clinical staff completed training in the Mental Capacity Act (MCA 2005) and deprivation of liberty safeguards (DoLS) as part of their induction. Hospital data showed 97% of registered nurses, 94% of allied health professionals and 95% of unregistered nurses/HCAs had training in the MCA 2005 and DoLS. This was about the same as the hospital target of 95%. The hospital also provided guidance to staff in its "Mental Capacity Act 2005" and "Deprivation of Liberty Safeguards Practice and Procedures" policies. We spoke with a senior nurse on Bensan Ward who demonstrated clear understanding of the correct processes around DoLS, including use of the least restrictive options. The nurse told us they had never had to apply for a DoLS at Benenden Hospital, but knew exactly what to do if a patient needed one to keep them safe. This demonstrated staff had an appropriate level of training and awareness of the MCA 2005 and DoLS.
- Clinical staff completed mandatory training in informed consent as part of their induction. Hospital data showed 100% of registered nurses had training in informed consent. This was better than the hospital target of 95%. However, 92% of allied health professionals and 81% of unregistered nurses/HCAs had training in informed consent. This was worse than the 95% target. However, we saw clear guidance available to all staff as part of the hospital's "Informed consent policy".

Are surgery services caring?

Outstanding



We rated caring as outstanding.

Compassionate care

- Feedback from patients and those close to them was continually positive about the way staff treated them. We spoke with nine patients who had surgery at the hospital and one patient's relative. All patients we spoke with felt staff were very caring, and the care they received often exceeded their expectations. Patients described staff as "amazing" and "lovely". One patient told us they felt "really secure and looked after" and said they "couldn't have asked for better care". Another patient said they "couldn't fault it" and there was nothing they would want to change about their care. In theatres, we saw that all staff showed kindness and compassion towards patients during all interactions.
- Staff on Bensan Ward gave us examples of how they provided compassionate care and "went the extra mile" for patients. Examples included massaging patients' feet and helping patients celebrate their birthday if they spent it in hospital. The service prided itself on giving staff "the time to care", and staff described how they spent plenty of time talking and listening to patients.
- Patients' emotional needs were highly valued by staff and embedded in their care and treatment. Staff took the time to help boost patients' self-esteem, for example by helping patients style their hair and put on make-up during their stay on the ward.
- There was a strong emphasis on helping patients feel as normal as possible following surgery. Staff understood the importance of this to patients' self-esteem. The service encouraged early mobilisation on the same day of surgery for orthopaedic patients as part of their enhanced recovery programme. We saw that patients who had surgery the previous day were out of bed and dressed.
- We saw staff on Bensan Ward respecting patients' privacy by knocking on the door before entering patient rooms. A patient comment card we reviewed stated, "Dignity and respect [was] outstanding".
- The hospital used patient experience surveys to record feedback from patients. The patient experience surveys included asking patients whether they would recommend the service to their family and friends. We reviewed patient experience data for November 2016 to January 2017. This showed between 97% and 98% of day surgery patients would recommend the service during this period. The results ranged from 97% to 100%



Surgery

for inpatients, and 99% to 100% for patients who had eye surgery. This demonstrated a high level of patient satisfaction and meant almost all patients would recommend the service to friends and family.

- The hospital participated in the NHS friends and family test (FFT) for NHS-funded patients. Data for April to September 2016 showed between 95% and 100% of patients would recommend the hospital to their family and friends. This meant nearly all NHS-funded patients would recommend the hospital.
- NHS FFT recommendation rates were about the same as the England average for other independent hospitals in England in April to September 2016. Survey response rates varied from 36% to 65% during the reporting period. In four out of six months during the reporting period, response rates were better than the England average for other independent hospitals.
- The hospital signed up to the national “Hello, my name is” campaign. This was a national initiative to encourage hospital staff to always tell patients their name and introduce themselves. We saw that staff always introduced themselves when they met a patient for the first time. This was in line with NICE QS15, Statement 3, “Patient awareness of names, roles and responsibilities of healthcare professionals”.
- The hospital subscribed to the six C’s of nursing. The six C’s are national set of values that underpin compassion in practice. These are competence, caring, compassion, commitment, communication, and courage. Our interviews with patients and staff demonstrated staff worked in a way that showed commitment to the six C’s of nursing.

Understanding and involvement of patients and those close to them

- Relationships between patients, those close to them and staff were strong, caring and supportive. All patients recovering from surgery on Bensan Ward had named nurses to care for them. This allowed patients and their relatives to build positive relationships with the staff looking after them. A patient we met spoke very highly of “my nurse”.
- In theatres, we saw that all staff took extra care to ensure all patients felt relaxed, comfortable and at ease. Staff consistently modelled this behaviour throughout

our visit. We saw that staff always talked to patients and reassured them while they waited for surgery to start. We saw a surgeon explaining what was happening at every stage to a patient who had spinal anaesthesia and was awake during their operation. The surgeon regularly checked the patient was comfortable and pain-free throughout the procedure. We also saw an anaesthetist taking the time to talk to a patient, reassuring them and helping them feel at ease in the anaesthetic room.

- Patients and those close to them were active partners in their care. Patients we spoke with told us staff involved them and their relatives in discussions about their care. One patient told us, “My consultant is lovely. He is open to questions, and answers them to allow me to make decisions”. The patient described the consultant’s approach as “very reassuring” and “very informative”. A patient comment card we reviewed stated, “Conversations were acted on”.
- The hospital’s “day surgery customer feedback” results for November 2016 to January 2017 showed 100% of day surgery patients felt involved in their care and treatment. This demonstrated staff were fully committed to working in partnership with patients. The results for November and December 2016 showed 95.2% of patients felt involved as much as they wanted to be in decisions about their care and treatment. The remaining 4.8% of patients said they felt involved to some extent. The results for January 2017 showed 97.8% of patients felt involved as much as they wanted to be. The remaining 2.2% said they felt involved to some extent.

Emotional support

- A patient we spoke with told us they felt very nervous before surgery. They described how their surgeon and anaesthetist made them feel at ease. A comment card from another patient stated, “I was very nervous and they made me feel really good”. We saw that all staff in theatres considered the emotional needs of patients and helped them feel comfortable and relaxed before their operation. This showed staff understood the emotional needs of patients and took action to ensure patients felt comfortable.
- Bensan Ward had extended visiting until 8pm every evening. For an additional charge, visitors could eat a meal on the ward with their relative or friend. These



Surgery

measures allowed patients to receive emotional support from family and friends while they were in hospital. One patient commented, “The care afforded to all visitors was exemplary”.

- The hospital had its own chapel and a chaplain could provide emotional and spiritual support to patients and their loved ones upon request.
- The hospital’s “day surgery customer feedback” results for November and December 2016 showed 98.9% of day surgery patients found a member of staff to talk to about their worries or fears. The results for January 2017 showed 99.4% of day surgery patients who had any worries or fears discussed them with a member of staff. This demonstrated patients felt able to confide in staff to provide emotional support.
- Benenden Society members could access counselling services to help them cope with the emotional impact of surgery. They could also access a psychological wellbeing helpline 24 hours a day, seven days a week. This allowed them to receive emotional support from a counsellor over the telephone and signposting towards support services in their local area. The hospital could refer patients who were not Benenden Society patients to their GP for signposting to counselling services in their local area.

Are surgery services responsive?

Good



We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital underwent the first phase of an extensive redevelopment in 2016. This included a new theatre department, a new ward (Bensan Ward) and a new ambulatory care unit. We saw that the new facilities were spacious and fit for purpose. Staff and patients we spoke with were very positive about the new building.
- The second phase of building work was taking place at the time of our visit. This included a new eye department and a new, onsite magnetic resonance imaging (MRI) and computed tomography (CT) suite. The new facilities were part of a completely new

building. This meant patients could still have treatment in the existing facilities during the development. Therefore, there was no adverse effect on service delivery during the redevelopment. The opening of the new MRI and CT suite later in 2017 would allow rapid access for urgent imaging requests for surgical inpatients 24 hours a day, seven days a week.

- Between October 2015 and September 2016, there were 8,169 visits to theatre. Of these, 6,729 patients (82.3%) had day case surgery and 1,440 (17.7%) had an overnight stay.
- The service provided a diverse range of elective surgery to meet the needs of the local population. This included orthopaedic surgery, gynaecology surgery, urology surgery, vascular surgery and eye surgery.
- The hospital accepted a range of treatment funding options. These were self-paying, private medical insurance, Benenden Society membership and NHS funding. Data showed 33% of inpatients had NHS-funded treatment at the hospital between October 2015 and September 2016.
- The hospital regularly met with local NHS commissioners to plan services and review their performance. The service also engaged with external services to help with service planning and delivery. For example, the hospital had an external review of the nursing establishment on Bensan Ward in September 2016.
- All admissions for surgery planned in advance were elective procedures. Due to surgery being elective at the hospital, service planning was straightforward as the workload was mostly predictable.

Access and flow

- The theatre team had an on-call rota to cover any unplanned returns to theatre outside of normal operating hours. Anaesthetists also participated in an on-call anaesthetic rota to ensure 24-hour anaesthetic cover. We saw evidence of two incident investigations where patients returned to theatres out of hours. We saw that the theatre team, including surgeon and anaesthetist, attended promptly and managed the situations effectively.
- The hospital reported 91 cancelled procedures for a non-clinical reason in October 2015 to September 2016.



Surgery

During the same period, there were 8,169 visits to theatre. This meant only 1.1% of operations were cancelled. The hospital treated 66 patients (73%) within 28 days of the cancelled appointment. However, the hospital offered patients a choice of dates and some patients chose to have their operation later than 28 days after the cancellation.

- The hospital director told us the reason for some cancellations was patient choice. For example, some patients chose to cancel their scheduled operation if an earlier date became available. This meant they had their surgery sooner than planned. However, the hospital reported all rearranged operations as cancellations. Consultants gave 48 hours' notice if they needed to cancel an operating list for a non-clinical reason other than unexpected sickness.
- The hospitals aimed to treat at least 80% of Benenden Society members, insured and self-funding patients within 11 weeks of referral from their GP. Hospital data showed 85% of patients in these groups had their operation within 11 weeks of referral in October 2015 – September 2016. This was better than the hospital's 80% target.
- For NHS-funded patients, the hospital aimed to treat 90% of patients within 18 weeks of referral as agreed with commissioners. Data for October 2015 to September 2016 showed referral to treatment (RTT) within 18 weeks was worse than the 90% agreed commissioning target in five months of the reporting period. The worst performing month was September 2016, when only 79% of NHS-funded patients had their operation within 18 weeks of referral. The best performing months were December 2015, March 2016 and April 2016, when 94% of patients had their surgery within 18 weeks of referral.
- The hospital told us there was some data entry and quality issues around RTT for NHS-funded patients in 2016. This was because their internal reporting systems used different measures. This meant the hospital did not become aware of the dip in RTT performance until December 2016. However, the hospital took immediate action to address these issues and changed their performance measures. This allowed them to monitor

RTT accurately and address any decline in performance. The hospital reported improved RTT performance of 95% at the time of our visit. This was better than the commissioner's target of 90%.

- The hospital frequently converted day case patients to overnight stays. This was because patients were not medically fit for discharge on the day of their operation. This did not affect admission times for the next day because Bensan Ward had a sufficient number of beds for unexpected overnight stays. However, it did mean additional, unplanned time in hospital for some patients. A nurse told us there were five day case to overnight conversions on one day the week before our visit. Staff reported day case to overnight conversions as clinical incidents. We saw that this was the most common category of clinical incident at the hospital.
- Staff felt the scheduling of operations was the reason for the high number of conversions of day case to overnight stay. This was because the hospital scheduled operating lists according to consultant availability rather than the type of surgery. For example, patients having gynaecology or general surgery may take longer to be fit for discharge. Therefore, operating on these groups of patients on an afternoon, rather than morning, list increased their risk of needing an overnight stay. The executive team were aware of these issues and were considering how to address them.
- The hospital did not stagger admission times for surgery. Patients having surgery arrived at 7am for admission onto a morning operating list and 12.30pm for an afternoon list. This meant patients at the end of the list often waited for over five hours before going to theatres. The hospital informed patients of the operating time window in their pre-admission letters. However, staff on Bensan Ward told us patients often complained about the length of time they waited between admission and surgery. We reviewed a comment card from a patient who waited from 1.30pm to 6.30pm for their operation. We also saw two formal complaints, which included details of excessive waits between admission and surgery for patients at the end of the list.

Meeting people's individual needs

- Nurses assessed patients' individual needs at pre-assessment clinic. Staff on Bensan Ward told us



Surgery

pre-assessment nurses communicated any additional needs to them in advance. This allowed staff on the ward to make appropriate arrangements before admission. A matron we spoke with felt pre-assessment was thorough and effective at identifying additional needs.

- The hospital had access to face-to-face and telephone interpreters for a range of different languages. Staff we spoke with knew how to book interpreters and gave us examples of times patients had used translation services.
- The hospital had suitable facilities to allow them to treat bariatric patients. The hospital accepted admissions from bariatric patients with a body mass index (BMI) of up to 55, subject to pre-assessment with an anaesthetist. We saw bariatric equipment including beds, seats and shower chairs provided in two of the larger patient rooms on Bensan Ward.
- The theatre department and Bensan Ward were accessible for wheelchair users. On Bensan Ward, there were two larger patient rooms, which gave wheelchair users additional space. We saw that all patient ensuite bathrooms on Bensan Ward were “wet room” with level access shower facilities. We also saw additional aids to support patients with limited mobility such as shower chairs. This allowed wheelchair users to access services on an equal basis to others.
- Staff gave us examples of action they had taken to meet individual patients’ complex needs, such as learning disability and dementia. On Bensan Ward, staff allocated any patients with dementia to a room adjacent to the nurses’ station. The ward allowed family members of patients living with dementia or learning disabilities to stay overnight in an adjacent room. In theatres, staff gave us an example of a patient with learning disabilities whose parents came into the anaesthetic room with them before surgery. The parents also waited in recovery to greet the patient when they woke up from general anaesthetic. This allowed patients with additional needs to have their loved ones with them to provide additional comfort and support.
- A senior nurse on Bensan Ward described briefing all staff, including the housekeeping team, on any patients with additional needs. The ward sometimes allocated

additional HCAs to shifts where there were patients with additional needs on the ward. This allowed staff to spend additional time with patients to ensure they felt supported and comfortable.

- All staff completed dementia awareness training at induction and then every three years. Hospital data showed 98% of unregistered nurses/HCAs, 95% of registered nurses and allied health professionals and 94% of non-clinical staff had up-to-date training. This was about the same as the hospital target of 95%. This meant all staff groups had awareness of how to meet the needs of patients living with dementia.
- We saw the hospital’s “Dementia Strategy and Annual Plan” for 2016 – 2019. The hospital was working towards gaining national dementia-friendly status in 2017. To help towards achieving this, Bensan Ward was beginning to introduce the national “blue butterfly scheme”. The scheme provided a discrete way to help staff easily identify patients living with dementia and better meet their needs. The hospital had a lead nurse for dementia care and planned to train a dementia champion in every area of the hospital by 2019. The hospital planned to look at benchmarking with the King’s Fund assessment tool for dementia environment.
- We reviewed patient menus on Bensan Ward and saw they included a range of healthy choices, including options for vegetarians. The service noted any specific dietary needs such as allergies and intolerances at pre-assessment. This allowed the catering team to prepare suitable meals in advance for patients with specific dietary needs.

Learning from complaints and concerns

- The hospital encouraged patients to raise concerns informally in the first instance so staff could try to resolve any issues immediately. The hospital displayed posters encouraging patients to raise any concerns with a matron or department manager. We saw “Feedback and Complaints” leaflets available throughout the hospital. The leaflets gave details of how to raise concerns and make a formal complaint. The leaflets also described escalation measures such as independent external review for any patients who wanted to escalate their complaint. Staff told us they gave a copy of the leaflet to any patient who raised concerns they were unable to immediately address.



Surgery

- Data showed the hospital received 19 formal complaints between October 2015 and September 2016. Of these, 10 complaints related to surgery. No patients escalated their complaint to the Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS) for independent review. The number of formal complaints improved significantly from the previous year, when the hospital received 70 complaints. This demonstrated the service acted on patient feedback and addressed concerns promptly to avoid the need for escalation.
- The hospital aimed to acknowledge formal complaints within two days and provide a full response within 20 working days. We reviewed the hospital's complaint log for April to September 2016. This showed the hospital met their target response time for four out of seven complaints relating to surgery during this period. However, we saw that the hospital apologised to patients where they did not meet the 20-day target. In two out of the three cases where the hospital did not meet the 20-day target, hospital staff had met with the patients in the interim. This allowed the patients to discuss their concerns further and for staff to update them on progress around the investigation.
- The relevant matron or department lead, such as the theatre matron or ward manager, investigated complaints relating to surgery. We reviewed four complaints relating to surgery and the hospital's responses. In all four cases, we saw evidence of investigation, explanation and apology. We saw the hospital was honest in its responses, for example, if staff had made mistakes or should have done things differently. This was in line with the regulatory duty of candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014.
- We saw evidence of learning from complaints. For, example, a patient complaint regarding cancelled surgery due to an expired MRSA result led to a change in screening practices. As a result of this investigation, the service took patients swabs and blood samples at pre assessment and not at the first clinic appointment. Staff told us they received feedback from complaints at departmental meetings. Ward and theatre meeting minutes we reviewed reflected this.
- The hospital actively sought patient feedback. We saw patient experience questionnaires available in clinical

areas. We saw the hospital took action to make improvements based on patient feedback. For example, two patients felt they did not have enough information about how their vision might be in the first few hours after eye surgery. Staff subsequently received feedback on the importance of providing patients with the appropriate information leaflets before their operation.

Are surgery services well-led?

Outstanding



We rated well-led as outstanding.

Leadership / culture of service related to this core service

- The service had a clear reporting structure. Staff in theatres reported to the theatre matron. Staff on Bensan Ward and the ambulatory care unit reported to the matron for wards and ambulatory care. The matrons reported to the director of patient services who sat on the hospital's executive committee.
- Every member of staff we met spoke positively about their relationships with both their line manager and the senior management team. Staff told us managers were approachable and dealt with any issues in a timely fashion. Examples included a matron resolving an issue with staff behaviour, and the dismissal of a member of the theatre team for misappropriation of controlled drugs.
- Staff told us the senior management team (SMT) were visible and approachable. The Director of Patient Services led the daily, multidisciplinary "ten at ten" meeting and discussed any concerns for the day with staff. The SMT had an "open door" policy, and staff we spoke told us they would feel confident to approach the SMT with any concerns.
- The hospital funded managers and team leaders to attend a three-day residential leadership course. This helped managers develop and continually improve their leadership skills. The hospital also ran an internal staff training and leadership programme, which more than 120 staff had attended at the time of our visit. A member of staff who attended the course found it beneficial for their continuing professional development (CPD).



Surgery

- The hospital offered a range of internal external training opportunities to help staff continually learn. This included the “Lord Plant travelling fellowship”. This was an annual grant to allow staff to travel to other hospitals and share best practice.
- Staff told us one of the best things about working at the hospital was the team. Staff descriptions of the culture included “friendly”, “happy” and “really lovely”. We observed positive working relationships between staff. Due to the small size of the service, everyone knew each other’s names and we observed friendly interactions between staff from all departments in the hospital. All staff we spoke with were proud to work at the hospital. We met several members of staff who had been happy working at the hospital for many years.
- The hospital demonstrated commitment to its value of wellbeing. Initiatives to support staff wellbeing included providing free counselling and physiotherapy. The hospital ran lunchtime clubs such as yoga and walking to encourage staff to exercise in their lunch breaks. The hospital also provided on-site vegetable growing plots for staff.
- There was a strong culture of openness and transparency. For example, we saw that the vast majority of incidents the hospital reported were “no harm”. The service actively encouraged staff to raise concerns. The hospital subscribed to the national “Sign up to safety” campaign. One of the pledges of this campaign was to “be honest”. We saw posters around the hospital encouraging staff to raise concerns and report incidents. All staff we spoke with knew what Duty of Candour meant and could describe their responsibilities relating to it.
- The hospital had clear referral pathways for Benenden Society members, self-funded, private insured and NHS-funded patients. All pathways required patients to have a GP referral to the hospital. This prevented any consultant from referring private patients to the hospital in line with Competitions and Marketing Authority requirements.

Vision and strategy for this this core service

- Surgical services shared the hospital’s vision to be “The patients’ choice, providing high quality, caring and responsive health and wellbeing services”. The hospital’s strategic goals were growth, excellence and efficiency.

The hospital shared the vision and strategic goals with staff in open sessions. The hospital also provided written information on the vision and values to new staff. Staff we spoke with demonstrated awareness of the vision. All staff were aware of the three strategic goals, which were printed on staff lanyards.

- The strategy for surgical services fed into the hospital’s strategic goals. For example, the hospital was growing and expanding and range of surgical services. The hospital introduced bariatric surgery in 2016 and was beginning to develop this new service. As part of the second phase of the hospital’s redevelopment, the hospital was building a new eye unit to replace the existing facilities. It was part of the hospital’s “strategic vision and goals 2016 -2018” to expand the range of eye procedures. This included the introduction of laser eye surgery and refractive lens exchange (surgery to replaces the lens of the eye). Theatres were beginning to embed a six-day working week as part of their 2017 “continuous improvement plan”.
- Surgical services followed the hospital’s values. These were care, mutuality, sustainability and wellbeing. Staff we spoke with knew the hospital’s values and described how they incorporated the values into their work. Examples included taking the time to listen to patients (care) and supporting colleagues (mutuality). This demonstrated the hospital values were embedded into the service.

Governance, risk management and quality measurement

- The hospital had a clinical governance committee (CGC) which provided quality and safety assurances to the executive team. We saw that the matron for theatres and the matron for the ward and ambulatory care unit represented surgery on the CGC. A range of sub-committees fed into the CGC. These included the infection prevention and control committee (IPCC) and the resuscitation advisory committee.
- The Clinical Governance Committee (CGC) met quarterly and discussed complaints and incidents, patient safety issues such as safeguarding and infection control, and clinical audit review. We saw the minutes from November 2015, February, April, and July 2016 which



Surgery

reflected this. The hospital followed their corporate “Clinical Governance Policy” (October 2016), which included roles and responsibilities, monitoring, reviewing, and auditing.

- Theatres and Bensan Ward held monthly team meetings. The relevant matron in these areas escalated any risks or areas of concern to the CGC. We saw copies of the minutes, which showed staff received feedback on incidents and complaints. This allowed the service to continually improve the quality of care.
- The hospital’s medical advisory committee (MAC) provided the formal organisational structure through which consultants communicated. The MAC advised the hospital’s medical director, who was a hospital employee, and worked to maintain high standards and improve the quality of services. A consultant surgeon represented surgery on the MAC. The MAC met every three months.
- We reviewed MAC minutes from December 2015, and April, July and September 2016. The minutes showed staff discussed key governance areas such as National Institute for Health and Care Excellence (NICE) guidelines, outcomes from root cause analysis, mandatory training and compliance data and incidents were discussed. This showed the MAC took action to continually improve the quality of care.
- The hospital held departmental risk registers. We saw that items on the theatre department risk register aligned with areas staff told us were on their “worry list”. The risk register also aligned with areas of risk we identified. For example, the intermittent problem with the doors into the theatre department giving uncontrolled access was listed as a risk. This showed the hospital understood the areas of risk relating to surgery.
- The hospital had a performance dashboard, which monitored monthly performance in a range of key areas relating to surgery. These included monthly WHO five steps to safer surgery audits, NEWS chart completion, dementia screening and early mobilisation. We saw that staff received feedback on key performance indicators at department meetings. This meant the service addressed any deterioration in performance and highlighted positive practice.
- The hospital actively engaged with staff through open staff forums, an annual staff survey, and local awards to recognise staff achievement. The hospital held an annual “Best of Benenden” awards ceremony, with dinner at a local hotel for around 150 staff. A HCA on Bensan Ward won the 2016 award for “Leading and inspiring others”. Staff spoke positively about the ceremony and those who received nominations for different awards told us it made them feel valued.
- The hospital’s annual staff survey provided a means of engaging with staff and seeking their views. The 2015 results reflected the positive and inclusive culture we observed; with 90.7% of staff saying they felt part of a happy and healthy workforce. The 2016 results were not yet available at the time of our visit. We saw that the hospital was taking forwards some of the suggestions for improvement from the survey. For example, the hospital was working towards full, six-day theatre lists.
- The hospital engaged with the local community through a range of projects. The hospital sponsored local midsummer and midwinter fairs in 2015 and 2016. At these events, the hospital carried out free health checks for cholesterol, body mass index, blood pressure and blood sugar. The hospital supported community events run by a local newspaper group and received a partnership award in March 2016 as recognition of their support. The hospital also chose a charity to support each year through fundraising events. In 2016, the hospital supported a local air ambulance charity.
- The hospital engaged with patients and their relatives through patient experience surveys and the NHS friends and family test (FFT) for NHS-funded patients. The hospital received a nomination for the “Best FFT initiative” at the NHS friends and family awards 2016. The hospital also ran focused patient surveys seeking feedback in specific areas. These included “spotlight on doctors”, “spotlight on nursing” and “spotlight on site development”.
- The hospital had an active patient engagement forum, which it introduced in September 2015. The forum gave patients and their relatives the opportunity to give feedback and make suggestions for improvement in a face-to-face environment.

Innovation, improvement and sustainability





Public and staff engagement



Surgery

- The hospital completed phase one of an extensive redevelopment in 2016. This included new theatres, a new ward (Bensan Ward) and a new ambulatory care unit. The hospital had started phase two of the redevelopment at the time of our visit. This included a new eye unit and an in-house MRI and CT suite.
- The hospital participated in a regional academic and health science network. Benenden Hospital staff were finalists at the network's 2016 awards ceremony for their poster, "Improving the end to end pathway for enhanced recovery". The hospital worked to encourage patients to mobilise on the day of joint replacement surgery. As a result of early mobilisation, the hospital's average length of stay following orthopaedic surgery was only three days. This was better than the average length of stay of 4.9 days for other independent hospitals that participated in the national joint registry (NJR). The hospital was working to reduce the average length of stay to less than three days by further promoting early mobilisation and improved pain management.
- The hospital received a national "Investors in People Silver Award" in recognition of its commitment to staff health and wellbeing. The hospital was aiming for Investors in People Gold Award at its next assessment in October 2017.
- The hospital was a finalist at a national awards ceremony for innovation in anaesthetics. The hospital's innovations in anaesthetics included the use of a multi-purpose anaesthetic breathing system. The system recycled anaesthetic gases, which reduced anaesthetic gas wastage into the environment. This saved money and reduced pollution in the theatre environment. In 2016, Benenden Hospital used a new device for difficult airway management that contained an integrated single-use flexible video scope. Anaesthetists at the hospital received training from the equipment manufacturer before the hospital introduced the device. This piece of equipment was disposable, which reduced the time needed for complex cleaning procedures associated with re-usable video scopes.
- Two members of theatre staff won the Best of Benenden "Innovation of the year" award for preparing a business case for a new human waste management system for the collection and disposal of surgical fluid waste. Theatres introduced the three new waste management suction units in 2016.

Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Outstanding 
Well-led	Outstanding 

Are outpatients and diagnostic imaging services safe?

Good 

We rated safe as good.

Incidents

- An electronic based system was used to report incidents. Staff were aware of the system and felt it was easy to use. Staff told us that if they reported a clinical incident on the electronic reporting system, they would receive feedback on the investigation and any outcomes or actions following it.
- The hospital did not report any ‘never events’ between October 2015 and September 2016. ‘Never events’ are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital reported no serious injuries between October 2015 and September 2016.
- Hospital data showed that between October 2015 and September 2016, there had been 771 clinical incidents reported across the hospital. Of these, 190 (25%) occurred within outpatients and diagnostic imaging. The rate was variable thorough out the year.
- Staff told us they were encouraged to report incidents and that they were confident about reporting issues and raising concerns with senior staff. Staff were able to

clearly describe the process for reporting incidents. They were aware of the type of incidents they needed to escalate and report. Staff told us they made time to report incidents. Staff also said there was an open no-blame culture for reporting incidents. This meant the hospital could be confident that all incidents including ‘low risk’ or near ‘misses’ were reported.

- All staff gave examples of incidents such as medication errors and injuries in the department.
- In the diagnostic imaging department, there were clear processes for reporting incidents relating to Ionising Radiation Regulation (IRR) and the Ionising Radiation (Medical Exposure) Regulations 2000 (IR (ME) R). Hospitals are required to report any unnecessary exposure of radiation to patients under the IR (ME) R regulations. Diagnostic imaging services had procedures to report incidents to the correct organisations, including the Care Quality Commission (CQC).
- Staff we spoke with in the radiology department told us they were encouraged to report incidents using the paper reporting system, this including both radiation and non-radiation related incidents. A service level agreement (SLA) with a local NHS hospital’s medical physics and engineering department. This department oversaw any radiation related exposure incidents as well as providing expert Radiation Protection support and advice.
- Radiation protection supervisors (RPS) employed by Benenden hospital ensured compliance with IR (ME) R. The RPS are the first point of reference in the investigation of all radiation related incidents.
- There was one IR (ME) R reportable incident to the CQC between July 2015 and June 2016. This was in relation to a radiographer changing a request form from a skull



Outpatients and diagnostic imaging

x-ray to a computerised tomography (CT) scan to detect the present of metal fragments prior to undergoing a magnetic resonance imaging (MRI) scan. This increased the patient's exposure to radiation. This was reported appropriately in line with protocol and investigated and learning was shared to improve and check communication procedures. We saw this incident was also discussed at the Radiation Protection Committee.

- Hospital data showed that between October 2015 and September 2016, there were 213 non-clinical incidents across the hospital. Of these, 33 (15%) occurred in outpatients and digital imaging.
- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. There were no incidents in which duty of candour actions had been required. Staff described how they would action any incidents in which they felt duty of candour was needed, and were clear that they would always inform their line manager for guidance and support. We spoke to one radiographer who gave us an example of duty of candour following an incident they were involved in. The radiographer had x-rayed the wrong site on the patient. They explained how they had tried to contact the patient, explain what had happened and apologise. At the time of inspection, they had been unable to contact the patient.

Cleanliness, infection control and hygiene

- All the areas we visited in the outpatients department were visibly clean and tidy and we saw good infection control practices in place. For example, we saw all staff in departments we visited were 'bare below the elbow'. This was in line with the hospital's 'hand hygiene policy'. In addition, we saw posters in consulting rooms reminding staff to be bare below the elbow.
- There were sufficient numbers of hand washing basins available. Soap and disposable hand towels were available next to sinks. Information was displayed about the World Health Organisation (WHO) 'five moments for

hand hygiene' near handwashing sinks. This served to remind staff of the importance of cleaning their hands before or after key activities, such as patient contact. Alcohol hand sanitising gel was readily available throughout the departments.

- However, not all hand wash basins were compliant with HBN 00-09, which says clinical hand-wash basins should not have plugs or overflows. Some of the hand wash basins had overflows present (although plugs had been removed). In addition, we found not all hand wash basins had mixer taps present. HBN 00-09 3.46-3.47 says that 'Health and safety regulations (The Workplace (Health, Safety and Welfare) Regulations, 1992) require that both hot and cold running water should be available in areas where employees are expected to wash their hands. Hands should always be washed under running water; mixer taps allow this to be practised in safety in healthcare settings where hot water temperatures may be high to control Legionella'. However, the hospital was aware of the non-compliant sinks. At time of our visit, the outpatients department was waiting to move into a newly built part of the hospital. All sinks in the new building will be fully compliant with current guidelines.
- Hospital data showed that the outpatient department hand hygiene compliance rate was 96% in for April and May 2016 and 97% in June 2016. For diagnostic imaging, the hand hygiene compliance rate for May 2016 was 100%, and for June was 92%. Where there were episodes of non-compliance we saw that members of staff were spoken to immediately. This meant the hospital could be confident staff were cleaning their hands in line with policy, and that staff were willing to challenge non-compliant behaviour.
- Equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection control. All equipment we saw had 'I am clean' labels on them, which indicated the date the equipment had been clean and was safe to use.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing



Outpatients and diagnostic imaging

procedures. This meant staff had the correct equipment available to adequately ensure staff safety and reduce the risk of cross infection when staff performed procedures.

- Not all seating in the outpatients and diagnostic imaging department was covered with a wipe-clean fabric. This was not in line with HBN 00-09 section 3.133 for furnishings, which states all seating, should be covered in a material that is impermeable, easy to clean and compatible with detergents and disinfectants. However, were told all new furnishings in the new departments in the newly built part of the hospital, will be fully compliant with current guidelines.
- We found gowns and towels in the disabled toilet. Staff told us the gowns were in the toilet as it had been used as a changing cubicle, but not at the moment. No staff could explain why towels were present. Linen should be stored in designated areas such as cupboards or trolley doors closed to prevent airborne contamination.
- We saw cleaning rotas for each consulting room, which indicated what needed to be cleaned and how often. We checked six of the cleaning rotas and saw they were fully completed and up to date.
- We saw the infection control environment and clinical practice audit for the outpatient department, which was undertaken in August 2016. The audit included an inspection of the cleanliness of the environment and equipment, management of sharps, waste and linen, hand hygiene and the use of PPE. The department was compliant in the environment section in 17 out of 18 standards. Non-compliances included furniture that was no longer intact and chairs that were not wipe-clean. In the clinical practice section of the audit, the department was compliant in 22 out of 24 standards. Non-compliances included, re-use of single use scissors, and sharps bins were found older than three months old.
- We saw a completed action plan for any issue that did not meet the required standard. Action plans were monitored and had been completed within the required timescales.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipe-clean materials. This meant the couches could easily be cleaned between patients.
- There were 'sharps' bins available in all the consultation rooms. We noted the bins were correctly assembled, and none of these bins were more than half-full, which reduced the risk of needle-stick injury. However, we noted in three out of the six sharps bins reviewed, one had not been labelled and dated before being put into use and the other two were older than three months. This was not in accordance with Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste, which says, "If the sharps receptacle is seldom used, it should be collected after a maximum of three months, regardless of the filled capacity". We brought this to the attention of the outpatient sister during our inspection, who immediately removed the sharps bins from use. Checking of sharps bins was added to the weekly rota for each room, to prevent this from happening again.
- Waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations
- Some areas of the department (corridors) had carpet, which could not be as easily cleaned as the laminated flooring when spills occurred. Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, the carpets were visibly clean and when the department moves to the new build all flooring will be compliant with current guidance.
- The outpatient department also undertook examinations of patients using nasendoscopes (procedure for looking at the roof of the mouth and throat). We were unable to observe procedures during our inspection. However, we spoke with staff at length (in outpatients and in the sterile services department) who explained the procedure of safe transfer of nasendoscopes, to and from outpatients to the endoscopy department. The service transferred nasendoscopes between the departments in a lidded, rigid plastic container. This meant staff could differentiate between clean and dirty nasendoscopes. When transferring clean nasendoscopes, a green sterile fitted single use cover will be in place. For dirty a red



Outpatients and diagnostic imaging

sterile fitted single use cover will be in place. The tray is lined with a clear fitted single use liner; this is to prevent drying out of the scope before cleaning, which could make it difficult to clean. This is in line with Health Technical Memorandum (HTM) 01-06: Decontamination of flexible endoscopes Part A: Policy and management.

- Once the scopes arrived in the endoscopy department a trained member of the endoscopy team would manually clean the scope prior to placing into an endoscope washer-disinfector for cleaning. The machine printed a receipt providing assurance it had performed complete cleaning after every cycle. Staff told us the printout alerted them if the machine had not worked correctly. This allowed staff to resolve any faults and re-process the endoscopes to ensure complete cleaning.
- The endoscope washer-disinfector had a barcode tracking system. This enabled the hospital to track the cleaning of endoscopes used by individual patients for quality control.
- The number of nasendoscopes enabled the scheduled nasendoscopy lists to proceed uninterrupted.
- In the diagnostic imaging department, we saw ultrasound probes were cleaned between each use with a triple cleaning system. At the end of each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff had used. The records showed each time a probe was cleaned with the three stages completed. We saw records were complete.
- Single use items of sterile equipment were readily available and stored appropriately in all areas checked. Instruments used for patient treatment that required decontamination and sterilisation were processed via the on-site sterile supplies department, to ensure compliance with regulatory requirements for cleaning (decontamination), Health Technical Memorandum (HTM) 01-01: management and decontamination of surgical instruments (medical devices) used in acute care.
- The hospital had a designated decontamination lead, in line with the recommendations of the Code of Practice on the prevention and control of infections and related guidance (the code), Criterion 1 that describes the systems to manage and monitor the prevention and

control of infection. We saw that both the sterile supplies and endoscopy department had been audited. We saw copies of these audits, along with action plans arising from them.

- The hospitals lead for infection prevention and control (IPC), who is also the director of IPC (DIPC), maintained links with the local NHS trusts infection control team. The DIPC monitored audit activity, provided guidance for wards and departments, as well as at meetings, and managed the infection prevention programme. This included training and supporting 14 link practitioners, in all departments and areas of the hospital. Link practitioners are members of the department, with an expressed interest in a specialty; they act as link between their own clinical area and the infection control team. Their role is to increase awareness of infection control issues in their department and to motivate staff to improve practice.

Environment and equipment

- The environment in all department areas we visited appeared uncluttered, and tidy.
- The consulting rooms were tidy and equipped with a desk and chairs and a couch area for procedures. There were trolleys in the rooms, which contained sterile disposable items, such as syringes, needles, and wound dressings, all these items were in date. Disposable curtains were in place and had been changed within the last six months.
- Some of the consulting rooms contained facilities appropriate to the speciality of the consultant, for example equipment for an exercise tolerance test (ETT), such as a treadmill. An ETT is a test to see how the heart responds to stress, and usually involves walking on a treadmill at increasing levels of difficulty, while the electrocardiogram, heart rate and blood pressure are monitored.
- We looked at three resuscitation trolleys in the diagnostic imaging and outpatients department. All trolleys were locked. Records indicated that the trolleys were checked daily on days when clinic operated. All drawers had the correct consumables and medicines in accordance with the checklist; we saw they were in date.



Outpatients and diagnostic imaging

The automatic electrical defibrillator worked and suction equipment was in order. This meant staff had access to equipment needed in the event of a medical emergency.

- The environment for diagnostic imaging was cramped and cluttered, due to the building works that were currently being undertaken throughout the hospital. However, the imaging rooms and equipment was visibly clean.
- The diagnostic imaging department had changing cubicles available for patients to use to prepare for an examination. The cubicles had lockable doors to ensure patient privacy. Patients carried their clothes in supplied baskets with them into the imaging rooms, which guaranteed the safety of their personal items
- However, the changing cubicles were not designated male or female and opened directly into the main waiting area. Staff advised us that the majority of the time patients remained in the changing room until they went into the imaging suite. However, privacy and dignity could not be guaranteed in the mixed sex waiting area outside of the changing area for patients awaiting procedures.
- In the digital imaging department, we saw specialist personal protective equipment such as lead aprons were available. We saw staff use them. The effectiveness of their protection was checked with regular audits. We saw copies of the audits that showed examinations had been undertaken to screen the PPE to see if any cracks or folds have appeared. We observed each item was labelled with the thickness of lead and we were told by the radiographer that visual examinations take place regularly and screening of the PPE will take place annually to ascertain if any cracks or folds have appeared. This complied with Regulation 9 (3) of the Ionising Radiation Regulations 1999. (IRR'99).
- We saw staff wearing personal radiation dose monitors and these were monitored in accordance with the relevant legislation.
- There were systems and processes in place to ensure the maintenance and servicing of imaging equipment. Across the department, we saw that a quality assurance (QA) programme was in place for all radiographic equipment requiring all checks to be performed at

regular intervals on all equipment, as required by current legislation. This meant the hospital had assurances imaging equipment was safe and fit for purpose.

- The physiotherapy department consisted of two treatment rooms and a gym where individual or group rehabilitation sessions were held. The department was tidy and well equipped.
- During our inspection, we looked at 10 pieces of equipment. All items had labels in place to show they had been tested for electrical safety, and were safe to use. This meant the hospital had assurance that all pieces of medical equipment were tested for electrical safety.
- Maintenance was generally undertaken using two methods: planned preventative maintenance (PPM) or reactive maintenance. PPM was undertaken on a regular programme (weekly, monthly, quarterly, yearly) to meet statutory requirements, legislation, manufacturer's guidance, and industry good practice. Reactive maintenance was undertaken on an as required basis to address damage, breakdowns, or failure.
- The hospital's estates department was responsible for all non-medical electrical equipment, as well as the generator, and boiler and ventilation. The hospital had a service level agreement (SLA) with another hospital's electronics and medical engineering department (EBME), who maintained the medical equipment. Representatives from the other hospital's EBME department visited the hospital every Monday, Wednesday, and Friday to undertake PPM, but were available in the event of an urgent medical equipment failure.
- Staff we spoke with had no concerns about equipment availability. If any equipment required repair, they reported it and it was fixed quickly. Staff were aware of the process for reporting faulty equipment.

Medicines

- Staff followed an up-to-date 'Medicines Management Policy', which included roles and responsibilities, monitoring, reviewing, and auditing.
- The outpatients department did not hold any stock of controlled drugs. Controlled drugs are medicines liable for misuse that require special management.



Outpatients and diagnostic imaging

- Emergency drug packs for cardiac arrest, anaphylaxis (allergic reaction), and deteriorating patients were available and standardised across the service. This meant staff were familiar with them as they were the same throughout the hospital.
- We saw medicines were stored securely and handled safely. In the outpatient department, we saw that medicines were stored in a locked room. Only nursing staff had access to the room using a coded keypad access. In the room, medicines were stored in the locked cupboards, which were accessed via key, which only trained nurses held.
- Staff told us every week a senior member of staff checked the medicines to ensure they were all in date, during our inspection we randomly checked medicines and found all of them to be in date.
- Appropriate medicines were stored in dedicated medicines fridges. We saw records, which showed daily temperature checks were undertaken. This provided assurance the hospital stored refrigerated medicines within the recommended temperature range to maintain their function and safety. We also saw recommended actions to be taken if the fridge temperatures were not in the correct range.
- We reviewed the hospitals prescription pad records. Initially, we found prescription pads were blank with no serial number or log book-recording serial number, date and time when the prescription pads were last used. They were also stored in an unlocked drawer in the medicine room. This meant it would not be possible to establish if any had been removed from the drawer, and no reliable system to track any that had been used.
- We highlighted our concerns around prescription pads to the pharmacy and outpatient managers, who took immediate action to correct this. All blank prescriptions were removed from the outpatient department, and stored in pharmacy. All prescriptions will now be given an individual serial number, and recorded when they are removed. Prescriptions will be collected on day of clinic and stored in a locked cupboard in the department, they will be given to the consultants as requested and prescribing pad log completed. During our unannounced visit, we saw this new system was in place.

- For our detailed findings on medicines, please see the Safe section in the surgery report.

Records

- The hospital had an up to date 'Policy for Management of Health Records and Clinical Information'. The policy included retention, secure storage and tracking of health records, order of filing and guidance on transporting health records.
- All medical records were kept on site or recalled from a medical records store in time for the patient's outpatient appointment. During clinics medical records were kept in staffed rooms, if staff left, the offices would be locked. Medical records were transferred to the consultant when the patient arrived.
- There was a specific team in the hospital that prepared the medical records one to two days in advance of a clinic to allow sufficient time to identify any gaps or issues. Medical records were checked and set up by the department in advance of the appointment. This was done in order to make sure the medical records were readily available and checked for accuracy and to make sure all relevant documentation was present. Medical records were taken back to the medical records storage area after clinics. Staff told us consultants were not allowed to take medical records off site to ensure patient notes were always available.
- There was an electronic tracker system in place, which we saw; this meant staff knew where the medical records were at all times.
- In the event a consultant wanted to take the medical records off site, they would have to complete a request form and obtain permission from a member of the hospital executive team. In advance of the medical records, being taken off site an agreement must be received and documented from the consultant, with the date they would return the records. The records would be tracked out of the hospital and to the consultant on the hospital electronic tracker system.
- Patient records in the outpatient department were paper based. We reviewed four sets of patient records. All records were legible, signed and dated. This was



Outpatients and diagnostic imaging

in-line with guidance from the General Medical Council. Records contained all the relevant information, including referral letters, and any procedures or discussion that had taken place.

- Staff told us they had no problems with accessing patient notes for their clinics, and could not remember a time when patient records were not available. Data provided by the hospital showed that between October to December 2016, no patients were seen without their medical records present.
- The Picture Archiving and Communication System (PACS), a nationally recognised system used to report and store patient images was available and used across the hospital. The radiology department also had access to an image exchange portal (IEP) for images held on other systems. This meant staff could view patient existing images instead of exposing them to unnecessary repeat procedures.

Safeguarding

- There was an up-to-date 'Safeguarding Policy', which combined both vulnerable adult and child safeguarding. The policy included roles and responsibilities, definitions and actions to take, if staff suspected a safeguarding issue.
- There have been no safeguarding concerns reported to the CQC between October 2015 and September 2016.
- All staff we spoke with knew who the lead was for safeguarding, and could explain the actions they would take if they had a safeguarding concern; this was in line with the policy. We saw there were posters on display in all areas of the outpatients and diagnostic imaging department, which gave contact name and numbers if a safeguarding concern was identified.
- Staff received mandatory training in the safeguarding of adults and children, as part of their induction followed by refresher training every three years.
- Safeguarding of vulnerable adults was undertaken every three years for all levels. Data indicated that over 99% and over of required staff had completed level one and 95% and over had completed level two, which is equal to and better than Benenden Hospital Trust target of 95%. Data indicated 100% of required staff had completed level three safeguarding of vulnerable adults training. This was in line with national guidance.

- Data showed 100% of required staff had completed safeguarding children level one training. This was better than the Benenden Hospital Trust target of 95%. Over 93% of relevant staff completed level safeguarding children level two. Data indicated 100% of required staff had completed level three safeguarding of children training.
- The matron for inpatients and ambulatory care was the safeguarding lead. The Director of Patient Services (DPS) was the hospital's executive safeguarding lead, and the chair of the Medical Advisory Committee (MAC) was the named doctor for safeguarding.
- We saw there were systems in place to ensure the right person, gets the right radiological scan at the right time. This included justification of the request forms. On receipt of the request by the modality, radiologist or radiographer could redirect to another imaging modality if it was felt the request examination was not appropriate. For example, an external company provided computerised tomography (CT) and magnetic resonance imaging (MRI). However, a radiologist reviewed all requests for these images before undertaking the procedure. This meant the hospital could be confident the imaging department ensured justification of exposure to keep patients safe.
- We observed two patients undergoing radiological scan during our inspection, and saw that staff 'paused and checked' patients' identifications before proceeding. This ensured the right person received the right radiological scan.

Mandatory training

- Mandatory training for all staff groups was comprehensive with modules accessed either through an online learning system or via face-to-face session. Mandatory training modules included safeguarding vulnerable adults, dementia awareness, fire safety awareness, infection control, manual handling and safeguarding children and young people. Other training was role-specific for example, fire wardens and fire marshals training, food safety general awareness, emergency first aid at work, and medical gases awareness.
- The Benenden Hospital Trust target for mandatory training compliance was 95%. Figures provided by us showed that registered nurses were expected to



Outpatients and diagnostic imaging

undertake 35 mandatory training modules. As of 25 October 2016, compliance for mandatory training for all 35 modules ranged between 80% and 100%. Infection control for link nurses had the worst completion rate of 80%. Twenty-three out of the 35 mandatory training modules had 95% and above completion rates in line with the hospital target. Twenty-seven out of 35 modules had 90% and above compliance. This meant the hospital could be confident the majority of staff were aware of their roles and responsibilities to keep patients safe.

- Allied healthcare professionals, such as physiotherapists and radiographers were expected to undertake 34 mandatory training modules. As of 25 October 2016, compliance for mandatory training for all 34 modules ranged between 67% and 100%. Intravenous administration and updates being the worst at 67%. Eighteen out of the 34 mandatory training modules were 95% and above, and twenty-three out of 34 modules were 90% and above. This meant the hospital could be confident the majority of staff were aware of their roles and responsibilities to keep patients safe.
- Non-registered clinical staff, such as clinical support workers (CSWs), were expected to undertake 24 mandatory training modules. As of 25 October 2016, compliance for mandatory training for all 24 modules ranged between 50% and 100%, with infection control for link workers and fire wardens level three as the worst at 50%. Eighteen out of the 24 mandatory training modules were 95% and above, and twenty-one out of 24 modules were 90% and above. This meant the hospital could be confident the majority of staff were aware of their roles and responsibilities to keep patients safe.
- Non-clinical staff, such as receptionists, were expected to undertake 39 mandatory training modules. As of 25 October 2016, compliance with mandatory training for all 39 modules ranged between 41% and 100%, with fire wardens level three as the worst at 41%. Twenty-nine out of the 39 mandatory training modules were 95% and above, and thirty-three out of 39 modules were 90% and above. This meant the hospital could be confident the majority of staff were aware of their roles and responsibilities to keep patients safe.
- The resident medical officers (RMO) were required to undertake their mandatory training with the agency that supplied them as part of their contract.

- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process and practising privilege.

Assessing and responding to patient risk

- We observed good practice for reducing exposure to radiation in the Radiology department. Local rules were available in the areas we visited. All rooms that perform radiographic examinations had all the necessary warning notices on the doors and illuminated boxes outside the rooms that light up when a radiographic exposure is made. Staff checked the warning signs checked regularly to ensure they worked correctly, and we saw evidence of these checks. This was in accordance with current legislation.
- There were two appointed and trained radiology protection supervisors (RPS). The RPS role was to ensure equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- There were emergency procedures in place in the outpatient department including call bells to alert other staff in the case of a deteriorating patient or in an emergency. The hospital allocated staff to respond to an emergency with the resident medical officer (RMO). This included dialling 2222 for the resuscitation team. Any patients requiring further interventions would be transferred to the neighbouring NHS Trust. We saw posters on display, prompting staff to dial this number in the event of an emergency.
- The hospital had access to a resident medical officer (RMO), on duty. The RMO was trained in advanced life support and advanced paediatric advanced life support (APLs). The RMO provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the local acute NHS Trust in line with the emergency transfer policy. Staff reported this rarely happened.
- Nursing staff told us if a patient was identified as having any health related risks then they would move the patient from the main waiting area, to one of the consulting rooms. They would make sure a trained staff member would remain with the patient



Outpatients and diagnostic imaging

- Staff, in outpatients told us they did not routinely take patient's base line observations, as patients did not usually require this. However, they would record the patient's observations if requested to do so, or if they assessed the patient as unwell. They would then report this to the consultant immediately.
- We did not see any signs prompting women to inform staff if there was a possibility they could be pregnant. Staff in diagnostic imaging confirmed they would not carry out a scan on a female patient of childbearing age, without asking the patient first, and document this on their system. To comply with IR (ME) R, as departments have to establish the pregnancy status of a patient prior to any relevant medical exposure.

Nursing staffing

- There are no national guidelines on staffing levels for outpatient departments. Outpatient department staffing levels and skill mix were planned using a local protocol that ensured a mix of registered nurses and clinical support workers, depending on the number and speciality of the clinics running.
- As of 1 October 2016, there was 8.4 whole time equivalent (WTE) outpatient registered nursing staff and 10.9 WTE clinical support workers (CSW) for outpatients. The outpatient department had a ratio of nurse to CSW of 1 to 1.3.
- As of 1 October 2016, there were 1.8 WTE posts vacant for outpatient registered nurses given a vacancy rate of 18%. For CSWs, there were 0.21 WTE posts vacant giving a vacancy rate of 2%.
- Between October 2015 and September 2016, the use of bank and agency nurses in the outpatient department was worse than the average of other independent hospitals we hold data for. Agency use was worse than the average for other independent hospitals in all except two months during this period (October and November 2015).
- Between October 2015 and September 2016, the use of bank and agency CSWs in the outpatient department was variable when compared to other independent hospitals we hold data for. Rates were worse in November and December 2015, February, April and May 2016.

Allied Health Professional Staffing

- There was a team of three physiotherapists, one full time and two part time, who provided inpatient and outpatient care. The service also used three bank physiotherapists to provide cover on the ward at the weekend.

Radiology staffing

- The radiology department consisted of 11 permanent members of staff. There was 1.0 WTE lead radiographer, 3.2 WTE radiographers, 1.2 WTE MR Radiographer, and 1.5 WTE sonographers. They were supported by 2.0 WTE receptionists and 0.96 WTE medical secretaries. The service also used six bank staff to provide cover when required.
- In addition, a Clinical Nurse Specialist in continence care provides support once a week for Trans rectal ultrasound of the prostate (TRUS). TRUS is an ultrasound technique that is used to view a man's prostate and surrounding tissues.

Medical staffing

- There were 116 consultants who had practising privileges at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trusts in the area.
- The hospital had two RMOs onsite 24-hours a day, seven days a week. The RMOs worked a one week on, followed by one week off, on a rotational basis. The RMO would provide support to the outpatient and digital imaging department in the event of an emergency or with patients requiring additional medical support.
- For our detailed findings on medical staffing please see the Safe section in the surgery report.

Emergency awareness and training

- The hospital did not receive emergency patients following a major incident. The hospital had an up to date 'Business Continuity Policy, Plan, and Procedure', which included roles and responsibilities, definitions and the procedure including escalation, of what to do in the event of something happening.
- The hospital ran regular exercises such as fire drills throughout the year to ensure all staff were trained in the requirements of emergency incidents. For example, staff completed fire safety training level two on



Outpatients and diagnostic imaging

induction and then yearly. Hospital data showed as of 25 October 2016, 96% of required staff had completed their fire safety training. This meant the hospital had assurances staff were aware of their responsibilities and roles to keep patients safe in the event of a fire.

- Fire wardens and Fire Marshalls were expected to undertake level three training and 100% of fire marshal had undertaken their training. However, only 63% of fire wardens had completed level three training. This meant that not all fire wardens had up-to-date training in this role.
- The hospital had backup generators in case of power supply to ensure services were not affected. Managers informed us that regular testing of generators took place as part of the business continuity plan. We looked at records to show that back-up generators were serviced and tested regularly.

Are outpatients and diagnostic imaging services effective?

We inspected but did not rate effective, as we do not currently collect sufficient evidence to rate this.

Evidence-based care and treatment

- The diagnostic imaging department had comprehensive policies and procedures in place. We saw these were in date, in line with regulations under IR (ME) R and in accordance with the Royal College of Radiographers standards
- We saw evidence of standard operating procedures, clinical protocols, and local referral guidelines. These were based on the Royal College of Radiologists guidelines, justification policy to ensure all medical exposures were justified prior to the exposure being made.
- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report to the radiation protection advisor (RPA) would be made. We saw evidence that systems were in place for the hospital

to report 'much greater than intended' incidents to the Care Quality Commission (CQC). This is a statutory requirement and the hospital actively engaged with the CQC.

- The Ionising Radiation Regulations 1999 (IRR '99) aims to protect the public and the health of the staff who work with ionising radiation by specifying the duties of the hospital to ensure compliance to the regulations. We observed compliance with the regulations through risk assessments, and quality assurance programmes. As well as, the provision of PPE, the development of local rules for each modality and the employment of radiation protection supervisors.
- Radiation protection policies, including Local Rules, were available within clinical areas. Staff in outpatients, radiology, and physiotherapy had a good awareness of and had read local policies. They were able to give us examples of how to find policies and when they had used them.
- The outpatients department undertook a variety of local audits. They were to check equipment, medicines management, electronic records, hand hygiene, and monthly spot check audits. We saw copies of these audits, along with action plans arising from them.
- The hospital had recently developed a dementia strategy, to be rolled out over the next three years. The strategy was based on the National Institute of Health and Care Excellence (NICE) guidance, including NICE CG42 Dementia: supporting people with dementia and their carers in health and social care.

Pain relief

- During our inspection, we did not find any patients who were in pain, or required pain relief. However, Staff described how they would offer support to patients who reported being in pain. Staff said that they would assess the level of pain and speak with the consultant for pain relief to be prescribed.
- Consultants discussed pain management within the consultation process for patients who were going to be booked in for a surgical procedure.
- The Physiotherapy department offered acupuncture and ultrasound therapy to provide pain relief, which they offered to the appropriate patients. Ultrasound is often used to provide deep heating to soft tissue



Outpatients and diagnostic imaging

structures in the body. Deep heating tendons, muscles, or ligaments increase circulation to those tissues, which is thought to help the healing process. Increasing tissue temperature with ultrasound is also used to help decrease pain.

- Patients received written advice on any pain relief medicines they may need to use at home, during their recovery from their outpatient procedure. For example, we saw in the patient information for patients following an injection with cortisone (a type of steroid). The information recommended the type of pain relief they should take at home, following the procedure.
- Nutrition and hydration
- There were water fountains in each department, which patients could use. Hot drinks were available from the hospital restaurant free of charge. Patients and staff could also buy hot and cold food from the restaurant.
- We looked at two patient information letters sent to patients before attending for an interventional radiological examination. These letters provided guidance to patients around nutritional and hydration requirements before the investigation. For example, patients who may be diabetic were requested to contact the department prior to attending to ensure the patient's health was not compromised prior to the examination.
- The hospital had a five star rating in the local authority 'Food Hygiene Certification Scheme'. This gave assurance that all best practice in food hygiene standards were adhered to.

Patient outcomes

- There were a variety of processes described to measure and audit patient outcomes, including an internal audit programme.
- The hospital's clinical audit schedule outlined, when, how often and who would undertake the audits in various areas. There were a number of local audits planned for outpatient and diagnostics. These included auditing of consent, standards of record keeping, imaging request forms, knowledge skills and competency and wrong site delivery / local rules.
- At a corporate level, the provider was working with the Private Health Information Network (PHIN). PHIN

planned to provide information for the public from April 2017 on 11 key performance measures. This meant a patient could make an informed choice where to have their care and treatment for providers offering privately funded healthcare.

- Physiotherapy staff asked all patients to complete a patient reported outcome measure (PROM). This enabled staff to measure the effect of treatment on each patient. See the main surgery report for a breakdown of the PROMs data.
- 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. Diagnostic imaging accreditation programme is designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff in safe environments. However, the manager told us they had plans to gain accreditation by 2018.
- For our detailed findings on Patient outcomes, please see the Effective section in the surgery report.

Competent staff

- Staff training and professional development needs were identified through informal one to one meetings with their managers, and annual appraisals. During appraisals, personal development goals were agreed, and individual performance was agreed.
- Hospital data showed between January to December 2016, 100% of nursing and clinical support workers (CSW) received an annual appraisal. This meant the service was able to address any potential staff performance issues. Staff told us appraisals were useful, and there were two-way discussions around performance and opportunities for training and progression.
- All new staff completed an induction programme. Staff told us the comprehensive programme included department tours, introduction to colleagues and completion of an induction booklet. During our inspection, we looked at three induction booklets and



Outpatients and diagnostic imaging

saw they were either completed or in the process of completion. This demonstrated the hospital ensured new staff had all the information and competencies they needed to do their jobs.

- Staff confirmed they were well supported to maintain and further develop their professional skill and experience. For example, CSWs working in outpatient department were given competency assessments so they could assist in certain procedures. These included venepuncture, testing urine, measuring and recording height and weight, blood pressures, oxygen saturations, and undertaking a 12 lead electrocardiogram (ECG) of the heart. During our inspection, we looked at four competency folders for CSWs, and saw they were all completed and up to date. This meant the hospital had up-to-date assurances of CSW competencies.
- All staff we spoke with in during our inspection told us they completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to do. Staff were also encouraged to undertake continuous professional development (CPD), and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. During our inspection, we saw six CDP folders for nursing staff. All certificates were up to date, for example, life support and safeguarding training, and competency assessments were completed. This meant the hospital had up-to-date assurances of nursing competencies.
- There were two radiation protection supervisors (RPS) on site, they had certificates of competence and had attended the required training. We saw the certificate of competence update for one of the RPS, which was dated 11 May 2016.
- One-hundred percent of nurses, who worked within the outpatient department for six months or more, had recorded validation of professional registration. This meant the hospital conducted annual checks to ensure all the nurses were registered with the Nursing and Midwifery Council (NMC).
- All Radiographic staff were trained by the Society and College of Radiographers (SCoR) and held either a Diploma of the College of Radiographers (DCRR) or a BSc (Hons) in radiology. All staff were registered on a two-year basis with the Health and Care Professionals

Council (HCPC). There are codes of Practice for both the SCoR and the HCPC which must be followed, any breaches will result in a radiographer being reported. No staff had been referred to either professional body for misconduct.

- There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen in the Medical Advisory Committee (MAC) minutes, during the inspection.
- Patients we spoke with told us they felt staff were appropriately trained and competent to provide the care they needed.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. From the care we observed, there was good collaborative working and communication amongst all members of the MDT. Staff of all grades, clinical and non-clinical worked alongside each other throughout the hospital. Staff we spoke with told us that they worked well as a team.
- Staff told us that they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of previous images of the same person requiring the test, even if these have been taken elsewhere, via the image exchange portal (IEP).
- Physiotherapy supported effective recovery and rehabilitation, including an appointment at pre-operative assessment for patients having orthopaedic surgery. At this appointment, staff gave patients exercises to perform before surgery. Physiotherapists also saw patients recovering from surgery at follow up appointments in outpatient clinics.
- The department had service level agreements (SLA's) with several different organisations. These included pathology services, medical equipment maintenance, and provision of Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) scanning. Contracts were in place and review dates documented.



Outpatients and diagnostic imaging

- Nominated link staff went to meetings, such as infection control. They communicated relevant information to staff in the department and took areas for escalation back to the meetings. We saw evidence of this in department meeting minutes.

Seven day Services

- The outpatient department ran clinics between 8.30am and 7pm, Monday to Friday. Saturday clinics were provided between 8.30am and 5pm. Staff cover was provided between these times.
- The diagnostic imaging department was open between 8am and 7pm, Monday to Friday, and Saturday between 8am and 2pm. A 24-hour a day, seven day a week service for urgent examination requests was available.
- There was a pharmacy service available at the hospital, Monday to Friday from 9am to 5pm.
- The physiotherapy department ran clinics at the hospital, Monday to Friday between 8am and 6pm.

Access to information

- Outpatient consultations within the hospital were consultant-led. Patients attending outpatients had an enclosed GP referral letter or their current medical records from a previous appointment or admission at the hospital.
- Images from other hospitals could be accessed via a secure computer network in the radiology department. Staff could see what previous scans or tests had been undertaken. This enabled staff to ensure patients did not receive repeat examinations and receive a higher dose of radiation than required. The consultants and RMO had access to these as required.
- Clinical and quality communication boards displayed the hospital's compliance with key clinical indicators and were shared within patient areas around the hospital.
- The hospital had daily 'ten at ten' meetings attended by representatives from all departments in the hospital, including outpatients, radiology, and physiotherapy. These meetings allowed for escalation of concerns or shortfalls in staffing. All departments of the hospital were represented at this meeting. During our inspection, we attended one of these meetings and observed positive multidisciplinary working between all staff groups.

- The Picture Archiving and Communication System (PACS) link all the patients' examinations and reports together. This meant Radiologists could access all examinations and reports during the reporting process, for individual patients. Report results were available promptly from the radiology management computer system.
- The Radiology staff told us that an Image exchange portal (IEP) which connects to other hospitals including two local NHS trust was in place to transfer images of their patients who have either received treatment at Benenden hospital or at other NHS trusts. This meant that images were shared between providers to prevent unjustified re-imaging of patients.
- Staff reported timely access to test results such as from bloods and diagnostic imaging. Results were available for the next appointment or during the same visit. This enabled prompt discussion with the patient on the findings and treatment plan.
- Doctors dictated clinic letters and they were typed by medical secretaries onsite. GPs were sent the clinic letter and a copy was retained on the patient records.
- There was a 48 hour reporting time for most scans. It was only in exceptional circumstances where a scan needed a second opinion that reporting and sending of results would take longer. GPs would then have the report faxed to them.
- Staff could access the hospital's policies and procedures via the hospital's intranet page. During our inspection, staff showed us how they did this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff followed the hospital's 'Mental Capacity Act 2005; practice and procedure Policy' (April 2016). This included responsibilities and duties, definitions, procedure and monitoring, review and audit.
- Staff followed the hospital's 'Deprivation of Liberty Safeguards; practice and procedures Policy' (April 2016). This included responsibilities and duties, definitions, procedure and monitoring, review and audit.
- Staff in outpatients, imaging, and physiotherapy told us they rarely encountered patients with dementia or who lacked capacity. They were able to describe the process



Outpatients and diagnostic imaging

they would follow if they suspected a patient lacked capacity and knew who to contact for further support or advice on this. We saw there was a flowchart on display in consulting rooms, for staff so they know who to contact if they have any concerns.

- During our inspection, we looked at five consent forms, for the diagnostic imaging department. We found all the forms to be fully completed.
- For our detailed findings on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the Effective section in the surgery report.

Are outpatients and diagnostic imaging services caring?

Good



We rated caring as good.

Compassionate care

- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- We spoke with six patients in outpatients. All patients we spoke with said the care they received was of a good standard. One patient told us “all aspects were first class”. Another patient told us “we have received 100% excellent service from all staff”, and a third said, “The service provided is excellent in all respects”. In diagnostic imaging, a patient told us staff were “warm and professional”.
- Staff introduced themselves with “my name is”. This campaign is focused on reminding staff to introduce themselves to patients.
- We witnessed staff approach people rather than waiting for requests for assistance. A patient told us “staff were very friendly and approachable, and always willing to help”. Patients we spoke with were overwhelmingly positive about the way staff treated them. Patients told us staff were “wonderful”, “fantastic”, “helpful”, “supportive”, “friendly” and “nothing is too much trouble”.
- We saw staff taking the time to interact with patients, in a friendly and welcoming manner. We observed instances where patients that had attended clinic on a regular basis had built positive relationships with the staff that worked there. We saw examples of caring interactions by staff, for example getting down to a patient level to interact with them and maintaining eye contact. We saw that consultants introduced themselves and shook patients’ hands when they called them in for their appointment.
- Consulting room and treatment room doors were kept closed. We saw staff knocked and waited for permission before entering, to maintain patient’s privacy. Each consulting room or treatment room door clearly displayed whether or not the room was actively in use. Staff made use of this signage, therefore protecting privacy and dignity of patients during consultations and procedures.
- Patients in the waiting areas appeared comfortable and relaxed.
- The outpatients and diagnostic imaging department provided an accompanying or chaperone service during physical or intimate care. This person acted as a safeguard and a witness for patients or healthcare professionals during intimate medical examinations or procedures.
- Chaperones were available. The hospital followed their up to date ‘chaperones policy’, which outlined roles and responsibilities, training and best practice guidance. We also saw that for some ultrasound procedures, patients were sent written information telling them that a chaperone could be arranged for their procedure. In addition, due to the intimate nature of some of the procedures, they could also arrange for same sex staff to undertake the examination. For example, for ultrasound scans of the scrotum and testes, they could arrange for a male sonographer to perform this procedure, if preferred.
- Posters informing patients that chaperones were available on display in the waiting areas and in all the consulting and treatment rooms. Patients were given the opportunity to accept or decline a chaperone during their appointment with a consultant.



Outpatients and diagnostic imaging

- We saw that enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to the waiting room or other locations in the hospital, such as the restaurant, with a clear and reassuring approach.
- The NHS Friends and Family Test is a satisfaction survey that measures patient's satisfaction with the care they have received. The data for all patients between April 2016 and September 2016 showed the hospital scored 95% and above. The hospital was the same or better than the England average for May, June, and September 2016. The response rates for this survey varied between 36% and 65%. The response rate for April to September 2016 was the same as the England average, except for May and September, when it was worse than the national average response rate, with a response rate of 36% and 41%. This showed that most patients were positive about recommending the hospital to their family and friends.
- We received 40 comment cards from patients who recently attended the outpatient department at the hospital. All were very positive about the care and treatment they received. Comments included, "excellent staff", "professional", "helpful", "kind and caring", and "I have nothing but praise for the staff and the doctors".

Understanding and involvement of patients and those close to them

- Staff responded positively to patients' questions and took time to explain things in a way the patient could understand.
- All patients we spoke with told us that their care was discussed in detail with them. Patients told us they were given time and were able to ask any questions and felt included in the decisions that were made about their care. One patient told us staff "fully explained treatment and made time to explain details", another patient told us they received an "excellent explanation" of their treatment. A third told us "you get treated as someone special".
- Clear concise information was provided to patients prior to their appointment. They told us the reception staff treated them kindness and respect.
- Staff photographs of who were on duty that day and their names were clearly and legibly displayed on the

reception room wall. In addition, there was a poster with an explanation of the uniforms staff wore. For example, the colours that would be worn by registered nurse, clinical support workers and the department sister. This meant patient could easily identify staff that were responsible for their care and treatment during their visit.

- Patients' families or carers could accompany them for their consultation as long as the patient agreed. However, they respected the decision of patients when they chose not to involve their loved ones. Clear and concise information was provided to patients before their appointment.
- We saw patients and people close to them being consulted before radiology procedures and staff were attentive to the needs of the patients.
- We saw patients and people close to them being consulted prior to radiology procedures and staff were attentive to the needs of the patients. There were no delays evident to patients care and treatment during the course of our visit to the radiology department.
- Patient feedback cards were available in the hospital reception area, allowing patients to leave comments, compliments, or concerns in relation to their experience. During our visit, we reviewed 10 hospital own feedback cards, which had been placed in our CQC feedback boxes. All feedback cards were extremely positive about the care and treatment received. Feedback cards were returned to the outpatient department for the hospital to use.

Emotional support

- All treatment and consultation rooms were private and could be used to deliver any bad news, which may adversely affect a patient's future. Nurses told us the consultants would inform them if they were about to break bad news to a patient so they would be available to support them. They spent as much time as was needed with the patient and those close to them. They provided support and gave them guidance on where to get further help and support.
- Counselling services for patients was available to Benenden members only. Other patients who required counselling would be referred back to their GP.



Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Outstanding



We rated responsive as Outstanding.

Service planning and delivery to meet the needs of local people

- A range of outpatient clinics was available to meet the needs of the client group. According to data provided by the hospital, this included cardiology, dermatology, ear, nose and throat, gastroenterology, general medicine, general surgery, neurology, orthopaedics, rheumatology, spinal services, urology, vascular and ophthalmology. Orthopaedics, general surgery, ear nose and throat, and ophthalmology had the highest attendance rates.
- On arrival patients reported to the main reception area where receptionists booked them in via an electronic booking system, directed them towards the appropriate clinics, and waiting areas.
- Some consultation rooms were used for specific specialties, with dedicated equipment, for example; cardiology, audiology and ophthalmology. This meant consultant would be able to work in an appropriate room according to their specialty and staff could be arranged to support and deliver the service.
- There were two waiting areas within the outpatient department (OPD) which were spacious and had comfortable seating for patients and visitors. There were cold drinks available in all of the areas and hot drinks were available free of charge in the restaurant. Magazines and newspapers were also available. However, the temporary waiting area in diagnostic imaging was small and cramped.
- Extended opening hours for outpatient, and diagnostic imaging meant patients could be seen after work and on Saturday mornings. In addition, the outpatient department offered booked and a walk-in service for pre-operative assessment clinics. The walk-in pre-operative assessment clinic ran between 8.30am

and 7pm, Monday to Friday. Saturday clinics were provided between 8.30am and 5pm. This allowed patients who work Monday to Friday 9am to 5pm to access healthcare at a time that suited their needs.

- An outside company supplied the mobile Magnetic Resonance Imaging (MRI) scanner. The diagnostic imaging department did not staff the scanner, but managed the scanner's appointments. However, in the plans for the newly developed area of diagnostic imaging, the MRI and CT service will be within confines the department.
- There were no waiting times for physiotherapy treatment and staff members used the service as well as NHS and private patients. The physiotherapy department told us they could offer an appointment within 48 hours of referral if appropriate for the patient. The physiotherapy department had a gymnasium area with fitness equipment and provided exercise classes including Pilates.
- There was sufficient consultant staff to cover OPD clinics. OPD clinics were timetabled to suit each specialist's availability and obligation as part of the consultants practicing privileges contract.
- The hospital was going through a major rebuild and landscaping programme at the time of our inspection. Free parking was available but patients told us it was sometimes difficult to park. The car park and department was clearly signposted.
- Clinics cancellations are monitored by the hospital. Consultants are required to give six weeks notice. The hospital told us no clinics have had to be cancelled or rescheduled, within six weeks of the date it is due to take place.
- When a clinic had to be cancelled at short notice, patients were contacted at the earliest opportunity. They were offered of an alternative consultant to see, or the next available appointment with their chosen doctor.

Access and flow

- There were 4,234 NHS funded patients who attended the outpatient and diagnostic imaging department for



Outpatients and diagnostic imaging

their first appointment from October 2015 to September 2016. There were 6,676 NHS patients who attended the outpatient and diagnostic imaging department for follow up in the same period.

- There were 15,240 patients who were other funded (Benenden Healthcare members, hospital funded (charitable cases), private health insurance, and self-pay) who attended the outpatient and diagnostic imaging department for their first appointment from October 2016 to September 2016. There were 19,979 other funded patients who attended the outpatients and diagnostic imaging department for follow up in the same period.
- Outpatients initially booked in at the OPD reception desk, they were then directed to one of two waiting rooms or could go to the restaurant to wait. We saw there were TV screens in both waiting rooms and the restaurant, so patients could see when they were called for their appointment. The TV screens also gave the location of the patient, in case staff had to go and find them, for example, we saw there were patients who had booked in, but their location was the restaurant.
- Receptionists alerted patients if clinics were running late and allow patients to rebook if they could not wait. We observed reception staff keeping patients informed by letting them know at check-in that clinics were over-running. In addition, the TV screens showed patients if the clinics were behind time. We saw during our inspection, that two clinics were running late by no more than 15 minutes.
- All the patients we spoke to told us they were happy with the length of time they had waited to be seen following referral and had been offered times convenient to them.
- The hospital met the target of 92% of patients on incomplete pathways 18 weeks or less from time of referral in the reporting period (October 2015 to September 2016), except for February, May and September 2016.
- In physiotherapy patients were seen within 24 hours of referral. For staff who self-refer to the service, they would be seen within 48 hours of referral.

- Pathology services were provided by a local NHS trust and samples were transported from the department three times a day. Staff said results were easily accessible online.
- The length of appointments was tailored according to speciality and treatment required. We were told that the majority of consultants requested an initial appointment time of 30 minutes. The physiotherapy department told us the initial appointment length was 60 minutes.
- There were no delays evident to patients care and treatment during the course of our visit to the radiology department.

Meeting people's individual needs

- Patients who were attending outpatients' and the physiotherapy department initially presented at the main building which was opposite from the car park. The hospital provided patients with umbrellas to use, when walking to the outpatient building in wet weather. For patients who were unable to walk between the buildings the hospital provided a minibus, if this was necessary the receptionists would radio for the minibus on an individual basis.
- The outpatients' department was located on the first floor and the physiotherapy department was on the lower ground floor of the outpatient building. This was separate from the main building. Both departments had stair and lift access. The digital imaging department was on the lower ground floor in the main building, with lift and stair access. Wheelchair access was via a ramp at the main entrance with automated doors. It was accessible to all patients, including wheelchair users.
- Staff helped patients out of vehicles and into the department and provided a wheelchair if required. The matron of the outpatient department also told us they accommodated assistance dogs if required. Assistance dogs are trained to aid or assist an individual with a disability. For example, guide dogs to assist the blind or visually impaired, or hearing dogs that assist people who are deaf or hard of hearing. Others include medical response dog, which assist an individual who has a medical disability such as hypo alert dogs who alert their diabetic owners of dangerous changes in their blood sugar levels.



Outpatients and diagnostic imaging

- The hospital had wheelchair-accessible toilets within the outpatient and main buildings of the hospital.
- Patients had access to a variety of information leaflets in the hospital. All information leaflets were in English. However, staff told us they could access written patient information in other languages through an electronic system and obtained when required.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.
- Free Wi-Fi was available for patients to use to enable them to make contact with their family and friends or use social media.
- Staff in outpatients and diagnostic imaging told us they rarely encountered patients living with dementia or who lacked capacity. They were able to describe the process they would follow if they suspected a patient lacked capacity and knew who to contact for further support or advice on this.
- Two staff nurses in the outpatient department were nominated “dementia champions”. They acted as a point of contact for staff that required more information about dementia issues. Staff knew who the champions were in the department. There were plans for providing further training for staff to become “dementia friends”. A dementia friend is someone who encourages others to make a positive difference to people living with dementia. They do this by giving them information about the personal impact of dementia, and what they can do to help.
- Data provided by the hospital showed that more than 94% of all staff had undertaken Dementia awareness training, which meant staff was aware of their roles and responsibilities for dealing with patient who are living with dementia. The hospital was in the process of developing a dementia strategy based on the National Institute of Health and Care Excellence (NICE) guidance, such as NICE CG42 Dementia: supporting people with dementia and their carers in health and social care. The dementia champions also told us the hospital had contacted the local town, which was “dementia friendly” and the use of a bus which is a mobile virtual dementia tour. This was to raise awareness among staff as it takes away people's primary senses, to let them experience the fear and frustration people living with dementia go through on a daily basis.

Learning from complaints and concerns

- The hospital received 19 complaints between October 2015 and September 2016. No complaints have been referred to the Parliamentary and Health Ombudsmen (PHSO), the Independent Sector Complaints Adjudication Service (ISACS) or the Care Quality Commission (CQC).
- The hospital had a clear process in place for dealing with complaints, including an up to date ‘Complaints Policy’, which provided a framework within which complaints were to be responded to. Staff we spoke to were aware of the complaints procedure.
- Where possible all complaints were dealt with at department level, through either the matron or the department manager. A senior manager had overall responsibility for responding to written complaints. The hospital acknowledged the complaint in two working days of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. If this could not be done, a letter was sent to the complainant explaining why. We reviewed three complaints relating to outpatients and saw they had been answered within the specified timeframe.
- A patient information leaflet was available in the departments we inspected, that outlined the formal complaints procedure. The Benenden Hospital leaflets ‘Feedback and complaints’ were located throughout the hospital and contained information on how to raise any concerns.
- For our detailed findings on learning from concerns and complaints, please see the Responsive section in the surgery report.

Are outpatients and diagnostic imaging services well-led?

Outstanding



We rated well-led as Outstanding.

Leadership and culture of service

- Outpatient staff reported to the outpatients’ manager, radiology staff reported to the radiology manager, and



Outpatients and diagnostic imaging

physiotherapy staff reported the lead physiotherapist. All departmental leads reported to the outpatients and diagnostic imaging matron, who in turn reported to the director of patient services.

- Staff told us that the outpatient department and diagnostic imaging service were well led. Staff told us they felt able to raise concerns and felt that the hospital was transparent with a “non-judgemental, no blame” culture. We heard there was a strong culture of openness from junior to senior staff, clinical and non-clinical. All staff told us the senior management team were approachable and supportive.
- Clinical staff said they “really loved working at the hospital, it’s like one big family, everyone knows each other” and that they felt valued and respected and were listened to.
- We observed a positive staff culture across the hospital. The staff told us they were positively encouraged to engage in “open and frank dialogue” with all the members of the team. They described a “no blame culture”. Nurses and administrative staff confirmed there was a supportive, nurturing culture within the hospital.
- Many staff had worked at the hospital for a long time, and said they enjoyed working there. Staff spoke positively about their relationships with their immediate managers.
- There was a positive regard for the welfare of staff. We were told of an example where a member of staff had required support and assistance in their personal lives. The extent of the support provided to staff went beyond what would usually have been expected from an employer.
- Sickness rates for outpatient nurses were higher than average for the other independent acute hospitals we hold this type of data for from October 2015 to June 2016 of the reporting period (October 2015 to September 2016). Except in October 2015 and May 2016, where it was the same or lower.
- Sickness rates for outpatient healthcare assistants were higher than average of other independent acute hospitals we hold this type of data for from October 2015 to June 2016 of the reporting period (October 2015 to September 2016). Except in February 2016, where it was the same or lower.

- Sickness rates for physiotherapists between October to December 2016, was 0%. For radiology staff, the rate for October 2016 was 1.53%, but was 0% for November and December 2016.

Vision and strategy for this this core service

- The hospitals vision was to be “the patients’ choice, providing high quality, caring and responsive and wellbeing services”. This was underpinned by four values of “care”, “mutuality”, “sustainability” and “wellbeing”. The hospital told us staff helped developed the values, which staff confirmed when we spoke with them.
- Staff told us they provided best quality care, by making sure they listened to patients, staying up to date with current practice, and ensured they learned from feedback.
- The values were prominently displayed on notice boards in the departments. The hospital values were well embedded with staff, who were able to explain the hospitals vision and values across the outpatient and digital imaging department. Appraisals were linked to the hospital values.

Governance, risk management and quality measurement

- The hospital had defined governance and reporting structure. There was a clinical governance committee (CGC) with a range of sub committees that fed into it. These included the infection prevention and control committee (IPCC), radiation protection committee, resuscitation advisory committee, occupational health and safety committee and information security forum.
- The clinical governance committee (CGC) was responsible for ensuring that the appropriate structure, systems, and processes were in place in the hospital to ensure the safe delivery of high quality clinical services. The matron for outpatients, physiotherapy, and diagnostic imaging was a member of the CGC, so that any problems within these departments could be raised for discussion with other hospital staff.
- The Clinical Governance Committee (CGC) met quarterly and discussed complaints and incidents, patient safety



Outpatients and diagnostic imaging

issues such as safeguarding and infection control, and clinical audit review. During our inspection, we saw the minutes of the CGC held in November 2015, February, April, and July 2016.

- The hospital followed their corporate 'Clinical Governance Policy' (October 2016), which included roles and responsibilities, monitoring, reviewing, and auditing.
- A Medical Advisory Committee (MAC) meeting was held quarterly. We reviewed the minutes of December 2015, and April, July and September 2016. The minutes showed key governance areas such as National Institute of Health and Care Excellence (NICE) guidelines, outcomes from root cause analysis, mandatory training and compliance data and incidents were discussed. This meant through the work of a multidisciplinary group and the MAC, action was taken to continuously improve the quality of care.
- The MAC and CGC committees fed into the hospital executive meeting, which met monthly. The minutes of August, September and October 2016 were reviewed. The minutes showed items discussed included regulatory compliance, incidents, inspections, hospital wide projects, and site development.
- The hospital held team meetings in each department including outpatients and the diagnostic imaging. Staff used the meetings for two-way information sharing. We looked at the minutes of August and September 2016 outpatient department team meeting, which showed managers shared information and learning with staff. We also reviewed the July and August 2016 minutes of the outpatient and diagnostic imaging leads meeting. These provided evidence managers discussed key issues such as the risk register, audit schedule, and feedback from all departments.
- The hospital had a Radiation Protection Committee (RPC), which met twice a year. The RPC was an important part of the radiation clinical governance process. The radiology manager chaired the group but attendees included the RPA, a consultant radiologist, and the hospital executive director.
- On reviewing the minutes of the last RPC, we saw radiation audits, the quality assurance programme, risk assessments, incidents, and radiation staff training were

all discussed. This gave assurance that radiation safety was a high priority across the hospital and the appropriate systems were in place to monitor radiation safety.

- The department managers logged identified risks on local risk registers. Key risks were placed on the hospital-wide corporate risk register.
- The hospital wide risk register highlighted key risks to the service. Actions taken to control or minimise the risks were detailed. Following these actions there was a residual risk (low and moderate risk) there was clear actions that were required or was being taken to further mitigate or minimise the risk. This included a timeframe for completion.
- For our detailed findings on governance, risk management and quality measurement, please see the well-led section in the surgery report.

Public and staff engagement

- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. We saw there were boxes throughout the hospital to place completed forms. The hospital also gathered patient opinion from the friends and family test (FFT). Departments used the results of the survey to improve the services.
- Staff told us they took part in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring in the previous days or planning for anticipated problems.
- Systems were in place to gather staff feedback to enable more effective working and improved patient experiences. Staff in the outpatients department, participated in productive outpatient processes. The purpose of these was to gather staff views, identify actions to improve safety and efficiency, and increase time with patients. For example, staff in the outpatient department had recently taken a personality test; by using the four-colour personality test to determine how best to address each personality with the goal of creating a balanced and productive environment. Understanding the different personalities allows individuals learn how to better deal with colleagues, by acknowledging their strengths and weaknesses. This



Outpatients and diagnostic imaging

meant the department had awareness that staff required different leadership styles, had particular expertise, and were flexible in their approach to the needs of their teams.

- There were rewards for staff that had been exceptional for example; there was a “Best of Benenden” award scheme, which was currently in its second year. Staff could nominate a colleague. Successes were awarded in four categories clinical excellence, innovation of the year, leading and inspiring others and support services excellence. Staff told us they received an email to say they had been nominated, which made them feel “honoured”, as they knew a peer had nominated them.
- During inspection we were given the Benenden Hospital Trust 2016 Yearbook, which showed the recipients on the “Best of Benenden” awards, these included the infection control link practitioners who won “clinical excellence” for working as a focused, enthusiastic and committed team. We also saw the housekeeping team won “support services excellence” for being cheerful, passionate, and helpful, despite the challenges of the new build.
- We saw that a radiographer and two clinical support workers won the “Lord Plant Travelling Fellowship”. The

fellowship allows staff to apply for a grant carry out a project for professional or personal development. During our inspection, we spoke with the two clinical support workers who were going to visit a gynaecology department at a German hospital. They told us they felt “privileged” and “proud” to have received this award.

Innovation, improvement and sustainability

- The hospital was currently undergoing a programme of building work. The outpatient, diagnostic imaging, and physiotherapy planned to move to a new location by summer 2017. Staff felt involved in decision-making and future service planning, including best use of facilities. For example, a clinical support worker told us they had been asked to join a group, which was looking at the new facilities and workflow.
- Staff signposted patients who needed to lose weight before surgery to various weight loss clinics within the hospital’s catchment area. Staff told us this was because research had shown patients find it easier to lose weight with brief advice to motivate weight loss through referral to behavioural weight loss programmes. We saw there was also a board in the waiting rooms, with this information prominently displayed.

Outstanding practice and areas for improvement

Outstanding practice

- We identified the hospital's commitment to staff wellbeing and their "Investors in People Silver Award" as an area of outstanding practice.
- We identified the hospital's work in enhanced recovery pathways to reduce the length of hospital stay for orthopaedic patients as an area of outstanding practice. As a result of early mobilisation, the hospital's average length of stay following orthopaedic surgery was only three days. This was better than the average length of stay of 4.9 days for other independent hospitals that participated in the national joint registry (NJR). The hospital was working to reduce the average length of stay to less than three days by further promoting early mobilisation and improved pain management.
- We identified the hospital's innovations in anaesthetics as an area of outstanding practice. The hospital won a national award for innovations in anaesthetics in 2016. Innovations in this area included use of a multi-purpose anaesthetic breathing system which recycled anaesthetic gases and reduced pollution in theatres.
- We identified the infection prevention and control leadership of the hospital and staffs commitment was an area of outstanding practice, with staff inspired to provide a good service to patients.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital take action to ensure there is permanent control of access into the theatre department.
- The hospital should take action to address operating schedules to reduce the number of day case patients needing to convert to an overnight stay.
- The hospital should take action to address admission times for surgery to ensure patients do not experience long waits in hospital on the day of their operation.
- The hospital should ensure signatures of clinical staff are legible with printed names in patient records.
- The hospital should ensure all staff complete safeguarding training for children and vulnerable adults at an appropriate level.