One Ashford Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

One Ashford Hospital is operated by One Ashford Healthcare Limited. The hospital has 20 inpatient beds and a further 10 day surgery beds. The hospital has three operating theatres, two of which have laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). The third theatre is used for the provision of endoscopy services. Facilities also include a physiotherapy gym, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, services for children and young people, and outpatients and diagnostic imaging. We inspected and rated surgery and outpatients and diagnostic imaging. The hospital introduced services for children and young people in April 2017. The hospital only carried out surgical procedures on children aged three years and over, and saw all ages of children in the outpatients department. This meant the hospital did not treat any children or young people under the age of 18 during the inspection reporting period (April 2016 to March 2017). Therefore, we did not report on services for children and young people as a separate core service. However, we reviewed the provision for children and young people during our inspection and reported on this within the surgery and outpatients and diagnostic imaging core service reports.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 and 28 June 2017, along with an unannounced visit to the hospital on 5 July 2017.

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

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

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

Services we rate

We rated this hospital as good overall.

- The hospital had a positive incident reporting culture, which encouraged staff to report incidents and raise concerns. Staff were able to give examples of lessons learned from incidents.
- The hospital had reliable systems to prevent and protect people from healthcare-associated infections. All areas we visited were visibly clean, tidy and uncluttered. Regular audits, such as hand hygiene audits, provided assurances around infection prevention and control practices.
- The hospital took a pro-active approach to monitoring for surgical site infections (SSIs). With patient consent, the hospital contacted patients' GPs 30 days after surgery to help detect SSIs.
- In the diagnostic imaging department, we observed good compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 and the Ionising Radiation Regulations 1999 throughout our visit.
- Services had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.
- Patients received care and treatment in line with evidence-based guidance. This included guidelines and publications from the National Institute for Health and Care Excellence (NICE), the World Health Organisation (WHO) and the Department of Health.

Summary of findings

- The hospital had effective systems for the granting and renewing of practicing privileges. This ensured patients received care and treatment from competent medical staff who worked to the hospital's values.
- The hospital monitored and met patients' nutrition, hydration and pain relief needs.
- We saw effective multi-disciplinary working between all professions and grades of staff. The hospital had a multi disciplinary complex case review team which reviewed more complex surgical cases. This ensured effective planning of the patient's surgical, post-operative and post-discharge care.
- The hospital participated in national audits to benchmark patient outcomes following surgery against other hospitals. These included the National Joint Registry (NJR), Public Health England (PHE) Infection Rate audits, and Patient Reported Outcome Measures (PROMS).
- The hospital also collected internal data to measure their performance. This included re-admission rates and unplanned transfers. The physiotherapy department used recognised outcome measures such as range of movement, pain scores and quality of life measures to establish the effectiveness of treatment.
- Staff in all departments treated patients with kindness and compassion, and involved patients in decisions about their care. Staff protected the privacy and dignity of patients throughout the hospital.
- In outpatients and diagnostic imaging, patients could access care and treatment promptly at a time that suited them. This included evenings and Saturdays. Outpatients we spoke with told us they had their first appointment within days of referral.
- The hospital was responsive to patients' individual needs. This included patients living with dementia and learning disabilities.
- The hospital took complaints seriously. We saw evidence of learning from complaints and changes to practice to help services improve.
- Hospital staff helped create the hospital's values. Staff were subsequently engaged with the vision and values, and incorporated the values into their day-to-day work.
- The hospital had an effective governance structure that proactively reviewed performance, identified areas of risk, and took action to mitigate risks and drive improvement.

However:

- On the resuscitation trolley in the theatre recovery area, we found one drug was in the wrong drawer and another medicine was missing from the trolley, despite being available elsewhere in the recovery area. We raised this issue immediately, and staff re-stocked the trolley with the correct medication straight away. During our unannounced visit a week later, we reviewed all of the resuscitation bags in the hospital and found they were in order. This meant the hospital took prompt action to keep patients safe.
- We saw staff wearing uncovered theatre scrubs outside of the theatre department. This meant theatre scrubs could be contaminated while outside theatres.
- Despite being within its review date, the hospital consent policy did not reflect that the hospital treated children and young people. It stated, "One Healthcare hospitals do not treat children under 18 years of age". This was incorrect as the hospital began treating children in April 2017. However, we reviewed three patient consent forms for children and young people, which showed staff had obtained consent appropriately in line with the appropriate legislation and guidance.

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

Summary of findings

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good**	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive to people's needs and well-led. • The service had an effective incident reporting culture, and effective systems to protect patients from avoidable harm or abuse. • There were reliable systems to prevent and protect patients from healthcare-associated infections. • Patients received care and treatment that reflected best practice guidance from competent staff. • Staff treated patients with kindness and compassion, and involved patients in decisions about their care. • The service had processes to meet patients' individual needs, including those living with dementia or learning disabilities • Staff were engaged with the hospital's vision and values. • There was strong leadership in developing and managing the hospital and its culture in its first year. • However, on the resuscitation trolley in the theatre recovery area, we found one drug was in the wrong drawer and another medicine was missing from the trolley, despite being available elsewhere n the recovery area. We raised this issue immediately, and staff re-stocked the trolley with the correct medication straight away. During our unannounced visit a week later, we reviewed all of the resuscitation bags in the hospital and found they were in order. This meant the hospital took prompt action to keep patients safe.

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Outpatients and diagnostic imaging

Good 

We rated this service as good because it was safe, caring, responsive to people's needs and well-led. We inspected, but did not rate, this service for the effective domain.

- The service had an effective incident reporting culture, and effective systems to protect patients from avoidable harm or abuse.
- We observed compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 and the Ionising Radiation Regulations 1999 throughout our visit.
- Patients received care and treatment that reflected best practice guidance from competent staff.
- Staff treated patients with kindness and compassion, and involved patients in decisions about their care.
- Patients could access care and treatment promptly at a time that suited them. This included appointments in the evenings and on Saturdays.
- We saw good examples of local leadership in the nursing, imaging and physiotherapy teams.
- Staff were engaged with the hospital's vision and values. They told us they enjoyed coming to work and were passionate about the care they gave to patients. This was consistent with the low staff sickness and turnover rates in the outpatient and imaging departments.

Summary of findings

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One Ashford Hospital

Services we looked at:
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to One Ashford Hospital

One Ashford Hospital is operated by One Ashford Healthcare Limited. The hospital opened in April 2016. It is a private hospital in Ashford, Kent. The hospital primarily serves the communities of Kent. It also accepts patient referrals from outside this area. The hospital provides services to NHS patients, and private patients who are either insured or self-pay to cover the costs of their treatment.

The hospital's registered manager has been in post since August 2016. The registered manager is also the hospital's controlled drugs accountable officer.

The hospital has been registered with CQC to carry out the following regulated activities since March 2016:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury
- Family Planning

This was CQC's first inspection of the hospital. There were no special reviews or investigations of the hospital by the CQC at any time during the 12 months before this inspection.

Our inspection team

The team that inspected the service was led by Kate Stoneman, CQC inspector. It comprised two other CQC inspectors, an inspection manager and two specialist advisors with expertise in surgery and radiography. The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Information about One Ashford Hospital

The hospital has one ward with 20 inpatient beds located in single rooms with ensuite facilities. There are a further 10 day surgery beds in the day surgery unit. The day surgery unit has single-sex shared bathroom facilities.

During our inspection, we visited the ward, theatres, imaging and outpatients' departments. We spoke with 35 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We spoke with four patients and reviewed 70 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 13 sets of patient records.

Activity (April 2016 to March 2017)

- In the reporting period, April 2016 to March 2017, there were 1,552 inpatient and day case episodes of care recorded at the hospital. Of these, 41% were NHS-funded and 59% were other funded. All inpatients were adults aged 18 and over.
- Forty-five per cent of all NHS funded patients and 49% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 3,733 outpatient attendances in the reporting period. Of these, 32% were NHS-funded and 68% were other funded. All outpatients were adults aged 18 and over.

Staffing

In the reporting period, 86 doctors including surgeons, anaesthetists and radiologists worked at the hospital under practising privileges. A regular resident medical officer (RMO) worked on a two weeks on followed by two weeks' off rota. The remaining two weeks each month were covered by two other regular RMOs, who each worked one week on followed by one week off. The hospital employed 27.7 whole-time equivalent (WTE) registered nurses, 17 WTE operating department practitioners (ODPs) and healthcare assistants in theatres, and 96 WTE other hospital staff including

Summary of this inspection

receptionists, administration and finance staff. The hospital also has its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety (April 2016 to March 2017)

- There were no reported never events. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident for that incident to be categorised as a never event.
- The hospital reported a total of 151 clinical incidents in the reporting period. Of these, 111 (73.5%) were no harm, 33 (21.9%) were low harm and seven (4.6%) were moderate harm. No clinical incidents resulted in severe harm or death.
- There were no serious injuries and no patient deaths during the reporting period.
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or E.coli during the reporting period.
- The hospital received 12 complaints in the reporting period. CQC directly received one complaint relating to the hospital. No complaints were referred to the Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

Services accredited by a national body

- The hospital's catering department received the maximum five stars rating from the Food Standards Agency on 17 March 2016.

Services provided at the hospital under service level agreement:

- Blood transfusion
- Clinical and non-clinical waste removal
- Interpreting services
- Housekeeping services
- Grounds maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Pharmacy
- Sterile services
- RMO provision
- IT support
- Occupational health services
- Dietician

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The hospital had a positive track record on safety, with no never events or serious incidents in the reporting period (April 2016 – March 2017).
- Patients were protected from risk of abuse and avoidable harm. Staff could confidently escalate risks that might affect patient safety and we saw effective systems for reporting, investigating and learning from incidents, which included duty of candour if applicable.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. They were supported by a programme of mandatory training in key safety areas.
- There were reliable systems to prevent and protect patients from healthcare-associated infections. All areas we visited were visibly clean, tidy and uncluttered. Regular audits, such as hand hygiene audits, provided assurances around infection prevention and control practices.
- The hospital had effective systems to assess and respond to patient risk. This included risk of falls and venous thromboembolism (VTE), as well as risks associated with surgical procedures or radiation.

Are services effective?

Good

We rated effective as good because:

- The hospital planned and delivered patient care in line with national guidance and best practice standards. Ongoing audits ensured these standards were maintained.
- The hospital had effective systems for the granting and renewing of practising privileges. This ensured patients received care and treatment from competent medical staff who worked to the hospital's values.
- The hospital monitored and met patients' nutrition, hydration and pain relief needs.
- We saw effective multi-disciplinary working between all professions and grades of staff.
- Consent forms for children and young people were completed appropriately in line with national legislation and provided clear guidance on completion for staff.

However:

Summary of this inspection

- Documentation for one mental capacity assessment we reviewed was not completed correctly. After we raised the issue, staff raised an incident on the electronic incident reporting system. Staff told us the issue was being reviewed and was on the agenda for the next Medical Advisory Committee (MAC) meeting.

Are services caring?

Good

We rated caring as good because:

- Throughout our inspection, we saw that staff treated patients with kindness and compassion. Staff protected the privacy and dignity of patients at all times, for example, by screening them behind curtains and closing clinic room doors.
- Patients spoke positively about the care they received from staff. During our inspection, we saw thank you cards, letters and comment cards from patients who were grateful for the care and treatment they had received.
- Patients were involved in decisions about their care. We saw that staff allowed patients sufficient time to ask any questions they had, and to discuss any anxieties or fears.

Are services responsive?

Good

We rated responsive as good because:

- Patients could access care and treatment in a timely way and at a convenient time. This included outpatient appointments in the evenings and on Saturdays.
- The hospital took pride in working with a local medical charity to provide private care to certain patients who had been waiting for treatment and might not otherwise be able to access private medical care.
- The hospital had systems, staff training and an appropriate environment to meet patients' individual needs. This included patients living with dementia and learning disabilities. Staff gave examples of responding to patients' individual needs, for example, by allowing the mother of a patient with learning disabilities stay overnight and helping the patient rearrange their room to lower their anxiety.
- The hospital took complaints seriously. We saw evidence of learning from complaints and changes to practice to help services improve. In many cases, staff were able to resolve informal complaints straight away and avoid escalation to a formal complaint.

Summary of this inspection

- The environment provided was appropriate and patient centred, with comfortable and sufficient seating, toilet and refreshment facilities. Free car parking and internet connectivity (Wi-Fi) enhanced facilities for patients and their families.

Are services well-led?

Good

We rated well-led as good because:

- Hospital staff helped create the hospital's values. Staff were subsequently engaged with the vision and values, and incorporated the values into their day-to-day work. The senior management team took action to address any behaviour that was inconsistent with the hospital values, regardless of the grade of staff.
- The hospital had an effective governance structure that proactively reviewed performance, identified areas of risk, and took action to mitigate risks and drive improvement.
- There were assurance systems to monitor compliance and performance. The hospital's monthly quality and safety data included indicators covering safety thermometer variables, readmission rates, patient satisfaction data and departmental key performance indicators.
- The hospital culture was positive and staff felt well-supported by their line managers. The senior management team had an "open door approach" and engaged with staff at regular staff focus groups.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Good

Surgery

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

Are surgery services safe?

Good

Incidents

- The surgery department reported no never events during the reporting period from April 2016 through March 2017. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident for that incident to be categorised as a never event.
- The hospital reported 151 clinical incidents during the reporting period, between April 2016 and March 2017. Of these, 124 occurred in theatre or inpatients; 73.5% were no harm, 21.9% were low harm and 4.6% (7 incidents) were moderate harm. The high rate of no and low harm incidents reflected that managers were made aware of problems, and could resolve them, before harm occurred. It reflected the positive incident reporting culture we observed.
- The hospital reported 59 non-clinical incidents between April 2016 and March 2017. Of these, 42% (25 incidents) occurred in surgery or inpatients.
- We saw that staff reported a variety of incidents but most common incidents related to patients staying on the ward longer than expected. We saw that this was investigated and the hospital found that this was related to some day surgeries being scheduled too late in the day. We saw that this information was shared at meetings and staff described the issue for us. Staff told us that the team had used this information to begin scheduling surgeries to take this information into account. However, some staff reported that some patients were still staying unexpectedly. Each stay was recorded as an incident.
- The hospital had a robust incident reporting culture. Staff told us the culture encouraged them to report incidents of all levels of harm, including extended stays. Notes from the 19 June 2017 staff meeting showed that staff were reminded at the meeting to report incidents. The hospital used the One Healthcare Incident and Serious Incident Reporting and Management Policy, due for review in October 2019. The policy provided a framework for incident and adverse event management. We saw that staff followed the policy when reporting incidents.
- Staff reported understanding how and when to report an incident using the electronic reporting system. After staff reported an incident, senior staff sent each staff member a hand written card thanking them for making the report and providing feedback. This encouraged incident reporting.
- Managers reviewed each open incident on the electronic reporting system, investigated and recorded learning from the incident. We saw learning was logged on the incidents we reviewed on the system. Monthly incident feedback forms and meeting notes showed that lessons from incidents were shared at team meetings.

Good

Surgery

- Under Regulation 20 of the Health and Social Care Act 2008 health care providers have a 'duty of candour' to patients. This duty requires health care providers to be open and honest with patients when anything goes wrong. Providers must notify patients (or another relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff were able to tell us about being open and honest with patients when anything went wrong or 'the duty of candour'.
- Staff told us the hospital had a culture that was open and honest with patients. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened. We saw information about the duty of candour posted on staff notice boards. Staff told us senior members of staff were involved when the duty of candour was used. They described the hospital director meeting with patients to discuss incidents. This meant that incidents were taken seriously and senior staff knew about them.

Clinical Quality Dashboard or equivalent

- The hospital used a red, amber, green (RAG) rated system to monitor falls, urinary tract infections and pressure ulcer rates. They began reporting these rates in July 2016 after their 'start up period'.
- The hospital reported 0%-1% falls rate during the reporting period except in December 2016 when the rate was 1.3%. The hospital's green target was 1% and amber target was 2%. CQC does not hold sufficient data to benchmark this against rates at other independent hospitals but the hospital met its internal safety target.
- The hospital reported no urinary tract infections during the reporting period except for in September and October 2016 when the rates were 0.4% and 0.6%, respectively. The hospital's green target was zero and amber target was 1%. CQC does not hold sufficient data to benchmark this against rates at other independent hospitals but the hospital met its internal safety target.
- The hospital reported no pressure ulcers during the reporting period except for in August 2016 and February 2017 when the rates were 0.4% and 0.8%, respectively. The hospital's green target was zero and amber target was 1%. CQC does not hold sufficient data to benchmark this against rates at other independent hospitals but the hospital met its internal safety target.
- There were two incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism in the reporting period. The hospital's green target was zero and amber target was 2%. The hospital's clinical audit outcome report for January through March 2017 reflected that VTE risk assessments were consistently performed. We reviewed five sets of records and found VTE assessments on all records.
- Staff gave us examples of how learning was taken with regard to pressure ulcers. The hospital investigated each incident, root causes were identified and lessons were learned. Staff reported that learning from incidents was shared and gave examples of learning from incidents categorised as 'pressure ulcers'.

Cleanliness, infection control and hygiene

- There were reliable systems to prevent and protect people from healthcare-associated infections. The departments used the One Healthcare Infection Control Assurance Framework, due for review December 2018 and Standard Infection Control Precaution Policy due for review February 2019. The policies outlined how Infection Prevention and Control (IPC) would be managed and supported throughout the hospital.
- The hospital also used a red, amber, green (RAG) rated IPC Plan to manage IPC actions. We saw the plan which was up to date, assigned responsible action holders, discussed key issues and did not have any actions rated as red (high risk). The plan included a small percentage of amber rated actions which did include further actions.
- There were no infections of Meticillin-Resistant Staphylococcus aureus (MRSA) in the surgical department during the reporting period, between April 2016 and March 2017. MRSA is a type of bacterial infection, which is resistant to many antibiotics and is capable of causing harm to patients.
- There were no infections of Meticillin-sensitive Staphylococcus aureus (MSSA) relating to the surgical department during the reporting period. MSSA is a type of bacteria in the same family as MRSA, but is more easily treated.

Good

Surgery

- There were no infections of Clostridium difficile (C.diff) relating to the surgical department during the reporting period. C. diff is a type of bacteria that can infect the bowel and cause diarrhoea.
- There were no infections of Escherichia coli (E.coli) relating to the surgical department during the reporting period. E. coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness, and other illnesses.
- Infection Prevention Committee minutes from January 2017 reflected that staff would make '30 day' phone calls for hip and knee patients. Staff verified that they contacted hip and knee patients 30 days after these procedures to verify whether they had experienced post-operative complications. In some cases, with permission, they would also contact the GP to verify if antibiotics had been prescribed. This helped them to understand if patients had contracted an infection after surgery. Senior staff explained that the information was recorded on individual patient information sheet. If the call required further action, the sheet was escalated to the ward manager to ensure follow up.
- The provider used evidence -based One Healthcare Corporate policies to manage infection prevention and hygiene. These included an MRSA Management Policy and Hand Hygiene Policy, Hand Hygiene SOP, Antimicrobial Policy and Antimicrobial Stewardship Policy, all of which were in date.
- The department performed monthly hand hygiene audits. Hand hygiene audits for March to October 2016 showed staff complied with handwashing techniques on 100% of the occasions observed in the theatres department (including endoscopy staff). In January the audit also reflected 100% compliance. This was better than the hospital's target of 90%. This provided assurances staff followed hand hygiene policies and best practice to help keep patients safe.
- We reviewed the theatre department and rooms on the ward, all of which appeared clean. We reviewed cleaning audits which showed clinical spaces and patient rooms on the ward were deep cleaned weekly.
- Curtains in the ward and theatre recovery area were all in date and changed in the past six months. This minimised infection risk.
- Ward rooms each had hand sanitising gel which patients reported seeing staff use. We saw one member of staff wash their hands before entering a consultation room with a patient.
- Personal protective equipment (PPE) including three sizes of gloves and aprons were available for staff in the theatre department and inpatient wards. Staff reported that this was easy to access and use. We saw staff wearing PPE in line with the hospital's policies in theatres. We did not observe staff performing any duties on the ward where they would have been required to wear PPE.
- The hospital reported six incidents of surgical site infection during the reporting period. These included one knee surgical site, three upper GI or colorectal surgical site, and two breast surgical sites. CQC does not hold sufficient data to benchmark this against surgical site infection rates at other independent hospitals.
- Senior staff told us that patients presenting with a suspected surgical sight infection were reviewed by the RMO for further treatment. The incident was investigated, a root cause analysis was performed with the consultant microbiologist and cases were discussed at the Infection Control Committee. They told us that during the reporting period from April 2016 through March 2017, incidents were not logged on the electronic system unless they were confirmed as hospital acquired. No incidents were logged as no infections were confirmed as hospital acquired. They advised that this system changed since March 2017 and now all suspected surgical site infections are logged on the system.
- We saw endoscopy equipment was decontaminated safely in an endoscope cleaning room with separate dirty and clean areas.The cleaning area and process was generally in line with Joint Advisory Group on GI Endoscopy (JAG) guidelines.However, the cleaning process did not follow JAG guidelines recommending two staff members clean endoscopy equipment, one on the clean and one on the dirty side of the cleaning areas. Staff explained that they did not currently clean enough scopes at a time for two staff members to be involved. Instead, one staff member cleaned on both sides of the areas. The staff member wore disposable apron and gloves of one colour on the dirty side of the area. When

finished, they disposed the gloves and apron and put on another colour apron and gloves on the clean side. The hospital policy did not address this element of cleaning scopes.

- We saw that a three-step cleaning and recording system was used to decontaminate some reusable equipment. The cleaning process and supplies were recorded in patient notes. The process was in line with the hospital's Medical Device Policy.
- The policies required that staff remain bare below the elbow in areas where they cared for patients. On the ward and in theatres we observed that all staff were dressed in scrubs and bare below the elbows.
- In the theatre department, we observed a red line across the floor at the entrance to theatres. Staff explained that no one should go past the line unless they were wearing scrubs. Signs in the changing room, quoting Association for Perioperative Practice (AfPP) guidelines, forbade staff from wearing jewellery in the theatre department (the hospital policy did not provide guidelines on this matter). However, we saw staff wearing jewellery and one member of staff in outdoor clothes behind the red line which was not in line with the AfPP guidelines.
- Further, we observed staff wearing theatre scrubs outside the theatre department with no cover over them. This meant theatre scrubs could be contaminated while outside theatres. Staff told us they were allowed to wear theatre scrubs in the hospital and we saw that the hospital's policy did not address this matter. However, this was not in line with the AfPP guidelines, which were posted in the theatre changing area. The guidelines recommended that staff change into outdoor clothes before leaving the theatre area. It recognised that this was not always possible and recommended putting on a fully fastened, clean, over jacket to leave the theatre environment, if changing was not possible.

Environment and equipment

- The hospital used a corporate medical devices policy, due for review in December 2020. The policy's aim was to ensure devices were fit for purpose, established and maintained in a safe and correct working condition, and operated competently.
- In April 2017 the hospital began offering limited surgical services to children and young people aged 3-18. The hospital ran children only surgery lists so children did not have surgery at the same time as adults. This meant that children were not exposed to adult patients during their time waiting in recovery and in theatre.
- All five pieces of equipment reviewed on the wards and in the theatre had been tested for electrical safety as reflected by electrical testing stickers attached to each piece of equipment.
- We saw secure sharps bins were available in treatment and clinical areas where sharps may be used. We saw that these containers were labelled, none were filled above the fill line and all were in the appropriate partially closed position. We saw posters in the theatre department reminding staff of correct processes for disposing of sharps. This demonstrated compliance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, 5(1) (d).
- We observed rubbish bins in the theatres department and on the wards. The bins contained little or no rubbish. In both areas we saw that individual bins were labelled for clinical or non-clinical waste. Clinical areas had black bags for general waste and orange bags for contaminated waste which was in accordance with the Department of Health (DH) Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We observed there were sufficient numbers of hand washing sinks available in both departments including in patient rooms. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were kept next to all sinks. We observed hygiene information displayed near sinks including the five moments for hand hygiene and twelve steps for effective handwashing.
- Staff reported they had the equipment they needed, which was new and in good condition. However, they also reported that they would also like additional, non-essential, equipment that they did not have. Staff explained that there was a process for getting new equipment. They said they were applying for new equipment and were supported in the process.

- We reviewed a difficult airway trolley kept in the hall between the theatres and observed seven pieces of equipment, all of which were in date. The trolley included difficult intubation guidelines, a flow chart for adults and a weekly audit chart (switched from a monthly chart in June 2017). This meant that all equipment and information was available in one place when it was needed.
- The hospital had a sepsis lead who coordinated sepsis training and response. We saw that there was a sepsis response trolley on the ward so that all the supplies staff needed to respond to a suspected sepsis case were in one place. We reviewed eight consumables in the trolley, all were sealed and in date.
- The hospital had applied for the National Breast and Implant Register to add all patients who have received or will receive implants at the hospital. The register allows implant safety to be monitored nationally and ensures patients can be contacted if problems with implanted devises are identified in the future.
- We checked 56 consumable items (for instance bandages, needles, syringes etc.) in the theatre department and ward, all were sealed and in date. This meant the supplies would be effective and clean.
- We saw that the theatres had "room in use" lights, which were illuminated during surgery. We saw that "x-ray in use" and "laser in use" signs were also available. We saw that lead lined jackets were available in various sizes for use during x-ray procedures. These measures protected patients and staff from unintended exposure to radiation.
- We saw the anaesthetic machines automatically ran checks and could not be used without first going through the check to verify the machine was working safely. The hospital kept paper logs of the checks. We reviewed them and saw the appropriate checks were performed daily without gaps in line with best practice. However, the anaesthetists did not review and sign the log book on the anaesthetist signature line. Although this is not mandatory, it is best practice.
- We saw resuscitation trolleys were available for staff to use in an emergency in the theatre department and on the ward. All trolleys were easily available and had seals which made them tamper evident. A separate paediatric trolley was available in theatres where children were present. We saw an audit list on each trolley which showed that the trolley's contents were checked daily.
- However, a review of the trolleys showed a paediatric mask was difficult to find on the paediatric trolley. When we asked staff about the mask, a member of staff had to call on a colleague to clarify what it was.

Medicines

- The hospital used the One Healthcare Medicines Management and Medicines Optimisation Policies, due for review in February 2020. The policies provided the overall framework and procedures for safe and effective medicines management and use of medicines.
- We saw the hospital's UK Controlled Drugs Licence which was in date and allowed the hospital to legally possess controlled drugs.
- The hospital had a Clinical Pharmacist and Pharmacy Technician on site Monday to Friday. There was no pharmacy on site. The hospital used a third party supplier, open Monday to Saturday 9 am to 5 pm, to dispense all medicines.
- The pharmacist worked closely with staff and saw patients with the resident medical officer (RMO) (a doctor who was available at all times to provide medical care in the hospital) Monday through Friday on ward rounds. Staff explained that this meant the pharmacist was available and involved in patients' day-to-day care with regard to medicines. We saw a nurse contact the pharmacist when a patient had specific medicines questions they could not answer.
- We saw that medicines on the ward and in theatre were kept securely; the fridge and controlled drugs (CD) cabinets were locked and orderly. We audited the CD log book against the CDs and found CDs had been logged correctly. The CD cabinet had an alarm which would sound if the door was open for too long.Staff reported only registered nurses had access to the key for the medicines cabinet and fridge.
- The hospital identified missed medicine doses as a risk that could cause significant harm to patients. The hospital performed a Missed Dose Audit for Inpatients in July 2016 to April 2017.The audit showed there were no

missed medicine doses during the period and there was one dose which was misreported, but the patient had received. This meant that patients were receiving medicines when they were supposed to.

- The hospital focused on medicines reconciliation (reviewing patient medications on admission) to reduce the risk of patients receiving the wrong medications which could cause patient harm or even death. The hospital's internal audit showed that in December 2016, the reconciliation rate was 72% which meant that 28% of the time patients' home medications were not reconciled which could put the patient at risk. Pharmacy began an improvement program, and in March 2017 (the most recent data) the rate improved to 100%. This provided assurances the hospital had reduced the risk of patients receiving the wrong medication.
- Fridges used for storing medicines had temperatures checked daily as reflected by ward temperature logs. However, fridge temperature records showed that only minimum (3°C) and maximum (19°C) temperatures, not actual temperatures, were recorded until the first day of our inspection. Staff told us specific temperatures had not been recorded, but they would be in the future. We saw on a return visit that actual temperatures had been recorded every day since the first day of our inspection. Further, staff explained the refrigerators had alarms that would go off if the temperature rose above acceptable levels. The alarms had not gone off so staff accepted that the temperatures had not gone above maximum temperatures.
- Rooms where medicines were stored outside of refrigerators had thermometers to monitor temperature. However, on the ward we saw that over the previous ten-day period, the temperature had exceeded 25°C on three days, although medicines in the room were not to be stored above 25°C. Staff advised us that when the room temperature went above 25°C they put the thermometer in the medicines cupboard and measured the temperature in the medicines cupboard. It had previously been below 25°C so they had taken no further action. However, this was not recorded.
- On the day we visited we saw that the temperature in the drug cupboard remained above 26°C, although a fan had been used to cool the room. Staff told us they had called the pharmacist to consider whether to put a contingency plan (moving the drugs) into action. This was in line with the SOP for Drug Storage which stated that medication may need to be moved if temperatures were out of range for a significant period of time.
- When we reviewed medicines in the resuscitation trolleys, we saw certain resuscitation medicines were stocked by the pharmacists in sealed medication bags. There was a system to check bags were in place and to monitor expiry dates. The pharmacy staff listed the medicines and expiry dates on a form and staff checked the dates on this form. We did not find any out-of-date medicines and we saw staff had highlighted items on the medicines lists that had a short expiration date.This meant the system worked for ensuring that medicines in the bags were in date and effective.
- However, the actual medicines were stored in a tamper proof sealed bag but were not checked regularly and there was no assurance that the correct medicines were in place. On the trolley in the resuscitation department we found medicine from one sealed medicines bag had been removed and placed elsewhere in the trolley while medicine from another emergency medicine bag was missing altogether. The Health and Social Care Act 2008 (12(2)(f) requires providers ensure sufficient medication is available in case of emergencies.
- In a resuscitation situation, having to identify a missing medicine and finding it elsewhere could cause a delay. However, this was not a breach of the HSCA because sufficient medication would have been quickly accessible in the theatres department which meant that the actual risk to patients in an emergency situation was low. When we raised concerns about the trolley with the pharmacy department, staffimmediately re-stocked the trolley with the correct medication, reviewed all other trolleys in the hospital, investigated the cause of the incident and considered practice changes to ensure that right medicines were in the right place in the future. During an unannounced visit a week later, we reviewed all of the bags in the hospital and found that all medicines in the bags matched the medicines lists. Senior staff assured us that a new process and policy were currently being formed. This meant action was taken immediately to keep patients safe.

Records

- The hospital's mandatory training compliance tracker reflected that 100% of theatre and ward staff had completed Information Governance Training. This provided assurances all staff had training to allow them to manage patient information.
- Staff reported that when the hospital first opened, all patient notes were recorded electronically, rather than on paper. Staff and consultants had concerns about the system which they reported to managers. The system was reviewed by the senior management team, Medical Advisory Committee (MAC) and board for final approval. The hospital switched to a paper system that included both nursing and consultant notes, which was in use at the time of inspection.
- The hospital performed a monthly record audit on 10 patient files. Based on these audit outcomes, the hospital has consistently rated its compliance level as "poor". Poor record keeping is a risk to patients as it could cause confusion or the wrong information could be conveyed. In April 2017, the hospital created an action plan to address a variety of concerns, for instance recording handovers, recording early warning scores in recovery, and overall completion of records (with patient information, consultant signatures, etc.). We saw that there was a target date of July 2017 for completion and responsible staff members named for each action.
- We saw that the June audit (the most recent available) reflected overall improvement. Several areas had improved from a red to a green rating including assessments for early warning scores, pressure sores, acute kidney risk, and fall risks. Some assessment areas remained red including nutrition and hydration, moving and handling, clinical records management, clinical handover, high impact IV cannulation and oxygen prescribing. Only high impact catheter care dropped from green to red.
- We reviewed five recent patient records. Records we reviewed were legibly printed in black with names and signatures and included necessary information including preoperative notes, consultant notes and consent forms. We saw one omission where the consultant had not recorded seeing a patient after surgery; staff were able to provide an explanation of this incident and demonstrate that the consultant had seen the patient but not documented it. We did not find any trends. Our review and the most recent audit suggested that quality of the records was improving.

Safeguarding

- The hospital used the One Healthcare Clinical Policies Safeguarding Adults at Risk Policy and the One Healthcare Clinical Policies Safeguarding Children Policy, both due for review in December 2018. The policies provided a framework for safeguarding to protect adults and children from abuse and neglect.
- We saw safeguarding procedures in the shared staff spaces. Staff we spoke to told us they had completed face-to-face and electronic safeguarding training. They reflected they understood the reporting process.
- Some staff members we spoke to were able to discuss a safeguarding issue that they were involved in. They described how they had escalated the matter and used the safeguarding process to support and protect their patient.
- The Safeguarding Children Policy addressed neglect and physical, emotional and sexual abuse (including sexual exploitation) and Female Genital Mutilation (FGM). We saw that FGM was also discussed at a July 2017 team meeting as reflected by the meeting notes. Staff verified that during the period they had been treating paediatric patients, there had been no paediatric safeguarding referrals.
- The hospital's director was the adult safeguarding lead and the Associate Director of Nursing was her deputy lead. They were trained to safeguarding levels 4 and 3, respectively. The hospital's Mandatory Training Compliance Tracker reflected that 100% of required ward and theatre staff had completed Adult Safeguarding Levels 1, 2 and 3.
- The hospital additionally had two paediatric safeguarding leads. A consultant, trained to children's safeguarding level 4, and a paediatric nurse, trained to children's safeguarding level 3. The hospital's Mandatory Training Compliance Tracker reflected that 100% of required ward and theatre staff had completed Children's Safeguarding Levels 1 and 2.
- However, at the time of inspection, only 50% of required staff had completed Children's Safeguarding Level 3.

Staff explained that training was scheduled to be completed by July 2017. Further, they told us that there were always a level three safeguarding trained staff member involved in care (a paediatric nurse) when paediatric patients were in the hospital and all consultants treating children had level 3 safeguarding training. We saw that the paediatric nurse was directly involved the paediatric surgery list we observed.

- After the training was concluded the hospital submitted information to CQC reflecting 100% of required theatres and ward staff had completed the safeguarding level three training. This meant all theatre and ward staff who treated children held an appropriate level of safeguarding training in line with the national intercollegiate guidance, "Working together to safeguard children" (March 2015).

Mandatory training

- The hospital used a corporate Mandatory Training Policy and Procedure, due for review April 2020. The policy set out mandatory training requirements determined by One Healthcare.
- The mandatory training policy stated that mandatory training was specific to an employee's role and site. New employees were responsible for attending induction or completing online training within seven days of commencement. Staff were responsible for renewing training in a timely fashion to remain compliant.
- Required training included consent, infection prevention and control, safety classes, patient moving and handling, dementia awareness, equality, diversity and human rights, information governance, safeguarding and resuscitation.
- The mandatory training compliance tracker reflected that training rates for ward and theatre staff were inconsistent. Staff in the wards and theatres were required to complete 28 mandatory training modules.
- The target rate for completion was 90% of staff members. The tracker showed theatre staff had met the target completion rate in 20 modules and ward staff met the target in 19 modules at the time of inspection. These included a variety of topics, for instance clinical subjects, equality and diversity, health and safety, dementia and information governance.
- However, as demonstrated by documents submitted prior to the inspection, staff in the theatre department did not meet the targets for 7 modules and in the wards for 11 modules. These included topics such as Blood transfusion, Communication, Dementia Awareness, Paediatric Immediate Life Support Training (PILS) or adult Immediate Life Support (ILS).
- The tracker reflected that, at the time of inspection, theatre and ward staff did not meet the training target for PILS or ILS. However, staff told us that training was imminent. Shortly after the inspection the hospital submitted information to demonstrate that 100% of required theatre and ward staff had completed the training.
- Staff explained that, to limit risk when the training was not competed by all staff, there was always staff present with current ILS training. Further, there was always staff with PILS training when children were in the hospital. The consultants, anaesthetist and RMO all had this training and the paediatric team always stayed on site until paediatric patients were discharged.

Assessing and responding to patient risk

- The hospital had strict admissions criteria which excluded higher risk patients. The policy considered long and short term medical conditions and patient complexity. Patient notes reflected that the policy was followed and concerns about patients meeting criteria were escalated. Staff we spoke to understood the criteria and how they limited risk.
- The hospital had a Procedure for the Care of Children and Young People at One Ashford, due for review December 2019, which referenced professional guidance from the Royal College of Nursing, British Association for Community Child Health and other professional bodies. It set out the criteria for admission and care of children. The hospital had only been treating children for three months at the time of inspection. Criteria for children limited care to healthy children who would not be expected to stay over night. TheProcedure for the Care of Children and Young People at One Ashford, due for review December 2019, only allowed for treatment of American Society ofAnaesthetists (ASA) level 1 (a healthy patient) and 2 (a patient with a mild systemic disease) patients between the ages of 3 and 16 for no more than one night's stay. In

practice, staff reported that only ASA level 1 children who were not expected to need overnight care were admitted. If patients needed an overnight stay they would be transferred to another hospital. Children were individually reviewed by the paediatric theatre team prior to admission.

- The hospital had an agreement with a local hospital and ambulance service to transfer critically ill children. In the three months the hospital had treated paediatric patients (at the time of inspection) one child had been transferred to another hospital. The transfer was in line with hospital policy and staff reported that it had run smoothly.
- A doctor described the hospital's multi-disciplinary complex case review team which reviewed complex cases. There were specific triggers to involve the group such as body mass index, co-morbidities, length of operation and other complexities. The team would review each case to ensure that the surgery and follow up were planned properly before the event.
- We saw each patient had a preoperative appointment with a preoperative nurse who had theatre experience. At the appointment, the nurse and patient had a detailed discussion about medical history and any other relevant concerns. This ensured that patients met criteria to be seen at the hospital.
- The nurse raised any concerns with the surgery team. If the anaesthetist or surgeon deemed the patient to be too high risk, or if the patient otherwise did not meet criteria, they would be referred to an acute hospital.
- We saw a staff member discussing family history and other risk factors with a patient. The staff member identified issues the patient was not aware could be risk factors and performed thromboembolism (VTE) and nutritional assessments. Risks were documented to be discussed with the anaesthetist.
- Our review of patient preoperative notes also reflected that it was standard practice to have an in depth discussion with patients to identify and address risk factors. This demonstrated a thorough risk assessment process.
- One doctor provided an example of a patient whose surgery he cancelled because of the high risk associated with the patient's pre-existing health conditions and the length of surgery. They explained that they discussed the decision and other options with the patient.
- We observed theatre staff carrying out the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for procedures. The WHO checklist is a national core set of safety checks for use in any operating theatre environment which ensured that staff checked the most important safety factors relating to specific procedures.
- The hospital performed an audit of WHO compliance from May 2016 through March 2017.The target score was 100%. The audit reflected that the theatre team had improved with 'sign in', 'time out' and 'sign' out procedures across the auditing period. In the most recent five months, from November 2016 through March 2017, the team had scored 100% in all these areas. However, the team did not meet the criteria for 'team briefing' on any month audited. Notes from the theatres February 2017 team meeting reflect that team briefings were discussed with the team. Notes from the April 2017 meeting reflect that the team briefing occurred 100% of the time but was not always documented.
- During the inspection we witnessed a team briefing where all staff were present and contributed during the team briefing.
- Staff monitored patients in recovery and on the ward using an early warning scoring system to evaluate deteriorating patients in accordance with NICE clinical guideline 50 Acutely ill adults in hospital: recognising and responding to deterioration. Staff described understanding how to use the scoring system and when to escalate concerns about patients based on the scoring system.
- Staff described increasing the size of the early warning score chart so that it was easier to read and using the scoring system to escalate patient care before a patient became critical.
- The hospital's audits reflected that 100% of surgery patients received venous thromboembolism (VTE) screenings during the reporting period from April 2017 through March 2017. Staff explained that this was part of the pre-assessment process. We reviewed five sets of surgery notes all of which included VTE assessments.

- We saw that allergies were documented throughout patient files in red and highlighted on the patient bed board in the ward. We observed a staff member discussing allergies with a patient. The focus on identifying and highlighting any allergies reduced the risks of patients having an allergic reaction in hospital.
- A staff member described care provided to patients with a high falls risk. They told us they reviewed patient notes, discussed falls risks at admission and provided extra assistance with getting out of bed, walking and bathing.
- Staff told us they encouraged all patients to "call not fall" to avoid falling incidents. One patient described how staff assisted them in getting out of bed and walking for the first time after surgery.
- We saw informational sepsis posters in the ward preparation room and the Inpatient Sepsis Screening and Action Tool for adults. Staff were able to discuss the markers for sepsis and how they used the Sepsis tool. Staff we spoke to told us they had not treated patients with sepsis or suspected sepsis, but that the tool and trolley had been applied by other staff members.
- The hospital had a service level agreement with a local NHS hospital and ambulance service to transfer patients for emergency care by ambulance to the acute trust hospital when necessary. Many of the consultants also worked at the local hospital and there were open communications between the two hospitals.
- The emergency code blue alarm was tested on Fridays. We saw two instances when the emergency alarm was rung during our inspection. In both cases staff including senior medical staff attended. In one case we witnessed senior staff go to the patient, ensure they were not in danger and enact a plan for observation.

Nursing and support staffing

- The use of bank and agency nurses, operating department practitioners (ODPs) and health care assistants (HCAs) in theatre departments was variable throughout the reporting period. The department did not use any bank and agency staff from April 2016 to September 2016. From October 2016 through March 2017 1% to 9.6% of ODP and HCAs used in the theatres was agency or bank which was in accord with an influx in illness rates during the same period
- The provider confirmed that there were no staff vacancies in the department on 1 April 2017.
- Staff turnover during the reporting period for theatre nurses was zero and for ODP and HCAs was 2%. Staff sickness rates were zero to 0.3% from April 2016 to November 2016, but rose to 2% to 4% from December 2016 to March 2017. There were no unfilled shifts reported and scheduling staff said that when shift changes arose they did not have problems filling them with competent staff.
- Staff we spoke with told us that the bank and agency staff in the hospital received a complete induction. Staff reported that they were available to support bank and agency staff when necessary. We saw agency inductions forms, signed by inductees and inducting staff members reflecting that agency and bank employees
- We saw the rota, which was planned with two weeks notice. We saw that the planner considered patient numbers and dependency as well as staff skills and experience to draft the rota. Staff told us that although one staff member usually drafted the rota, several staff members had the competencies to draft and update the rota.
- One nurse told us that the hospital required a nurse to patient ratio of at least one nurse to five patients but that the ratio was often better than that.
- The hospital had recently begun offering some paediatric care. We were told that all staff did not have competencies to treat paediatric patients but that there was always a paediatric consultant, anaesthetist,two registered children's nurses and an ODP with paediatric competencies present for paediatric procedures. Staff verified that patient surgery would be cancelled if all necessary staff were not on site and during our inspection we saw that necessary staff was present.
- The lead paediatric nurse worked part time at the hospital under practising privileges. The other paediatric nurses were bank nurses. This did raise a concern about continuity and the long-term viability of a department, which relied heavily on a bank member of staff to be present for every children's list. However we were assured that paediatric patients were safe because paediatric surgeries would be cancelled in the event that a paediatric nurses, anaesthetist and surgeon were not present.

- Senior staff told us the hospital was committed to investing in staff to care for paediatric patients. We saw one staff member having paediatric competencies assessed in the theatre department during our inspection. We saw the paediatric competencies checklist and the hospital reported they had contracted with experienced practitioners from the local trust to help ODP and nursing staff complete their competencies. This meant that the hospital was ensuring that appropriately trained staff would be available to support the paediatric bank nurses.

Medical staffing

- There were 89 consultants with practising privileges at the hospital. Practising privileges is a term which means consultants have been granted the right to practise in an independent hospital.
- Consultants were required to be available by phone or in person in an emergency or if questions about care arose. Staff told us nurses or the RMO were easily able to contact consultants by phone when they were not in the hospital and gave examples of when they had done so. They told us consultants welcomed calls about patients if they were not on site so staff were comfortable calling consultants whenever they felt it was necessary.
- We saw that there were two consultant paediatricians with practicing privileges at the hospital. The hospital required paediatricians applying for practicing privileges to complete a scope of practice document and submit a log demonstrating competency within their scope of practice.
- Staff told us that consultants would not be granted practising privileges if they were not able to provide assurances that they could attend patients in line with the hospital's Practising Privileges Policy. The policy required consultants with practicing privileges be available to attend the hospital within a time period (agreed on a one to one basis) dependant on the speciality and/or the timing in relation to specific procedures or make suitable cover arrangements should they not be available to the One Healthcare hospital during this time. Medical Advisory Meeting (MAC) Minutes from September and December 2016 reflected that time and distance for consultants and anaesthetists was discussed at MAC meetings.
- The hospital had a contract with a third party provider to provide Resident Medical Officer (RMO) cover. RMOs were on site and available 24 hours per day. The RMOs role was to provide immediate medical cover on the wards and when patient's consultants were not available, particularly during evening and weekend hours.
- Each RMO's shift was seven days. One regular RMO worked two weeks per month, while other regular RMOs usually worked the other weeks. Each new RMO received an induction to the hospital before working on site for the first time. We were told RMOs had a comprehensive RMO to RMO handover before each new weekly shift, although we were not able to observe this as there were no RMO shift changes during our inspection
- The hospital ensured that RMOs received appropriate rest time during their shifts. We were told the RMO could request cover if they had not had rest time in line with the hospital policy but staff we spoke to could not recall this had ever been necessary.
- Staff told us that they worked closely with the RMO who attended ward rounds. They told us the RMOs were accessible and responsive.
- The hospital had two paediatric consultants and a paediatric anaesthetist with practising privileges who were involved in paediatric surgery. All medical staff practiced paediatric care at a local NHS trust.
- The hospital used the same Guidelines for the Provision of Anaesthetic Services as the NHS to ensure that practitioners were working to the same standards.
- The consultant anaesthetists organised a rota so that an anaesthetist with practising privileges at the hospital was on-call 24 hours per day. We saw the monthly duty anaesthetist rota reflecting which anaesthetists were unavailable and that there was an anaesthetist on call every day.
- There was a theatre team on call rota for out of hours returns to theatre. We saw the weekly rota which included a daily on call rota and contact information for the on call anaesthetist and theatre team members.

Emergency awareness and training

Good

Surgery

- We saw that the hospital used a corporate Business Continuity Management Plan, due for review February 2020. The policy aimed to identify threats to business continuity and provided a framework for responding to incidents.
- The hospital worked closely with local medical and emergency services to plan regional response to emergency situations. Although independent hospitals are not required to be part of the emergency plan, they participated in the region's emergency planning team where representatives from different services worked organise and plan for the responses to regional emergencies.
- Staff described a practice scenario where an unattended box was left at the hospital reception area. This helped staff to prepare for an incident where an unidentifiable package might be left at the hospital. Staff were able to describe how they applied learning from the scenario in a real life situation.
- We saw records reflecting the hospital's emergency generator was checked and load tested monthly by an engineer. The engineer checked for leaks, fluid levels and battery condition to ensure that the generator would be working when it was needed in an emergency.
- We saw that the hospital held quarterly emergency (practice) scenarios which allowed staff to practice responding to emergencies and trainers to evaluate the response. The last two quarters scenarios were presented by an outside trainer.
- We saw staff received positive ratings for all three scenarios they had performed. While there were some learning points, the team was graded 'no risk' which meant that they were performing well and did not require training or evaluation outside of the hospital's regular training and practice scenarios.
- Staff told us about their involvement in regular emergency scenarios, the most recent of which was a cardiac scenario. They reported learning from the scenarios and being reassured by the positive outcomes.
- We saw fire alarm records reflecting the hospital tested fire alarms weekly and different call point locations were tested at that time. Staff verified that the test was performed every Friday.
- We saw the most recent fire evacuation drill record. This showed staff and patient evacuation time was satisfactory. There were mechanical issues which needed to be addressed; for instance a lock did not automatically release, automatic gas valve shut off was not initiated by alarm activation, the main door to the kitchen required repair, car park barriers did not remain open and the fire alarm panel was not configured correctly.
- We saw the hospital's 2016 Fire Evacuation Action Plan reflected that technical issues with the lock, gas valve shut off, main kitchen door and alarm panels had been identified and were all resolved by August 2016. The barrier did not open automatically but the hospital resolved this concern by assigning the security guard on duty to open the barrier when the fire alarm sounded.
- We saw that the hospital's most recent fire safety risk assessment was performed in May 2017. The assessment highlighted four areas needing improvement. These included replacement of neoprene seals, replacement of a door, working practices and signage. The hospital had an action plan reflecting that risks had been evaluated and there was a clear action plan with due dates. All actions had been completed with the exception of theatre door fire seals which were due to be completed by November 2017.

Are surgery services effective?

Good

Evidence-based care and treatment

- We reviewed the hospital's clinical policies and saw they were based on evidence based guidance including NICE, WHO, Department of Health and other national guidelines and publications. We saw that staff were informed when policies changed and asked to sign a form to show they reviewed the changes.
- A staff member we spoke with described using evidence based guidance to develop policies and practices for patients living with dementia and learning difficulties.
- The September 2016 Medical Advisory Committee (MAC) meeting notes showed NICE guidelines were considered by MAC members in drafting the sepsis policy.

- Staff monitored patients in recovery and on the ward using a scoring system to evaluate deteriorating patients. This was in accordance with NICE clinical guideline 50 Acutely ill adults in hospital: recognising and responding to deterioration, which recommends staff monitor patients regularly after surgery and take action if they show signs of becoming worse. This can help avoid patients deteriorating further.
- The department performed clinical and non-clinical audits to evaluate patient care and manage risks. Departmental meeting notes and action plans showed managers and staff used information from audits to improve care.
- We saw that the audit template used for adult and paediatric care included a section for 'notable trends' where learning was included and an 'action plan' section. For instance, we saw a paediatric audit template where learning was identified and actions outlined about paediatric pathways and risk assessing minor procedures and cascading this learning. A physiotherapy audit highlighted that all records were not signed. Learning to be actioned included sending a message to the team and including the matter at the next staff meeting.
- The hospital had a pre-assessment policy which was next due for review in December 2018. The policy required that all women of child bearing age (12-55) provide information about contraception and the possibility of pregnancy. The patients were required to take a pregnancy test on the day of surgery if they were undergoing a general anaesthetic.
- The hospital was not JAG accredited (an accreditation given by the Joint Advisory Group on GI Endoscopy). Staff explained that they could not apply for accreditation until the hospital had been running for at least one year, but that they hoped to apply in April 2018.

Pain relief

- Staff reported that they regularly monitored pain using a one to 10 pain scale for adults and with sad to happy faces for children. They explained that different consultants managed pain using different drugs but staff monitored pain for all patients. We saw evidence of regular pain monitoring in patient records. This meant staff could treat pain in its early stages.
- One patient we spoke to reported that staff checked on their pain levels regularly, although they had not had any pain after the procedure.
- A review of written complaints showed a patient complained that their pain was not managed appropriately and they were discharged without necessary pain medications.Staff logged learning about ensuring that patients went home with appropriate pain medication even when they had a low pain level at discharge, a need for further training around pain control was identified and four pain management education sessions were undertaken by the hospital's pain champion.

Nutrition and hydration

- Patients were given information about fasting times before surgery. We saw that patients were scheduled in consideration of fasting times. For instance, staff told us diabetic patients and other patients more sensitive to starvation times would be scheduled first on the surgery list.
- Children were treated on paediatric only lists so they could not always be seen first on the list. However age and starvation times were considered when scheduling paediatric treatment.
- One patient on the ward told us that the menu offered enough choices. A staff member had read the menu to the patient who had chosen a post surgery meal before surgery. After the surgery the patient felt nauseous so staff administered nausea medication and offered appropriate food options.
- Kitchen and ward staff reported that kitchen staff spoke to patients to identify their dietary requirements.
- The hospital did not employ a dietician. However, they had a contract with a local trust to provide an appropriately qualified, competent and experienced dietitian to assess and provide nutrition and dietetic support to the One Ashford Hospital private patients. The dietician could address patients with a variety of complications such as; appropriate diagnoses, colorectal surgery, ITU recovery, malnutrition, nutrition support, weight reduction and child health.
- Additionally, the contract included nutrition and dietetics training sessions for the hospital's staff.

Good

Surgery

Patient outcomes

- The hospital participated in the National Joint Registry (NJR), Public Health England (PHE) Infection Rate audits, and recently commenced Patient Reported Outcome Measure (PROMS) audits. However they were not yet able to benchmark against national averages.
- The hospital performed a range of internal audits for instance; VTE assessment (97%-98% January through March 2017); Early Warning Score Assessments (98% January through March 2017), Pressure Sore Risk Assessments (90%-100% January through March 2017), Slips Trips and Falls Assessment (80%-100% January through March 2017), Moving and Handling Risk Assessment (57% improved to 100% January through March 2017).
- The hospital reported six cases of unplanned transfers of an inpatient to another hospital during the reporting period. We saw that these were logged on the incident reporting system so each incident would have been reviewed and closed by a senior member of staff. This number of unplanned transfers was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- The hospital reported three cases of unplanned readmission within 28 days of discharge in the reporting period. This number of unplanned readmissions was not high when compared to a group of independent acute hospitals which submitted performance data to CQC. These were logged as incidents on the hospital's incident log.
- The hospital was a member of the private healthcare information network (PHIN) which requires the submission of certain data. The hospital reported it was in the process of submitting data and had been working toward PHIN requirements.

Competent staff

- The hospital granted practising privileges in accordance with the hospital policy dated October 2015. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these doctors also worked at NHS trusts in the area. A review of Medical Advisory Committee (MAC) meeting minutes and five consultant files reflected that there was an effective process for granting practising privileges at the hospital.
- The hospital reported that 100% of theatre and inpatient staff received their annual appraisal in the 2016 reporting year. Staff were in the process of receiving appraisals for this reporting year. Staff who had had appraisals told us that they felt they were productive. One staff member told us the appraisal was an opportunity to suggest changes to their role. They believed the manager would consider the changes based on their conversation.
- We saw that the ward manager had weekly meetings with direct line repartees to build relationships and progress goals.
- The hospital had a single competency sign off to verify staff were competent when they were employed. However, there was no formal staff reassessment.Staff were advised to raise concerns if they needed further training to use equipment so the training could be arranged. However, there was no equipment competency sign off sheet, which meant there was not a system to ensure all staff were competent to use all equipment.
- Departments kept competency files for each staff member reflecting their training and competencies. However, there was no means of recording and reviewing staff competencies other than to go through individual staff members folders. When we raised this matter, staff told us they were drafting a tracking template.
- One staff member described being able to work across two departments to maintain competency. The areas were closely related and competencies complemented each other.
- The hospital had a policy for assisting with surgical procedures which was due for review in January 2020. The policy allowed for surgical first assistants or surgical care providers to assist directly in surgical procedures. These assistants were not employed by the hospital but were treated as non-consultants with practicing privileges. First assists were required to provide

evidence of registration, indemnity insurance, appraisal, DBS expiry, health clearance, and training. We saw that all checks had been made and four first assists had been reviewed and signed off to practice at the hospital.

Multidisciplinary working

- We saw that staff worked closely between departments. For instance, the preoperative assessment nurses worked closely with anaesthetists to consider patient care and risks. The pharmacist and RMO attended ward rounds to have direct understanding of patients. Staff reported that consultants were available to respond to questions and concerns.
- A doctor described the hospital's multi-disciplinary complex case review team which reviewed complex cases. There were specific triggers to involve the group such as body mass index, co-morbidities, length of operation and other complexities. The team would review each case to ensure that the surgery and follow up were planned properly before the event.
- The physiotherapy department provided inpatient and outpatient care. The physiotherapist worked with ward staff to provide physiotherapy to patients directly after surgery. Inpatient physiotherapy was usually provided on the ward.
- We saw that physiotherapists, nurses, the pharmacist and consultants worked together to plan and implement patient discharges.
- We saw that staff from all departments shared information at a variety of meetings. Staff from across the hospital attended the daily communications meetings and we saw there were representatives from a variety of disciplines at the senior management and committee meetings.
- The hospital had a service level agreement with a local NHS trust to provide pathology, infection prevention and control link practitioners and other services to the hospital. Staff reported that there was a close working relationship between the two hospitals.
- Link nurses for key issues such as sepsis, dementia and learning disabilities shared learning and information across the hospital.
- Staff described working with practitioners outside of the hospital when patients needed additional assistance or support. For instance, staff told us they had talked with GPs, pharmacists from a drug specific clinic, community nurses and stoma care nurses to help patients. One staff member said they were happy to reach out to anyone necessary to support patients.

Seven-day services

- The provider offered surgery services Monday through Saturday and wards were open seven days a week.
- The diagnostic imaging and physiotherapy services were open Monday through Friday and some Saturdays. However, both were available evenings and weekends to support inpatients as needed to respond to urgent requests for imaging or physiotherapy services.
- Consultants or their nominated cover were available by phone or to come into the hospital at all times. We saw the theatre team and anaesthetists had on-duty rotas so that the hospital could provide care, when necessary, 24 hours a day seven days a week.

Access to information

- We saw the surgery team had access to complete patient history information collected by the pre-assessment nurse. This meant the team had the necessary information to discuss risks or concerns and put protections in place.
- We saw that there was a bed board (an electronic screen with information about each patient) in the nurses' room so that the nurses had an overview of the needs of patients on the ward.
- We observed team briefings in the theatres department and saw that all staff were involved and shared relevant information. All issues from the briefing were logged; however they were logged on a single briefing sheet, not by individual patient, which could cause confusion.
- We saw that on the ward there was a whiteboard in each patient's room. This allowed staff to communicate with each other and patients by posting important information and preferences. It also provided patients and family with an easy way to communicate concerns or post reminders to discuss questions with staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

- The hospital used a Consent for examination or treatment policy which was based on patients', 'fundamental legal and ethical right to determine what happens to their own bodies ' which was due for review in 2020 and incorporatedfive versions of the consent forms.
- The mandatory training tracker reflected that 90% of required ward and theatres staff completed consent training. Mental Capacity Act (2005) training was included in the consent training curriculum.
- We reviewed six recent records which reflected patients had received information about their procedure both verbally and in writing. The patients had consented for all procedures performed. Staff had informed patients about their procedures, patients had agreed to the procedures and the information and agreement was documented. This meant staff were following the One Healthcare consent policy.
- Patients attending the hospital for cosmetic surgery were required to provide informed consent under the Consent policy used for all patients in the hospital. The policy noted that while written consent was not a legal requirement, it was good practice to receive written consent in many circumstances, including when 'clinical care is not the primary purpose of the procedure.'
- The hospital reported that the surgeon would not consent a cosmetic patient until the surgeon had seen the patient three times. However, the hospital's consent policy did not require a cooling off period. This was not in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery which states cosmetic surgeons should, 'Ensure that consent is obtained in a two-stage process with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on the decision'.
- We reviewed a mental capacity assessment for one patient. The consultant performed a mental capacity assessment and filled out the correct consent form and the right people were involved in the decision. However, the consent form lacked information and did not accurately record the process for determining that the patient did not have capacity. When we raised the matter with the hospital they agreed that the form was not filled in correctly. A full review of the file reflected that appropriate actions were taken, but it was incorrectly documented. After we raised the issue, staff raised an incident on the electronic incident reporting system. Staff told us that the issue was being reviewed and was on the agenda for the next Medical Advisory Committee (MAC) meeting.
- We saw "One Healthcare parental agreement to investigation or treatment for a child or young person" forms. Parents or legal guardians signed these consents on behalf of children who were not competent to provide consent. We saw these forms also had a space for children to sign as well as the parent to show their involvement in decisions about their treatment. The associated guidance stated, "It is good practice when a person with parental responsibility signs the consent form to involve the child in the decision making and to allow them to countersign the consent form where the child's level of development allows".
- However, the One Healthcare consent policy stated, "One Healthcare hospitals do not treat children under 18 years of age". This was incorrect as the hospital began treating children in April 2017. Further, the policy included "One Healthcare parental agreement to investigation or treatment for a child or young person" consent form. This was confusing and indicated the policy was out of date.
- As of June 2017, we saw the One Healthcare clinical policy "Procedure for the care of children and young people at One Ashford" showed an issue date of "December 2017". This was confusing and indicated the policy had yet to be issued. This meant staff would not know if they had to follow the policy for treating children and young people before or after the issue date.

Are surgery services caring?

Good

Compassionate care

- The hospital's patient satisfaction survey collected the Family and Friends Private Healthcare Information Network (PHIN) questions. The provider reported on this quarterly, and the hospital achieved a satisfaction score of 96% between October and December 2016. However, the response rate represented a limited sample of 7%. Meeting minutes from the hospital's quality and risk

committee meeting in December 2016 reflected that the hospital focused on improving the response rate to the survey. Subsequently scores improved to 99% based on a 19% response rate from January to March 2017. This meant almost all patients who responded were satisfied with the care they received.

- We saw a folder of thank you cards and compliment letters sent by patients and colleagues kept in a folder by a staff member on the ward.
- We sent comment cards to the provider for patients to complete ahead of the inspection. We received 32 cards relating specifically to surgery. Two included negative comments, one about cleanliness and one temperature. The other cards were, positive, including comments such as, "The care during and after my hip replacement has been first class"; "All the staff were professional, friendly and caring, I had everything I needed" and "All the staff were sympathetic to my varying needs and treated me well".
- One patient told us that all the nurses were nice and the patient had no concerns about her care. Another patient told us how a security guard went out to the car park to assist in carrying their bags.
- Staff asked patients how they would like to be addressed and this was documented in their notes.
- Staff supported the 'hello, my name is…' campaign. We observed nurses and other professionals introducing themselves to patients at all times.
- Each room on the inpatient ward had a patient board stating their specific nursing requirements and the patient's "wish for the day". One patient we spoke to told us that she liked this section and intended to fill it out although she had not yet done sow saw that patients were treated in individual rooms which enabled their privacy and dignity to be protected. We observed nurses ensuring that doors were closed during treatment.
- One staff member noted because of the high staff to patient ratios, staff was able to use all their skills, build relationships with patients by chatting and providing personal care as well as nursing care.

Understanding and involvement of patients and those close to them

- The hospital assigned a named qualified nurse to each patient upon admission. The nurse was responsible for ensuring the patient was kept informed of their treatment at all times.
- A health care assistant described how it was on a patient's board that they had a hearing impairment and therefore communicated with the patient by writing things down to ensure they understood.
- The service involved patients' relatives and people close to them in their care. One paediatric patient had their mother present in the recovery room to comfort them when coming round from anaesthetic, in accordance with the hospital's usual practice for children.
- We reviewed comment cards that stated "The anaesthetist and surgeon both answered all of my questions and were reassuring and honest. Overall I felt cared for, not hurried and kept informed at all times" and "caring, professional staff who looked after my daughter well. Everything about the operation and post-operative treatment was explained fully".
- The reservations team was able to provide treatment cost information to patients before care. The hospital ensured self-paying patients had paid in full before the start of their treatment. This ensured patients had peace of mind and would not have unexpected costs to their bill due to fixed procedure prices.

Emotional support

- We saw staff in recovery reassuring patients who were worried or anxious as they recovered from anaesthetic.
- One comment card stated, "The staff looked after me very well, especially after being so anxious about the operation. On the ward I was checked on at all times and any questions were answered".
- We observed that sufficient time was allocated for the pre-assessment appointment to allow patients time to discuss any fears or anxieties.
- We witnessed a preoperative nurse providing emotional support to a patient when discussing their medical history and concerns. This included contacting the pharmacist to answer the patient's medicines specific concerns.

Good

Surgery

- Visiting hours on the ward were from 10am to 9pm to allow patients to have emotional support from family and friends.
- All patients received a follow up telephone call one day after discharge from one of the nurses to check on their welfare and recovery. This enabled patients to continue to feel supported by staff after they left the hospital and for nurses to advise on ongoing care and treatment if necessary.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital provided surgical services to local people, which were also offered by the NHS, for instance endoscopy, orthopaedic, gynaecological, urological, and plastic surgery. Some patients were funded by the NHS to help reduce NHS waiting times. Some private patients were funding their own care to access care more quickly than on the NHS.
- In April 2017, the hospital began offering paediatric care in response to a gap independent healthcare market.
- The facilities and premises were appropriate for the services provided. The building was accessible and designated paediatric spaces were responsive to children's needs.
- We saw that the hospital worked with a local medical charity which funded medical procedures to provide private care to certain patients who had been waiting for treatment and might not otherwise be able to access private care.

Access and flow

- Patients were able to schedule appointments to suit their needs. One patient told us that three weeks after contacting the provider for a consultation they had had their surgery. The patient told us they chose the provider because they were in pain and the provider was able to schedule a consultation and surgery without delay.
- During the reporting period from April 2016 through March 2017, 41% of patients were NHS-funded. We saw that the patient record included NHS 18 week response time information, which was also highlighted on the electronic patient profile. This meant the hospital could consider response times when scheduling.
- The hospital cancelled ten procedures for non-clinical reasons during the reporting period. All appointments (100% of patients) were rescheduled within 28 days in line with the NHS Constitution pledge.
- Staff described working closely with patients and other medical care providers to support patients after discharge. For instance, staff described calling patients one day and 30 days after discharge to monitor their progress.

Meeting people's individual needs

- The environment on the ward and in the theatres was clean and welcoming. Patients had private rooms which were spacious and designed to feel open. For instance, there were domed ceilings and some rooms over looked a garden. Rooms included a bed, flat screen TV, chairs, sink, patient board and en suite bathroom. The rooms had furniture to accommodate patients and their visitors.
- We saw that there was a child friendly recovery bay in the theatre recovery area which was decorated in a monkey theme. The bay was beside the paediatric resuscitation trolley. There was room for parents to be with their children in recovery.
- We saw that there was an enclosed children's waiting space with children's books and toys in the general waiting area.
- We saw there were disabled toilets throughout the hospital.
- The mandatory training compliance tracker reflected that 66% of theatres staff completed their communication training and 88% completed dementia training. This was below the target of 90% which could mean that staff may not have necessary skills to deal with all patients.
- The hospital had a dementia link nurse who organised dementia care including policy, training, accommodation and equipment. We saw that the

hospital used patient passports and were told the ward had a designated dementia bedroom (we were not able to see this during our inspection as it was occupied by a patient). The room was located next to the nurses' station and staff told us it was decorated with dementia friendly décor.

- The hospital used specialised equipment to help patients living with dementia perceive their surroundings. We saw equipment including blue toilet seats, red rimmed plates, red flatware, date and time clocks, and signs using pictures to communicate all in line with best practice.
- Staff explained that they had only had one patient on the ward who was living with severe dementia. However, the staff used the dementia room and equipment to support other patients with individual needs. For instance, they used the space for one patient with poor vision and another patient who was confused after surgery and benefited from the pictures, date and time clock and being near the nurses' station.
- The hospital had a learning disabilities link nurse who was currently working on the learning disability information folder. We reviewed one patient file for a patient with learning disabilities. The file reflected that hospital staff had considered the patient's individual needs and acted to fulfil them. For instance, they catered for him with familiar food from outside the hospital, ensured his room was arranged in accordance with his wishes and enabled family and carers to stay with him over night.
- Staff told us how patients living with dementia or learning disabilities were able to come to the hospital before admission to meet staff and to see the room they would be staying in.
- Staff told us that they understood interpreters were available, and would know who to contact if they need an interpreter, but they had never had to use this service.
- We saw that there were communication boards on the walls of all rooms in the ward. There was a section where staff could post relevant information and a section where patients could put reminders or questions on the board. This helped to support communications between staff and patients.
- We saw that theatre staff discussed individual patient needs at the theatre briefing so that they could address these needs as required.
- Staff told us the chef met daily with patients to discuss their dietary needs and preferences. The menu included a three course meal but there was also food on offer all day. The menu could be adapted for individual dietary needs and there was an allergy sheet provided daily.Staff gave examples of adaptations they had made for patients for instance, smoothies for a patient with swallowing difficulties and soya based meals for a vegan child.
- Staff described adding stewed prunes to the menu in response to patients' requests for them.

Learning from complaints and concerns

- The hospital followed the corporate complaints and compliments policy, due for review in February 2018. The policy outlined the complaints process and timelines. It encouraged staff to resolve "concerns or comments" when they arose and outlined response times for responding to complaints. It required that the hospital acknowledge complaints within two days and respond within 20 days.
- Staff we spoke to described responding to concerns as they arose. On the ward they said these tended to be issues that could be immediately addressed such as concerns about noise and temperature.
- The hospital had twelve formal complaints from April 2016 through June 2017. There were no themes or patterns across the complaints. None were reopened or escalated for further review. The hospital acknowledged complaints within two days in 100% of complaints and sent a response within 20 days in 83% of complaints.
- Under the complaints policy, the hospital director was directly involved in the complaints process. The director coordinated the response to the complaint and would approve and send the response letter. Complaints documentation we reviewed showed that the manager was directly involved in all complaints and met face-to-face with complainants if they wished; staff verified this.
- Response letters we reviewed were clear and complete, addressed issues raised and apologised for mistakes

Good

Surgery

- We saw learning was taken from complaints and incidents, and causes were logged. Complaints were a standing agenda issue at theatre meetings and were discussed at some ward meetings. Staff reported that learning was shared at meetings and directly between staff.
- Minutes from the April 2017 quality governance committee meeting showed that complaints were discussed and would be a standing issue on their agenda. The notes showed the hospital was not yet benchmarking their complaints rate against national standards but would begin to do so for the next report.

Are surgery services well-led?

Good

Leadership / culture of service

- Staff told us they were aware of the organisational structure and responsibilities. We saw organisational structure charts reflecting that there was a clear reporting structure from staff to the hospital director in both the theatre department and the wards. The Associate Director of Nursing managed the theatre manager and assistant director of nursing directly. The theatre manager managed the theatre team, pre-assessment team and endoscopy manager.The Associate Director of Nursing managed overall the inpatient department, day surgery unit, outpatient department and infection prevention control nurse. These departments were operationally managed by Nursing leads.
- We saw that managers were visible and available in their departments. Staff told us there was an “open door” policy in the hospital and that managers were accessible. They told us managers had been able to help them with the issues they raised but that they felt they could escalate issues if they needed to. We saw information about organisational responsibilities on staff bulletin boards throughout the hospital.
- Staff told us that they had good relationships with their immediate supervisors. They said that they felt comfortable discussing questions or concerns with their supervisors and that the hospital had an open culture. Staff said that they would feel comfortable approaching senior management if they needed to. One staff member commented that the senior managers at the hospital provided more support than she had had from senior managers in other organisations. For instance, they appreciated hand written notes from senior management and the hospital’s international nurses' day celebration.
- Other staff told us that they did not have a direct relationship with senior management but felt important information was provided by immediate supervisors.
- Staff told us that there was a culture of learning and innovation. The hospital encouraged staff to take responsibility for sharing knowledge and information. For instance by encouraging staff to act as leads in areas such as dementia and learning difficulties.
- We saw notes from staff meetings reflecting that relevant topics were discussed at meetings, for example, incidents, documentation, audits and training feedback. Staff told us meetings were scheduled to encourage high turnout. Staff were also required to read meeting notes. Notes were kept in the office with a sheet for each staff member to sign verifying they had read the document. This provided assurances staff had received important information, such as learning from incidents and changes to practice.
- Other written communications were kept in the office including new policies and policy and practice updates. We reviewed the last eight signature sheets for meeting notes and other communications and saw that all staff had signed to acknowledge that they had read all documents.
- The paediatric lead was a consultant who represented the paediatric service on the Medical Advisory Committee (MAC) and the paediatric committee.

Vision and strategy for this core service

- Vision values and strategies were incorporated across the hospital. Staff members we spoke with had an understanding of the hospital’s vision and values and took pride in them. Staff told us how the values applied in their day-to-day work. Staff demonstrated ownership and engagement with regard to the hospitals values.
- The hospital’s values were drafted by staff members before the hospital opened. The values included care, quality, excellence, leadership, innovation, honesty and

value. The vision was drafted based on consultations with staff across the hospital. Staff forums were held to consider staff views on the first draft. The vision was shared with existing staff and new staff were introduced to the vision at their induction.

- The hospital's "One Charter" discussed how those values could be put into action across six elements of patient care: meet and greet, person centred care, communication, equality and diversity, environment and safety and feedback and complaints. The values and vision were incorporated in the One business plan. The strategy for the inpatient department was still forming under a new lead but would incorporate treating all patients the same whether they were funded privately by the NHS and to focus on progressing as a team. This meant improving standards by focusing on nursing strategy and training with input from nurses.
- The theatre department's vision was to better utilise all of the department's recourses as the theatres were not currently engaged throughout the day. They aimed to become better publicized so that the public knew they were in Ashford and increase their reputation in the area.

Governance, risk management and quality measurement

- The hospital used the corporate Risk Management Strategy/ Policy which was due for review in January 2018. This outlined the policy and procedures for risk management.
- The Director of Governance and Support Services was the overall governance lead for the hospital directly reporting to the Hospital Director. They chaired the Hospital Quality Governance Committee which the Hospital Director attended. The Quality Governance Committee reported to the Medical Advisory Committee (MAC) and the One Healthcare Board.The theatre department and wards had managers who attended quality and other committee meetings. This meant that each department fed directly to the governance committee and was engaged in governance.
- The hospital also had a designated consultant governance lead and paediatric lead that were part of the MAC. This ensured there was a clear governance structure to assure the quality of the service and allow for continuous improvement.
- The Senior Management Team (SMT) also shared information at the monthly heads of departments meetings. Once the SMT had reviewed and considered the information, they produced an integrated governance report that was fed upwards to the hospital's quality governance committee for review and feedback.
- There was a process for reporting against the governance framework for all staff at this hospital. There was one open hospital in the One Healthcare group and staff told us the hospital would benchmark with the second hospital One Healthcare intended to open later in 2017. They were also working towards benchmarking with other independent hospitals in the region and nationwide.
- The hospital used online systems to monitor incidents and risks. There was a dashboard showing types of incidents, status and outcome. We saw that after an incident was logged, it was reviewed by senior staff and could only be closed by senior staff after it had been investigated or reviewed. This meant managers and senior staff were aware of all incidents and outcomes.
- Risks were kept on online risk registers for the departments and hospital. Only senior staff had access to the risk register but learning about risks and incidents was shared at team meetings, which was verified by staff.
- Under the policy, there was a quality governance structure in place to monitor performance and risk. All the hospital committees and working groups fed back to the senior management team at the Quality Governance Committee. The April 2017 meeting minutes reflect that the committee was using a new strategy and did not have a set agenda. They were considering agenda items some of which included incident reporting, service feedback, patient safety, risks, policies and guidelines, health and safety, infection control, medicines management, information governance and safeguarding. The senior management team then fed back to the board. This ensured that there was a hospital-wide discussion of risks, and senior management and the board were aware of performance, risks and risk management.
- The hospital kept a risk register for hospital level and departmental level risks. The registers included general

risks as well as risks identified in departments or raised in incident reports. The register outlined information about the level of risks, controls, responsible members of staff, review dates and close dates. This meant that one staff member was responsible for individual risks and risks would be monitored and addressed until they were resolved and closed. The board and senior management team reviewed the hospital's risk register to give oversight and obtain assurances around the management of risks.

- The risk register reflected that the highest risk issue for surgery included operating on the wrong patient due to incorrect operating list. The risk was caused by an issue with changing the list on the computer system. Staff explained they had previously mitigated the risk by changing the lists by hand, but were now able to make the change on the system. We saw the day's updated list. Theatre meeting minutes from the April meeting reflected that the issue was discussed there.
- The second risk related to loading contaminated waste on trolleys. The risk remained on the risk register and was mitigated by educating staff about loading waste trolleys and using two people to move trolleys through the waste pathway. Relevant staff we spoke to verified that they were aware of the risk and how to mitigate it.
- The third risk related to disposal of contaminated waste in theatres. We saw that the risk related to lack of a magnetic lock which meant waste could not be disposed of using the appropriate pathway. We saw that the lock had been changed and the appropriate 'dirty waste' disposal pathway was used at the time of the inspection.
- The hospital had a Medical Advisory Committee (MAC) which met bi-monthly. A MAC is responsible for advising on medical practitioners' accreditation and advising on clinical, practice patient care and safety. The committee included consultants to represent the types of care provided at the hospital and included the quality governance lead .The committee discussed relevant risks, clinical issues and practising privileges as well as business and logistical matters. There was a consultant paediatrician on the MAC committee who could address issues and provide the senior management team with assurances around paediatric care and policy.
- We saw that the Infection Prevention Committee met every other month to discuss a variety of topics such as sharps, antibiotics, infection, waste and audits. The committee was chaired by the hospital director and consultant microbiologist and attendees included the infection control advisor and lead as well as representatives from departments across the hospital. This meant that infection control was addressed at the highest level and staff across the hospital were involved.

Public and staff engagement

- The hospital engaged with staff prior to the hospital's opening so a staff perspective informed the hospital's culture and methodologies.
- Since opening, the hospital had started regular staff focus groups. We saw these advertised and displayed on staff notice boards and on the hospital intranet. This gave the staff a forum and the opportunity to engage with senior management and each other.
- The hospital had daily morning communication meetings attended by staff and senior managers. The day we attended 16 staff members joined. We saw that the meeting had a clear purpose and was a succinct exchange of information.
- Staff we spoke with told us they felt engaged. However, results from the May staff survey reflected that not all staff felt that they received adequate communication from senior staff. Senior staff told us they were discussing the issue to find a means of engaging these staff.
- The hospital encouraged patients to fill out a patient experience survey after their discharge. We were told that the hospital was starting a patient engagement group so the patients' views could be considered in making changes and improvements. We saw that the hospital was preparing to start the group. It had drafted the Terms of Reference for the patient focus group and was advertising for a staff representative from each department to join.

Innovation, improvement and sustainability

- We saw that the hospital provided care in a new, environmentally friendly, building, receiving an award for exceptional sustainable places in December 2016. The hospital benefited from natural light, reused rain water for flushing toilets and energy from solar panels.

Good

Surgery

- We saw that the hospital had begun to add children's services in April 2017. The hospital was providing four to five surgeries per month at the time of inspection but hoped to increase those numbers to 25 surgeries per month. The hospital was committed to increasing its paediatric department to provide paediatric patients with more services.
- We saw that the hospital took pride in working with a local medical charity to provide private care to certain patients who had been waiting for treatment and might not otherwise be able to access private care.
- The hospital was committed to excellence and was preparing to apply for JAG accreditation in April 2019. We saw the hospital's Endoscopy Interim Service Review Action Plan which outlined the actions and timetable for applying for JAG accreditation in 2019. The plan reflected that the hospital was working toward making necessary submissions in October 2018.
- The hospital provided staff with fresh fruit on "free fruit Friday". This showed staff appreciation and encouraged staff to eat healthy snacks.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Incidents

- There were no safeguarding concerns reported to CQC in the reporting period April 2016 to March 2017 for this service.
- In the same reporting period, the hospital reported no never events in this service. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital used an electronic computer system for reporting incidents. Between April 2016 and March 2017, the hospital reported 151 clinical incidents. Of these, 25 related to outpatient and diagnostic imaging services. All were reported as no harm. We reviewed the incident log and did not identify any common themes. Incidents had occurred across different clinical specialities. We saw that two of the incidents involved falls, and that following an investigation the managers fed back to the relevant staff with lessons learned. There was no harm to the patient or staff in either case.
- There was no comparable data for the reported rate of clinical incidents with other independent acute hospitals that we hold this type of data for in the same reporting period.
- Managers and staff we spoke with attributed incident reporting to the open and honest culture supported by the hospital governance committee.This increased staff awareness and better reporting, and there was a “no blame” culture supported by the hospital governance committee. Staff demonstrated how they would access and use the electronic incident reporting system which showed they were confident in using the system. We saw incidents discussed as a standing agenda item in the minutes of the quality governance and Medical Advisory Committee (MAC) meetings.
- There were eight non-clinical incidents reported between April 2016 and March 2017 related to outpatient and diagnostic imaging services. There was no comparable data for the reported rate of clinical incidents with other independent acute hospitals that we hold this type of data for in the same reporting period, as there were less than 10 modelled records.
- We saw ‘thank you’ cards hand written by a senior manager thanking staff for raising incidents. The cards included the outcome of incidents raised and we saw these displayed on staff notice boards. We were given an example of a patient who fell at the hospital entrance. The patient was assessed by a doctor and suffered no harm. Staff were able to describe the outcomes of the investigation and recalled the lessons learnt. Staff explained that key learning outcomes from incidents were shared at departmental meetings and information related to this was accessible to all relevant staff from the hospital intranet. We saw this documented in the staff meeting notes from November 2016 and March 2017, and in the heads of departments meeting notes dated February 2017.
- There was no incident reported to the Care Quality Commission concerning the Ionising Radiation (Medical

Exposure) Regulations 2000 (IR(ME)R) within the reporting period. Staff we spoke with described the process for reporting IR(ME)R incidents if they occurred and explained they would be fully investigated including taking any actions if required.

- We saw that for patients who had undergone scans and magnetic resonance imaging (MRI) procedures, the hospital used an adaptation of the WHO safety questionnaire and verbal safety checks were made by staff prior to their scans. This helped to assure that potential risks were identified and acted upon.
- Duty of candour (DoC) is a statutory requirement under the Health and Social Care Act (Regulated Activities Regulations) 2014 for healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person. Staff we spoke with understood that the DoC legislation is about being open and honest. Staff gave an example of an information recording error. Even though the patient did not experience harm, staff apologised and explained to the patient what went wrong. We saw the hospital training records that indicated DoC was included in mandatory training for all staff. We saw a poster displayed on the staff notice board describing the process to follow should DoC apply.

Cleanliness, infection control and hygiene

- Overall, the outpatient and imaging departments complied with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015).
- There were no infections of Meticillin-Resistant Staphylococcus aureus (MRSA) in the outpatients department during the reporting period, between April 2016 and March 2017. MRSA is a type of bacterial infection, which is resistant to many antibiotics and is capable of causing harm to patients.
- There were no infections of Meticillin-sensitive Staphylococcus aureus (MSSA) relating to the outpatient department during the reporting period. MSSA is a type of bacteria in the same family as MRSA, but is more easily treated.
- There were no infections of Clostridium difficile (C.diff) relating to the outpatient department during the reporting period. C. diff is a type of bacteria that can infect the bowel and cause diarrhoea.
- There were no infections of Escherichia coli (E.coli) relating to the outpatient department during the reporting period. E. coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness, and other illnesses.
- All areas we visited were tidy, clean and uncluttered. We looked at cleaning checklists for the period of three months prior to our visit which showed that the consulting rooms were reported to have been cleaned daily including dusting of desks and surfaces, floors and restocking of dispensers. Our findings were consistent with the department infection prevention and control environmental audit compliance rate, which showed 92% for cleanliness in December 2016. This was better than the hospital compliance target of 90%.
- The consulting and treatment rooms had flooring which allowed effective cleaning and removal of body fluid spillages. All 13 rooms had seamless, smooth and slip-resistant flooring. This was compliant with the Health Building Note 00-09 (HBN 00-09): Infection control in the built environment (Department of Health, March 2013). All the rooms were visibly clean and free from stains.
- We saw disposable curtains fitted in the consultation, physiotherapy and imaging areas. Each had a label showing the curtains were changed within the last three months. According to HBN 00-09, using disposable curtains that are routinely changed helps to reduce bacterial cross contamination.
- We saw 'I am clean' labels on equipment, which indicated the date the equipment had been cleaned. This meant that equipment was cleaned and ready for use.
- HBN 00-09 states, "There needs to be a clear demarcation between clean/unused equipment and soiled/dirty equipment. Clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined". We saw clean and dirty equipment separated and stored appropriately in clean and dirty utility rooms.

Good

Outpatients and diagnostic imaging

- Staff completed infection prevention and control (IPC) training as part of their annual mandatory training programme. As at April 2017, data provided to us showed 100% completion rate for all clinical and non-clinical staff for this service.
- We observed that all medical and other staff had worn clothing bare below the elbows to reduce the risk of infection to patients. This was consistent with the hospital standard infection prevention and control precautions policy.
- Hand sanitiser was available in each consulting room and all waiting areas, and we saw staff using the product. During our inspection, the infection control link nurse told us that hand hygiene compliance was monitored bi-weekly using an observational hand hygiene tool adapted from the WHO's "5 Moments for Hand Hygiene". We saw the observational audit report for the hospital in quarter three showed 100% compliance for the outpatient and imaging departments. We also saw posters displaying the "5 Moments for Hand Hygiene" above each hand wash basin in all the consulting and treatment rooms. This acted as a reminder to staff the need for hand hygiene.
- Hand washbasins were installed in all clinical areas. These were medium or large integral basins with sensor taps that were touch free, and had no plugs. This helped to reduce the risk of spreading infection and complied with the Health Building Notes (00-10 (2013): Part C – Sanitary assemblies).
- We saw bins for the disposal of sharp objects were available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. All the bins we saw were closed with temporary lids, clearly marked and placed close to work areas where medical sharps were used. Staff had completed labels on the bins which ensured traceability of each container. We saw the sharps audit completed in December 2016 showed 100% compliance for outpatient and imaging departments. We saw this discussed in the staff meeting minutes.
- Waste in outpatient and imaging areas was separated in different coloured bins to identify categories of waste. This allowed the hospital to safely handle biological or hazardous waste and was in accordance with HTM 07-01, Control of Substance Hazardous to Health (COSHH) and Health and Safety at Work Regulations.
- We reviewed the outpatient department's toy cleaning checklist for the five months before our inspection. We saw that staff had cleaned toys daily whenever they were used. Toys in the waiting area and consulting room were visibly clean. This showed staff had cleaned the toys and followed hospital policy.
- An infection control link person was nominated for each area and their activities coordinated through an infection control sub-committee of the Quality Governance Committee. We saw examples of completed infection control audits. These audits helped managers and staff to assess the effectiveness of their infection control measures and to identify any areas that might require improvement.

Environment and equipment

- The outpatient and imaging environments we observed supported the safe delivery of diagnosis, treatment and care. For example, consulting rooms were secured, well lit, air-conditioned and equipped with appropriate levels of sterile consumables held in covered trolleys and storage racks.
- There was one consulting room specifically designed and dedicated for children. We saw age appropriate toys available in the consulting room and a play area within the room had age appropriate table and chairs. These were visibly clean, tidy and uncluttered. Our findings were consistent with the completion of toy cleaning checklists we saw five months prior to our inspection.
- All rooms were fitted with security call alarms so emergency assistance could be summoned if required.
- We saw staff using personal protective equipment (PPE) such as gloves and disposable aprons in all areas visited. PPE including all sizes of gloves were readily available in each clinical area. We also saw radiation protection equipment such as lead aprons and glasses were available in the imaging department.
- Outpatient and imaging staff had access to emergency equipment including oxygen and resuscitation items for adults. Staff also had access to paediatric resuscitation items including pulse oximeters and weighing scales.

There was a paediatric resuscitation medicines bag in the resuscitation trolley in outpatients. We observed this was sealed and all medications were in date. We saw evidence that staff inspected and checked the defibrillator and suction daily and other equipment on the resuscitation trolley weekly.

- We saw a total of 34 items of equipment and service records, and all the equipment had regular service maintenance, calibration and safety checks. This followed the Medicines and Healthcare products Regulatory Agency (MHRA) Managing Medical Devices April 2015 guidance , which states the provider must "ensure that devices are regularly checked for functionality prior to use by the user in line with the manufacturer's instructions and throughout the expected lifetime of the device".
- Staff told us they had access to equipment to help with lifting patients with limited mobility, such as from a wheelchair to an examination couch. This was stored within the physiotherapy department but the equipment was not frequently required in the outpatient department.
- In the imaging department, we saw a number of installed features designed to prevent or minimise accidental exposure to ionising radiation or magnetic fields. Doors were fitted with electronic interlocks to prevent access when the equipment was operating. Emergency stop buttons were clearly positioned in the rooms and illuminated warning signs were fitted to doorways which lit automatically when the interlock was turned on. Key control systems fitted to the imaging devices helped to prevent uncontrolled or unauthorised use. We saw records that confirmed these protective measures. The facilities were registered with the health and safety executive (HSE) and audited annually by an HSE approved radiation protection adviser (RPA).
- There was prominent signage outside the MRI suite to warn patients with pacemakers or other surgical devices not to enter due to the powerful magnetic field generated. Signs advising women who may be pregnant to inform staff were clearly displayed in the x-ray area, in line with best practice. Pregnancy tests were completed to confirm status for relevant procedures. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.
- Single use items of sterile equipment were readily available and stored appropriately in all areas checked. All items we saw were in date, such as syringes and wound dressings. Correct storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination reduced. We saw examples of single use items being used once and safely discarded after use.
- Instruments used for patient treatment that required decontamination and sterilisation were handled through an external sterile supplies contractor.

Medicines

- The hospital had no pharmacy dispensary on-site. All pharmacy supplies were from an external pharmacy supplier. However, the hospital pharmacy team was readily available to offer support and advice to both staff and patients, maintained adequate stock levels, and dispensed prescriptions in a safe and timely manner. Appropriate security procedures were in place to ensure only approved staff could access medicines, and these arrangements were clearly communicated to relevant staff.
- Medicines in outpatients and imaging were stored in locked cupboards. Registered health professionals held the keys. This was in line with standards for good medicines management and prevented unauthorised access to medicines. Pharmacy staff described a comprehensive process of receiving Medicines and Healthcare Regulatory Agency (MHRA) and NHS Patient Safety Alerts and these were actioned and cascaded appropriately. We saw meeting minutes showing these were discussed at quality governance meetings.
- We saw systems implemented to check for date-expired medicines and unused contrast medium and to rotate medicines with a shorter expiry date. All the medicines we looked at were within the expiry date.
- In the outpatient department, each consulting room contained a copy of the British National Formulary (BNF) Issue 73 March to September 2017, which was the latest edition in print. We also saw a copy of the latest edition British National Formulary for children (BNFC) September 2016 to 2017 kept in the consulting room dedicated for children. The BNF is updated in book form twice a year and the BNFC annually, and details all medicines that are generally prescribed in the UK, with

information about indications, dosages, contraindications, cautions and side effects. It is considered an essential resource for safe prescribing and the availability of the latest copy indicated that an appropriate level of support was provided to the consultants in clinics.

- Doctors hand wrote prescriptions on private prescription (FP10) forms. We saw each prescription had a serial number on it. Doctors could request individual prescription forms during clinic sessions and a registered nurse would then issue the form.We noted unused prescriptions were checked and stored in a locked drawer at the end of clinic. This reduced the chance of prescription forms being lost or stolen.
- We saw that medicines requiring storage in atemperature-controlled environment were held in designated fridges. These were locked andincorporated digital thermometers with a clear display that allowed temperatures to bemonitored. We saw completed ambient room and fridge temperature checks recorded daily on a standardised form between February and May 2017, all were within range. Staff we spoke withdescribed the process for dealing with out of rangetemperatures and included reporting any issues as an incident onthe electronic reporting system
- The hospital used an electronic system for requesting x-ray, MRI or other diagnostic tests. We saw that the system provided for authorisation. This meant that imaging requests made by GPs or other practitioners were only made by approved persons in accordance with the Ionising Radiation (Medical Exposure) Regulations also known as IR(ME)R.
- The imaging service followed a corporate policy designed to detect and prevent contrast-induced nephropathy (CIN), which is kidney injury in susceptible individuals caused by the use of contrast media in imaging. We saw staff used safety questionnaires which enabled the doctors to check for CIN. Imaging staff we spoke with described appropriate actions they would take in the event of any allergic reactions. This followed the Royal College of Radiologists Standards for Intravascular contrast agent when given to patients.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- The hospital provided information that showed no patients were seen in outpatients without all relevant medical records being available in the reporting period. Staff we spoke with confirmed these figures. There was no comparable data with other independent acute hospitals that we hold this type of data for in the same reporting period, as there were fewer than 10 modelled records.
- We reviewed four patient records for adults who had minor procedures. In all four sets of records, we saw staff followed specific procedure pathways. All four pathway checklists had legible entries, were signed and dated in line with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance.
- All four of the patient records for adults we saw contained evidence of the doctor's treatment notes and consent forms were filed. All entries were legible, signed and dated. This meant that patient records were complete and contemporaneous. This was in line with the completion of accurate and contemporaneous medical records which formed part of the practising privileges agreement for all consultants, who were also registered data controllers with the Information Commissioning Office (ICO) as part of this agreement.
- We reviewed three patient records for children and young people who had minor outpatient operations. In all three sets of records, we saw staff followed specific procedure pathways. Children aged three to 16 years had a risk assessment before any imaging or minor outpatient operation. In the records we reviewed, we saw evidence of risk assessments where applicable. Overall, we saw an appropriate standard of documentation for children and young people patient records. We saw staff had signed and dated all entries in line with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance.
- We saw patient records securely stored in locked storage when not used which meant that only authorised staff were able to access them. This included records for patients who were seen for consultation only. The key to the locked storage was held by the nurse in charge.

Safeguarding

- The hospital safeguarding lead for children and adults was the hospital director and the associate director of

nursing was the deputy lead. Both had completed levels four and three safeguarding training, respectively. Staff we spoke with demonstrated a good awareness of what to do if they had safeguarding concerns and could identify the children's and adult's safeguarding lead.

- We saw the hospital's safeguarding policies were introduced for children in August 2016 and for adults in February 2016. The policies were accessible in the outpatients' adults and children policy folders, including staff signature sheets that showed staff had read the policy.
- We saw data that 100% of outpatient and imaging staff had completed adult safeguarding training levels one and two. This was better than the hospital compliance target rate of 90%. This indicated staff had the knowledge to identify vulnerable adults and appropriately report concerns when required. This followed the hospital safeguarding adults at risk policy.
- The hospital additionally had two paediatric safeguarding leads. A consultant, trained to children's safeguarding level four, and a paediatric nurse, trained to children's safeguarding level three. The hospital training matrix demonstrated 100% of required outpatient and imaging staff had completed children safeguarding training levels one and two.
- At the time of inspection, only 50% of required staff had completed children safeguarding training level three. Staff explained that training was scheduled to be completed by July 2017. Further, they told us there was always a level three safeguarding trained staff member involved in care (a paediatric nurse) when paediatric patients attended outpatient, imaging and physiotherapy appointments. The service held dedicated clinic days for children to ensure appointments were only booked when paediatric nurses were available. All consultants consulting and treating children had level three safeguarding training. We saw that the paediatric nurse was directly involved in the paediatric minor operations list.
- After the training was completed the hospital submitted information which reflected 100% of required outpatient and imaging staff had completed children safeguarding level three training. This meant all outpatient and imaging staff who treated children held an appropriate level of safeguarding training in line with the national intercollegiate guidance, "Working together to safeguard children" (March 2015).
- We saw safeguarding was discussed and was a standard agenda item in the April 2017 quality Governance Committee meetings minutes the hospital provided. We saw examples of discussions such as ensuring staff who were involved in caring for children to complete safeguarding children level three training. We saw representatives from this hospital participated in the regional safeguarding network for independent and NHS hospitals. This was documented in the minutes of the Kent and Medway safeguarding network meetings held in November 2016 and February 2017.
- We saw completed risk assessment forms for children who needed minor interventional procedures, such as allergy testing. The registered children's nurse, who had level three safeguarding training, performed all risk assessments for children who needed to have a procedure. Staff we spoke with told us procedures were not delayed as there were dedicated children's clinic days always attended by the children's nurse.
- We saw a chaperone policy for older children or adolescents who attended outpatient and imaging appointments without a parent or guardian. Staff knew how to access the policy and gave examples of circumstances in which they may need to apply it. However, staff also told us most children attended with their parents. In all the children's records we reviewed, we saw that a parent or guardian had accompanied their child. We saw posters with information about the chaperone process were displayed in all of the consulting rooms we visited.

Mandatory training

- All staff completed mandatory training using online learning and face-to-face training. This included modules in life support, fire safety, infection prevention and control, safeguarding children and adults, health and safety, and equality and diversity.
- We were shown data that indicated outpatient staff achieved 91% compliance with completion of mandatory training which was a higher rate than the hospital target of 90%. Compliance rates were monitored and we saw future training dates planned for

staff that needed to finish their mandatory training. Staff were also advised to attend refresher training when necessary. We saw training compliance was reviewed regularly as part of a standing agenda item in departmental meetings and was recorded in the minutes between November 2016 and March 2017.

- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested. Staff told us there were no barriers to completing training and they were given protected time to complete training.

Assessing and responding to patient risk

- Immediate or emergency assistance from the hospital resuscitation team could be summoned by the use of the "crash call". Medical assistance was provided by the resident medical officer (RMO) and the senior nurses.
- Where patients required specialist emergency care, there were clear protocols in place for the transfer of patients to the local NHS accident and emergency facility by ambulance. Staff we spoke with described what they would do when specialist emergency care was required and this was in line with hospital policy. We saw the hospital had a children retrieval service arrangement with an NHS hospital trust in London which meant that critically ill children could have immediate specialist ambulance transfer to the trust if required.
- We saw a hospital "walk-in walk-out outpatient safety checklist" based on the World Health Organisation (WHO) Surgical Safety checklist used for minor procedures in the outpatients department. This included 'sign in' checks where the patient identity and minor operative site was confirmed and 'sign out' checks where the instruments used were counted back and any specimens were labelled and sent to the laboratory. We saw the adapted version of the checklist used for patients who had a minor procedure in outpatients during our review of patient records.
- We saw measures in place for reducing exposure to radiation in the diagnostic imaging department. For example, up-to-date local rules were available in every imaging area we visited and signed by all members of staff, which indicated they had read the rules and understood their responsibilities. We also noted imaging protocols and policies stored in folders in each room and staff demonstrated a clear understanding of these protocols.
- We observed good radiation compliance during our visit. The department displayed clear warning notices, doors were shut during examinations and warning lights were illuminated. We saw radiographers referring to the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R for patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor was contactable if required, which complied with IR(ME)R.
- The radiation protection advisor performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks. This helped to assure the hospital that imaging equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IRMER 2000. We saw records of these checks during our visit.
- Lead aprons limit exposure to radiation to keep patients safe. We saw lead aprons available in all appropriate areas of the imaging department. We saw evidence which showed checks of the effectiveness of their protection occurred regularly and equipment provided adequate protection as per regulations.
  Managers we spoke with told us they calculated nursing staffing levels dependent on the number of clinics and the numbers of patients attending clinics as well as other factors such as procedure support and chaperoning.
- Registered nurses and healthcare assistants (HCAs) staffed the outpatient clinics. Staff told us that either overtime was paid or a bank nurse called in when required. We saw sufficient staff to meet patients' needs present during our inspection.
- Hospital data showed sickness rates for outpatient registered nurses and HCAs were variable from April 2016 to March 2017.There was no staff sickness rate for the months from April to August 2016 and March 2017. The hospital reported no unfilled shifts from July to September 2016. There was no comparable data with

other independent acute hospitals we hold this type of data for in the same reporting period. This meant the service had sufficient nursing staff on all shifts to provide appropriate care and support.

- The rate of outpatient nurse and health care assistant turnover was 4.1% between April 2016 and March 2017. This represented 0.20% of one full time equivalent (FTE) member of staff. There was no comparable data with other independent acute hospitals that we hold this type of data for in the same reporting period. This meant the team was stable and experienced. The outpatient manager stated that nursing retention was due to positive factors such as development and promotion.
- The use of bank and agency nurses and health care assistants in outpatient departments was variable from April 2016 to March 2017. There was no use of bank and agency staff from April 2016 to August 2016. The use of those staff for the months September 2016 to March 2017 was variable between one percent and 18%. We were told the reasons were due to staff annual leave entitlement and sickness.
- There was no staff turnover within this area in the last 12 months and sickness level was low.

Medical staffing

- RMOs working at the hospital had advanced children life support (APLS) training. This ensured the hospital always had a member of staff with APLS training on the premises to respond to any emergencies involving children. We also saw training records, which provided evidence of in-date children advanced life support (EPALS) training for the children's lead nurse.
- Radiology consultants were on-site during clinic hours to manage urgent work and the reporting requirements for the hospital. The service used image-sharing computer software to access results.
- Outpatient clinics were timetabled to suit each consultant's availability and obligation as part of the consultant's practising privileges contract. Staff told us consultants in clinics were assisted by the RMO in cases where urgent or additional medical support was required. During our inspection we did not observe this as it was not required.

Emergency awareness and training

- Staff described participating in regular medical emergency simulations, for example cardiac arrest and reported the learning experience in positive terms.
- We saw an in-date version of the policy for managing radiation incidents. This demonstrated that the hospital had considered potential risks to safety and had prepared responses for any such eventuality.
- We saw a current version of the business continuity policy which was issued in March 2017.
- We saw action cards in the event such as a flood, fire or electrical failure in the hospital business continuity policy. This showed clear processes for staff to follow in the event of a flood or fire.
- The hospital participated in the region's emergency planning team and was the only independent hospital that was part of this group. Staff provided an example of a recent simulation exercise of an unattended box which was left at the hospital reception area.

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate, the effective domain.

Evidence-based care and treatment

- Policy documents were updated regularly by One Ashford and issued for implementation. These were available on the hospital intranet as well as in the policy folder located in the outpatient and imaging staff offices.
- We also saw local policies and standard operating procedures such as consent, management of medicines and emergency evacuation. We saw how policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. New national guidance was disseminated through head of departments monthly by the hospital governance team. These were assessed for their relevance by the Medical Advisory Committee (MAC) and cascaded, including to Consultants. This meant that staff had evidence-based and clear instructions to follow to provide safe care.
- Staff followed the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists

standards in the speciality areas we visited. We saw evidence of checks and audits demonstrating the department monitored compliance with these guidelines which meant that staff provided safe care to patients.

- Audits included environmental, medicines management, hand washing and infection control checks and the results of these were shared among staff. We observed examples shared on staff notice boards and in departmental meeting notes.

Pain relief

- The outpatient department had no medicine dispensary on site. However, patients were given prescriptions if pain relief was required.. Staff told us medications requiring prescription were prescribed by doctors only.
- The hospital used a pain assessment tool where adult patients were asked to score discomfort based on a range from 0-10. Staff told us that they did not get many patients who attended outpatients who reported they were in pain and used the pain assessment tool as required. We did not see the tool used by staff at the time of inspection as none of the patients reported discomfort.
- The hospital used age appropriate tools for the assessment of children's pain. We saw a pain assessment scale staff used in the physiotherapy department. The chart had pictures of faces so that young children could easily report their level of pain. The use of a pain scoring system allowed staff to give appropriate medicines or support with alternative pain management techniques and review the effectiveness of the intervention.

Nutrition and hydration

- Patients were assessed for malnutrition when they attended outpatient appointments. We saw weights recorded in all four adult and three child patients records. None of these patients were malnourished, but had access to dietetic support if required.
- Staff told us that patients would be offered a choice of sandwiches after a minor procedure if required.

Patient outcomes

- The hospital also used a computerised reporting system to provide data on patients who required re-admission, transfer to another hospital, unplanned return to theatre, infections, incidents relating to a thrombolytic event or other significant events. Details of this were outlined in the surgery report.
- The hospital participated in the National Joint Registry (NJR), Public Health England (PHE) Infection Rate audits, and recently commenced Patient Reported Outcome Measure (PROMS) audits. However they were not yet able to benchmark against national averages.
- The hospital was a member of the private healthcare information network (PHIN) which requires the submission of certain data. The hospital reported it was in the process of submitting data and had been working toward PHIN requirements.
- In outpatients, we saw examples of physiotherapy outcomes listed in electronic records. Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and the quality of life measures in order to establish the effectiveness of treatment. As of June 2017, data we saw demonstrated most of the patients had improved mobility and decreased pain and discomfort.

Competent staff

- All new staff had an induction package, which included core competencies and knowledge that was signed off by their line manager. We saw examples of this in the staff files for nurses and radiographers we reviewed.
- Data provided by the hospital showed 100% validation of professional registration for doctors practising under the rules of privileges in the reporting period from April 2016 to March 2017. We saw data also showed 100% validation of professional registration of nursing staff.
- Hospital data showed 82% of registered nurses and healthcare assistants received a performance appraisal, as of June 2017. During our inspection we saw the remaining 18% of staff had dates booked to complete their appraisals. We saw staff files contained evidence of regular performance meetings between appraisals. Regular reviews and appraisals allowed the hospital to identify, monitor and support staff performance and personal development.
- There was a clearly defined performance management system in place. Concerns about staff performance were

initially dealt with through informal discussions documented in the staff file. If concerns continued, the formal process was triggered in consultation with the human resources lead supported by a third party human resources support partnership. We were told this had never been necessary for this service.

- There were processes in place for confirmation of practising privileges. Consultants were offered practising privileges by the MAC only after thorough interviews and HR had received the necessary assurance documentation.
- All appraisals were shared by the consultants following their appraisals with the NHS trust in which they worked. Where the hospital director provided information for NHS appraisals, this routinely included data relating to that consultant's practice such as surgical site infections, complaints and morbidity and mortality. The data also included outcomes collected by the hospital as part of their regular practising privilege reviews.
- In the imaging department, we saw evidence of a competency and induction folder for new and bank staff. This meant that new and bank staff could integrate safely and efficiently into the workforce.

Multidisciplinary working

- We saw effective multi-disciplinary working between all professions and grades of staff. This included housekeeping, catering and pharmacy staff.
- There was consistent evidence of close collaboration across different services within outpatients and diagnostic imaging. We saw imaging staff discussed with the reservation team how they could arrange suitable appointment times for patients to be seen straight after an outpatient appointment. Staff told us they felt well supported by other staff groups and there was good communication within the teams. We saw a physiotherapist communicating with an outpatient nurse about a patient's treatment plan.
- We heard positive feedback from staff at all grades about the good teamwork within the hospital generally.

Access to information

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet and we were shown examples. Computer terminals were located in all consulting rooms and offices to enable staff to do this. Staff were generally positive about the hospital's intranet and reported managers communicated effectively with them via e-mail.
- The imaging department used picture archiving and communication system (PACS) technology. This enabled the hospital to quickly store, retrieve, distribute and view high-quality medical images. This meant the hospital was able to provide rapid electronic access to diagnostic results. For example, the department was able to share images with radiologists at the local NHS hospital, if the need arose.
- The imaging department had a system in place for radiologists to urgently communicate any unexpected findings with GPs. Radiology staff would contact GPs by telephone and staff we interviewed told us this system worked well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw "One Healthcare parental agreement to investigation or treatment for a child or young person" forms. Parents or legal guardians signed these consents on behalf of children who were not competent to provide consent. We saw these forms also had a space for children to sign as well as the parent to show their involvement in decisions about their treatment. The associated guidance stated, "It is good practice when a person with parental responsibility signs the consent form to involve the child in the decision making and to allow them to countersign the consent form where the child's level of development allows".
- Consultants took consent and assessed Gillick competence for young people under the age of 16 if required, the statutory process for assessing that young people under the age of 16 were competent to make decisions about their own care and treatment should they not wish to involve their parents. We reviewed three patient consent forms for children and young people. These showed staff had obtained consent appropriately in line with the appropriate legislation and guidance.
- We reviewed four patient records for adults who had minor procedures. All four records contained a minor procedure pathway form that was completed which

stated, “Consent form completed”. We saw all four records contained consent forms. This meant there was documentation of a patient’s agreement to the intervention and the discussions which led to that agreement. All entries were legible, signed and dated, and included the doctor explaining the benefits and risks of the procedure to the patient. This showed staff followed the One Healthcare consent policy.

- We observed examples of verbal consent demonstrated by patients undergoing diagnostic imaging in the x-ray room.
- The provider had a policy to guide staff in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA) which included Deprivation of Liberty Safeguards. We saw this in the policy folder kept in the outpatient staff office. Staff we spoke with demonstrated awareness of how the Mental Capacity Act 2005 related to their practice and were aware of who to contact if they required guidance.
- However, the One Healthcare consent policy stated, “One Healthcare hospitals do not treat children under 18 years of age”. This was incorrect as the hospital began treating children in April 2017. Further, the policy included “One Healthcare parental agreement to investigation or treatment for a child or young person” consent form. This was confusing and indicated the policy was out of date.
- As of June 2017, we saw the One Healthcare clinical policy “Procedure for the care of children and young people at One Ashford” showed an issue date of “December 2017”. This was confusing and indicated the policy had yet to be issued. This meant staff would not know if they had to follow the policy for treating children and young people before or after the issue date.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

- The hospital carried out an internal survey that was an adapted version of the NHS Friends and Family Test (FFT). An external contractor distributed the survey and analysed results. The score from January to March 2017 was 99%, with a response rate of 19%. There was no comparable data with other independent acute hospitals that we hold this type of data for in the same reporting period, as there were less than 10 modelled records. The NHS FFT was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS. The hospital told us further work was being carried out to improve the response rates to 35%. We saw this documented in the hospital quality account issued in April 2017.
- We received 37 comment cards from patients who attended the outpatients, imaging and physiotherapy departments. The comments were positive and praised the hospital staff, environment and facilities. Comments about staff included "good, clean, professional”, “every time I visit, I am greeted by warm friendly smiles. Exceptional service by all in every aspect”, “clear explanations and felt informed at all times” and “excellent care and facility”. Patients who used the physiotherapy service commented, “very happy with the service I received, nothing was too much trouble excellent customer service” and “everyone from reception to physio very helpful, treated me very well”. Patients who attended the imaging service stated, “treated with dignity and respect at all times, able to book MRI appointment quickly, able to provide food avoiding intolerances”, “I got to ask a lot of questions and they answered them all” and “staff were very attentive, environment was pleasant and welcoming”.
- Patients told us that staff and their consultants explained things in detail and allowed time for any questions.
- In the imaging suite, we saw staff ensuring that patients’ dignity was maintained despite the need to wear examination gowns during the process. We also saw curtains were drawn around a cubicle in physiotherapy department which provided the patient privacy and dignity during their treatment.
- We saw posters displayed informing patients of their right to request a chaperone for any consultation, examination or treatment. Staff told us it was not

Good

Outpatients and diagnostic imaging

frequent a chaperone was requested. However, when required they offered patients a chaperone before any examination or procedure and were able to anticipate requests based on the clinic schedule.

- We observed staff were friendly and professional when they spoke with patients. We observed all staff were approachable and greeted patients and visitors with "hello my name is". We saw staff were polite and respectful of confidentiality. Patients were able to have conversations with staff without being overheard and minimal patient identifiable data was discussed.

Understanding and involvement of patients and those close to them

- Staff photographs and names were clearly and legibly displayed on noticeboards at the entrance into the main waiting area and outpatient departments. This helped patients and visitors identify key staff encountered during their visit.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need. Patients reported that staff and consultants were approachable and took time to provide an explanation and this made them feel part of the decision-making about their treatment and care.
- Patients we spoke with told us they were informed about the fees for their consultation before their appointment. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.

Emotional support

- We observed relatives were invited to accompany patients into consultation rooms, which indicated that the hospital encouraged a friend or partner to attend the appointment in order to provide emotional support.
- Staff we spoke with told us they were able to access counselling services which provided confidential emotional support if required.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- A range of outpatient clinics were made available to meet the needs of the client group. According to data the hospital provided, this included orthopaedics, ear, nose and throat (ENT), gynaecology, dermatology, gastroenterology, neurology, urology, ophthalmology, cosmetic surgery, general medicine and rheumatology. Orthopaedics was the most attended clinic.
- These outpatient clinics were supported by diagnostic imaging services including Magnetic Resonance Imaging (MRI) scans, x-ray and ultrasound scans. These facilities supported consultants in clinical decision-making.
- Evening and Saturday outpatient clinics were routinely offered, which afforded additional choice and convenience to patients.
- The environment provided by the hospital met the needs of the patient, with comfortable seating, toilets and refreshment facilities. We also saw many free car park spaces were provided on-site during our inspection.
- The outpatient waiting area had a café which offered patients, children and parents a choice of refreshments while they waited for their appointment.
- The hospital had children retrieval service arrangements with the local hospital in emergencies and a London hospital for specialist services. This meant that critically ill children could have immediate specialist transport to those hospitals if required.

Access and flow

- GPs referred the majority of new NHS and private patients who used the service. We were told referrals were also received from physiotherapists and other registered healthcare practitioners. A patient we spoke with confirmed this.

Good

Outpatients and diagnostic imaging

- Between April 2016 and March 2017, no patients waited six weeks or longer from referral to receive appointments for MRI, x-ray or ultrasound tests.
- Patients we spoke with said they had their first appointment within days of referral. They also reported that they did not wait long to see a nurse or a doctor when they attended for a clinic.
- Staff arranged follow up appointments in line with consultant and patient needs.
- Opening hours for outpatient clinics varied. Specific clinics were held on different days and times to ensure there was provision to suit patients' availability.
- Staff told us delays in outpatients did not happen often and we saw appointment lists that supported this. This was consistent with the examples on audits of wait time on patients' arrival at outpatients for the past six months we saw. Staff and managers expressed strong commitment to the efficiency of the departments and gave examples of their responses when clinics ran late. Patients were kept informed and personal apologies made when there were delays.
- If a clinic appointment ran behind schedule staff provided patients with refreshments. During our inspection, there were no delays and we did not see staff offering refreshments in the department.

Meeting people's individual needs

- Hearing loops were available in the waiting area, which helped those who used hearing aids to access services on an equal basis to others.
- We saw details of a telephone interpretation service used by the hospital. Staff we spoke with told us they had not needed to use the service. However, they were able to describe the service and knew who to contact if required.
- We observed the waiting room and clinic areas were accessible to all people including wheelchair users. This included level access and automatic doors from the car park and throughout the departments. Physiotherapy appointments were provided on the first floor and we saw this was accessed by a lift which was also suitable for wheelchair users.
- The outpatients department had toy boxes and books available in the dedicated consulting room for children and waiting area to provide distraction and comfort to children. We saw three different toy boxes and books for different age groups that were suitable for toddlers and slightly older children.
- We saw adults and children had separate waiting areas in an open plan environment, resulting in the provision of privacy and dignity for both groups. This arrangement minimised the risk of abuse as waiting areas were often left unsupervised. Staff we spoke with told us that they always encouraged adults to supervise their children. We saw posters displayed in the children waiting area to act as a reminder.
- We observed all seats in the waiting area were suitable for bariatric patients. Bariatricsis the branch of medicine that deals with the causes, prevention, and treatment of obesity. This allowed bariatric patients to sit anywhere they chose.
- The hospital had a dementia champion who took a lead role on dementia education. Staff were encouraged to undertake training, which was offered by the hospital dementia champion. Staff we spoke with demonstrated a good understanding of caring for patients living with dementia.
- We were provided with examples of when staff distributed a "this is me" document and provided to patients during pre-assessment appointments. This document was created by the Alzheimer's society and the Royal College of Nursing. It is completed by the patient, their family or carers prior to admission. It has specific headings identifying the different needs or preferences of a patient. This meant staff were able to gain a deeper and more personal understanding of patients' needs if they are unable to effectively communicate them. We saw the hospital "Living with Dementia Strategy" paper which promoted this.
- We saw a variety of literature and patient information leaflets produced by an external contractor with reference to professional healthcare organisations, throughout the outpatient, imaging and physiotherapy departments. These were available to help patients understand their condition and treatment, and were available in larger print for people with visual impairment.

Good

Outpatients and diagnostic imaging

- Staff told us that patients were given an opportunity to view the different hospital areas prior to outpatient appointment and / or admission to become more familiar with the surroundings and to meet staff who will be caring for them during their inpatient stay.

Learning from complaints and concerns

- Complaints were discussed at the head of department daily briefings and departmental meetings. They were also reviewed at the quarterly quality governance committee meetings. Complaints were also discussed at quarterly MAC meetings.
- The hospital received 12 complaints from April 2016 to March 2017. The assessed rate of complaints per 100 inpatient and day case attendances was 0.67. Only two out of the 12 complaints were related to outpatient and imaging departments; both cases were resolved at a local level and were not escalated to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Staff at all levels described an open and honest culture and a willingness to accept responsibility for any shortcomings.
- There was a robust system in place for capturing learning from complaints and incidents. The senior management team "signed off" every complaint, which was logged onto the incident reporting software. Anonymised complaint logs were used to help inform all staff and changes to practice were fed back through the heads of departments to frontline staff.
- All written complaints were acknowledged within two days of receipt. The acknowledgement letters would confirm the hospital director's understanding of the complaints and the complainants were invited to a face-to-face meeting with the appropriate staff to resolve matters quickly. If further investigation was required, this was within a 20-day timescale in accordance with One Healthcare policy. We saw two written complaints related to outpatient and imaging departments and noted both acknowledgements and responses were within the time scale set by the policy.
- Concerns raised in comment cards were acted upon. The hospital director discussed any concerns or complaints with the departmental manager as soon as possible. The imaging department manager provided us with an example where the hospital did not offer a CT scan service. The hospital wrote a letter of apology to the patient, acknowledged what had gone wrong and explained that CT scans were offered to patients at local hospitals most convenient to them. The patient was satisfied with the outcome. This was consistent in both complaints we looked at.
- Managers we spoke with told us where complaints involved clinical care, a consultant not directly involved with the patient's care carried out the investigation.
- All complaints were reported via the hospital reporting structure. This enabled all staff to learn from complaints within the hospital.
- The hospital used children's feedback forms in the outpatients and imaging departments. We saw "patient experience survey paediatric outpatients" leaflets displayed in the appropriate areas throughout the department. This was child-friendly and contained expression faces to indicate if this child's experience was happy, neutral or unhappy. Children could then give feedback by ticking an appropriate box to show how they felt about this service. This would enable the service to receive feedback from its youngest patients who may not be able to write.
- Feedback was sought from young people who used the service, as well as the parents of younger children. We saw that the service monitored trends on a quarterly basis which allowed the service to identify any areas for improvement.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership and culture of service

- Staff we spoke with felt managers and the hospital Senior Management Team (SMT) were open and approachable. They told us they felt established at the hospital since it was set up a year ago. They described the SMT as very visible and they felt able to discuss any issues with them on a daily basis. The SMT had an open door approach and during busy days, they visited clinical areas at least twice daily to "ensure the day was going smoothly".

Good

Outpatients and diagnostic imaging

- We saw good examples of local leadership in the nursing, imaging and physiotherapy teams. For instance, one member of staff told us about the support they received when they felt bullied. The manager intervened and escalated this to the SMT. The issue was resolved in line with the hospital policy.
- Staff we spoke with told us they enjoyed coming to work and were passionate about the care they gave to patients. This was consistent with the data provided by the hospital of low staff sickness and turnover rates in the outpatient and imaging departments.
- The consultant paediatrician was the hospital designated lead at board level for children and young people.

Vision and strategy for this core service

- The hospital had a structured senior management team led by the hospital director / chief nurse. The associate director of nursing, director of governance and support services, human resources manager and theatre manager reported to the hospital director. The nursing managers reported to the associate director of nursing. The physiotherapy manager, lead pharmacist and imaging manager reported to the director of governance and support services.
- Staff we spoke with told us the hospital was "unique" as all staff were involved in writing the values of the organisation during the setting up stage, and involved in producing the hospital vision statement. We saw staff were very proud of their involvement and were clear about the values of the organisation. They were committed to working towards achieving the broad vision and strategy "One Healthcare, One You". Examples of this included the hospital providing care of "quality, value, leadership, excellence, innovation and honesty". This meant staff had a say in decisions concerning them and ensured that they were working towards the same goals.
- The hospital vision statement and strategy were shared at staff forums and we saw positive feedback received. It was also shared at heads of departments meetings and departmental meetings. We saw the vision statement was on posters displayed in appropriate areas and on staff computers as desktop wallpapers.

Governance, risk management and quality measurement

- The director of governance and support services was the overall governance lead for the hospital, and led the hospital quality governance committee. The hospital quality governance committee reported to the Medical Advisory Committee (MAC) and the One Healthcare board. The hospital also had a designated consultant governance lead who was part of the MAC. This ensured there was a clear governance structure to assure the quality of the service and allow for continuous improvement.
- There was a process for reporting against the governance framework for all staff at this hospital. There was one open hospital in the One Healthcare group and staff told us the hospital would benchmark with the second hospital One Healthcare intended to open later in 2017. They were also working towards benchmarking with other independent hospitals in the region and nationwide.
- The provider had an electronic incident reporting system that fully linked complaints, incidents and risk reporting. This assisted managers in monitoring processes and to identify any developing trends or patterns.
- The safety records were monitored monthly by the executive team. Lessons learned were discussed and disseminated across the organisation.
- There were clear lines of accountability and responsibility with explicit and effective information flow pathways. The SMT also shared information at the monthly heads of departments meetings. Once the SMT had reviewed and considered the information, they produced an integrated governance report that was fed upwards to the hospital's quality governance committee for review and feedback.
- The hospital MAC met bi-monthly to review clinical performance, incidents and complaints. We saw minutes of MAC meetings from the past six months where feedback was obtained from the consultant body on new developments and initiatives from within the various specialities.

Good

Outpatients and diagnostic imaging

- Updates to NICE guidance or safety alerts were shared via the monthly heads of department and departmental meetings. We saw examples of this in the minutes of the meetings we reviewed.
- Departmental managers demonstrated a clear understanding of the risks within their areas. They provided an example such as doors that opened outwards which was consistent with the One Healthcare risk register we saw. Risks were broken down by departments and they were able to identify clinical and non-clinical risks.

Public and staff engagement

- Staff of all grades we spoke with expressed pride in their team work and the services they provided. This was consistent with the feedback provided by patients who completed the "Tell us about your care" comment cards placed throughout the hospital prior to our inspection.
- The service had local patient experience surveys for adults and children. This meant the services gained feedback from patients or service users for any improvements that needed to be made and compliments about staff who had provided quality care. In the February 2017 outpatient survey, we saw this service had in the previous three quarters consistently achieved 100% where patients would recommend to family and friends if they needed similar care or treatment.
- We were told the hospital had aspired to set up a patient focus group. The hospital aimed to recruit five patients in order to commence and confirmed one patient had been recruited. Staff we spoke with told us the purpose of the group is to provide patients the opportunity to have their say and influence any improvements in the care they received.
- Prior to the set-up of the hospital a year ago, the hospital engaged with staff through 'engagement' meetings from key departments. These meetings gave staff a chance to participate and be involved in shaping the structure and methods to achieve the hospital goals.
- The hospital had started regular staff focus groups which provided staff with the opportunity to interact with one another. We saw this advertised and displayed on staff notice boards and on the hospital intranet. Staff we spoke with told us there was always good attendance of approximately 20 staff at a time.

Innovation, improvement and sustainability

- There were opportunities for internal promotion and further learning and development. For example the hospital funded a diploma course in human resource management for human resource staff. Staff we spoke with told us consultants provided on the job training for nurses.
- The hospital had an eco-friendly building which used natural resources such as rain water and solar panels to obtain energy. The hospital achieved a world leading sustainability award for exceptional sustainable places in December 2016. This indicated the hospital prided itself in a building designed to reduce overall impact on the environment and human health by reducing and efficiently using energy and water resources.
- The hospital had a "free fruit Friday" where all staff were provided fresh fruit throughout the hospital. Staff we spoke with told us they welcomed this initiative.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve
The provider should

- Review policies for consent and clinical procedure for the care of children and young people to make sure they are current.
- Check theatre scrubs are not worn in common areas or are worn in compliance with AfPP guidelines.
- Adopt a procedure so all resus trolleys are stocked with the correct emergency medicines.
- Adopt a procedure so all emergency medicines are in the correct locations in resuscitation trolleys.
- Adopt a procedure so all relevant staff know where to find equipment and medicines on the resus trolleys;
- Make arrangements to monitor and recorded temperatures in any fridge or room where medicines are stored.
- Have processes to monitor when temperatures in relation to medicine storage are escalated to pharmacy in line with the hospital's SOP for drugs storage.
- Monitor staff competencies to use medical equipment.
- Make arrangements for staff to meet all mandatory training targets.
- Monitor mental capacity forms completion to be assured it is completed in line with relevant guidance.
- Rectify concerns identified in the hospital's 2017 fire risk assessment.
- Adopt a policy to include the Royal College of Surgeons Professional Standards for Cosmetic Surgery regarding cooling off periods.