Nuffield Health Plymouth Hospital

Quality Report

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Date of inspection visit: 7 and 8 July 2015 (announced) and 15 July. (Unannounced).
Date of publication: 04/11/2015

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection as part of the programme of independent healthcare inspections under our new methodology.

Our inspection was carried out in two parts: an announced visit on 7 and 8 July 2015 and an unannounced visit on 15 July 2015. Our key findings were as follows:

We rated the hospital as requires improvement overall, with surgery and children and young people's services rated as requiring improvement, outpatients and diagnostic services rated as good.

Our Key findings

- Staff told us, without exception, that they enjoyed working at the hospital. They found the management to be supportive and approachable.
- Surgical services were rated as outstanding for caring, good for effective and responsive with well led and safe requiring improvement.The service required improvement in some areas of risk management and quality performance processes. There was good flow throughout the surgery department and patients' needs were assessed and actions were taken in a timely and effective manner. Patient feedback was overwhelmingly and consistently positive regarding care received. Staff were visibly committed to person-centred care, attentive to needs, reassuring, compassionate and professional. There were effective systems that enabled patients to be fully informed and included in all aspects of their treatment and care.
- We found the outpatients and diagnostic imaging service at this hospital to be well run, with safe practices. There was a culture of learning and openness within both radiology and the outpatients departments. Patients were able to contribute their comments about their care and the facilities in the hospital.
- We found that the service provided for children and young people required improvement. There was no assurance that appropriately trained nursing staff provided care for children at all times. There was little contingency to cover for sickness or annual leave of the paediatric nurse, creating a risk that surgery would be cancelled if she were unavailable. There were no audits or outcome measures available for children. There were no methods for collecting the views of children in order to inform service delivery.
- Medicines were available for children and emergency drugs were being held in the same emergency drugs box that was used for adults. Systems were in place to minimise the risk of incorrect doses of emergency medicine being administered to children.
- There was a lack of leadership at hospital management level for ensuring oversight and monitoring of the childrens' services, with decisions being made only in response to the inspection team raising concerns.

We saw several areas of outstanding practice, including:

- The Patient-Reported Outcomes Measures (PROMs) data for April 2014 to December 2014, published in May 2015 showed that patients evaluated the effectiveness of hip and knee replacement surgery as very positive. The first (EQ-5D Index) for hip replacement surgery showed that the hospital's score (0.50) was significantly better than the England average (0.44). Overall, these scores ranked the hospital as the sixth best in the country. The PROMs for knee replacement surgery (Oxford Knee Score) ranked the hospital as 19th best in the country.
- The hospital demonstrated patient-centred handovers during shift changes. Staff handovers were conducted in each patient's room using the care plan to review and discuss all care and treatment. This system fully involved and included patients and enabled care to be led by patients' needs. It also provided clarity on what tasks would be completed by which staff and when.
- The physiotherapy service demonstrated dynamic and innovative working. Staff were skilled and independent practitioners who worked responsively and flexibly to meet patient needs. The team demonstrated how they used all opportunities for professional development, which improved their practice for the benefit of patient care.

Summary of findings

- The hospital had direct access to electronic information held by community services, including GPs. This meant that staff could access up-to-date information about patients – for example, details of their current medicine.

However, there were also areas of poor practice where the service provider needs to make improvements.

An action that a provider of a service MUST take relates to a breach of a regulation that is the subject of regulatory action by the Care Quality Commission. Actions that we say providers SHOULD take relate to improvements that should be made but where there is no breach of a regulation.

Importantly, the provider must:

- Provide enough appropriately qualified nursing care for children undergoing procedures.
- Ensure that registered nurses caring for children are suitably assessed and can demonstrate appropriate skills required to provide safe care for children.
- Ensure that registered nurses caring for children are provided with opportunities to maintain and update standards of practice in care for children in order for the service to deliver safe care and treatment.
- Provide adequate opportunity to staff who care for children to access professional supervision.
- Ensure risk and management of childrens' services are an integral part of the governance systems and processes to provide assurance and ensure safe care
- Ensure there are robust governance and risk management arrangements in place to identify and manage issues at all levels of the organisation to enable appropriate action to be taken to maintain a safe service.
- Ensure that 100% compliance with the World Health Organisation (WHO) surgery checklist is maintained and verified in all areas where surgical procedures are undertaken.

In addition, the provider should:

- Ensure that the children's service is represented at the Medical Advisory Committee in line with organisational policy.
- Ensure that children's services are monitored through the governance arrangements and that there is representation at senior management and executive level.
- Train staff on the duty of candour regulation and make sure they understand its application in practice when an incident occurs.
- Consider improving the environment for children in the outpatient's department, ward and recovery areas as they are not child-friendly.
- Consider consulting with children, young people and their families to gain their views for potential improvement of the service.
- Consider a meaningful review of children's services and consider gathering data to inform improvements in effectiveness of the service to children.
- Obtain feedback from adults and children visiting the outpatients department
- Provide systems and processes to enable all relevant staff to be aware of the surgical department's risks and priorities and to have effective action plans to improve quality and reduce risks to patients.
- Review the patient discharge information shared with GPs to ensure that the same relevant information is communicated for all patients.
- Provide appropriate training opportunities for staff to update their basic life support skills and monitor completion rates.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	The surgical services at Nuffield Health Plymouth were rated as outstanding for caring, good for effective and responsive and requires improvement for safe and well led, some areas of risk management and quality performance processes. We saw evidence that patients were risk assessed to ensure only those who met strict eligibility criteria received treatment at the hospital. Records highlighted that risks were continually reviewed and actions were updated from pre-admission through to discharge. Staffing levels were sufficient to meet the needs of patients and there was good access to medical support at all times. Treatment and care was provided in line with national guidance and there were processes in place to update policies and procedures. The service scored highly on national patient outcomes for knee and hip replacement surgery. There was good flow throughout the department and patients' needs were assessed and actions were delivered in a timely and effective manner. Patient feedback was overwhelmingly and consistently positive regarding care received. Staff was visibly committed to person-centred care, attentive to needs, reassuring, compassionate and professional. There were effective systems in place which enabled patients to be fully informed and included in all aspects of their treatment and care. Review of the five steps to safety checklists did not demonstrate robust evidence that safety processes were embedded to prevent further occurrence of wrong site surgery. Outstanding care was provided to patients who consistently provided positive feedback. Staff were seen to be providing person-centred care, which was responsive, attentive, reassuring, compassionate and professional. Staff on the surgical ward cared for patients so they remained fully informed, included and supported in all aspects of their treatment and care at all times

Summary of findings

There were governance processes and evidence of investigation of serious incidents and ongoing audits. There was evidence of investigation of serious incidents and audits were undertaken but there was a lack of detail and recording to demonstrate how some issues had been interrogated or how action plans would be used to drive improvements. All staff we spoke with enjoyed working at the hospital and were proud of the care they provided. Senior staff were reported to be visible and supportive. There was evidence staff were striving to make improvements through education and innovation.

Services for children and young people

Requires improvement

Services for Children and Young people require improvement. Caring was rated as good, safe, effective and responsive were rated as requires improvement, and well led as inadequate. The hospital had policies in place to ensure appropriately qualified staff cared for children in outpatients, operating theatres and on the ward. But there was no assurance that appropriately trained staff provided care for children at all times. Monitoring of skills by the hospital management team ensured medical staff were competent to practice.

Nurses were allocated to any children admitted for surgical procedures one of which was a registered children's nurse (RN child) and others were adult nurses who were assessed for children's competencies. These competencies were arranged and assessed locally, requiring little demonstration of competence in practical skills with caring for children.

There had been limited procedures undertaken for children aged between three and eight years, as a result a temporary decision has been taken by the hospital management since the inspection to only undertake surgical procedures for children aged eight years and above. The hospital was unable to demonstrate the basis for this decision within the governance and risk arrangements.

The hospital policy did not follow the Royal College of Nursing guidance around safe staffing for children. There was little contingency to cover for sickness or annual leave of the RN (child) creating a risk that surgery would be cancelled if she were

unavailable. The RN (child) offered support to any member of staff and department around the care of children and staff found her to be always available.
Children benefitted from the standards of care and infection prevention activities afforded to adults in the hospital. There was little evidence of specific provision for care of children in the hospital and ward environment.
There were no audits or outcome measures available for children. There were no methods for collecting the views of children in order to inform service delivery. The hospital leadership meetings had no lead representation to advocate for the care of children at the time of our visit but a new lead was identified on our return in the week of 14th July 2015.
Medicines were available for children and emergency drugs were being held in the same emergency drugs box that was used for adults. Systems were in place to minimise the risk of incorrect doses of emergency medicine being administered to children.
The hospital was responsive when concerns were raised, by investigating situations and drawing up action plans.
Governance and leadership was designed for adults' services with insufficient systems and processes in place specifically for children's services.
Parents and children we spoke with felt informed and cared for by staff at the hospital.

Outpatients and diagnostic imaging

Good

We found the outpatients and diagnostic imaging service at this hospital to be well run with safe practices.
Audit programmes were in place to monitor safety of care provided to patients. There were sufficient trained staff numbers for the needs of patients in the department. Patients were seen promptly and felt informed of any procedures and plans for their health care
There was a culture of learning and openness within both radiology and outpatients departments.
Patients were able to contribute their comments about their care and the facilities in the hospital.

Summary of findings

Staff were able to contribute to their thoughts and ideas about the hospital environment and the care they deliver by attending regularly held forums. Diagnostic imaging had devised a survey for patients to feed back their thoughts about the service. The hospital had processes to ensure staff maintained their competencies in order to practice safely which included confirmation that consultants met the requirements for practising privileges.

Staff were aware of complaints and incident reporting procedures and were confident in their abilities to deal with any complaint. Apologies were offered to patients who complained and they were responded to in a timely way. They felt part of a team, proud to work at the hospital and able to instigate changes if a need was identified. Staff felt listened to and care for by the hospital and were positive about the appraisal process in supporting them professionally. They were able to access training to maintain and develop their skills

Summary of findings

Contents

Requires improvement

Nuffield Health Plymouth Hospital

Services we looked at

Surgery; Services for children and young people; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Nuffield Health Plymouth Hospital

Nuffield Health Plymouth Hospital is an independent hospital, which is part of the Nuffield Health corporate group. It provides outpatient services to adults and children from birth upwards and surgical services to adults and children over the age of eight years. There have been limited procedures undertaken for children aged between three and eight years, as a result a temporary decision has been taken by the hospital management since the inspection to only undertake surgical procedures for children aged eight years and above.

Surgical specialities at the hospital include acute surgical care including orthopaedics, spinal neurosurgery, general surgery, endoscopy, gynaecology, ear nose and throat, oral surgery, facial-maxillary, breast reconstruction, plastic surgery, ophthalmology, vascular surgery, gastroenterology, and pain management. It also provides diagnostic services and laser treatments.

The hospital was registered with CQC in 2010 The registered manager has been in post since June 2013.

The hospital had one ward with 35 rooms all with ensuite bathrooms and four day care beds. The 35 rooms included two rooms with access for disabled people. Facilities to provide high dependency care were in place but were not in use at the time of our inspection due to a limited access to staff with higher dependency skills.

There were three operating theatres and a separate endoscopy unit. There was also a recovery (post-anaesthetic) area in the theatre suite.

The outpatient department has 12 consulting rooms, one minor operations room, one treatment room, pathology (including Phlebotomy) pharmacy and physiotherapy. Radiography services consist of a plain x ray room, fluoroscopy, ultrasound room and mammography room. Scanning facilities we also provided by a third party and so were not inspected at this time.

Between April 2014 and March 2015 a total of 5,897 surgical procedures were undertaken. The majority of patients were treated as day case (4,300), as opposed to inpatients (1,593). The majority of surgery was for adults aged 18 to 74 years (5,219), with less than 1% (34) for children aged 0-17 years.

There were 34 surgical procedures carried out on children aged three years and over between April 2014 and March 2015 and 222 children were seen in the outpatient department. There was one scheduled paediatric surgical list per month. Most of the children's surgery, (23) was done as day case and 12 cases during outpatients appointments. During the same period, only three children had been inpatients.

Our inspection team

Our inspection team was led by:

Inspection Lead: Gail Richardson Inspector Care Quality Commission

The team included CQC inspectors and a variety of specialists:

A consultant surgeon, a theatre manager. A radiographer, a director of nursing and a children's nurse.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider :

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of this inspection

• Is it well led?

The inspection team inspected the following three core services at the Nuffield Heath Plymouth Hospital

• Surgery

• Services for children and young peoples

• Outpatient and diagnostic imaging services.

Prior to the announced inspection, we reviewed a range of information we held about the service.

We carried out this comprehensive inspection as part of our in depth inspections of independent hospitals. Our inspection was carried out in two parts: the announced visit which took place on 7 and 8 July 2015; and the unannounced visit, which took place on 15 July 2015.

During our visit we spent time on the ward and in the outpatient department observing the treatment and care provided. We also spent time in the operating theatres, recovery, and endoscopy area of the hospital.

We spoke with the management team of the hospital and a representative of the medical advisory Committee, a variety of staff, including nurses, doctors, therapists, managers and support staff. We also spoke with patients and relatives.

Information about Nuffield Health Plymouth Hospital

Services are provided to NHS patients and private patients.

The hospital has a workforce of 38.8 whole time equivalent nursing staff and 16.8 whole time equivalent healthcare assistants. There is a resident medical officer, employed through an agency, on site at all times.

The hospital has 168 consultants who have “practicing privileges”. This means that they have been approved to work at the hospital, although they are not directly employed. At the time of our inspection, senior staff told us this information was being fully updated as part of the revision of the practicing privileges systems.

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?

Requires improvement

- Staff mostly understood their obligations under the duty of candour rules to explain and apologise when things went wrong. They understood the need to be open and transparent. The hospital matron took lead responsibility for safeguarding adults from abuse and the paediatric nurse performed the role in relation to children advising the matron when required. Staff reported incidents of harm or risk of harm, which were investigated and any lessons to be learned were shared. There were enough staff in all areas of the hospital apart from paediatrics where one paediatric nurse was supported by nurses trained to care for adults. However, nursing staff did not have opportunities to maintain and update their skills and experience to care for children and young people in a surgical setting due to the limited amount of surgery on children performed at the hospital. Following our inspection, increased access at an alternative hospital was organised to support staff skills in this area. We saw that medicines were available for children and that emergency drugs were being held in the same emergency drugs box that was used for adults. Systems were in place to minimise the risk of incorrect doses of emergency medicine being administered to children. The Resident Medical Officer worked on the ward and provided care in emergencies until the consultant or emergency services were called. Staff handovers were conducted in each patient's room using the care plan to review and discuss all care and treatment. Audits of safer surgery checklists demonstrated further work was required to ensure the standard was met at all times.

Are services effective?

Good

- Paediatric care was not audited for patient outcomes to establish if it met national targets and benchmarks. This was because such small numbers of procedures were undertaken. As a result it was not clear how the service measured this aspect and used information to improve the service provided. Three out of the four directors did not have a medical background and the Medical Advisory Committee was not involved in the development and agreement of all national Nuffield policies but consultants from most specialties within the Hospital, was involved in the development of clinical services within the hospital. This meant that local procedures

Summary of this inspection

and service plans did routinely include input from experienced and highly qualified consultants who were responsible for the delivery of the clinical service. Systems were in place to ensure that practising privileges for consultants working at the hospital were up to date. Staff demonstrated an understanding of the Mental Capacity Act 2005. There was a dementia lead in the hospital, who was used as a source of reference for staff. While staff had received training on the deprivation of liberty safeguards they said they had never had to submit a request to restrict a patient's liberty.

- We did not have enough evidence to rate the effective domain for outpatients and diagnostic imaging.

Are services caring?

Good

- We saw all staff throughout the hospital treating patients with kindness and compassion. Friends and Family Test scores for NHS-funded patients between October 2015 and March 2015 were consistently high, demonstrating patients' happiness with the care they received. There was support available for adult patients who were vulnerable or had extra care needs. A psychologist was available by appointment in the outpatients department to meet with young people. Visiting hours were flexible and there were facilities for relatives to stay overnight to support their emotional wellbeing. Extra staff were available to support patients with an encroaching dementia.

Are services responsive?

Good

- Admission, treatment and discharge pathways were well organised and flexible so that they were responsive to patients' changing needs. Access to pharmacy support was always available, including outside normal working hours. The hospital provided elective surgery and treatment. As no emergency and high dependency care was provided, patients with multiple health problems would not be considered for treatment. The hospital services were accessible to both private and NHS patients who met the criteria for treatment. There were systems to respond to complaints, with review at head of department and hospital board level. Clinical complaints were reviewed at the Medical Advisory Committee meetings. A recent example of complaints management was provided when learning was taken through the MAC meeting and information cascaded to consultants.

Summary of this inspection

Are services well-led?

Requires improvement

- Staff were clear about and worked in accordance with the values and principles of the hospital. They felt supported by their line managers and were clear that patients were at the heart of what they did. There was a governance structure that involved key performance indicators being reviewed and discussed.The Medical Advice Committee (MAC) was made up of consultants who worked at the hospital and met to discuss issues related to their practice. Other hospital groups included regular meetings between nursing staff and estates and heads of departments meetings. All of which fed into the hospital Integrated governance committee together with other governance groups including pathology, radiology and blood transfusion. The Integrated Governance Committee reported to the Hospital Board which then reported to the company executive board. Governance minutes submitted to the board were not well documented, for example, there was no evidence of discussion, debate or recommendations or information about how issues were moved to the risk register for action.
- While some departments demonstrated governance systems were in place locally there was little evidence of robust overarching governance and risk systems that ensured the hospital management team were able to capture, identify and manage issues and risks at organisational level. Issues which affected the delivery of safe and effective care were not identified with adequate action being taken.
- The radiography department had a strong ethos of self-governance using audit and learning to ensure their practise was safe for patients and in responding to patient's needs.
- There was insufficient oversight of the service for children and young people. Review of paediatric outcomes were not measured to ensure review and development of the service. No review had been considered to ensure that the service was suitable. Since the inspection, we have been advised by the hospital management team that a review of the children's service had led to an agreement to treatment only children over eight instead of children over the age of three years. This decision took immediate effect as a temporary initiative, with plans for a review in the future however the hospital was unable to demonstrate the basis for this decision within the governance and risk arrangements.
- In the surgical department there were governance processes and evidence of investigation of serious incidents and ongoing

Summary of this inspection

audits. However, in some areas there was a lack of detail and understanding to demonstrate how issues had been interrogated, or how action plans would be used to drive improvements.

Detailed findings from this inspection

Requires improvement

Surgery

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

Information about the service

Nuffield Health Plymouth Hospital provided routine, non-urgent surgery for adults and children who met strict eligibility criteria. Surgery was not appropriate for any patients' risk assessed with the potential to require high dependency recovery facilities. The service included three operating theatres, two recovery areas with six beds, an endoscopy suite, and four bedded recovery area, and a ward consisting of 35 single rooms used for both inpatient and day case surgical patients. Theatre one was digitally enhanced (providing increased technical and visual aids) and was used for all elective laparoscopic procedures and general surgery. This included; general and plastic surgery, gynaecology, ear, nose and throat (ENT), oral and facial-maxillary, ophthalmic, breast reconstruction and minor orthopaedic procedures. The theatre lists ran from 8am to 8.30pm Monday to Friday and occasionally on Saturdays.

Theatres two and four had laminar flow specialised air filtration systems. Surgical procedures in these theatres included; major orthopaedics, major plastics, neurosurgical spinal procedures, ophthalmic and general surgery. The theatre lists ran from 8am to 8.30pm Monday to Friday and occasionally on a Saturday

The endoscopy suite was used for all endoscopic procedures, for analgesic injections and sclerotherapy (foam treatments) for varicose veins. The suite was open Monday to Friday, from 8am to 5pm.

Between April 2014 and March 2015 a total of 5,897 surgical procedures were undertaken. The majority of patients were treated as day case (4,300), as opposed to inpatients (1,593). The majority of surgery was for adults aged 18 to 74 years (5,219), with less than 1% (38) for children aged 0-17 years. There was one scheduled paediatric surgical list per month. Most of the children's surgery, (23) was done as day case and 12 cases during outpatients appointments. During the same time period, only three children had been inpatients.

Between April 2014 and March 2015 the percentage of NHS patients receiving treatment was 55.21% and private patients was 44.79%. The most common types of surgery performed were; diagnostic colonoscopy (425), sclerotherapy treatments of varicose veins (339), cataract treatment with lens implant (300), abdominal (inguinal) hernia repairs (294) and diagnostic gastroscopy (233). Nearly all of the children's surgery (33:34) and just under two thirds of surgery for adults aged over 75 years (61.85%) were for private patients' (407:658).

During our inspection we visited all the surgical areas. This included the theatres and recovery areas, the endoscopy suite and the surgical ward. We spoke with six patients and two relatives of patients and 19 staff in a range of roles. These included; consultant surgeons and consultant anaesthetists ward sisters, theatre manager, matron, resident medical officer, and nurses in a variety of roles, administration staff, operating department practitioners, porters, student nurses and care assistants. We observed care being given to patients and we looked at nine care and medical records. Before and during our inspection, we reviewed the provider's performance information.

Requires improvement

Surgery

Summary of findings

The surgical services at Nuffield Health Plymouth were rated as outstanding for caring, good for effective and responsive and requires improvement for safe and well led. The service required improvement in some areas of risk management and quality performance processes.

We saw evidence that patients were risk assessed to ensure only those who met strict eligibility criteria received treatment at the hospital. Records highlighted that risks were continually reviewed and actions were updated from pre-admission through to discharge. Staffing levels were sufficient to meet the needs of patients and there was good access to medical support at all times.

Treatment and care was provided in line with national guidance and there were processes in place to update policies and procedures. The service scored highly on national patient outcomes for knee and hip replacement surgery.

Review of the five steps to safety checklists did not demonstrate robust evidence that safety processes were embedded to prevent further occurrence of wrong site surgery.

Outstanding care was provided to patients who consistently provided positive feedback. Staff were seen to be providing person-centred care, which was responsive, attentive, reassuring, compassionate and professional. Staff on the surgical ward cared for patients so they remained fully informed, included and supported in all aspects of their treatment and care at all times

There was good flow throughout the department and patients' needs were assessed and actions were delivered in a timely and effective manner. Patient feedback was overwhelmingly and consistently positive regarding care received. Staff were visibly committed to person-centred care, attentive to needs, reassuring, compassionate and professional. There were effective systems in place which enabled patients to be fully informed and included in all aspects of their treatment and care.

There were clear governance processes and evidence of investigation of serious incidents and ongoing audits. However, in some areas there was a lack of detail and understanding to demonstrate how issues had been interrogated, or how action plans would be used to drive improvements. All staff we spoke with enjoyed working at the hospital and were proud of the care they provided. Senior staff were reported to be visible and supportive. There was evidence staff were striving to make improvements through education and innovation.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

Overall, we judged the surgical services to require improvement for safety.

Review of the five steps to safety checklists did not demonstrate robust evidence that safety processes were embedded to prevent further occurrence of wrong site surgery.

There were processes in place for reporting incidents and staff confirmed they received feedback and shared learning. All areas in the department were visibly clean. Infection control issues were regularly monitored and reviewed. An infection control audit dated April 2015 identified improvements to practice were required.

Patients were risk assessed to ensure only those suitable received treatment. Risks were reviewed and actions updated during each patient's stay. Staffing levels were sufficient to meet the needs of patients and there was good access to consultant medical support at all times. Care records were stored safely, were well organised and treatment plans were clear. Medicines were handled and stored safely.

Incidents

- Records showed there was a consistent rate of clinical incident reporting. Incidents were reported on the provider's electronic reporting system. All surgical incidents in the theatre department were reported by staff to the theatre manager who completed the electronic incident report. Ward staff completed incident reports individually and staff demonstrated an understanding of the processes to follow. Staff told us any identified feedback and learning from incidents was given individually and if appropriate, cascaded through team meetings and handovers. We saw records had documented this.
- There had been eight serious incidents that had been investigated between April 2014 and March 2015. These included two cases of serious injury, and one police investigation as the gas cylinder store was broken into. These incidents had been reviewed through the hospital's governance processes and appropriate actions taken, including notifying CQC.
- There was one reported never event during the last year (March 2015). A never event is a serious incident which should never occur because strong systems are available nationally to prevent them. This was for a wrong site surgery and was assessed as having moderate impact on the patient. A root cause analysis (RCA) investigation had been completed to more fully understand the incident and consequences. We saw records which showed action plans and learning. These were further documented as discussed in clinical heads of departments' meetings and various professional meetings, including the Medical Advisory Committee. The surgical staff we spoke with demonstrated familiarity with the incident and an understanding of the key issues, learning and changes to practice as a consequence.
- The hospital did not hold specific morbidity and mortality (M&M) meetings. All unexpected outcomes and post-operative deaths were recorded and a summary report was produced. This was reviewed in order to identify trends. Relevant information was disseminated at other staff meetings. These included; senior management team meetings, clinical head of department and departmental meetings, and medical advisory committee (MAC) meetings.
- There had been one case of unexpected death between April 2014 and March 2015, and one unexpected death during May 2015. The hospital notified CQC of these cases. Coroners' reports showed these deaths had not been related to any surgical procedures undertaken at Nuffield Health Plymouth.

Duty of candour

During November 2014, a new regulation was introduced to providers of NHS patients requiring them to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. This related to incidents termed as 'reportable patient safety incidents' and include any unintended or unexpected incidents occurring to a patient leading to death, severe, moderate or prolonged psychological harm. This regulation requires staff to be open, transparent and candid with patients and relatives when things went wrong. Staff throughout the surgical department demonstrated an understanding of this and what actions needed to be taken when patient treatment or care had gone wrong or not been satisfactory.

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

- Senior staff regularly monitored patient safety risks and outcomes. Incidents of pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism (VTE) were recorded and reported at the clinical heads of department meeting. The VTE screening rate was consistently at 100%. Since April 2014 there had been three cases of VTE, one urine infection (catheter related) and no pressure ulcers. During the same time period, there had been no patient falls recorded.

Cleanliness, infection control and hygiene

- All surgical and ward areas appeared visibly clean. On entry to the hospital, all visitors reported to a reception desk. We observed staff asked people to use antibacterial hand disinfectant on arrival. This was also available at the entrances the main ward and theatre areas, as well as in each patient's room on the ward.
- Processes were in place to protect patients from hospital-acquired infections. All private patients were risk assessed and tested for Methicillin resistant Staphylococcus Aureus. From April 2014 to March 2015 there had been no incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections. There had been one case of Methicillin-sensitive Staphylococcus aureus (MSSA). . All NHS patients were routinely screened for MRSA infections prior to admission. This was part of the NHS commissioning contract.
- The hospital had a multidisciplinary infection prevention and control committee which met every quarter . The group consisted of staff from all areas of the hospital and included a microbiologist, housekeeping staff, ward and surgical staff and a pharmacist. The purpose of this group was to review feedback and learning from infection prevention audits and national policy updates. In addition, any infection related incidents which were subject to a root cause analysis (RCA) were discussed for learning and service improvements. We reviewed the minutes of the last three meetings and saw records of discussions and actions taken to mitigate infection control risks.
- The most recent Infection control audit dated April 2015 identified improvements were required by staff working in the surgical department. For example, on the surgical ward hygiene standards, such as staff having short nails, no nail varnish or jewellery rings, were assessed as 73% compliant. Trays and trolleys used for sterile equipment were noted not to be have always been cleaned. The compliance rate for this in theatre was 71%, and on the ward; 79%. Action plans and timescales had been identified, with plans for further audit in the following months. Hand hygiene audits showed mixed compliance with the provider's policy. Regular, specific hand hygiene audits had been completed on a monthly basis. We saw the audit for April 2015 which showed a range of staff had been observed and good compliance was noted. However, the general infection control audit included hand hygiene. The audit completed during April 2015 showed hand hygiene compliance of 53%. The subsequent actions documented included mandatory hand hygiene for all theatre staff. In addition, staff 'champions' had been identified to promote good infection control and prevention practice on the ward and in theatre. Senior staff assured us these actions had been subsequently completed but not fully documented.
- Processes were in place to ensure the theatres were appropriately cleaned. Two dedicated cleaners were contracted to work in the theatre areas. Staff said there we no issues with the standard of cleaning. Theatre staff followed daily and weekly cleaning schedules. We saw records confirming these tasks had been completed. The hospital had a contract with an external company who completed a deep clean of the whole department twice per year. As part of this process, microbiology plates were left and later tested to check potential infection risks had been eliminated.
- In the operating theatre area and endoscopy suite, staff followed pathways to keep sterile and contaminated equipment separate.
- The entry and exit used for surgical deliveries and collections were the same which presented potential infection control risks. One corridor and store room were designated as 'clean' and used for sterile equipment and had direct links into the theatres. A different corridor, linked by different doors to the theatres and the sluice room, designated as 'dirty' was used for contaminated equipment. There was one direct access/exit door to the theatre department on the 'dirty' corridor near the sluice room. This meant sterile equipment delivered to the unit came through the same door as the contaminated equipment was removed.

Therefore, at one place the flow of sterile and contaminated equipment crossed each other. Best practice guidance suggests the flow of sterile and contaminated equipment should be segregated (HBN 13 Sterile Services Department, DoH, 2004). Appropriate controls were in place to minimise the possibility of cross-contamination between clean and dirty instrumentation, by the use of locked and labelled trolleys, separate storage areas for clean and dirty instruments, and the requirement of staff to follow appropriate standard operating processes.

- The endoscopy suite had clear systems in place for the flow of sterile and contaminated equipment to be kept separate and staff followed appropriate decontamination procedures.
- Personal protective equipment such as aprons and gloves were readily available and we saw staff using them when care or treatment was provided to patients.
- We saw staff cleaning equipment after use. There were 'I am clean' stickers on equipment and facilities such as bathrooms, to indicate when items or areas had been cleaned and were ready to be used again.

Environment and equipment

- The hospital had adequate security systems in place to protect patients and staff. These included CCTV, alarm systems and coded door locks. Entry onto the ward and surgical areas on the first floor of the building was accessible through a staffed reception area on the ground floor.
- Each individual patient room contained two lockable cabinets. One was used to store medicines patients brought with them on admission. The other was available for patients' personal belongings. In addition, in each room there was a suction machine and oxygen available for use if required.
- Resuscitation equipment for adults and children was available in the theatre department and on the surgical ward. The contents complied with recommendations of the Resuscitation Council. Records confirmed daily checks of the accessible equipment had been completed. Once a week the locked equipment was checked by staff and then resealed. We saw records confirmed this.
- The hospital had systems in place for the safe provision and use of surgical instruments. Clinical instruments were sterilised by Nuffield Health sterile services unit. These services complied with International Organisation for Standardisation (ISO) 9001/13485 for Quality Management System and Medical Device Management for sterile surgical instruments.
- Staff told us theatre lists were produced two weeks in advance and this gave enough time to ensure the correct equipment had been ordered and received. There were three equipment deliveries and collections per day. We observed the equipment orders and delivery system in operation for the days we were on site inspecting
- The hospital had contracts in place with an external company to service and maintain medical gas pipelines and systems. The laminar flow hoods in two of the theatres were tested by an Electro-Biomedical engineer.
- The hospital provided a range of equipment to meet patients' post-operative needs. This included a toilet seat rise, a long-handled shoe horn and grabber (to pick up items), walking frames, sticks and crutches. Other items, such as wheelchairs, were readily available to borrow in return for a donation though a local charity.

Medicines

- Medicines were supplied from an on-site pharmacy and stored securely in locked medicine trolleys and cupboards. Medicines that required cool storage were stored in a locked fridge, specifically for that purpose. Records showed temperatures were checked daily and all within the appropriate range.
- There was a monthly multidisciplinary medicines forum which was used to discuss issues relating to medicines, prescribing policies, incidents or alerts. We saw records documented this and when information was to be shared at staff shift handovers and other meetings.
- Patients' allergies were clearly documented in the care plans and prescribing documents.
- Staff were aware of the policy for the safe storage, handling and administration of medicines.
- Controlled medicines were stored appropriately in locked cupboards on the surgical suite and the ward. There was documentation of daily controlled medicines checks which were completed in line with national guidance (DoH, 2013, Controlled Drugs; Supervision of Management and Use Regulations).

Records

- The hospital used a specific Nuffield Health care record which contained all information regarding patients' pre-admission, admission, treatment, post-operative care and discharge information. There were two versions of the care record; one for long stay care (more than 24 hours) and one for day and overnight care (less than 24 hours). We looked at nine patients' care records and saw information was clear, factual and organised. Each entry was dated and signed by staff.
- The care records included pre-admission assessments and investigative tests which ensured patients met the admissions criteria and were suitable for treatment at the hospital.
- We saw the theatre records section of care plans were clear and documented checks to ensure safe surgery and treatment was undertaken. Following each patient's surgical treatment, daily multidisciplinary records were maintained of all care and treatment provided.
- The hospital had good processes in place to access medical records, which were requested in advance of a patient's admission to the hospital. This ensured consultants had appropriate information to support clinical decisions. New records were created for those patients who did not have any previous records. We spoke with clerical staff who told us they could not recall any issues or problems accessing medical records.
- Patient confidentiality was maintained and records were secure. Each patient's care record was kept with them in their room. Medical records were stored securely but accessibly in trolleys in staff areas or in the clerical office.
- The hospital had a good rate of compliance (93%) with the NHS Information Governance Toolkit.
- Improvements were required to provide complete records of clinical processes. This was demonstrated with surgical instrument set checks completed at the start of a procedure. This required two staff to call out and check off all instruments were present. We observed this in practice to be undertaken correctly. However, we saw that the recording of this check was not fully completed or robust for example: We looked at six instrument set sheets which had been signed but had not been marked to confirm each individual item was present. One sheet had ticks next to only six of the 26 instruments. The words 'not on set' had been written and then crossed out, with the ticks remaining. These practices provided incomplete records and audit trails of the surgical sets. We observed end of surgery checklists were documented in patient records. In addition, three of the six surgical set sheets had been signed by one staff member, instead of both of the responsible staff. Good, standard surgical practice for instrument checking procedures requires signatures from both accountable staff and careful documentation. This is in recognition that these practices can reduce incidents of unintended retained instruments (The Association of Perioperative Practice, 2012). When we revisited the hospital on 15 July we saw a system had been put in place to audit this practice with one audit having been completed. As only one audit had been completed we cannot comment on the effectiveness of the new system.

Safeguarding

- Staff we spoke with were knowledgeable about the provider's safeguarding process and were clear about their responsibilities. Staff said the most recent safeguarding training they had attended had been provided by an external provider and topics had increased to include signs and symptoms of 'child conditioning' and 'cyber bulling'. Staff said the training had made them think about vulnerabilities for patients they had previously not considered.
- Safeguarding training was a mandatory element of training for all staff at induction and then through annual updates.

Mandatory training

- Staff completed the following mandatory training, which was a mixture of classroom and e-learning. The training was updated annually and we saw records dated May 2015 which showed the percentage of staff with in date training.

Required mandatory training

Percentage of staff who were had in date mandatory training

Fire

92%

Health and safety

93%

Integrated governance

83%

Vulnerable adults

91%

Safeguarding children

91%

Manual Handling

87%

Basic Life support attended by admin staff and

Immediate Life Support attended by clinical staff.

54%

Infection prevention

87%

- Senior staff were aware of the low compliance with basic life support training and told us the provider's life support trainer had not been able to facilitate all planned sessions. This situation had recently been rectified and life support training compliance figures were rising.
- Senior staff confirmed all but one of the surgical team had recently completed immediate life support training. In addition, we spoke with staff from human resources who told us they were in the process of transitioning from one record keeping process to an alternative one. Staff felt as a consequence the records were not a true reflection on the actual numbers of staff with in date training, which they believed to be higher.

Assessing and responding to patient risk

- Each patient had a care record completed. These included information and an audit trail of relevant information from pre-admission through to discharge. This included; previous medical history, investigative tests, current medication and known allergies. The pre-operative assessment was combined with a general health assessment. Staff said this information was used to more effectively assess and minimise risks and adverse surgical outcomes.
- The care record included risk assessments. These included; manual handling, pressure care, venous thromboembolism (VTE), bleeding and falls risks and nutritional care. In the nine care records we looked at we saw risk assessments had been completed and reviewed where necessary.
- The hospital employed two resident medical officers (RMO) via an agency who were available on site 24 hours a day, seven days a week. The RMO was available to assist nursing staff and consultants by completing any necessary medical tests and writing prescriptions required by the lead consultant.
- Both RMO's were trained in advanced life support and would lead the response team in the event of any unexpected patient risks or emergencies until a consultant or ambulance arrived. We saw records detailing emergency resuscitation scenarios practiced by staff. The actions taken to the scenarios were assessed and discussed with staff for further learning by the hospitals resuscitation officer
- Escalation processes were understood and followed by staff. Patient care was consultant-led and staff and patients confirmed treatment and care was reviewed daily by the consultants.
- The rate of emergency patient transfers to an acute hospital had remained consistent. Between April 2014 and March 2015 there had been nine cases of unplanned transfer. This was comparable to other similar hospitals. Staff we spoke with were familiar with the escalation process and where necessary, patients were transferred by ambulance. The closest hospital with an emergency department was Derriford Hospital (Plymouth Hospitals NHS Trust) which was 0.2 miles away. There were no further hospitals with emergency departments within a 25 mile radius of Nuffield Health Plymouth.
- Theatre and surgical ward staff attended a qmultidisciplinary resuscitation meeting. The standing agenda included review of the resuscitation trolley and medicines, staff training needs and feedback on practice resuscitation scenarios. In addition guest speakers were invited to present on related topics. We reviewed meeting minutes for the previous three months and saw actions to improve patient safety. For example, national resuscitation guidelines were discussed, a consultant anaesthetist had given a presentation, and audits of daily checks on arrest bells and monthly checks of resuscitation trolleys had been reviewed. Responsibilities for sharing learning and information with other staff was documented as completed.
- The surgical staff followed the World Health Organisation (WHO) safe surgery checklist. This internationally recognised process of safety checks reduces mortality and morbidity issues. Senior staff

assured us compliance to the safe surgery checklist was audited every quarter (three months). The process involved randomly selecting 20 sets of patient records from the previous months surgeries and reviewing the appropriate checks had been signed by staff to confirm they had been completed. We looked at audit records dated the second quarter which were referenced on the June 2015 governance meetings, and saw actions relating to the safe surgery checklist were recorded. In addition, we saw safe surgery checklist was documented as discussed during surgical staff meeting minutes. The hospital provided us with the audit profoma and evidence of review of ten checklists carried out in July 2015. Of these, two were recorded as not having the site of surgery marked, for five of the forms the written consent was marked as not legible and on five written consent was marked as legible. We were not provided with an overall report from any audits or documented information on the action taken from these findings. The never event in March 2015 was linked to the surgical site not being marked and the hospital was not been able to demonstrate robust evidence that safety processes are embedded to prevent further occurrence.

- The assessment and actions taken to prevent patients developing venous thromboembolism (VTE) was consistently 100%, and much better than expected compared to other similar hospitals. During the period April 2014 to March 2015, three patients developed a VTE or pulmonary embolism (PE).
- Staff were observed completing parts of the World Health Organisation surgical safety checklist before procedures started. This was an internationally recognised system of checks designed to prevent avoidable harm during surgical procedures.

Nursing and other staffing

- The hospital followed a patient dependency calculation to ensure adequate staffing levels to meet patients' needs from admission through to post-operative care. The dependency calculation was based on a ratio of one nurse or care assistant for every five patients. There were two nurses on duty per shift as a minimum. Staff working in the theatre and on the ward felt there were enough staff to safely support patients' needs.
- There were sufficient senior staff to support junior staff with the safe treatment and care of patients. The surgical staff team was led by one whole time equivalent (WTE) manager, who was supported by 2.6 WTE nurse team leaders. There were 11.7 WTE nurses, 5.2 WTE care assistants and 6.9 WTE operating department practitioners (27.4 WTE surgical staff in total). During the period April 2014 to March 2015, no agency staff had been used in the theatre departments. Staff shortfalls were filled by part time or bank staff. In the inpatient area there was one WTE nurse manager who was supported by 2.6 WTE nurse team leaders. There were 13.3 nurses in post and 1.8 care assistants (18.7 inpatient staff in total). Between April 2014 and March 2015 no agency nurses, allied health professionals, clerical staff or care assistants had been used, apart from the final month of reporting. During March 2015, a low level of nurse agency staff were used (2%) and a moderate level of agency care assistants were used (20%). Senior staff were not aware of any specific reason for this.
- There were 9.8 WTE physiotherapists employed to work both in the hospital. One physiotherapist was employed in a managerial and supervisory role.
- Within the surgical department, there was a moderate care assistant vacancy rate (14%) and more variable sickness absence rates. During February 2015 care assistant sickness peaked at 32%. Senior staff told us sickness had since stabilised.
- Staffing vacancies and sickness absence levels in the inpatient services were generally low. There were no vacancies in the inpatient areas for care assistants and allied health professional. There were low vacancy rates for clerical staff (3%), and moderate nurse vacancy rates (16%).
- There were generally low rates of sickness absence (below 10%) for physiotherapists, administration and clerical workers. There were moderate rates of sickness absence for nurses (18%) and care assistants (13%) working in the inpatient department.

Surgical staffing

- There were adequate numbers of surgical consultants to meet the needs of patients. There were 158 consultant surgeons and anaesthetists who had employment in other NHS posts and had practicing privileges at Nuffield Health Plymouth Hospital. Practicing privileges were granted to consultants who agreed to practice following the hospitals policies and provided evidence of appropriate skills and registration. This included evidence of registration and being on the specialist

register with the General Medical Council (GMC). There were an additional 10 consultants who worked solely in private practice. The organisation had a responsible officer (doctor) who was responsible for ensuring these 10 consultants had their practice revalidated and had annual appraisals (as required by the GMC). We spoke with the responsible office who confirmed this was completed.

- Consultants were responsible for their patients' care 24 hours a day, seven days a week. It was the responsibility of each consultant to provide cover for any absences with an alternative consultant with appropriate skills who also had practicing privileges at the hospital. We observed consultant cover information and contact information was available for other staff to view.
- The hospital employed two resident medical officers (RMO) via an agency who were available on site 24 hours a day, seven days a week. The RMOs completed routine tasks on behalf of consultants such as blood tests and prescribing medicines.

Major incident awareness and training

- Senior staff were aware of the hospital's major incident policy and how to access this.
- Staff reported fire alarms were regularly tested and staff were aware of where patients had to be evacuated. Staff notice boards provided fire marshal details.

Are surgery services effective?

Good

Overall, we judged the surgical services were effective. Treatment and care was provided in line with national guidance and there were processes in place to update policies and procedures. Patients' pain, nutrition and hydration needs were effectively assessed and actions put in place in a timely manner. The service scored highly on national patient outcomes for knee and hip replacement surgery. There were appropriate staffing levels to effectively meet patients' needs. Surgical staff were supported with annual appraisals and access to continuing professional development.

Evidence-based care and treatment

- Care was provided in line with guidance from the National Institute for Health and Care Excellence (NICE). For example, NICE CG3 (2003) was followed regarding pre-operative tests, and NICE QS49 (2013) for surgical site infections. The pharmacist also reviewed the use of medicines to optimise the most effective outcomes.
- The hospital had processes in place to keep staff updated on national guidance. A central team who supported all Nuffield Health hospitals checked the NICE website every month. New national guidelines were sent for clinicians to review for appropriateness and they were discussed at monthly clinical heads of department meetings. New guidance was imported onto the hospital's intranet and emailed to clinical leads for discussion with their teams. We saw clinical heads of department and team meeting minutes documented clinical updates. We spoke with staff who demonstrated awareness of relevant national policy. We saw copies of up to date guidance available in the main staff dining room.
- All patients undergoing a joint replacement consented to have their prosthesis registered on the National Joint Registry. This was done to contribute to the ongoing monitoring by the NHS on the performance of joint replacement implants, the effectiveness of different types and to improve clinical standards
- The consultants providing upper and lower gastric surgery procedures reported very low infection rates. One consultant told us in the past 13 years they could recall only one case of deep surgical infection (not post-operative surgical site infection, which was reported as occasional). The hospital provided incident records of unplanned readmission to the hospital within 28 days of surgery. These were dated from September 2014 to February 2015. Of the 11 unplanned readmissions, three were recorded as due to wound infections.
- The orthopaedic consultants told us they met monthly and the consultant general surgeons told us they met fortnightly to share good practice discuss relevant clinical updates and case reviews. As the majority of consultants worked for another local NHS trust, these meetings were not always facilitated at Nuffield Health Plymouth.
- Processes were in place to ensure surgical procedures were effective. MAC meetings were attended on a quarterly basis by the consultant speciality leads, and members of the hospital's senior management team. Clinical outcomes were monitored by the chair of the MAC. Any concerns were reviewed and also raised with

the medical director of Derriford Hospital (Plymouth Hospitals NHS Trust) as most of the consultants had contracts to work there. In addition, Derriford hospital shared clinical information with Nuffield Health Plymouth as required.

- The endoscopy service had completed six months' worth of audit and evaluation as part of an application for Joint Advisory Group (JAG) accreditation (Royal College of Physicians). Completion of this process would confirm the endoscopy service had demonstrated that it had the competence to deliver against defined, recommended standards.

Pain relief

- Patients were prepared for their procedures and informed of the types of pain relief available to them during pre-operative assessments. The five patients we spoke with confirmed staff had regularly checked if they required additional medicines to relieve pain or other symptoms and these were supplied in a timely manner.
- Post-operative pain was assessed by staff using a recognised 1-10 scoring system (modified early warning system; MEWS). Pain levels were constantly monitored and effectively managed in the theatre recovery area. Staff said patients were not transferred back to the ward until pain scores were assessed as being at four or below. We saw this documented in patients records.
- Patients discharged from inpatients and day case surgery were provided with analgesia following surgery and to take home.
- Pain relief was provided to prevent pain impacting on patients' post-operative recovery process. The physiotherapists reviewed patients' pain relief needs prior to commencing therapy. Where required, additional when required (PRN) medicines were requested for patients half an hour prior to starting a physiotherapy session. We saw PRN medicines were prescribed appropriately for patients'.

Nutrition and hydration

- Processes were in place to assess and appropriately respond to patients' nutrition and hydration needs. Each patient's nutritional risks were assessed and recorded, using a recognised assessment tool (malnutrition universal screening tool, MUST). Actions and referrals to other services were made as appropriate. We saw patients' nutritional needs had been assessed in the care records we looked at.
- Symptoms of nausea and vomiting were assessed and treated in the surgical recovery area. When symptoms were effectively managed (within a defined scale recorded in the care plan) care and treatment continued on the surgical ward. We saw evidence of this documented. This ensured patients nutrition and hydration needs continued to be met.

Patient outcomes

- The effectiveness of abdominal (inguinal) hernia repairs, knee and hip replacements was reviewed by patients' completing a PROMs (Patient Reported Outcome Measures) questionnaire before and after surgery. This information was submitted to a national data base which analysed the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The most recent PROMs data was reviewed; April 2014 to December 2014 and was published May 2015. Nuffield Health Plymouth Hospital's score (0.09) for the effectiveness of hernia surgery was not significantly different to the England hospitals' average score (0.08).
- Other PROMs data showed good patient outcomes. The PROMs data relating to how patients evaluated the effectiveness of hip replacement surgery was positive. The first (EQ-5D Index) showed Nuffield Health Plymouth Hospital' scores (0.50) were significantly better than the England average (0.44). Overall, these scores ranked the hospital as the sixth best in the country. The PROMs for knee replacement surgery (Oxford Knee Score) ranked the hospital as 19th best in the country.
- Patients had post-operative support to maximise recovery. The physiotherapy service was provided flexibly, and was based on meeting individual patient's needs. For example, staff said each individual session and each course of physiotherapy lasted as long as the patient required, in order to make the best recovery possible. We saw patients individual post-operative needs were documented in care records.
- NHS patients participating in the PROMs processes for varicose veins, inguinal hernias and knee and hip surgery had three or six month post-operative follow up by a consultant. Unlimited post-operative follow ups were available to private patients who had surgery from

a specified list of more than 20 procedures. The'Recovery Plus' programme supported patients to recover and achieve good results from knee and hip replacement surgery and other procedures.

- Whilst the rate of unplanned readmissions had shown a slight increase, the rate remained similar to expected when compared to other similar hospitals. Between April 2014 and March 2015, 12 patients had unplanned readmissions. Most of the readmissions related to poorly controlled pain and post-operative infections.
- The unplanned readmission rate within 30 days for a specific procedure was worse than expected compared to other similar hospitals. This was for repairs of inguinal hernias carried out by a laparoscopic approach (as opposed to open surgery) between October 2013 and October 2014.

Competent staff

- All physiotherapists had to have been employed in senior roles with a minimum of three years' experience before being eligible to apply for a post with Nuffield Health Plymouth hospital.
- A senior nurse or manager was on duty each shift to provide expert advice and support for more junior theatre staff and this was also the case on the surgical ward.
- We saw a resource file which agency staff were required to work through before starting work at the hospital. This was countersigned and confirmed as completed by Nuffield Health staff who said this ensured all agency workers were familiar with the provider's policies and procedures.
- Nuffield Health Plymouth Hospital had historically maintained paper based practicing privileges files for each consultant. At the time of our inspection these systems were being refined to enable more effective identification of consultants' dates for appraisal, revalidation renewal and indemnity. Any necessary information was shared with the consultant's main employer as part of 'whole practice appraisal'. Nuffield Health Plymouth Hospital also received individual consultant appraisals from the local hospital trust (Plymouth Hospitals NHS Trust).
- Systems were in place to ensure all nurses and physiotherapists working in the inpatient department had their registrations checked on appointment and at the time of renewal by the HR department. There were two systems for recording staff registration verification which were being used to fully update information as part of the revision of the practicing privileges systems. While the systems were being updated senior staff assured us they were confident all staff had in date professionals registration. Of the nurses working in the inpatient department, 89% had their registration checked and 71% of physiotherapists.
- The senior management team were confident all consultants' registrations were in date. We were told the hospitals IT system was set to alert administration staff when any consultant's annual registration was due for renewal. Administration staff then accessed the General Medical Council (GMC) website and printed copies of renewed certificates for personnel files. Senior managers told us if there were any issues obtaining a certificate, a letter would be sent to the consultant reminding them of their obligation to provide evidence of registration. If no response was received, practicing privileges were suspended until registration was evidenced to have been renewed. We observed information relating to this system in practice.
- The surgical department consistently supported staff to have an annual performance appraisal. Records showed 100% of nurses, operating department practitioners and care assistants had received an annual appraisal during 2013 and 2014.
- The surgical ward consistently supported staff to have an annual appraisal. Records showed 100% of nurses, care assistants, allied health professionals and administration and clerical staff had received an annual appraisal during 2013 and 2014
- Senior staff demonstrated an awareness of staff development and performance needs. This was achieved by observation in practice and by discussions with staff. There was evidence this was being managed effectively but this was inconsistent throughout the department. For example, on the ward we were given examples of how learning needs had been identified and improved by joint working and mentoring, and increased supervision and training. In another example on the surgical suite, variable staff performance with computer skills had been identified. However, there were no clear action plans to address these issues.
- Staff were supported to maintain and further develop their professional skills. Physiotherapy staff confirmed they were provided two hours per month of protected time for continuing education. Staff said this had recently included journal reviews and consultant

presentations. Other senior ward staff maintained annual staff training plans. Records showed staff had been supported to attend university modules and other external courses. Staff had also been provided protected study time.

Multidisciplinary working

- All staff reported good working relationships with colleagues throughout the surgical department. There were no routine multidisciplinary handovers as care was led by consultants and responsive to patients' needs. There were three admission times on the ward and morning and afternoon theatre lists, therefore, there were no routine times when consultants or physiotherapists were present in the department.
- Opportunities were missed to strengthen multidisciplinary team working. There had been one whole team meeting on the ward between January 2015 and June 2015. Senior staff said whole team meetings had not been regularly facilitated due to a lack of staff availability to attend.
- Senior nurses, physiotherapists, and managers told us they worked collaboratively with colleagues during various hospital-wide governance meetings.
- There were good processes in place to liaise with patients' GPs prior to admission. Systems were in place to ensure GPs provided all relevant health information and the results of any diagnostic tests for the patient being referred. This was necessary to ensure patients were suitable for surgical treatment at the hospital.
- There were inconsistencies with how post-operative information was shared with GPs. We saw the templates used to contact GPs following discharge were different for private and NHS patients. The template used for private patients was pre-populated with less relevant discharge information than the NHS template. For example, the following information was not included: adverse effects or allergies, immediate post-discharge requirements, planned follow up arrangements or request to be notified if the patient experienced a venous thromboembolism (VTE) within 90 days of discharge. Staff could not explain why the information was different and said the private patient letter could be expanded to include the other information which was not pre-populated.
- Staff told us liaison with others services and professionals for discharge planning started on admission. For example; the physiotherapists assessed what equipment might be required on discharge and contacted the relevant services promptly to avoid discharge delays.

Seven-day services

- The hospital did not provide seven-day surgery lists but did provide medical and nursing treatment and care 24 hours a day, seven days a week. Surgery was booked Monday to Friday from 8am to 8.30pm and occasionally on Saturdays. The endoscopy suite was open Monday to Friday, from 8am to 5pm.
- Each patient's clinical care was the responsibility of their consultant 24 hours a day. If the consultant was unable to attend for any reason, it was their responsibility to organise another suitable consultant with practicing privileges to take over the care of the patient. Systems were in place to ensure all staff were aware of any consultant changes. We saw this information was visible to staff.
- The hospital had two resident medical officers (RMO) with one being available on-site cover 24 hours a day, seven days a week. They provided cover for routine or urgent clinical treatment.
- The surgical services had support from other professionals who worked out of hours to maintain the safety and wellbeing of patients. There was an on call rota which included one of the ward sisters, a physiotherapist, radiographer and one of the senior management team. There was an on call theatre team, including an anaesthetist. The hospital pharmacist was contactable for advice via the telephone. A member of the pathology team at the laboratory at Exeter Nuffield Hospital was available for urgent diagnostic tests required out of hours.

Access to information

- There were systems in place to ensure patients' medical records were available in advance of clinical consultations. The majority (99%) of the consultants had secretaries who were responsible for sourcing existing medical records. These were requested in advance of a patient's admission to the hospital. Administration staff said they could not recall the last time there had been any issues accessing information that impacted consultations or treatment. Preoperative investigative test were completed in a timely way, which enabled patients to have their procedures promptly

Requires improvement

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nuffield Health Plymouth Hospital followed a strict referral process and did not provide treatment to patients who lacked capacity to consent. We looked at nine care and medical records and saw consent documents were fully and clearly completed.
- There were effective processes in place which demonstrated patient consent was obtained for joint surgery. The National Joint Registry (NJR) reviewed evidence that patients had consented for their personal information to be included on the national registry. The NJR looked at patient information from 1 January 2014 to 28 January 2015. During this period at Nuffield Health Plymouth, there had been 185 knee, 171 hip, eight shoulder and one ankle replacement operations (total 365). The evidence of consent was found to be 100%, which exceeded the NJR desired rate of 95%.
- Consent was not regularly kept for decisions regarding emergency resuscitation. This was because under the hospital's criteria for accepting referrals (non-urgent, routine surgery), every patient would have been considered for resuscitation.

Are surgery services caring?

Outstanding ☆

Overall, we judged the surgical services as outstanding for caring. Outstanding care was provided to patients who consistently provided positive feedback. Staff were seen to be providing person-centred care, which was responsive, attentive, reassuring, compassionate and professional. Staff on the surgical ward cared for patients so they remained fully informed, included and supported in all aspects of their treatment and care at all times.

Compassionate care

- We spoke with six patients who all said staff had been attentive, kind and compassionate**.** Two relatives of patients told us they had also previously been patients at the hospital and had found care to be faultless and that Nuffield Health Plymouth would always be their first choice for healthcare
- The patients we spoke with all said they had never had to use the call bell as staff frequently checked how they were feeling. One patient said; "staff are wonderful, it is like they anticipate what I need before I even realise I need it."
- During our time on inspection we observed the atmosphere on the surgical ward was calm, friendly and professional. Staff clearly knew their roles and those of their colleagues and worked cohesively to provide consistent care and attention to patients. We did not hear a call bell ring once.
- Staff were visibly committed to providing person-centred treatment and care. Patients confirmed staff took time to interact with them and people close to them in a respectful and considerate manner. One patient told us all staff were cheerful and kind and just could not do enough to ensure their comfort.
- Staff told us they never made assumptions about how patients preferred to receive their care. For example, staff said they always addressed people by their full title and checked with them what they like to be known as. We saw personalised information was recorded throughout care plans.
- Staff said they read patients' care plans prior to introducing themselves. Staff said this enabled them to take account of and be respectful of patients' personal and cultural choices. Staff said they promoted dignity and respect when providing care. For example, staff said they always kept a dialogue going with patients and explained what they wanted to do, checking permission before proceeding. Staff said they kept people covered as much as possible when providing physical or intimate care. We observed staff knocked on patients' room doors before entering, introduced themselves and clearly explained what they would like to do.
- There were systems in place to gather patients' feedback on compassionate care. NHS patient feedback on care and compassion was good. The hospital had a moderate response rate to the Friends and Family test (FFT). Between October 2014 and March 2015, between 97 and 100 patients per month completed the FFT. Analysis of the survey results showed consistently high levels of satisfaction with the quality of care received.
- A patient-led assessment of the care environment (PLACE) was completed annually. During 2014, the

PLACE score for privacy, dignity and wellbeing at 77.14%. Senior staff said since this audit the whole of the inpatient ward area had been refurbished providing increased privacy and dignity for patients

Understanding and involvement of patients and those close to them

- All the patients we spoke with said they felt fully involved in all aspects of their treatment and care. Patients confirmed they had had information explained in ways that they understood, including risks and benefits of procedures. Patients felt they had time to reflect on this information and choose when they wanted to proceed.
- The hospital had other systems in place to gather feedback which included private patients. Each month a document was produced with evaluated patient feedback for the previous month. The evaluation included questions which provided a mix of ratings and qualitative information. We looked at these records for a six month period from March to August 2015. The patient response rate was between 146 and 215 per month (average 184.) A range of patient opinions had been sought including the helpfulness of staff, which extended to all the clinical staff groups reception, booking, housekeeping and catering staff. Patients reported on how they had been included in their treatment and care, how risks, benefits, and outcomes had been explained and how dignity, respect and privacy maintained. Patient feedback was overwhelmingly positive, with overall satisfaction rated at 95% for five months and 96% for one month. Examples of the numerous qualitative statements left by patients included the following. “Because I was so well briefed, I cannot fault my stay. It was all calm and relaxed but also highly efficient. I never felt hassled.”, “Efficient, friendly staff working in a clean, welcoming environment. Nothing was too much trouble and there were no long waits to see Doctors or physiotherapists. More like going for a spa break than an operation.”, and “Everyone in the hospital treated me very well, they really enjoy their jobs and made me feel safe and well cared for.”
- Shift handovers on the ward were conducted with the full involvement of each patient and took place in the patient’s room with the staff changing shift. This approach was patient centred, personalised and private and ensured each patient was fully involved and informed in all aspects of their treatment and care plans. Staff told us they took as much time as was required to complete a full handover for each patient. The patients we spoke with all confirmed staff encouraged them to participate and be involved, ask questions and provided information in a manner which they understood.
- Each patient was involved in a combined pre-operative and general health assessment. Patients told us advice was discussed with patients regarding their procedures and their overall health and wellbeing.
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- Patients and their carers or relatives, with the patient’s permission, were involved in discharge planning. We saw these discussions documented in care records.

Emotional support

- We observed a patient (with their consent) receiving ophthalmic treatment. Staff throughout the procedure were calm, supportive and attentive to the patient’s emotional needs. Staff demonstrated empathy and an understanding of the impact of the treatment on the patient. We observed when the patient became anxious staff were able to provide a level of reassurance which improved the patient’s confidence, enabling the procedure to be completed.
- Staff said if patients were particularly anxious and requested a partner stay with them for an extended period in the evening, this could be accommodated.
- Staff said patients were encouraged and supported to use resources such as music or relaxation CDs which could be listened to for comfort and reassurance during procedures.

Overall, we judged the surgical services as outstanding for caring. Outstanding care was provided to patients who consistently provided positive feedback. Staff were seen to be providing person-centred care, which was responsive, attentive, reassuring, compassionate and professional. Staff on the surgical ward cared for patients so they remained fully informed, included and supported in all aspects of their treatment and care at all times.

Compassionate care

- We spoke with six patients who all said staff had been attentive, kind and compassionate**.** Two relatives of patients told us they had also previously been patients at the hospital and had found care to be faultless and that Nuffield Health Plymouth would always be their first choice for healthcare
- The patients we spoke with all said they had never had to use the call bell as staff frequently checked how they were feeling. One patient said; "staff are wonderful, it is like they anticipate what I need before I even realise I need it."
- During our time on inspection we observed the atmosphere on the surgical ward was calm, friendly and professional. Staff clearly knew their roles and those of their colleagues and worked cohesively to provide consistent care and attention to patients. We did not hear a call bell ring once.
- Staff were visibly committed to providing person-centred treatment and care. Patients confirmed staff took time to interact with them and people close to them in a respectful and considerate manner. One patient told us all staff were cheerful and kind and just could not do enough to ensure their comfort.
- Staff told us they never made assumptions about how patients preferred to receive their care. For example, staff said they always addressed people by their full title and checked with them what they like to be known as. We saw personalised information was recorded throughout care plans.
- Staff said they read patients' care plans prior to introducing themselves. Staff said this enabled them to take account of and be respectful of patients' personal and cultural choices. Staff said they promoted dignity and respect when providing care. For example, staff said they always kept a dialogue going with patients and explained what they wanted to do, checking permission before proceeding. Staff said they kept people covered as much as possible when providing physical or intimate care. We observed staff knocked on patients' room doors before entering, introduced themselves and clearly explained what they would like to do.
- There were systems in place to gather patients' feedback on compassionate care. NHS patient feedback on care and compassion was good. The hospital had a moderate response rate to the Friends and Family test (FFT). Between October 2014 and March 2015, between 97 and 100 patients per month completed the FFT. Analysis of the survey results showed consistently high levels of satisfaction with the quality of care received.
- A patient-led assessment of the care environment (PLACE) was completed annually. During 2014, the PLACE score for privacy, dignity and wellbeing at 77.14%. Senior staff said since this audit the whole of the inpatient ward area had been refurbished providing increased privacy and dignity for patients
- **Understanding and involvement of patients and those close to them**

- All the patients we spoke with said they felt fully involved in all aspects of their treatment and care. Patients confirmed they had had information explained in ways that they understood, including risks and benefits of procedures. Patients felt they had time to reflect on this information and choose when they wanted to proceed.
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Are surgery services responsive?

Good

Overall, we judged the surgery services to be responsive. There were systems in place which ensured effective access and flow through the department. Treatment and care was responsive to patients' individual needs and the hospital positively responded to patient feedback. Policies and processes were followed to appropriately respond to and investigate complaints. We saw evidence of actions staff had taken in response to feedback in the surgery service.

Service planning and delivery to meet the needs of local people

- The hospital had a patient focus group which met four times a year to discuss topics and issues relating to the patient experience. The group had five members who had all previously been patients. Tasks of the group included reviewing patient satisfaction survey results and participation in the annual patient led assessment of the care environment assessment (PLACE). The group was also involved in food tasting and was asked their opinions on facilities. They were consulted about future developments of the service. Most recently, the focus group had been discussing how best the hospital could support patients with signs and symptoms of dementia care.
- There were several choices of admission time to the surgical ward and theatre. These ensured patients were able to remain in the comfort of their own homes rather than have long waits in the hospital for theatre.

Access and flow

- Systems were in place to effectively manage patient access and flow in the surgical department. Admission to the ward was staggered with three separate arrival times at 7am, 11am and 1pm. This was the standard Monday to Friday. There were occasional admissions during the weekend in response to patient requests. As surgical procedures were elective and low-complexity, admissions were planned two weeks in advance with allowance made for the potential increase in a patient's length of stay.
- The majority of patients had their surgery within the national standard of 18 weeks from time of referral to treatment (RTT). The service had set internal targets against the RTT standards. This was 90% for patients requiring admission and 95% for patients who had day case surgery. Data for the month of March 2015 showed the standard RTT was not achieved for trauma and orthopaedic surgery (84%) which was due to some patients requesting to wait for a Consultant to return from long term sickness absence. The standard had been achieved for surgery related to urology, general surgery and gastroenterology (94-100%).
- The majority of surgeries cancelled were for clinical reasons. There were approximately 491 surgical procedures per month at the hospital. Between December 2014 and May 2015, 28 surgeries had been cancelled. This accounted for a cancellation rate of slightly less than 1%. Of those procedures cancelled, 86% (24) were for clinical reasons.

Meeting people's individual needs

- The patients we spoke with said they had been provided with written information about their conditions before admission which they had found beneficial to discuss with staff. We saw patients were provided with a 'Going home' information pack. This contained information related to their specific procedure and their recovery. For example, there was advice on food and drink, wound care, driving, pain relief, complications and contact numbers.
- The hospital was responsive to feedback. The patient focus group worked with the hospital to raise issues relating to patients' needs. The group had recently noted the bins in the toilets were foot operated which was not ideal for wheelchair users. The hospital had replaced these with hand operated bins. In addition, the group noted a wheelchair user could have had difficulty moving around in the patient rooms on the ward. In response the hospital had removed a wardrobe in a room to allow more space. A clothes rail had been fitted to ensure the same facilities were available.
- Patient satisfaction survey information between December 2014 and May 2015 suggested improvements

could be made to discharge processes. In particular there was some dissatisfaction in relation to how medicines were explained (between 63% and 74% of respondents were satisfied)**.** Senior staff said in response to this, an additional nurse had been recruited. This was to enable increased individual patient time to discuss information and recovery plans.

- Staff in the endoscopy suite told us patients' music could be played during procedures to help reduce anxiety.
- The six patients we spoke with told us the food provided was good and they were offered frequent hot and cold drinks. We observed patients had full jugs of water within easy reach and food looked fresh and appetising.
- There was flexibility in meal times and patients were able to eat when they felt able to. There was a wide and varied menu and individual needs could be accommodated; for example, vegetarian and gluten free options were available. We saw a kitchen area which was stocked with cans of soup and other foods to make light snacks and meals. Staff said this enabled patients, particularly post operatively, to have food at other times to the scheduled hot meal times.
- Relatives were able to visit patients as they wished during the day until 9pm.
- Patients and staff had access to a telephone translation service if required. We spoke with one staff member who had experienced using this and they told us the service was prompt and efficient.
- One staff took a 'dementia lead' role on the ward. This was to support patients who may have had some symptoms and to advise staff. Staff were able to describe how the Mental Capacity Act 2005 worked to ensure patients' best interests were served. There was also written guidance available for staff. The hospital had never had to make a Deprivation of Liberty safeguard.

Learning from complaints and concerns

- The hospital had policies and processes in place to appropriately investigate, monitor and evaluate patients' complaints. An acknowledgement of any complaint was provided within two working days and a full written response was sent within 20 working days. We saw records which showed this was achieved for the majority of complaints received.
- Complaints were discussed at the weekly senior management team meeting and with the relevant heads of departments as required. Relevant complaint information and learning was escalated to other senior clinical and governance meetings. These included a monthly clinical heads of department meeting, a quarterly integrated governance meeting and a quarterly medical advisory committee.
- The hospital took appropriate action in response to complaints. During 2013 there were a total of 21 complaints, and 37 during 2014, an increase of 76.2%. Senior staff said this had been related to some consultants' attitudes to patients (within clinics). This information had been shared with the Medical Advisory Committee, who subsequently wrote to all the consultants with further advice regarding professional conduct. We saw records of this.
- Feedback from the patient satisfaction survey raised concerns regarding the décor of the hospital. In response, the hospital had put an improvement plan in place. We saw this had started with a refurbishment of all the inpatient rooms.
- There was mixed patient feedback on the NHS Choices website. From January 2014 to June 2015 seven feedback comments had been left. Three of these were negative and concerned disappointment with the admissions and outpatients procedures and apparent misinformation regarding test results. Four were very complimentary regarding care and treatment received. The hospital had posted appropriate individual feedback on the website, including further actions they planned to take as a consequence.

Are surgery services well-led?

Requires improvement

Overall, we judged that leadership in surgical services required improvement. There were clear governance processes in place but some senior staff were not able to fully demonstrate an understanding of key risk management issues. There was evidence of investigation of serious incidents and audits were undertaken but there was a lack of detail and recording to demonstrate how some issues had been interrogated, or understanding of how some action plans would be used to drive improvements.

Requires improvement

Surgery

The workforce was relatively stable and there low levels of sickness absence and vacancies. There was evidence that staff were striving to make improvements through education and innovation. The physiotherapy service and surgical ward staff had shown innovation and initiative with the development new processes and services for the benefit of patients.

All staff we spoke with enjoyed working at the hospital and were proud of the care they provided. The senior management team were reported to be visible, approachable and supportive.

Vision, strategy, and sustainability for this core service

- There was a corporate strategy and vision for the hospital which included the promotion individual, prompt care and treatment and whole health well-being. We spoke with staff who demonstrated familiarity with the overall goals. We saw posters on staff information boards relating to the organisation's vision and objectives.
- For most staff groups, there were high levels of staff stability and low levels of staff turnover. This contributed to the sustainability of the service. All the staff groups employed to work in the surgical department by Nuffield Health Plymouth Hospital had been employed for more than one year.
- The hospital had successful recruitment processes which supported the sustainability of the service. During 2013 there had been a 10% nursing vacancy rate and 11% operating department vacancy rate. During 2014 there remained only a 5% nursing assistant vacancy rate in surgery.

Governance, risk management and quality measurement for this core service

- The hospital had a governance structure in place from ward to board and vice versa. Key governance, risk and quality information from all staff departmental meetings was fed through to other governance meetings on a monthly or quarterly basis. These included; health and safety, infection control, information governance and resuscitation committee meetings.
- Relevant information from the staff departmental meetings was passed to heads of departments and integrated governance meetings and the Medical Advisory Committee (MAC). In addition, the senior management team met weekly to maintain an overview of the day to day patient, staffing and amenities issues.
- There was mixed understanding at senior level in the theatre and surgical ward of governance and risk management priorities. For example, on the ward, senior staff explained how audit information had been used to make risk and quality improvements. We saw actions taken included a letter to all staff from the pharmacist and matron, detailing new expectations. In addition, senior ward staff said they observed practice and spoke with individual staff as required to ensure processes improved. In another example in the theatre, audit information had shown identified areas of non-compliance with the World Health Organisation (WHO) safe surgery checklist. The only action evidenced in place was to provide verbal reminders to improve compliance. Senior theatre staff were not able to identify what other actions may have been required to effectively monitor and drive through improvements.
- There were no other plans in place to effectively monitor change and the theatre manager was unclear if the current actions were sufficient to and drive through improvements. We were not supplied with audit reports or action plans which demonstrated a robust process about a meaningful sample of safe surgery checklists being reviewed during the audit or that findings were reported and acted upon through the hospital governance systems.
- Incidents identified as having moderate risks were subject to a root cause analysis (RCA). Records showed information was analysed for learning and service improvements and how and when this was to be shared with professionals. Most of the staff we spoke with demonstrated an understanding of issues of recent RCA investigations and learning.

Leadership, culture and innovation of service related

- The senior management team were highly visible throughout the surgical department, often undertaking walks around all areas. Staff described knowing them on first name terms and were encouraged in conversation and feedback.

Requires improvement

Surgery

- The senior ward and surgical staff were also described as accessible and supportive by staff. We were told of examples of how managers had supported staff in flexible and thoughtful ways in response to personal issues which had impacted on their working life.
- The way staff spoke about patients and their roles demonstrated a culture of patient-centred care. Staff told us they enjoyed their jobs, were proud of the hospital and of the treatment and care they provided to patients.
- Three of the four senior management team at Nuffield Health Plymouth Hospital were non-clinical with the matron providing clinical leadership. The Medical Advisory Committee (MAC), made up of registered Consultants from most specialties within the Hospital, was involved in the development of clinical services within the hospital. National policies do not require local Consultant approval but they are entitled to review, for example the Practice Privileges Policy. New clinical services are discussed at MAC and have to be signed off by the MAC Chair. Local policies/SOPs are also discussed and signed off by the MAC Chair for example the VTE SOP. National policies are designed and implemented with support from a number of clinicians across Nuffield Health, including senior Board members for the Hospital Division, to include the Medical Director (Consultant Orthopaedic Consultant), the Chief Nurse, the Chief Pharmacist, lead Pathologist.
- Student nurses said staff at all levels had been supportive and encouraging. The students said this had made them feel appreciated and valued members of the surgical department. The students told us consultants had treated them with the upmost consideration in theatre by enabling them to fully observe, and by taking time to explain procedures.
- There was evidence staff were striving to make improvements through education and innovation. Surgical nursing staff developed a new pre-operative process for patients. This followed reflection on learning from attendance at an infection control conference. Six months after the new initiative, post-operative infection rates were shown to have reduced by 54%. In recognition, staff had been nominated for and won an internal award.
- The physiotherapists were encouraged and supported to develop specialist complementary skills. This included acupuncture, hand splinting and women's health. One of the physiotherapists had trained in clinical Pilates and had designed a six-week course. The course was designed to strengthen and stabilise muscles in a relaxed group setting. Feedback from the first group had been very positive. There were enough patients' on a waiting list to facilitate two further groups. In response, other physiotherapists were planning to train in order to meet demand for the service.

Requires improvement

Services for children and young people

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

Information about the service

Nuffield Health Plymouth provides outpatient consultations and surgical procedures for children and young people. There were 34 surgical procedures carried out between April 2014 and March 2015 and 222 children were seen in the outpatient department. Children from birth to 18 years of age were seen in outpatients and surgical procedures were only performed on children aged three years and above.

The ward was not dedicated to children's services only. It was arranged in single rooms with private ensuite facilities in each and adults or children were allocated to any one of these rooms.

Surgery for children was planned as day case surgery but there was provision if needed for an overnight stay. There were facilities for parents to stay with their child in the same room. There was a separate area where children could be recovered from their anaesthetic which was away from the adult recovery area.

Consultant surgeons were responsible for the medical care of the child during their stay and resident medical officers with paediatric skills were available at the hospital 24 hours a day.

The hospital employed a children's nurse dedicated to the care of children for the duration of their stay. Other registered nurses who were trained to care for adults would also provide care according to hospital policy, when the registered children's nurse was not on duty.

Outpatient services for children included consultations, pre-operative checks, investigations and private appointments for psychological support.

During our inspection we spoke with ten staff including student nurses, one patient, and one relative and observed six sets of children's records.

Requires improvement

Services for children and young people

Summary of findings

Overall, we judged services for Children and Young people require improvement with aspects of well led being inadequate.

The hospital had policies in place to ensure appropriately qualified staff cared for children in outpatients, operating theatres and on the ward. There were fixed monthly sessions booked using a process to ensure appropriate staff were available. There was a potential that staff would not be available to provide direct care for children at all times, For example, should a child below 14 years old need to stay overnight and the RN child had already worked all day. The hospital policy did not follow the Royal College of Nursing guidance around safe staffing for children. Children between the ages of 14 and 16 could be cared for overnight by adult trained nurses only when risk assessed as suitable and with the support and advice from the children's nurse. There was no risk assessment tool or policy statement specifically for the situation of a child over 14 needing to stay the night. There was little contingency to cover for sickness or annual leave of the RN (child). The RN (child) offered support to any member of staff and department around the care of children and staff found her to be always available.

Monitoring of skills by the hospital management team ensured medical staff were competent to practice.

The RN child was allocated to children admitted for surgical procedures unless the child had been assessed as suitable for care by a nurse trained in adult care who had been assessed as having additional competencies in child care. These competencies were arranged and assessed locally, requiring little demonstration of competence in practical skills with caring for children.

There have been limited procedures undertaken for children aged between three and eight years, as a result a temporary decision has been taken by the hospital management since the inspection to only undertake surgical procedures for children aged eight years and above. The rationale for this decision was discussed at the integrated governance meeting held 21 July 2015. No documented risk assessment was available for this decision.

Children benefitted from the standards of care and infection prevention activities afforded to adults in the hospital. However hand hygiene technique was not communicated to children.

There were no audits of outcome measures available for children. There were no methods for collecting the views of children in order to inform service delivery.

The Medical Advisory Committee had no lead representation to advocate for the care of children at the time of our visit but there were two committee members who carried out regular paediatric practice. A new lead was identified on our return in the week of 14th July 2015.

Medicines were available for children and emergency drugs were being held in the same emergency drugs box that was used for adults. Systems were in place to minimise the risk of incorrect doses of emergency medicine being administered to children.

The hospital was responsive when concerns were raised, by investigating situations and drawing up action plans. Governance and leadership was designed for adults' services with insufficient systems and processes in place specifically for children's services.

Parents and children we spoke with felt informed and cared for by staff at the hospital.

Requires improvement

Services for children and young people

Are services for children and young people safe?

Requires improvement

The hospital had specific policies in place to ensure children were cared for in theatre and on the ward by appropriately qualified staff. However, the policy did not follow the Royal College of Nursing guidance around safe staffing. There were fixed monthly sessions for childrens surgery and a booking process to ensure appropriately trained staff were available for these sessions. There was little contingency to cover for sickness or annual leave of the registered children's nurse which could result in children's surgery being cancelled or their being cared for by nurses who did not have appropriate skills and knowledge to ensure the safe care of the child.

Following our inspection, the hospital management made a decision to raise the age of children admitted for surgical procedures from three years to eight years of age. There was no evidence of a risk assessment being undertaken to give a rationale for this decision.

There was a tool for registered nurses (adult) to acquire skills to care for children but it had little assessment of practical skills specific to children.

Monitoring of surgeons and anaesthetists paediatric skills by the hospital management team ensured medical staff were competent to practice.

Children attending this hospital benefitted from the standards of monitoring, preventing infection and safe keeping of records put into place for all patients.

The majority of the staff were trained in level one safeguarding children and steps were taken to ensure that there was always a member of staff in the hospital who had completed level three safeguarding training and we were told of plans to ensure all clinical staff were trained to level two.

The outpatients department posed some potential risk for children visiting the area with doors opening to the car park and a hot drinks machine within reach of young children.

Incidents

- There had been no incidents relating to children and young people in the 12 months prior to our inspection.
- Staff said they were confident in reporting incidents and found no difficulties with using the system.
- There were no reported mortality and morbidity issues involving children. We were told mortality and morbidity issues were treated as adverse incidents and reported using the electronic reporting system. These would then be discussed at meetings of the senior management. Notes from the clinical heads of department meeting of April 2015 showed the action plans in place and progress achieved. Heads of department disseminated the information to their teams.

Duty of Candour

- Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. There was no record of training on duty of candour and staff we spoke with were not aware of the term "duty of Candour" although staff described dealing with comments or complaints in an open and honest way.

Cleanliness, infection control and hygiene

- An infection prevention and control committee had representation from all areas of the hospital. This committee met two monthly to discuss and review infection control issues and formulate action plans. Processes were in place to protect patients from hospital acquired infections. Hand disinfectant was available at all entrances to the hospital, main ward and theatre areas, as well as in each patient's room. We observed staff asking people to use antibacterial hand disinfectant on entry to the hospital.
- From April 2014 to March 2015 there had been no incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections. There had been one case of Methicillin-sensitive Staphylococcus aureus (MSSA) which did not involve a child. There were no incidents of serious infection involving children. We were told a history was taken to preoperatively assess whether children were at risk of carrying an infection and tested if there was a risk. Children being admitted for surgical procedures were asked to shower to prevent

infection developing. Immediately prior to surgery children under eight years of age would shower at home and children over eight years would use a medicated sponge to wash

- Staff taught and encouraged parents to use hand disinfectant but this teaching was not applied to the children and it was not expected that parents would teach their children the technique. We were told by staff they had not thought about children's' hand hygiene but that the question had prompted them to consider their practice for the future.
- Infection control audits were completed every three months as part of a national Nuffield Health audit programme. Compliance was assessed using a robust assessment tool based on observations and an individual assessment of knowledge about infection control. The most recent infection control audit for the hospital was completed in April 2015 and showed good compliance in most areas. Hand hygiene in this audit showed only 53% compliance and an action plan was formulated to provide mandatory hand hygiene workshops for staff with progress to be reviewed in June 2015.
- We observed multi use equipment with stickers stating the equipment had been sanitised following previous use and was ready to be used again.
- In the outpatients there was a play table for young children which looked clean. Staff were unable to tell us how often the toys were cleaned but children's' toys were included in the infection prevention and control audits.

Environment and equipment

- The outpatients department posed some potential risk for children visiting the area. The outpatients department had a coffee machine with the hot dispensing outlet being positioned within reach of young children. At the main entrance to the outpatient department were automatic sliding doors which opened on to a car parking area. This could cause a hazard for lively young children running around and potentially out of the doors. Notices in the department advised parents of the hot drinks dispenser and to supervise their children.
- Suitable and appropriate resuscitation equipment for children was available in the outpatients department and on the ward areas. There was clear guidance of how often it should be checked according to the hospital policy and a register was completed with the date of the check and who completed it. Security was maintained using a tag to keep the equipment out of the reach of children and the trolley in outpatients department was kept in a corridor close to clinical areas and not in a general waiting area.
- We saw equipment was labelled to indicate it had been serviced and when it was due to be serviced next.
- The ward consisted of single rooms with private washing and toilet facilities. Staff told us children or adults would use any available room. The room could be anywhere on the ward area and may not be close to the nurses station.

Medicines

- There was a pharmacy service available Monday to Friday 8. 30 am to 4. 30pm when most of the routine and take home medications were organised. Should any special medications be required outside of these hours, the pharmacy manager and the pharmacist were available for advice by telephone and the on call pharmacist for the local NHS trust was available for emergency situations. The resident medical officer had access to the pharmacy 24 hours a day if required.
- We were told any new drugs for use in the hospital applications were discussed at the Medical Advisory Committee (MAC) meetings.
- The emergency drugs for child resuscitation had been changed in June 2015. Staff told us the emergency drugs on resuscitation trollies were monitored on a monthly basis and replaced in good time if 'use by' date was approaching. We observed the adult adrenaline being held in a 10 millilitre syringe and expressed a concern about the risk of confusion of children's doses. Adrenaline used in a cardiac arrest emergency is the same as used in adults but would be calculated according to the child's weight. An internationally recognised scale to identify the dose of emergency medicine required for the child was available on the resuscitation trolleys. A colour coded name band system was used for children at admission which corresponded to the emergency drug scale available.
- Adrenaline used for anaphylaxis and not that used in a cardiac emergency. The emergency drugs packs were amended in June 2015 to add an "Anapen" (auto-injector of epinephrine/adrenaline) for treatment of anaphylaxis. The adrenaline used in an adult anaphylaxis emergency is exactly the same as that used

in a child with the exception of the dose size which is worked out on an age basis. Adrenalin was also stored to use for children in the event of anaphylaxis (a life threatening allergic reaction). Anaphylaxis kits were available throughout the hospital on the resuscitation trollies and in key departments

- We were assured at the time of the inspection and since the inspection that all resident medical officers were clear about the process and that the paediatric nurse was trained to understand the process.
- The child records we saw identified allergies for staff to see.
- Nuffield Plymouth Hospital Children's service policy stated only nurses who were qualified as RN (child) or were RN (adult) with additional competencies should provide care for children under the age of 16 years. This would include the administration of medicines. It was not clear that if a child stayed in overnight, medicines would be administered in accordance with the policy. Since the inspection the hospital advised us that in the event of a child needing to stay overnight a childrens nurse from another Nuffield hospitals would be called upon to cover the shift. This would mean only nurses who were qualified as RN (child) or were RN (adult) with additional competencies would administer medicines. We have not been able to test this policy statement.

Records

- Children's medical records were all paper based with current files stored at the hospital and were secured in filing cabinets in a room which was locked when no staff were present. Older notes were stored off site but accessible on the same day. Staff told us they could contact the local NHS hospital if they needed further information of the patient's medical history.
- The six records we observed were legible dated and signed giving a clear plan for ongoing medical review.
- We saw child nursing records including appropriate use of Paediatric Early Warning Scores (PEWS). This is a method of identifying and assessing the need to escalate a deteriorating condition. All entries were signed and dated.
- We were told that patient records were audited 3 monthly with records being chosen at random which may or may not include a child's record. There was no regular audit of children's records and staff could not tell us when a child's record had been part of an audit.

Safeguarding

- Training records showed that 91% of all staff had completed safeguarding children level one but it was not specified whether the remainder of staff outstanding the training were in contact with children. The royal college of paediatrics and child health recommends that all staff who have some degree of contact with children should have completed level two safeguarding training as a minimum. Six staff in the hospital had completed safeguarding training at level three which was appropriate and followed the Nuffield Health Group Safeguarding and Protecting Vulnerable People Policy. Two of these staff were senior managers and four were nursing staff who would when required be allocated specific care of children at the hospital. Senior managers informed us about future plans for all clinical nursing staff to complete level two safeguarding children training. The senior managers had completed the required levels of safeguarding training in accordance with the Intercollegiate document and the Nuffield Health Safeguarding and also Mandatory Training policies
- Contact details were displayed in all local areas of the hospital if staff needed to make a safeguarding alert. The staff we spoke with could not tell us of a time they had reported a safeguarding concern for a child but could name the people with extra safeguarding children knowledge and who could provide support with any safeguarding issues. Guidance relating to safeguarding and child maltreatment was displayed in the operating theatres for staff to see.

Mandatory training

- In May 2015 only 54% of staff were up to date with basic life support training. The hospital had identified this before our visit stating it was due to the trainer being unavailable. We were told an alternative trainer had been identified to deliver basic life support for administration staff and immediate life support training for all clinical staff. Some staff in the hospital had already attended basic life support training and further sessions were being planned for the very near future.
- Nuffield Health cardiopulmonary resuscitation policy of 31/01/2015 stated that all staff caring for, or supervising children must be trained in basic paediatric life support. Resident medical officers were trained in advanced paediatric life support and were available 24 hours a

day to respond to emergency situations. We were told by senior managers that the RN (child branch) had completed the European Paediatric Basic Life Support (EPLS) training detailing that it was due for updating in December 2015. The recovery nurses carry out Paediatric basic life support and children are recovered by the recovery Paediatric Link Nurse who has completed the Nuffield Health Paediatric competencies. The ODPs complete paediatric BLS and work with a paediatric anaesthetist when paediatric patients are undergoing surgery.

- The hospital had recently changed to an electronic record of training completed and were not able to provide the information for the status of staff training. We saw the lesson plans for basic life support which included the need for staff to demonstrate skills in paediatric basic life support. Staff told us of scenarios arranged in clinical areas for staff to practice emergency responses. One of these scenarios was based on an 8 month old child. The responses were assessed by the resuscitation officer for and were reported as being carried out correctly, these sessions were used to develop further learning.
- In order for a nurse to be competent to work with children and young people they had to be assessed by the RN child nurse who would use a framework developed by Nuffield Health Group. We saw a completed framework assessment which required the RN (adult) to read policies and demonstrate theoretical knowledge and understanding of a range procedures including knowledge of consent, hospital policies for the care of children and demonstrating an understanding of pain tools in the children's care record. Some demonstration of skills by the RN (adult) was required and included completion of paediatric basic life support training, being able to calculate medications competently, monitoring and interpreting of a child's vital signs. Staff told us they had read documents but there had been no assessment of their nursing activity with children. Guidelines stated the assessment was valid for two years and staff we spoke with were within this timescale.

Assessing and responding to patient risk

- The hospital had policies in place which ensured children's risks were assessed by appropriately qualified medical staff. The hospital's practising privileges policy stated that any consultant treating children, including anaesthetists, had to evidence continuing paediatric training and updates of paediatric resuscitation skills. We saw this confirmed and documented in records maintained by the hospital.
- All children and young people attending for surgery had a pre-admission risk assessment conducted by the RN (child branch). Staff in outpatients and in the pre assessment clinics all said they would contact the paediatric nurse for any pre-operative assessment a child might need. A young person of either 16 or 17 years of age would have an assessment by the RN (child) to identify if he needed to be nursed by an adult trained nurse or a children's trained nurse.
- We saw evidence of the Paediatric Early Warning Score (PEWS) being completed. These were charts developed by the NHS Institute for Innovation and Improvement which could be used and adapted by the organisation to monitor the condition of a child who had undergone surgery and identify when further assessment or review was required. The scores were calculated by generating a combination of scores from a selection or routine observations and provided an indication of when intervention was needed. Guidance was provided on the form for children of varying ages and expected normal ranges.
- The five steps to safer surgery (used to increase the safety of patients undergoing surgery) was appropriately completed for the records of a child we saw having surgery.
- The hospital had a policy for the transfer of children, to an acute hospital if their condition deteriorated. There were no children reported as having been transferred.
- For the once monthly paediatric surgery list an anaesthetist with paediatric training would care for the anaesthetic needs of the children undergoing surgery.

Nursing staffing

- The hospital had policies and standards in place to ensure appropriately qualified staff cared for children in outpatients, operating theatres and on the ward. One registered children's nurse (RN child) was employed by the hospital. Registered adult nurses (RN adult) had been assessed using the Nuffield Health Group competency tool as having additional skills to care for children who were between the ages of 12 and 16 years. Six were part of the ward team, three nurses were in theatres and two nurses in outpatients. We were told by nursing staff that children did not often stay overnight;

however, in order to follow the hospital children's' service policy, if a child were to stay in overnight one of these nurses would need to be on duty. The duty rota for childrens' surgical lists of 28 May and 25 June showed no planned paediatric competent nurses on the night shift. This gave no assurance that appropriately trained staff provided care for children at all times. The RN (child) told us there was an RN (child) who would work on a bank nurse basis but she would need to be booked well in advance in order to arrange to be able to work at the time she was required.

- Surgery would only be undertaken for children over three years of age and only if the RN (child) approved that all paediatric services available were sufficient. This included the RN (child) pre-assessing the patient and being on duty for the patient's admission. The duty rota for the ward had the RN (child) on duty for the times of the paediatric surgical lists. If she were not available the list would be cancelled. At the time of our inspection children undergoing surgery were cared for by the RN (child) before and after their procedure which did not include an overnight stay. The hospital policy stated that young people aged 16 and 17 years may be cared for by registered nurses trained to care for adults. Children between 14 and 16 years of age could be cared for overnight by adult trained nurses when risk assessed as suitable and with the support and advice from the RN child.There was no risk assessment tool or policy statement specifically for the situation of a child over 14 needing to stay the night. There was an assessment document for use in the event of a child needing to be transferred to another health facility if they needed additional treatment.
- One of the outpatient nurses with children's competencies would be on duty when patients of 12 years and over were to undergo procedures in the outpatient department. Should a child of less than 12 years of age need to undergo a procedure in the outpatients department, the RN (child) from the ward would attend the outpatients department. The appointment for this would be arranged by the consultant's secretary who would liaise with the outpatient department manager. The outpatient department manager was responsible for appropriately staffing the department which included following the hospital policy for care of children in the department. We were assured by the hospital that if a child needed care from the RN (child) for a procedure in the outpatients department, it would be booked for a time when she had no other commitments.
- For children less than 14 years who needed to stay overnight, the paediatric nurse would be on call and sleep overnight in the hospital providing advice and care if requested to by nurses on the ward. For patients over the age of 14 there may be occasions where the patient may need to stay overnight and the RN (child) would be on call but not on the hospital site. The patient would be risk assessed by the RN (child) prior to this occurring. This could leave the child being directly cared for, at times, by an RN (adult) who may not have undertaken additional competencies for children's nursing. The Royal College of Nursing (RCN) defining staffing levels for the care of children states there should be a minimum of two registered children's nurses at all times in all inpatient and day case areas. The hospital did not meet this standard at the time of our inspection with only one RN (child) in the hospital. We were told the service for children was not run as a specific children's ward. Therefore, the hospital followed the RCN (2013) guidance of one RN (child) for up to four children over the age of two years and had other RNs (adult) available for support. Surgical lists were limited to ensure no more than four children were on the ward at any one time. Since our visit to the hospital the registered manager has informed us that with advance notification of a child needing to stay overnight, arrangements would be made for an RN (child) to move from Exeter Nuffield Hospital to the Plymouth hospital for that shift.
- Adult trained nurses on the ward who had no additional nursing competencies with children, informed us they had an overview of children's needs on the ward at staff handover times but did not undertake any vital signs observations for the child. Should they need any advice regarding the care of children they said they would call the RN (child) at home if she were not available in the hospital.
- Since our visit, the hospital manager has informed us a decision has been made to raise the current minimum age of three for children admitted for surgical procedures to eight years of age. This decision followed discussion with theatre staff, the MAC chair and anaesthetic lead.

Medical staffing

Requires improvement

Services for children and young people

- Hospital policy stated that any of the 31 consultants who had practicing privileges to see children at this hospital, were responsible for the care of child during their stay in the hospital 24 hours a day.
- Resident medical officers (RMO) who provided routine medical care 24 hours a day had paediatric competencies. Most children stayed for one day only and none were reported to stay over the weekend.

Major incident awareness and training

- Senior staff were aware of the hospital's major incident policy and how to access this
- Staff told us there was regular testing of fire alarms and drills where the outpatients department had to be evacuated. Notice boards displayed who the fire marshal was that was on duty and relevant numbers to call.

Are services for children and young people effective?

Requires improvement

We judged children services as requiring improvement in effectiveness. Of the 34 children who underwent surgical procedures between April 2014 and March 2015 outcomes of the treatments were not collected by the hospital. The hospital did not have a process in place to capture if a child had required readmission following their procedure as any child would be readmitted to a local NHS hospital for ongoing care.

Systems were in place to ensure medical staff were competent to care for children. There was a strategy to ensure children were cared for by appropriately qualified nursing staff but there was a risk children would have their procedure cancelled due to absence of competent nursing staff. This was because there was only one registered nurse qualified to look after children RN (child).

Evidence-based care and treatment

- There was no evidence of any regular audit procedures specific to children's services at the time of our inspection.
- The hospital had a process for adopting NICE (National Institute for Health and Care Excellence) guidelines. We saw notes of senior management meetings where guidelines were discussed and assessed for relevance to the service detailing required actions and review dates. Managers cascaded this information to staff at their team meetings and medical staff would be informed if the guidance was relevant to their area of practice Theatre staff showed us the most recent NICE guidance "suspecting child maltreatment 2009" which was displayed in theatres for staff to see. .

Pain relief

- A Wong and Baker pain assessment tool designed for children of three years and above, was included in the patient record for nursing assessment. During our inspection older children were seen to be asked if they had pain as they were old enough not to need to use the child friendly version of the pain chart.

Nutrition and hydration

- A children's menu had recently been updated following a standard review by the hospital. This meant that any children could choose from an alternative menu providing more child friendly food choices giving encouragement to have a balanced diet. We did not see any young children in the hospital, therefore did not observe any child specific crockery and cutlery being used.

Patient outcomes

- If a child required readmission postoperatively, we were told by staff the child would not be readmitted to this hospital. Should children need further intervention due to infection or other complication, they would attend the local GP or NHS hospital. We were not shown any evidence of current monitoring of outcomes for children's surgery or methods of capturing any admissions or attendance to the acute hospital or GP. A gap analysis undertaken in June 2015 had identified a plan to capture outcomes for children's surgery.

Competent staff

- Nuffield Group practising privileges policy (the hospital management give a medical practitioner permission to practise as a medical practitioner in that hospital) stated the expected level of experience for a surgeon or anaesthetist to acquire before they were permitted to care for children at this hospital. If any consultant did not meet these criteria, they would not be allowed to perform surgery on children at this hospital.

- Processes were in place to ensure medical staff that cared for children had the appropriate competency and experience to safely care for children. We saw notes of MAC meetings where revalidation for consultants was monitored. This included monitoring of the consultants' paediatric experience in hospitals other than Nuffield Health Plymouth and taking appropriate action. In June 2015, of 36 consultants who saw children at Nuffield Health Plymouth, five had their practice at the hospital restricted to seeing and treating adults only and three were limited to seeing children as outpatients only in line with their skills and competence.
- Many of the surgeons and anaesthetists were also practising at the local NHS acute hospital undertaking comparable work where their competencies and appraisals were regularly monitored and shared with Nuffield Health Plymouth.
- There was one RN qualified in the care of adults and children employed by the hospital who ensured she was on duty when children's surgery was being performed in the hospital. We saw duty rotas specifying when her responsibilities were dedicated to children. She told us approximately 75% of her time was spent providing care for adults.
- The RN (child) updated her skills by attending other clinical areas to increase her experience. An example being to undertake alternative practice at another Nuffield Group hospital that performed children's surgery. This had not been possible for the previous year due to work pressures. The RN (child) had not received clinical supervision for their paediatric practise but was unable to provide evidence of the most recent supervision session.
- For the 12 months between April 2014 and March 2015, the hospital performed 28 procedures on children above three years of age. The RN (child) was uncertain that caring for the number of children attending the hospital would provide enough experience to maintain their paediatric skills. The regulatory body for nurses and midwives, the Nursing and Midwifery Council (NMC) have confirmed they will be implementing revalidation for nurses and midwives to go throught the process in April 2016. This includes 450 hours of practice within the specialty of nursing over a three year period and 40 hours of continual professional development (CPD). We raised the issue of maintaining competency with the senior managers of the hospital and were told an action plan would be put into place. This was to include working on a children's ward at another Nuffield Group hospital each month and liaising with the local NHS trust regarding continual professional development opportunities.
- Eleven RNs (adult) in the hospital had extended their skills by completing a competency framework for children's nursing. This was assessed by the RN (child) who had completed a course in teaching and assessing a number of years previously and had updated mentorship skills with the local nurse education provider. We saw that the competency framework required the nurses to read documents and describe understanding of how to provide care for children and demonstrate calculation of medicines suitable for children. It did not require demonstrating skills directly with a child. One nurse who had completed the framework a year ago told us they had looked after only one or two children in the previous six months. Hospital policy stated that post-operative care for children between the ages of 12 and 16 years should be managed by the RN child but if unavailable, could be provided by other paediatric competency assessed nurses. The under 18 year old we saw was cared for by the RN child. Children above the age of 12 years visiting the outpatient department for a consultation could be cared for by paediatric competency assessed nurses.

Multidisciplinary working (in relation to this core service)

- Staff we spoke with in outpatients, radiology, theatre and the ward were all aware of the policies in place for the care of children and when they should request the services of a RN (child) or a paediatric competent RN (adult). Staff would move between ward and outpatients as required by the needs of the child. Nurses for adults did not have any input to the care of the child unless the child was between 16 and 17 years of age and had been assessed by the RN (child) as suitable to be cared for by an adult nurse.
- Radiology did not provide a service for children under the age of 8 years but had a policy displayed for staff to see regarding when they required support from the RN (child).
- Physiotherapists saw children over the age of 12 years when required. We saw records stating they had been assessed in competencies with treating children.

Requires improvement

Services for children and young people

- There were no play therapists in the hospital but parents we spoke with were encouraged to be involved in the care of their child.
- We saw letters to GPs of children informing them of the clinical interventions and plan of care for the child.

Seven-day services

- We were told children did not stay in the hospital over the weekend. Provision of medicines and nursing care were available seven days a week in the hospital. The RMO had access to pharmacy provision at all times and pharmacy staff were available for advice if it was needed.

Access to information

- GPs were kept informed of the ongoing plan of care for the child by the consultant who wrote to the GP and kept a copy in the child record. There was direct access to electronic record systems held by the GP which enabled staff to access current medical information for the patient.
- Medical secretaries ensured patient records were available for the consultant to view at the child's appointment. Staff could not recall a time when a child did not have any notes available. A telephone call to the parent and child from the RN (child) formed the pre assessment consultation. The RN (child) commenced the nursing care record which was available when the child attended the hospital for the planned procedure.

Consent

- Consent for children below the age of 16 years followed national guidance, Seeking consent, working with children. (Department of Health, 2001) and was obtained from their parent or guardian. Children over the age of 16 years were asked if they would like to consent for themselves. We saw a young person aged 16 years who was accompanied by his mother. We saw he was given choices of treatment and responses were dealt with appropriately and according to the patient's wishes. This was in accordance with the hospital policy for seeking consent. The patient said they had felt informed throughout the process.
- The clinical records we reviewed contained evidence of the consultant offering choice to the child prior to full consent being confirmed by parents or guardian or where appropriate the child themselves. For example, entries to the record for a child under 16 years of age included "the [child] will think about this further at home"

Are services for children and young people caring?

Good

We judged the children service as caring. We only saw one young person treated at this hospital. The patient was treated with compassion appropriate to age and given choices for his care.

The environment was designed and had facilities suitable for adults with very little provision for varying ages of children; however, staff caring for children were able to respond appropriately to children's needs. Children were informed of procedures in a way they could understand and parents were included in the care of their child. Parents and children said they felt informed and cared for by staff at the hospital.

Compassionate care

- Children we met were treated with respect and provided with information they could understand.
- We saw a child being spoken to in an appropriate way for their age and ability. The RN (child) cared for the child post operatively maintaining supervision in the individual room. Parents were involved but the child was given time to make their own choices. Pain was assessed and treated appropriately according to the child's perception of pain.

Understanding and involvement of patients and those close to them

- A parent stated "I feel that we have been fully informed and supported. The pre-op was even done in the half term holiday, not to interfere with schooling"
- If parents wanted to stay with their child, accommodation, in the form of a pop-up bed, was available.
- Patient records showed that children of all ages were consulted and supported to make their own decisions wherever this was appropriate.

Requires improvement

Services for children and young people

- We saw the RN (child) caring for a child at all times before and after surgery and in the operating theatre a nurse with paediatric competencies cared for the patient. Both child and parent knew who to talk to for support.
- Information was provided in simple format for parents to take away enabling support of the child following surgery.

Emotional support

- The child was offered support from their parent by accompanying them to the operating theatre. The parent was able to leave the child in the care of clinical staff in the hospital and displayed no anxious behaviour in doing so. Staff were available for further support if it was needed.
- The RN (child) contacted parents on the day following their child's surgery to reassure the family and offer appropriate advice should there be any concerns.

Are services for children and young people responsive?

Requires improvement

We judged services for children and young people to require improvement for being responsive.

The senior management had reviewed needs of children but did not identify specific needs of children they cared for in making any of the environment child friendly. Some provision was made for children for example menu choices had been increased for children; there was a separate recovery area from adults following surgery. Other distractions or entertainment items were not provided. There were no specific child friendly rooms or anaesthetic areas although some professionals were skilled in distracting children at times when they might be nervous or distressed.

Complaints and comments processes were suitable for adults but there was little consultation with children and their families. Children could use the same forms or be supported by the adults to comment and feed back their view on the service.

Service planning and delivery to meet the needs of local people

- There were no survey/feedback forms aimed at gathering the views of children and young people which would enable their views and experiences to be used to improve services.
- The hospital admission policy set out the limitations of patients accepted for admission. It allowed the refusal of admission for those with primarily psychiatric needs and if relevant staff were not available to care for the patient.

Meeting people's individual needs

- Children were cared for in individual rooms of the surgical ward which gave them privacy when they needed it. There was no evidence of facilities specific to the needs of children such as lower hand wash basins or low toilets.
- There was no multi faith room at the hospital but staff informed us there was a list of contact details for churches of varying faiths and if a patient needed personal space for religious reasons, a room could be made available.
- A Gap analysis of children's services was performed in June 2015 to identify where improvements in the children's service could be made. It recognised there was no provision to keep children occupied and entertained. The action from the analysis was to encourage parents to supply entertainment equipment from the child's home. There was no action identified for the hospital to provide equipment to distract or entertain children should the child become upset or anxious.
- Following feedback from inspections at other Nuffield Hospitals, the hospital had introduced information about surgical procedures in the form of leaflets designed for children. These were sent out to children before their outpatient appointment giving them information on what children should expect including possible complications. This was provided to the hospital by a private company and was written in an easy to understand format and printed and given to the parent or child depending upon the age of the child. The information we saw included some simple line drawings to support the explanation but was more suited to the older child to read for themselves and so relied on the parent informing the young child of its content.
- A recent change to provision of food meant that children could choose from an alternative menu to the adult menu offered.

Requires improvement

Services for children and young people

- The outpatient waiting area had an activity table to amuse young children. There was no available reading matter or other activity for older children or young people. A notice advised parents to supervise their child whilst visiting the department. We saw no children in the outpatient department during our visit. At the time of our visit there were no leaflets or information in child friendly format available in the department. We have since been provided with child friendly booklets designed for children and young people to prepare them for their hospital visit. These are sent to the family a week before admission.
- Following surgery there was a recovery area for children separate to the adult area. There were no distractions for children in the anaesthetic room.

Access and flow

- There was a process for arranging when children should be admitted to ensure the correct nursing staff skill mix for surgical procedures. Patients had to be booked in at least seven days in advance. We were told the booking team arranged directly with the RN (child) before sending appointments to the child. This process had recently been reinforced following a child being accepted for surgery at a time when the RN (child) was not planned to be on duty. On this occasion the RN (child) was able to rearrange her working time.
- Children were prioritised to be first on the surgical list.

Learning from complaints and concerns

- There had been no complaints over the previous 12 months involving children and young people.
- There was no evidence of children or parents being involved in contributing to the design of the complaints services. There was a patient forum but none specifically for children or parents.

Are services for children and young people well-led?

Inadequate

Services for children and young people were inadequate in aspects of leadership. Governance and leadership was designed for adults' services with insufficient systems and processes in place specifically for children's services. We were not made aware of any strategy for future improvement of the children and young people's service.

There was good governance around the consultant paediatricians' skills and competence to practise for children. Leadership meetings responded to issues brought to them but did not take a proactive approach to developing children's services to ensure they were monitored and kept under review. Nurses were aware of their responsibilities and the systems in place. They felt supported in caring for children but there was little evidence of development around nursing practice for children. There was a lack of consideration of risks to children undergoing surgical procedures at the hospital. Some aspects of the service were improved by raising the admission age from three years to eight years of age but the managers could provide no rationale for the decision. The risk was not identified, leaving a lack of clarity about whether the risk was reduced.

Vision, strategy, innovation and sustainability and strategy for this this core service

- There was a set of EPIC values (Enterprising, Passionate, Independent and Caring) for the hospital as a whole but staff could not tell us of any strategy specifically for the children and young people's service.
- A concern was expressed regarding the service being sustainable with present staffing numbers should paediatric procedures increase.

Governance, risk management and quality measurement for this core service

- The children's service policy stated that the MAC should include a paediatric consultant of any speciality to advise and support the MAC and children's services team. We saw minutes and agendas from MAC meetings, none of which included a consultant lead for services to children and young people or reference to the care of children or young people. We were told that the previous paediatric lead had stood down but had been acting as a link. A new paediatric lead had been appointed in the week of 15th July 2015. We were also told that two other consultants with paediatric experience attended the MAC. Should there be any concerns, the lead children's nurse would provide a report for the senior leadership meetings.

Requires improvement

Services for children and young people

- We viewed the board meeting minutes of the previous three months which showed no discussions relating to children services.
- The hospital had governance procedures in place to ensure staff caring for children were qualified and competent to do so. The governance of competencies for nurses caring for children was not a robust procedure. This was because the assessment was based on the nurse describing procedures, reading policies and calculating medications. They were not observed to be competent in providing care for children.
- The children's service policy outlined responsibilities of senior staff stating that where children's services were being provided, there should be appropriate infrastructure and staffing in place to ensure the delivery of an effective children's service at all times. There were insufficient registered children's nurses employed to meet the RCN guidelines on safe staffing for children creating a risk that child surgery could be cancelled.
- There was a hospital risk register which had no entries relating to children's services. We had no evidence that risks for children were identified and managed and that issues which affected the safe delivery of the service were identified and reported through the hospital governance process.
- Children's services benefitted from audit and quality checks carried out for the hospital as a whole but we saw no evidence of measures of effectiveness for the service. Since our inspection a decision was made at the integrated governance meeting held 21 July 2015 to increase the age of children undergoing surgical procedures from age three to age eight. The Rationale for this decision was stated as being based on the equipment required for older children is less specialist and that staff felt more competent in caring for children over eight years old. There was no evidence that this decision had been based on a risk assessment having been completed regarding the safe care of children.
- There was a lack of leadership at hospital management level for ensuring oversight and monitoring of the childrens' services, with decisions being made only in response to the inspection team raising concerns.

Leadership and culture of service

- The RN (child) was lead nurse for the children's service. The ward manager ensured that the RN (child) or a nurse with children's nursing competencies was on the ward or outpatients when a child was being cared for. They felt the RN (child) was supportive and always available for advice they needed.
- Resident Medical Officers with paediatric skills were on duty at the hospital but did not lead the service. The medical lead for children was appointed in July 2015 replacing the lead who had stepped down.
- The staff we spoke with told us they addressed issues as they arose and felt they could approach any of the leadership team. Staff felt they would be listened to by the ward managers and the leadership team who would value their opinion.

Public and staff engagement

- Any feedback forms about the service were designed for adults. There was no opportunity specifically for children to contribute their opinions on the care they received.
- There was a staff forum and a patient forum both held on a quarterly basis. The meeting notes we saw showed no discussion involving the care of children.

Innovation, improvement and sustainability

- The RN (child) showed us an admissions booklet which had adapted for use with children although a reference to adult care and not children was in the booklet and needed to be corrected.
- We saw records of an impact analysis of children's services that had been carried out by the matron to identify areas for development. One action was to provide leaflets to children and families giving information about the procedure they were undergoing. One leaflet we saw contained diagrams and was suitable for older children.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatient services consisted of 12 consulting rooms, a minor operations room, a treatment room and a physiotherapy suite. These were staffed by six and half whole time equivalent nurses and 9.8 whole time equivalent care assistants. Treatment rooms were also used by physiotherapists who were not managed by the outpatient department manager.

Minor operations for procedures requiring local anaesthetics only, were undertaken Monday to Friday between 08.00 and 19.30.

Between April 2014 and March 2015 the outpatient department saw 21,292 patients in consultant led clinics. 65% of this activity was for NHS funded patients.

Laser procedures were managed under the outpatient department management but were out of the scope of the CQC registration requirements so were not part of this inspection.

An alternative provider to Nuffield Health operated a mobile MRI scanning service at the hospital four days a week and a CT scan one day a week. These services were overseen by the Nuffield Health Plymouth diagnostic and imaging department.

Nuffield Health Plymouth operated a radiology department which provided services for plain x ray, fluoroscopy, ultrasound and mammography.

During our inspection, we spoke with 22 staff who were receptionists, hostess staff, health care assistants, nurses and the nursing manager. We also spoke with six patients and carers and reviewed six sets of patient records.

Summary of findings

Overall, we found the outpatients and diagnostic imaging service at this hospital to be well run with safe practices.

Audit programmes were in place to monitor safety of care provided to patients. There were sufficient trained staff numbers for the needs of patients in the department. Patients were seen promptly and felt informed of any procedures and plans for their health care

There was a culture of learning and openness within both radiology and outpatients departments. .

Patients were able to contribute their comments about their care and the facilities in the hospital.

Staff were able to contribute to their thoughts and ideas about the hospital environment and the care they deliver by attending regularly held forums. Diagnostic imaging had devised a survey for patients to feed back their thoughts about the service. The hospital had processes to ensure staff maintained their competencies in order to practice safely which included confirmation that medical staff met the requirements for practising privileges.

Staff were aware of complaints and incident reporting procedures and were confident in their abilities to deal with any complaint. Apologies were offered to patients who complained and they were responded to in a timely way. They felt part of a team, proud to work at the hospital and able to instigate changes if a need was

Good

Outpatients and diagnostic imaging

identified. Staff felt listened to and care for by the hospital and were positive about the appraisal process in supporting them professionally. They were able to access training to maintain and develop their skills

Are outpatients and diagnostic imaging services safe?

Good

Outpatients and diagnostic imaging were judged to be run in a way that would protect people from abuse and avoidable harm. There was a culture of safety awareness and staff felt they were given the time to provide good, safe care in both outpatients and diagnostic imaging.

Incidents were reported and learning identified from them. An action plan was put into place and communicated to staff for their action.

There was a programme of audit including infection control which identified risks and identified appropriate actions to eliminate those risks. There was no current audit of the 5 steps to safer surgery although the outpatient manager informed us plans to commence this audit in September 2015.There were sufficient, adequately trained staff to perform outpatient activities for adults who visited the departments.

Equipment was maintained in working order and available for use by staff. Regular checks were documented on the emergency equipment ensuring it was available if a patient's condition should deteriorate.

Patient records were held securely to protect confidentiality and prevent unauthorised access.

The hospital had a process for monitoring mandatory training completed by staff. There had been a problem with delivery of training for basic life support but this was being rectified with some staff having already completed it. Staff knew who the safeguarding lead was and how to report any safeguarding concerns

Incidents

- No serious incidents involving outpatients department had been reported between April 2014 and March 2015.
- A system was in place for staff to report incidents that were unexpected or untoward. Staff were aware of the system and felt it was easy to use. They received feedback at the department team meetings or individually if it was more appropriate. An action plan was produced following an incident with learning points identified. We saw this documented in records. One staff

member described how they had been able to gain more experience with an unfamiliar procedure following an incident report. The outpatient department staff had used the reporting system when a piece of ophthalmic equipment that had failed. Replacement equipment had been ordered and steps were taken to ensure safe use of the existing equipment.

- Problems were responded to and reported using the electronic reporting system for the hospital. Staff told us of an occasion where a piece of equipment unexpectedly failed, trapping a patient's legs. Following an investigation an action plan was put into place to prevent a reoccurrence. This consisted of advice on how to use the equipment until the replacement arrived.
- The radiology department were aware of reporting processes. Radiation protection services were contracted to a provider other than Nuffield Health. There was a local radiation protection advisor within the radiology department who reported any radiation incidents to the regional service. Staff were aware of risks in the department and the incidents that had been reported were regarded by the regional radiation protection service as not requiring any further action.
- Staff demonstrated an understanding of the principles related to Duty of Candour (a new regulation to be open, transparent and candid with patients and relatives when things went wrong). Some staff were not familiar with the term duty of candour, however, all the staff we spoke with confirmed they informed and apologised to patients when care was not as it should have been.

Cleanliness, infection control and hygiene

- All areas of the outpatient department and diagnostic imaging appeared to be visibly clean.
- Hand disinfectant was available at entrances to the hospital. We observed staff using disinfectant gel and washing their hands between patients.
- The hospital had an infection and prevention control committee which met quarterlyto discuss measures needed to mitigate the risks of infection. A staff member from the outpatients department attended meetings and fed information back to staff at the team meetings. We reviewed the minutes of the last three team meetings and saw records of actions for staff to prevent infection in the hospital. For example, one action was to ensure taps were turned off using elbows or paper towels to prevent the risks of spreading infection.
- Any patient who had surgery in the hospital might return to the outpatients department for further wound management. These were managed with the support of the infection prevention and control team who would undertake an investigation into the possible causes of the infection if it was indicated.
- We saw stickers on multi use equipment which staff signed and dated to indicate it had been cleaned and was ready for use.
- Disposable curtains were in place to provide screening for patients where privacy was required. The curtains were dated and the protocol was that they were changed every six months. The curtains we saw were within this six month period.
- We observed examination couches being cleaned and coverings changed between patients to reduce the risk of cross infection.

Environment and equipment

- Resuscitation equipment was available and accessible for use in the outpatients and radiology departments with the emergency equipment being placed in a corridor between the two departments. There was clear guidance of how often it should be checked according to the hospital policy. We observed the register had been signed daily by the person completing the check.
- We saw clinical equipment was labelled to indicate it had been serviced and when it was due to be serviced next.
- Consulting rooms contained facilities appropriate to the specialty of the consultant practitioner, for example ophthalmic equipment.
- The waiting area was equipped with groups of chairs and the reception desk was clearly visible on entry. There was a separate waiting area on the upstairs floor for other consulting rooms as well as individual waiting areas for radiological procedures. Seating capacity had been increased for patients by rearranging chairs between the waiting areas which alleviated previous overcrowding.
- Clinical waste was stored in the appropriate bags in a sluice area away from patients and visitors access and removed twice a day or more often if requested by staff.
- Bins for the disposal of sharps were available and were seen to be signed and dated by the person setting them up. This was in line with the hospitals policy
- The minor operations theatre was equipped with a ventilation extraction system to ensure clean air is

circulated in the room at the time of surgical procedures. The ventilation extraction system was tested weekly by the laser protection supervisor of the hospital and annually by an external maintenance company. There was no record of any faults and all results were within safe limits.
- There were facilities for health professionals to decontaminate hands.
- We saw records which showed the radiography machines were checked monthly. The fluoroscopy unit was reported to be showing signs of age with gradual image degradation over the previous two years. Steps had been taken to assess whether the image produced remained within acceptable limits. This included weekly testing by the radiology team and a six monthly testing by the manufacturer (Philips). The records of the testing we saw provided results that the equipment was working within the manufacturer's specified recommended limits.

Medicines

- There were systems in place for patients attending the outpatient department to receive any required medicines in a timely way. Prescribed medicines were dispensed from the onsite pharmacy department between the times of 08.30 to 16.30, Monday to Friday.
- The outpatient department performed patient testing for allergies. Fridges were in place to hold the allergens needed for this testing. Temperatures were observed as having been checked daily and staff described the protocol for action if the fridge was outside of the permitted temperature. The protocol was also displayed near the fridge. The completed records of the fridge temperatures were sent to pharmacy for their review.
- No controlled drugs were kept in the department. Patients who had chemotherapy were allocated a room on the ward but treated as an outpatient. We observed chemotherapy medicines were stored appropriately and separately from all other medicines on the ward. The oncologist who prescribed chemotherapy had practice and privilege rights at Nuffield Plymouth.
- The pharmacist was not a member of the medical advisory committee (MAC) but could be present and contribute to the meeting as required. An on call pharmacist was available during out of hours to provide advice to staff if required.

Records

- A system was in place to ensure patient records were available for the time of their appointment.
- Nuffield Health Plymouth Hospital had close links with the nearby NHS hospital and patient records could be requested from the NHS medical records department if there was a need. Clerical staff told us there were no problems with accessing medical records for patients and new patients had a new set of records made up prior to their appointment. Medical records were all paper based with current files stored at the hospital. They were secured in filing cabinets in a room which was locked when no staff were present. Older notes were stored off site using an alternative data management company which provides secure storage for records. An agreement was in place that assured records would be available on the day of request by the hospital.
- The six records we observed were legible, signed and dated giving a clear plan for ongoing medical review.
- Nuffield Health used care records to document patient details from pre-admission to admission for procedure and discharge from the hospital. The care record was initiated at the pre admission clinic and included base line observations of blood pressure, pulse, temperature as well as a history of individual needs. The outpatient manager audited the care records three monthly by taking a random sample and using an assessment tool to ascertain compliance. The audit results we saw undertaken in February 2015 showed full compliance by the staff completing the records.

Safeguarding

- Nuffield group policy required all staff to complete and update level one safeguarding training annually. Two senior staff members were to have completed level three safeguarding training. The hospital kept a record of training completed by staff. The record of mandatory training from May 2015 showed that 91% of all staff at the hospital had completed their level one safeguarding training for children and adults.
- Radiographers felt able to challenge requests if there was insufficient justification for a procedure. This contributed to ensuring patients were not exposed to unnecessary radiation.

- All staff knew who the safeguarding leads were and how to contact them if they had any concerns. Staff we spoke with were knowledgeable regarding the safeguarding policy and procedures but could not describe a time they had reported any abuse.

Mandatory training

- The hospital had a programme of mandatory training in place which included fire, health and safety, integrated governance, infection control, manual handling and safeguarding. In May 2015, the percentages of hospital staff having completed the core subjects were between 87% and 92% apart from basic life support which was 54%. Senior managers said the low compliance figure was due to a lack of trainer availability. Since our inspection, senior staff confirmed the training issues for basic life support training, including annual updates had been resolved, and staff had completed the training or were booked to attend.
- We were told the hospital was making a transition from one training record system to another. Senior staff said this had caused issues with data not reflecting the true (higher) number of staff with mandatory training in date.

Assessing and responding to patient risk

- Patient's risks were assessed and reviewed at every outpatient consultation. Procedures performed in either the treatment room or minor operation room required no general anaesthetic and patients sat in one of the waiting areas following the procedure where refreshment would be available. The patient would be observed by staff and have their wound checked prior to going home. We were told if a patient felt unwell staff would find a room for them to lie down and recover. Staff felt confident a bed would be found on the ward if a patient needed it but that this had not been necessary. Staff were aware of the transfer policy and actions to take should a patient become unwell and need more urgent care at another hospital.
- A pre admission assessment was carried out for patients undergoing procedures who needed to be admitted to the hospital. This assessment would identify any risks to the patient based on their medical history, whether these risks could be minimised and if the hospital could safely care for the patient.
- For patients undergoing a minor surgical procedure the five steps to surgical safety checklist was completed. The use of this checklist supported patient safety and was explained by staff but we did not see any completed versions. Audits on the five steps checklists had not been carried out in outpatients minor operations room because the checklist had been recently introduced. There were plans for auditing to commence in September 2015 and to be carried out quarterly
- Radiation regulations in the radiology department were adhered to. There was a radiation protection advisor in the department. Every room used for radiology had a set of rules that were read and signed by any staff using that room ensuring staff were aware of safety and minimising patient risk. There had been no reported incidents regarding radiation exposure, these incidents are reportable to CQC.

Nursing staffing

- Staff working in the outpatient and diagnostics service told us there were adequate staffing levels to safely meet patient's needs. Staffing of the outpatient department was stable with no turnover of nurses and care assistants in 2014.
- The outpatient department was staffed with 5 WTE (whole time equivalent) nurses, 9.8 WTE care assistants, 0.6 WTE nurse team leader and a nurse manager. Absence rates due to nurse sickness were low over the previous six months. There were no vacancies for care assistants and a 5% vacancy for nursing staff. No use of agency or bank staff had been reported for this period.
- Staff were planned to work a week in advance to cover outpatient clinics between 08.00 and 20.00 Monday to Friday. The final planned clinic list was known the afternoon before the clinics which might have required a different level of staffing. Staff in the department worked flexibly within these hours wherever possible to cover the needs of patients. The outpatient manager told us that the Nuffield Health Group were investigating acuity tools they could use for assessing staffing levels needed in outpatients departments. This would help in planning the numbers and types of staff needed on a day to day basis.
- The outpatient department provided placements for student nurses but these staff were not included in the staffing numbers.

Medical staffing

- Consultants held regular clinics and were responsible for the care of their patients. The majority had

secretaries based in the outpatient department who organised the clinic lists around consultant availability. If the consultant was delayed or unable to attend it was their own responsibility to provide cover for any clinics, with an alternative appropriately skilled consultant who also had practicing privileges at the hospital The RMO was not involved in supporting the consultant clinics.

Major incident awareness and training

- Outpatient staff told us there was regular testing of fire alarms and drills where the department had to be evacuated. This had been practiced twice in the previous six months. Notice boards displayed who the fire marshal was that was on duty each day and relevant numbers to call. We were told there was a policy regarding terrorist activity but staff were not readily familiar with the detail. Emergency generators were in place in the hospital to maintain services in the event of a power cut.

Are outpatients and diagnostic imaging services effective?

We did not have sufficient evidence to provide a rating on the outpatient department's effectiveness.

Treatment and care was provided in line with national guidance and processes were in place to update policies and procedures.

All staff had received an annual appraisal of their performance and were supported with development opportunities. The hospital had procedures in place to monitor the competencies of staff and suspended them from practicing in the hospital if standards were not met.

Staff worked in their own team and with other departments in the hospital. Information was shared with the teams at team meetings. There was also evidence of working with departments outside of Nuffield Health Plymouth hospital.

Evidence-based care and treatment

- Guidance is provided by the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) for the safe use of radiological equipment. This includes guidance for operating procedures, incident reporting, training and equipment maintenance and medical physics' role. We observed that every room in radiology had written procedures which were read and signed by any staff using radiology equipment. This ensured staff were aware of safety procedures to minimise patient risk.
- The National Institute for Health and Care Excellence (NICE) provides guidance on improving health and social care. We saw records where NICE guidelines were discussed and what action was required. Nice quality standard Quality Standard 84, (encouraging activity in in all people in contact with the NHS) was incorporated into the patients' pre admission clinic. We saw this discussed when a nurse was taking the history of a patient attending the clinic.

Pain relief

- The nursing records used for escalating a deteriorating condition included a pain assessment chart. We did not observe its use in outpatients at this time but staff told us they asked if patients needed any pain relief following procedures carried out in the department.

Patient outcomes

- No audits for minor operations were undertaken to monitor and measure outcomes. People who returned were those who needed further, more invasive treatment. It was left to consultants to monitor their own successes or otherwise of treatments.

Competent staff

- The hospital had processes to ensure staff maintained their competencies in order to practice safely.
- The hospital had a system of monitoring staff appraisal rates and re-registrations where required. Before our visit the hospital told us 100% of nursing and care staff were up to date with appraisals in 2014. 90% of nursing staff had their registration verified on 31 march 2015, meaning they had maintained their qualification to practice. Staff we spoke with told us they had annual appraisals and were able to access further training.
- Practising privileges and competencies of surgeons and anaesthetists were monitored and they would be suspended from practising in the hospital if the standards were not met. We saw evidence of monitoring including which areas a consultant would be allowed to practise. There was a responsible officer who oversaw the consultants appraisals prior to revalidation should

they only work in the Nuffield hospital and not in the NHS. The hospital also received the most recent appraisal for individual consultants who worked at the local NHS hospital and the Nuffield.

- The hospital had a process of induction for new staff to complete which a new member of reception staff had completed. She told us it included information on health and safety procedures, corporate information and meeting and greeting patients.
- We saw records which documented radiology staff received annual appraisals with six monthly reviews. One member of staff told how she had been able to access further training in mammography following appraisal.
- The outpatient manager instigated opportunity for nurses to reflect on their learning following any training they had attended to further consolidate learning and contribute to revalidation. The form was given to staff following a study day.

Multidisciplinary working (related to this core service)

- Outpatients and diagnostic imaging were working with outside agencies increasing links locally to improve the service for patient care. These included specialist nurses from the local NHS trust hospital. For example, the vascular nurse from the local NHS hospital supported the nurses who care for patients during and after sclerotherapy (undertaken for varicose veins) in the minor operations theatre. This increased the communications between the Nuffield hospital and the NHS hospital with staff sharing skills and knowledge on effective treatments for patients.
- As part of a research study, diagnostic imaging was providing a chest x ray service for patients of a local GP surgery.

Seven-day services

- Outpatients operated Monday to Friday with alternate Saturday clinics for plastic surgery. The last appointment during weekdays was 19.20 which offered flexibility for patients who wished to attend after office hours.
- Radiology was available for in patients out of hours by using an on call system with Radiographers needing to be able to reach the hospital within 45 minutes of being called. Should there be an urgent need for a CT scan the patient would be transferred to the local NHS trust hospital following the hospital patient transfer policy. The records we saw detailing transferred patients between April 2014 and June 2015 were not specifically for radiological investigations.
- An x ray service was provided on a Saturday morning if requested by the consultant. This was usually for orthopaedic patients.

Access to information

- There was a process in place to ensure medical records were available for patients attending the outpatient department. 99% of consultants had medical secretaries in the hospital who would request the notes in time for the appointment. If further clinical information was required the secretaries would contact the patient's GP. The secretarial staff said they had not experienced any problems in gaining the information from the GP in a timely way.
- We saw letters written to GPs of patients in order to communicate health information regarding plans for patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duty when obtaining consent and ensured explanations were in a way patients could understand. Patients felt they were given choice and understood the information provided for their decision making. Nuffield Health Plymouth Hospital followed a strict referral process and did not provide treatment to patients who lacked capacity to consent. We looked at six patient records and saw consent was clearly documented
- There were standard operating procedures available for obtaining consent from people with reduced mental capacity and those under and over 16 years of age. Outpatient staff would call on the nurse for paediatrics to assess whether the child or young person was able to consent for themselves.

Are outpatients and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging services were judged to be caring.

Good

Outpatients and diagnostic imaging

We saw patients being treated with respect and provided with information in a way they could understand. Staff were confident in their approach to patients and could offer privacy if the patient needed it. There was a risk that patients might be overheard when talking to staff at the outpatient reception desk

Patients felt they were given choice and were fully informed about their procedure and any follow up appointments. Patients felt cared for and not rushed. Staff were available to support patients throughout their visit to both departments.

Some patients who were attending as outpatients were provided with a ward bed to provide them with privacy as they could feel unwell for duration of their treatment.

Patients were involved in contributing opinions to develop provision at the hospital. Surveys were undertaken and rated the hospital highly although this did not represent individual departments.

Compassionate care

- We witnessed staff behaving in a caring manner towards patients. On arrival at the hospital patients were greeted by a receptionist as they approached the reception desk and given information on completing the appointment paperwork. All patients we saw understood the information they received and any queries were dealt with when they asked a receptionist for more help. Reception staff responded in a friendly manner and stopped their conversation with inspectors in order to help patients. Reception was placed away from the chairs in the waiting area but was not private. It would be possible for other patients to hear conversations between staff and a patient particularly if the staff spoke loudly. For example if a patient had difficulty hearing. Reception staff told us that if a more private conversation was needed staff would guide the patient to a private room.
- Patients were accompanied by nurses and shown which department they needed to attend. Staff were seen to be available for patients if they needed any further support or chaperone before, during or after their consultation.
- We observed an assessment of a patient pre operatively who received an explanation of the process in a private room.
- Patients who had chemotherapy were treated as outpatients but allocated a room on the ward. This was to allow them to lie down as the treatment could make them feel unwell. The oncologist worked at the local NHS trust and had practice and privilege rights at Nuffield Plymouth
- The hospital participated in the Friends and family test for the NHS patients they treated with 84% of the responses stating they would recommend the hospital to their friends and family should they needed similar care and treatment. The radiology department had developed their own patient satisfaction survey which was handed to five patients a month, chosen at random. We were told any recommendations were acted upon but no examples were illustrated. Survey response rates were based on the hospital as a whole and outpatient survey results could not be identified.

Understanding and involvement of patients and those close to them

- Patients we spoke with said they were very happy with the service. One patient told us they felt the service was relaxed and not rushed. Another patient who had used the choose and book system said they were well informed and would choose this hospital again if they needed further investigations.
- Two patients and one relative we spoke to said they had been kept well informed and were aware of their ongoing plans for care. The patients we saw had no communication or language problems.
- 2014 Nuffield patient surveys rated the hospital as either good or excellent averaging 97%

Emotional support

- One patient we spoke to in the outpatients department told us he had felt supported by staff and informed of the options for his care.

Are outpatients and diagnostic imaging services responsive?

Good

Outpatients and diagnostic imaging services were judged to be responsive.

Good

Outpatients and diagnostic imaging

Patients were seen promptly following arrival and given time if they needed it to make choices or decisions. Information was available in a variety of formats and provided with information they could understand.

Refreshments were readily available in waiting areas for patients waiting for appointments and following any procedures. Facilities were available for privacy and dignity throughout both departments.

More time could be organised for radiological procedures if the patient needed it.

Patients were responded to in a timely way following any complaints and informed of actions taken where appropriate.

Service planning and delivery to meet the needs of local people

- The site assessment overview completed in May 2014 for the patient led assessment of the care environments (PLACE) stated there was a lack of parking spaces for the patients. There was no charge for parking and parking attendants monitored the area. Plans had been made to address these issues to meet the needs of patients using the service. We saw notes from patient forum meetings discussing plans to optimise parking facilities.
- The outpatient department was clearly sign posted at its entrance door. The waiting area was equipped with chairs for patients to sit. There was space for patients to walk around the chairs, including those with mobility problems who needed more space. For example wheelchair users or those using crutches.
- The outpatients department had weekly meetings to discuss capacity of staff to meet the needs of the patients. Staff worked flexibly whenever they could within the hours of 08.00 to 20.00 to meet any unexpected need.
- We were told about a time the outpatient waiting area on the upstairs floor was regularly overcrowded. Lack of space was also identified in the Patient Led Assessment of the Care Environment (PLACE) overview of May 2014. This was dealt with by rearranging chairs so that some of the larger chairs were placed downstairs which created more space and seating area upstairs.
- The radiology department had individual investigation rooms each of which had separate waiting areas and were equipped with toilet facilities and changing rooms. We were told relatives could wait with the patient if this was what the patient preferred but would be asked to wait in the nearby main reception area of the hospital if it became busy.

Access and flow

- Patients were seen in a timely manner in the outpatient department. Three patients we observed were called to see their consultant within 10 minutes of their arrival.
- One patient told us they had made their appointment only the week before and had been able to choose their appointment time. They were pleased about being seen quickly and it was arranged at a similar time to an appointment her husband was attending.
- The radiology department offered 20 minutes for each appointment which could be extended if it was needed. Appointment times were booked with the patient as a telephone contact and longer appointment times could be booked for any patient with special needs. This ensured the patient was given choice about the appointment and was able to discuss any special requirements.
- We saw from the patient focus group minutes of February 2015 that a project had been implemented to ensure NHS patients who were referred to the radiology were seen within four weeks. There was no evidence that this approach had an impact on the NHS referral to treatment standards.
- There were two entrances to the hospital, one was the main hospital entrance and the other was an outpatient department entrance. Both areas were staffed with reception staff who would direct patients to the department they were visiting. The radiology department had a reception area also. We saw reception staff were available at all times of our visit in each area.

Meeting people's individual needs

- Staff were aware of how to access translation services for patients who needed it. Radiology staff told us of a time when a patient had translation services provided over the telephone.
- Refreshments in the form of drinks and snacks were available for patients if they had to be nil by mouth before their procedure. Refreshments were freely available for patients to help themselves in outpatients. The outpatients department posed a potential risk for children visiting the area. A notice advised parents to

supervise their child whilst visiting the department. A coffee machine was available for patients and visitors but may have posed a risk of scalding for young children visiting the department as it was at table height with nothing preventing children from reaching it.

- There was adequate provision of seating for adults in the waiting areas. Radiology rooms had their own dedicated changing and waiting areas.
- Dressing gowns were provided in radiological changing areas to maintain dignity when waiting for an investigative procedure.
- We were told any bariatric patients needing radiological services may need to be referred to Cheltenham Nuffield Hospital as there were no facilities suitable in the department. This information was available for patients in the booklet "what to expect at your x ray appointment".
- A member of the patient focus group told us of a time she raised concern with the hospital. This was regarding difficulty some people may have using a pedal in the X ray patient's toilet area, for example, those in a wheelchair. The bin was replaced with a hand operated version.
- Leaflets giving information for patients on how to complain were available at the reception desk for patients to take.
- Rooms were available to allow privacy for a patient if they needed it for example if a mother needed to breast feed or should a patient become upset or need to talk privately.
- Patients visiting radiology received leaflets about the x-ray with a telephone help line number if they needed further support. Radiographers were involved in the appointment process for x rays and would speak to patients on the telephone and were able to and answer their concerns by talking to the patient on the telephone. Patient information was available about the different procedures in radiology and what to expect

Learning from complaints and concerns

- A process was in place to deal with complaints and concerns where the hospital should provide a response to the complainant within 20 working days. The replies that we saw were within this timeframe. The senior management team discussed complaints at meetings of the board and the medical advisory committee. The information was cascaded to staff at managers and team meetings. Leaflets advising of how to make a complaint were available in the outpatient waiting area which provided information on how to make a complaint and the processes involved. Information was also available on the hospital website. Contact information for the Independent Sector Complaints Adjudication Service, Care Quality Commission and the Parliamentary and Health Service Ombudsman were provided in the leaflet and on the website.
- Staff told us they would try to resolve any complaint from a patient locally in the first instance. One example was of a delay to an appointment for which staff apologised at the time and arranged another appointment. If the person wanted to take it further, staff would raise it with their manager. Reception staff told us they had training on handling conflict and a panic alarm was in place at the reception desk should a situation become more threatening.
- Two patients we spoke with told us they did not know how to make comment but would find out if they needed to, one of them saying they would look on the internet.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging services were judged to be well led. The manager had been in post for the previous six months and had demonstrated how the department was managed and how changes had been implemented along with plans for the future of the service. The service was represented at board level using a system of reporting and meetings through staff representatives, information was shared from board to staff and vice versa.

We found staff were encouraged and felt able to contribute ideas of how they delivered care to patients. They described feeling part of a family and felt supported by their managers.

Audit processes were undertaken and seen by staff as a positive action to improve services.

Partnership working with the local NHS trust was evident to develop patients' services.

Good

Outpatients and diagnostic imaging

Learning and development was actively encouraged in both departments.

There was a process for staff and patients to contribute their views. The feedback was not specific to the outpatient department but plans were in place to develop a patient satisfaction form specifically for outpatients.

The radiography department had a strong ethos of self-governance using audit and learning to ensure their practise was safe for patients and in responding to patient's needs. Radiology collected feedback from patients in their department but this was limited and at random. It was unclear whether any actions had resulted from the feedback.

Vision, strategy, innovation and sustainability and strategy for this this core service

- The hospital had a set of EPIC values (Enterprising, Passionate, Independent and Caring). This was displayed on the outpatient department noticeboard for staff to see. We observed staff demonstrated these values when providing patient care.
- There was evidence of staff feeling able to make improvements to their department. Radiology were introducing greater skill mix into the department by training assistant practitioners, giving more time for radiographers to use their more specialist skills.

Governance, risk management and quality measurement for this core service

- There was evidence of the hospital having governance systems and risk management systems in place. A lead for the outpatient and radiology departments attended meetings for heads of department, information governance, health and safety and clinical forums. The outpatient manager had a process to ensure all staff received the information for hospital wide meetings and encouraged staff to contribute their thoughts and ideas to the board. The hospital risk register for May 2015 showed no risks identified specifically for outpatients or diagnostic imaging. Between April and May 2015 there were eight incidents reported for diagnostic imaging and nine incidents reported for outpatients. Incidents were reported using the electronic reporting system and action plans written with dates for completion were identified. These were shared with staff at team meetings and staff confirmed this.
- We saw results of regular audits for infection prevention and control. The results were discussed and action plans made to mitigate any shortfall in the standard of practise. Audit results were passed to the senior management meetings and the Medical Advisory Committee (MAC) for discussion and review. Information from the hospital board was shared with staff at weekly department team meetings. The five steps to safer surgery checklist had recently been introduced so had not been audited but the manager had plans to commence an audit programme in September 2015.
- Radiological equipment was checked daily to ensure it was safe to use and any concerns were reported to senior managers. Radiology staff used peer groups where a radiologist would review the report of another radiologist and they could compare their knowledge and skills, this helped them to identify gaps in their practise and how they could improve.
- The pharmacy department told us they did not have a representative at the MAC but did have a voice and could attend if they needed to. The lead radiographer told us radiologists used a system of peer review to ensure their reporting practises were of good quality.

Leadership/culture of service

- We saw senior managers visiting the departments at our visit and were told this was a daily occurrence. Staff told us they could discuss any issues with the management team and felt listened to.
- The outpatient manager was available for advice and support and responded to concerns immediately at the time of our visit. She held team meetings weekly and ensured that staff received any communications with a system of staff signing once the item had been read.
- We saw evidence that team meetings were used as learning experiences one example being a quiz on infection control.
- Radiology staff told us they were supported in their development by having yearly appraisals with their manager, including six monthly reviews. Staff told us any learning needs were identified and had been funded by the hospital.

Culture within the service

- Staff told us they would approach their manager if they had any concerns.

Good

Outpatients and diagnostic imaging

- We saw managers and members of the senior leadership team in the clinical areas of the hospital talking to staff, which made the leadership team visible and accessible to staff promoting an open culture.
- Staff felt they could suggest changes. For example, the rearrangement of the waiting areas to increase seating capacity for patients was instigated by reception staff discussing ideas with the matron.
- Staff told us they felt supported and proud to be part of the team. One member of staff said "it was like being part of a family" Staff were able to access some benefits including free gym membership and access to physiotherapy services if they needed it. This made them feel valued and cared for.
- Students who, as part of their training, had a placement in the outpatient department said they had an allocated mentor and felt well supported by staff.

Public and staff engagement

- The outpatient department held weekly team meetings involving all staff who were encouraged to contribute to the agenda. Minutes were written which staff who could not attend were able to read and sign ensuring they were aware of relevant information.
- Employee forum meetings were held on a quarterly basis. We saw minutes of the most recent meeting in June 2015 where a variety of concerns were discussed including issues regarding affecting staff, patients and the environment. It was evident that a two way discussion was held with issues raised by staff as well as the management of the hospital.
- A patient focus group was held every quarter of a year when members could express their opinions on service and facilities in the hospital. New members were recruited by means of a tea party to promote membership. Members of the focus group undertook the patient led assessment of the care environment (PLACE) the results of which were available to the public. We saw actions had been taken by the hospital as a consequence of feedback. For example, feedback from the PLACE assessment had contributed to the refurbishment programme which was nearing completion and new chairs had been supplied to the outpatient department.
- The hospital had a system for all patients attending the hospital to feed back their comments. The results of this feedback did not single out the departments within the hospital. Radiology used a patient feedback form specific to their service. The admin staff handed the forms out to five patients a month who were chosen at random. We were told that actions were taken on any results but no examples were given. Although this did give some specific feedback it did not allow every patient the opportunity to give their comments on the radiology service.
- The outpatient department manager told us she had identified that patients visiting outpatients did not always have their views represented. As a result she was planning to design a feedback form specifically for those people visiting the outpatient department.

Innovation, improvement and sustainability

- The outpatient department was working with other Nuffield Health hospitals to compare and improve practices. The pre assessment nurses attended a 6 monthly group forum and a yearly conference.
- The radiology department were undertaking procedures to support local GP surgeries with research. This was in the form of chest x rays to provide data for the research the GP was carrying out.
- Staff skills were maximised by the training of an assistant practitioner to support radiology staff. This meant radiographers could supervise the assistant practitioner in the more routine tasks and use their specialist skills for more complex procedures.
- Nuffield Health Plymouth staff were engaging with specialist nurses from the local NHS trust. This was to provide a sharing of skills and knowledge to maintain and improve standards of care.

Outstanding practice and areas for improvement

Outstanding practice

- The Patient-Reported Outcomes Measures (PROMs) data for April 2014 to December 2014, published in May 2015 showed that patients evaluated the effectiveness of hip and knee replacement surgery as very positive. The first (EQ-5D Index) for hip replacement surgery showed that the hospital's score (0.50) was significantly better than the England average (0.44). Overall, these scores ranked the hospital as the sixth best in the country. The PROMs for knee replacement surgery (Oxford Knee Score) ranked the hospital as 19th best in the country.
- The hospital demonstrated patient-centred handovers during shift changes. Staff handovers were conducted in each patient's room using the care plan to review and discuss all care and treatment. This system fully involved and included patients and enabled care to be led by patients' needs. It also provided clarity on what tasks would be completed by which staff and when.
- The physiotherapy service demonstrated dynamic and innovative working. Staff were skilled and independent practitioners who worked responsively and flexibly to meet patient needs. The team demonstrated how they used all opportunities for professional development, which improved their practice for the benefit of patient care.
- The hospital had direct access to electronic information held by community services, including GPs. This meant that staff could access up-to-date information about patients – for example, details of their current medicine.

Areas for improvement

Action the provider MUST take to improve

- Provide enough appropriately qualified nursing care for children undergoing procedures.
- Ensure that registered nurses caring for children are suitably assessed and can demonstrate appropriate skills required to provide safe care for children.
- Ensure that registered nurses caring for children are provided with opportunities to maintain and update standards of practice in care for children in order for the service to deliver safe care and treatment.
- Provide adequate opportunity to staff who care for children to access professional supervision.
- Ensure risk and management of childrens services are an integral part of the governance systems and processes to provide assurance and ensure safe care
- Ensure there are robust governance and risk management arrangements in place to identify and manage issues at all levels of the organisation to enable appropriate action to be taken to maintain a safe service.
- Ensure that 100% compliance with the World Health Organisation (WHO) surgery checklist is maintained and verified in all areas where surgical procedures are undertaken.

Action the provider SHOULD take to improve

- Ensure that the children's service is represented at the Medical Advisory Committee in line with organisational policy.
- Ensure that children's services are monitored through the governance arrangements and that there is representation at senior management and executive level.
- Train staff on the duty of candour regulation and make sure they understand its application in practice when an incident occurs.
- Consider improving the environment for children in the outpatient's department, ward and recovery areas as they are not child-friendly.
- Consider consulting with children, young people and their families to gain their views for potential improvement of the service.
- Consider a meaningful review of children's services and consider gathering data to inform improvements in effectiveness of the service to children.
- Obtain feedback from adults and children visiting the outpatients department.

Outstanding practice and areas for improvement

- Ensure there is evidence that all professional clinical staff have had their professional registration verified.
- Provide systems and processes to enable all relevant staff to be aware of the surgical department's risks and priorities and to have effective action plans to improve quality and reduce risks to patients.
- Review the patient discharge information shared with GPs to ensure that the same relevant information is communicated for all patients.
- Provide appropriate training opportunities for staff to update their basic life support skills and monitor completion rates.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance 17(2) (b) In relation to children there were not sufficient systems and process that enable the provider to identify and assess risks to the health safety and/or welfare of people who use the service. Children's services benefitted from audit and quality checks carried out for the hospital as a whole but we saw no evidence of measures of effectiveness for the service. Since our inspection a decision was made at the integrated governance meeting held 21 July 2015 to increase the age of children undergoing surgical procedures from age three to age eight. There was no evidence that this decision was based on a risk assessment having been completed regarding the safe care of children. There was a lack of leadership at hospital management level for ensuring oversight and monitoring of the children's services. While some departments demonstrated, governance systems were in place locally there was little evidence of robust overarching governance and risk that ensured the hospital management team were able to capture, identify and manage issues and risks at organisational level. Issues which affected the delivery of safe and effective care were not identified with adequate action being taken.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1) Sufficient numbers of suitable qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of the Part.

There was a risk of inadequate numbers of appropriately qualified nurses to care for children undergoing procedures at this hospital as there was only one qualified registered nurse for children employed

18(2) (a) receive such appropriate support, training, professional development, supervision and appraisals as is necessary to enable them to carry out the duties they are employed to perform

There was a lack of robust systems and process to ensure registered nurses (adult) were competent to provide care for children. The registered children's nurse was not enabled to undertake sufficient practice and experience outside of the hospital to maintain competence nor were they able to access professional supervision.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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