Nuffield Health Brentwood Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Brentwood Hospital is operated by Nuffield Health. The hospital/service has 42 beds. Facilities include four operating theatres (three laminar flow and one state of the art digital), one endoscopy theatre, 16 consulting rooms, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, services for children and young people, and outpatients and diagnostic imaging. We inspected all three services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 28 February 2017, along with an unannounced visit to the hospital on 10 March 2017.

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

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

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

Services we rate

We rated this hospital as Good overall.

- There was evidence of incident reporting, a good level of understanding of duty of candour amongst staff and actions and learning from incidents were discussed at the service's Quality and Safety Committee meetings and Heads of Department meetings, and staff gave examples of where learning had occurred.
- For the period October 2015 – September 2016, 100 per cent of patients were risk assessed for venous thromboembolism (VTE) and there were no cases of hospital-acquired VTE.
- The pharmacy lead had recently ran a teaching session for nursing staff within the service to ensure good practice in medicines management. We were given examples of learning from these sessions such as clearer labelling of medications.
- Staff knew how to report a safeguarding concern and who the safeguarding lead for the hospital was. The safeguarding lead ran training days each month. Training included 'Prevent' training to help staff identify individuals at risk of radicalisation and female genital mutilation (FGM) awareness.
- mandatory training records which showed a current compliance rate of 97% overall for the whole hospital
- We observed the World Health Organization (WHO) 'Five Steps to Safer Surgery' checklist being undertaken, alongside record completion, both of which were completed appropriately.
- Staffing levels were assessed on a daily basis using the 'professional judgement' model and Nuffield Health at provider level was assessing the most appropriate acuity tool to use at the time of our inspection
- The resident medical officer (RMO) attended each nurse handover which took place three times a day, between shifts, to ensure they were informed about patient conditions and progress.
- Policies were updated in line with national guidance and best practice and shared at provider level.
- The hospital responded to audits to improve patient outcome. For example the implementation of education and training to improve post operative analgesia prescribed before discharge from recovery, which increased from 60% compliance in September 2016 to 100% compliance in February 2017.
- The hospital could access nutritionists from the community where more specialist advice or input was required.

Summary of findings

- PROMs results from November 2016 for NHS-funded patients receiving a primary knee replacement showed the service was within the estimated range of the England average.
- PROMs results from November 2016 for NHS-funded patients receiving a primary hip replacement showed the service was within the estimated range of the England average.
- Funding had been agreed to improve the environment of the endoscopy department.
- The service was compliant with referral to treatment (RTT) times for NHS patients admitted within 18 weeks of referral, with over 90% of patients admitted within this timeframe between October 2015 and September 2016.
- The service had a structured process in place for the medical advisory committee (MAC) and Practising privileges were routinely discussed as part of the MAC.
- The hospital had a risk register which was detailed with updates, progressions dates and actions to mitigate risks.
- Service leads displayed strong leadership and management and there was a drive to promote a positive, open and transparent culture.
- The service had recently refurbished their theatres department, including a development of a new digital theatre of which staff were proud of.

We saw several areas of outstanding practice including:

- We saw evidence of the application of "Human Factors" approach, when the hospital investigated incidents. For example we reviewed one investigation which considered the training and competency of staff as well as custom and practice, as part of the review process.
- There was evidence of innovative work to improve and engage all staff in infection prevention and control, such as running lab experiments with staff to show the difference in bacteria levels with good hand hygiene practice, and an anti-microbial awareness week.
- In January 2017 "Think Like a Customer" (TLC), was rolled out across the hospital and was part of the Nuffield organisations aspiration to become "one Nuffield" , with an aim to improving patient experience. There was a monthly newsletter published which included results from quality indicators, complaints and net promoter score, and also reviewed feedback from patients to improve the overall patient experience.
- The hospital had a clear strategy to improve services for children and young people with evidence of progress completed in the last twelve months and with a clear progression for future developments.
- The Senior Management Team ran a number of staff engagement strategies in the hospital to improve patient experience, to engage staff and to consistently review the leadership of the service. These included the "have you say make a difference" monthly meetings, and the annual "leadership MOT" review.

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	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated surgery as good overall because: • Incidents were reported and investigated appropriately and staff could give examples of learning from incidents. • There was evidence of innovative work to improve and engage all staff in infection prevention and control, such as running lab experiments with staff to show the difference in bacteria levels with good hand hygiene practice, and an anti-microbial awareness week. • The pharmacy lead had recently run a teaching session for nursing staff within the service to ensure good practice in medicines management. We were given examples of learning from this session such as clearer labelling. • Both nursing and medical staffing levels were appropriate to meet patient need. • Policies were updated in line with national guidance and best practice and staff were aware of any updates or new policies and procedures. • The ward ran teaching sessions for nursing staff every Tuesday on different topics to maintain and develop staff competencies. • There was effective multidisciplinary team working to maximise patient outcomes, with good communication between staff at all levels. • Staff displayed compassionate care and patients and families were involved in their own care. • Services were planned and delivered to meet individual patient needs, including assessment of medical, social, psychological and physical needs. • Complaints and concerns were investigated appropriately and there was evidence of learning from complaints and concerns in order to improve services.

Summary of findings

- Service leads displayed strong leadership and management and there was a drive to promote a positive, open and transparent culture. Staff described the culture as “supportive” and “like family”.

Services for children and young people

Children and young people’s services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated this service as good because:

- Staff completed safeguarding risk assessments and followed guidance to protect service users from harm.
- There were systems and tools in place to recognise and manage the deteriorating child or young person.
- The hospital maintained systems to keep children and young people safe in line with national guidance.
- The care and treatment for children and young people was planned and delivered using evidence based guidance and standards.
- Children and young people received care from the multidisciplinary team who worked together to achieve the best outcomes.
- Care was patient centred and individual to each child or young person’s needs.
- The emotional support for children was recognised in the care provided with distraction techniques observed during the inspection
- All children were placed first on the theatre list as a priority to minimise waiting time for children.
- All admissions for children and young people were pre assessed by the consultant and the lead nurse.
- The hospital had a clear strategy to improve services for children and young people with evidence of progress completed in the last twelve months and with a clear progression for future developments.
- Staff confirmed their concerns raised were acted upon and an example was given regarding the adult focused rooms which now feature child friendly wall stickers.
- The hospital maintained systems and processes to promote staff and user engagement.

Outstanding ☆

Summary of findings

Outpatients and diagnostic imaging

Good

Outpatient and diagnostic imaging services were a small proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated this service as good because:

- Incidents were reported and investigated appropriately and staff could give examples of learning from incidents.
- 100% of staff had received an appraisal and completed mandatory training.
- The imaging department had implemented a pause and check process before every patient examination to ensure the delivering of safe and effective patient care as part of clinical imaging services using ionising radiation.
- There was good multidisciplinary team working and good communication between staff at all levels.
- Staff interactions with patients and visitors were friendly and respectful. Care was given with compassion and dignity.
- Patients could choose appointment times to suit their needs. The diagnostic imaging department provided a walk in x-ray service so that patients could have their x-ray in conjunction with their appointment.
- Complaints and concerns were investigated appropriately and there was evidence of learning from complaints and concerns in order to improve services.
- There was strong leadership from the service managers. Staff spoke highly of their managers. Managers promoted a positive team culture that created a “lovely place to work”. Managers worked hard to make the department an effective and safe place for patients, visitors and staff.

Summary of findings

Contents

Good

Location name here

Services we looked at
Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Brentwood Hospital

Brentwood Hospital is operated by Nuffield Health. The hospital/service opened in 1970. It is a private hospital in Brentwood, Essex. The hospital primarily serves the communities of Brentwood,Billericay,Basildon and Romford. It also accepts patient referrals from outside this area.

The hospital had a registered manager in post since January 2016.

The hospital also offers cosmetic procedures such as dermal fillers and, ophthalmic treatments. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, and a two specialist advisor with expertise in surgery.

Information about Nuffield Health Brentwood Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited the ward, theatres, outpatients and disgnositc areas. We spoke with staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with patients and relatives. We also received 18 'tell us about your care' comment cards which patients had completed prior to our inspection.

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

Activity (October 2015 to September 2016)

- In the reporting period October 2015 to September 2016 There were 5,605 inpatient and day case episodes of care recorded at The Hospital; of these 38% were NHS-funded and 62% other funded.
- 28% of all NHS-funded patients and 25% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 24,298 outpatient total attendances in the reporting period; of these 81% were other funded and 19% were NHS-funded.

298 Doctors worked at the hospital under practising privileges. Three regular resident medical officers (RMO) worked on a week on, week off rota.The hospital employed 52 registered nurses, 26 care assistants and 96 other staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety in the reporting period October 2015 to September 2016:

No Never events

Clinical incidents 340 no harm, 109 low harm, 25 moderate harm, 0 severe harm, 0 death

One serious injuries

No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)

Summary of this inspection

No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

17 complaints

Services accredited by a national body:

- BUPA accredited for Breast Cancer and Cataract Services
- HFEA accredited for Fertility Services
- Pathology Accredited by CPA
- Pathology blood transfusion MHRA

Services provided at the hospital under service level agreement:

- Catering
- Clinical equipment maintenance
- Domestic waste disposal
- Histopathology services
- Laundry services
- Maintenance of building
- Medical waste disposal
- MRI
- Theatre site cleaning
- Microbiology
- Hospitals Sterilisation Services Units

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?

Outstanding 

We rated safe as Outstanding because:

- There was evidence of incident reporting, a good level of understanding of duty of candour amongst staff and actions and learning from incidents were discussed.
- For the period October 2015 – September 2016, 100 per cent of patients were risk assessed for venous thromboembolism (VTE) and there were no cases of hospital-acquired VTE.
- Staff knew how to respond to patient risk and there were arrangements in place for the management of deteriorating patients. The Hospital was planning to move to the National Early Warning Score (NEWS) by April 2017, in line with Royal College of Physicians recommendations.
- There was evidence of how infection prevention and control was being maintained with innovative examples, such as experiments to show the amount of bacteria that was present on jewellery or after touching a door handle to emphasise the importance of good hand hygiene and IPC compliance.
- Staff knew how to report a safeguarding concern and who the safeguarding lead for the hospital was. The safeguarding lead ran training days each month. Training included 'Prevent' training to help staff identify individuals at risk of radicalisation and female genital mutilation (FGM) awareness.
- There was a high level of compliance with mandatory training.
- Records were stored securely. We were shown the online, password-protected system for consultants to access the notes for their private patients, meaning consultants did not have to carry any patient records with them.

Are services effective?

Good 

We rated effective as Good because:

- The hospital responded to audits to improve patient outcome. For example the implementation of education and training to improve post-operative analgesia prescribed before discharge from recovery, which increased from 60% compliance in September 2016 to 100% compliance in February 2017.
- The hospital could access nutritionists from the community where more specialist advice or input was required.
- PROMs results from November 2016 for NHS-funded patients receiving a primary knee replacement showed the service was within the estimated range of the England average.

Summary of this inspection

- PROMs results from November 2016 for NHS-funded patients receiving a primary hip replacement showed the service was within the estimated range of the England average.
- The hospital's policy on consent to examination or treatment was comprehensive, in date and compliant with national guidance. For patients undergoing cosmetic surgery there was a two-week 'cooling off' period for the patient to have enough time to consider the surgery.

Are services caring?

Good

We rated caring as Good because:

- Between April 2016 and September 2016, monthly Friends and Family test results were between 97% and 100%. Response rates were 100% for each month except June where they were 95%, which was significantly higher than the England average for independent acute hospitals.
- All interactions we saw between staff and patients or families were positive and showed compassionate care.
- The patient we spoke with described their experience of staff as being "engaging" "helpful" and "respectful".
- The hospital had introduced "Think Like a Customer (TLC),which incorporated patient satisfaction, complaints and feedback to assist in seeking and using feedback from patients.
- Parents were able to accompany their child to theatre and be present in the recovery area.

Are services responsive?

Good

We rated responsive as Good because:

- The service was compliant with referral to treatment (RTT) times for NHS patients admitted within 18 weeks of referral, with over 90% of patients admitted within this timeframe between October 2015 and September 2016.
- Services were planned and delivered to meet individual patient needs, including assessment of medical, social, psychological and physical needs.
- Complaints and concerns were investigated appropriately and there was evidence of learning from complaints and concerns in order to improve services.
- The service had introduced a 'blue pillowcase' system to indicate where a patient was living with dementia so that staff knew that they may have different or more complex needs.

Summary of this inspection

- The hospital offered a Nuffield teddy bear to all children who attended the hospital for surgery. In addition, the ward had a variety of leaflets and books that described, going to hospital, going for tests and going to surgery, to explain and reassure children when anxious.

Are services well-led?

Good

We rated well-led as Good because:

- The hospital was part of the Nuffield health organisation and shared in the organisations four values, to be enterprising, passionate, independent and caring.
- Staff felt confident to raise concerns and there was an open door policy throughout the senior management team and local managers.
- There was an active medical advisory committee, who supported the matron in governance and the overseeing of investigations.
- Practising privileges were overseen and there were clear process in place for the granting of practising privileges and withdrawing if criteria was not met.
- The hospital had a clear strategy to improve services for children and young people.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	☆ Outstanding	Good	Good	Good	Good	Good
Services for children and young people	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	☆ Outstanding	Not rated	Good	Good	Good	Good
Overall	☆ Outstanding	Good	Good	Good	Good	Good

Notes

Aggregation principles overridden as children and young peoples services accounted for a small part of overall service provision.

Good

Surgery

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

Are surgery services safe?

Outstanding ☆

Surgery was the main activity at the hospital. The hospital had 41 inpatient rooms (a further room on the ward was used for the resident medical officer). There was also a double room for the close monitoring of patients who had undergone microvascular Deep Inferior Epigastric Perforator (DIEP) flap breast reconstruction. The theatre department consisted of one digital theatre, three laminar flow theatres, and one endoscopy theatre with an adjacent endoscopy processing suite. There were six recovery bays, one of which was designated for children and young people.

There were 5, 605 inpatient and day case episodes of care recorded between October 2015 and September 2016, of which 38% were NHS funded and 62% were privately funded. Of NHS funded patients, 28% stayed overnight during this period and of privately funded patients, 25% stayed overnight.

Surgical specialities included orthopaedics; gynaecology; spinal surgery; urology; colorectal; ear, nose and throat (ENT); ophthalmology; general surgery; and cosmetic and reconstructive surgery, maxillary facial and chronic pain service.

We carried out this inspection on 28 February 2017 and returned for the unannounced inspection on 10 March 2017. We inspected all areas of surgery including theatres and the adjacent endoscopy unit, the ward and recovery areas. As part of the inspection, we spoke with staff including the theatre manager and deputy manager; ward manager; one endoscopy staff nurse; one endoscopy health care assistant; two consultant anaesthetists; two IPC leads; one band five nurse; three consultant surgeons including the Chair of the Medical Advisory Committee (MAC); one resident medical officer (RMO); the HR manager; and two members of staff from the bookings department. We also spoke with a patient on the ward, reviewed patient feedback and reviewdata from the service before, during and after the inspection.

We rated safe as Outstanding.

Incidents

- Between October 2015 and September 2016 there were 350 clinical incidents reported in surgery, which represented 74% of the total clinical incidents at the hospital. This was a higher rate than the average reported for other independent acute hospitals. None of these resulted in death or severe harm.
- Between October 2015 and September 2016 there were 10 non-clinical incidents reported in surgery, which represented 36% of the total non-clinical incidents at the hospital.
- The service reported no never events between October 2015 and September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- All incidents were reviewed by the matron, who then, depending on the clinical classification, or severity of the incident, would determine what level of investigation would be completed, and if required external review.

- We saw documentation that incidents were appropriately investigated by the department head with a root cause analysis (RCA) carried out for all incidents graded as moderate or above.
- We saw evidence of the application of "Human Factors" approach, when the hospital investigated incidents,to look into the potential causes of an incident. For example we reviewed one investigation which considered the training and competency of staff as well as custom and practice, as part of the review process.
- All staff we spoke with knew how to report an incident through the hospital's electronic system and could give examples of where they had reported incidents.
- We asked five members of staff about their understanding of duty of candour and they were all able to explain it and give examples where it would need to be used or where they had used it. Duty of candour means that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- The theatre manager told us of two incidents that had occurred in theatres since this data had been submitted. In both incidents, duty of candour had been carried out and actions had been identified to minimise the risk of similar incidents reoccurring; for example implementing a red tag system for the emergency instrument kit, so it could be easily identified in the event of a major bleed. In both incidents the theatre team took part in debriefing sessions
- Actions and learning from incidents were discussed at the service's Quality and Safety Committee meetings and heads of department meetings. Learning and feedback from incidents was then cascaded back through clinical department meetings. Staff we spoke with at all levels could give examples of where learning and feedback had been shared.
- There had been no patient deaths within the previous 12 months (expected or unexpected).

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

- The theatre manager put together the dashboard for the theatres department,including for example falls and MRSA. The information was collated by the hospital matron to provide a hospital-wide overview of safety. Any themes were discussed at monthly quality and safety meetings and learning and information was shared by heads of department at staff team meetings.
- For the period October 2015 – September 2016, 100 per cent of patients were risk assessed for venous thromboembolism (VTE) and there were no cases of hospital-acquired VTE.
- Falls were recorded on the electronic incident reporting system. Between October 2015 and September 2016 there were three patient falls across the hospital.

Cleanliness, infection control and hygiene

- All areas of the theatres and ward that we inspected were visibly clean.
- Data provided by the service prior to inspection showed there were seven surgical site infections (SSIs) between October 2015 and September 2016, out of a total 5,391 visits to theatre in this period. These had been discussed in the service's annual infection control report and route cause analyses completed. SSI care bundles had been implemented as part of the quality improvement plan in this report, consisting of a minimum of 10 patient observations.
- The hospital reported no cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), E-coli, or clostridium difficile (C.difficile) between October 2015 and September 2016.
- A local standard operating procedure was in place to ensure all patient (both private and NHS patients) were screened for MRSA, and contained guidance for the management of a colonised patient.
- There was an infection prevention and control (IPC) lead for the hospital and another for the theatres department,as well as each department ,who all had an identified link nurse. We spoke with both of them who explained the work they were doing to maintain and improve IPC. For example, they had involved staff in experiments to show the amount of bacteria that was present on jewellery or after touching a door handle to emphasise the importance of good hand hygiene and IPC compliance. There had also been a recent staff learning session about clean equipment in the sluice area and an anti-microbial awareness week led by the pharmacist.

- The IPC lead shared their work at Medical Advisory Committee (MAC) meetings and heads of department meetings to share progress with their audit schedule and any areas for improvement.
- We reviewed IPC audits for the last 12 months and saw there had been gradual improvement over this period, for example in relation to dust on high surfaces. Audits also included actions for improvement such as reminders to housekeeping staff about dust in out-of-reach areas.
- IPC audit results and themes were discussed at monthly Infection Prevention Expert Advisory Group meetings. We reviewed the minutes of these meetings from November 2016, December 2016 and January 2017 which included sharing actions for improvement from audit results and reminders to staff about IPC issues such as the appropriate use of personal protective equipment (PPE).
- Routine cleaning of theatres was done by the team at the end of each day. We saw records for this showing staff were compliant with this and cleaning had been signed off by the team.
- Deep cleaning of theatres was carried out every six months by an external company. These always took place on a Sunday so they did not affect theatre lists.
- Staff were familiar with the service's policies on hygiene, cleanliness and IPC.
- We saw staff displaying good IPC practices by regularly using the hand sanitisers when moving between areas; using personal protective equipment (PPE) as appropriate and by complying with the 'bare below elbows' policy.
- The service also conducted a patient-led assessment of hand hygiene practices (a checklist in each bedroom on the ward) which had led to actions for improvement such as adjusting the locations of hand hygiene gel in the bedrooms.
- The MRSA screening rate for January 2017 was 74% (of a total 484 admissions). The theatre lead explained this figure comprised all patients who presented as requiring MRSA screening.

Environment and equipment

- Access to the ward and theatre department was secure and required card access. On the ward there was a CCTV camera by the nurses' station.
- The ward, theatre and recovery areas were organised and free from clutter. However, in theatres the fire escape door was partly blocked on the outside by light materials such as paper, cardboard and leaves, although it could have been quickly moved in the event of an emergency.
- We checked a range of equipment in theatres, the endoscopy unit, recovery and on the ward. There was one electric razor in theatres which was past the date for servicing (December 2016). We raised this to the nurse in charge and it was taken out of use. All other equipment we checked was within date, including servicing dates for electrical equipment. Equipment within the endoscopy room was all single use.
- We saw there was full tracking and traceability for theatre equipment sets and endoscopy scopes.
- We checked the difficult intubation trolley and the paediatric anaesthetic trolley in the theatre department. Both were complete and daily checks at the end of theatre lists had been completed and signed off in accordance with policy for both.
- We checked the resuscitation trolleys in theatres and on the ward. These had been in place since February 2016 and were fully stocked with completed and signed off check lists as per the service policy.
- The two fire extinguishers at the nurses' station on the ward were in date and had been serviced.
- Part of the ward was carpeted. This was on the hospital risk register and plans had been established to remove the carpets and install hard flooring for IPC purposes.

Medicines

- Medicines were stored appropriately and securely. We checked medicines on the ward and in theatres and saw they were all within date.
- There was an up-to-date controlled drugs (CDs) policy that was appropriate for the service. Controlled drugs audits took place quarterly and was scored on a red/amber/green scale with actions for improvement recorded and owners and target dates allocated for each action so the service could monitor progress.
- The pharmacy lead had recently run a teaching session for nursing staff within the service to ensure good practice in medicines management. We were given examples of learning from this session such as clearer labelling.
- Medication safety update newsletters were provided to clinical staff monthly to disseminate information. We reviewed the November 2016 newsletter which provided information in line with "world antibiotic week".

- A review of patients medications would be completed prior to surgery, to ensure that patients knew which medication to stop and which to continue to mitigate any risks. This included a "managing warfarin" (a blood thinning medication) document, which ensured that patients knew when to stop and re start their warfarin.
- As part of the hospitals Commissioning for Quality and Innovation (CQUIN), patients who were identified as susceptible to developing Acute Kidney Injury (AKI), had a review of their medication by the pharmacist who would liaise with the GP to continue on going monitoring in the community.

Records

- We checked five sets of patient records on the ward (four private patients and one NHS patient) and saw they were clear and legible, with evidence of consistent and regular recording including appropriate consultant input.
- There were two sections to patient records, one for nursing input and one for consultant input; however these were kept together to ensure medical notes made by consultants under practising privileges were integrated and accessible to staff.
- Risk assessments had been completed in full at the pre-assessment stage and we saw that all patients except the endoscopy patient had a pre-assessment documented in their records.
- However, one set of notes belonging to an NHS patient lacked a concise previous medical history although we had no further concerns as any risk had been picked up and documented at the pre-assessment stage.

Safeguarding

- Staff knew how to report a safeguarding concern and who the safeguarding lead for the hospital was. The safeguarding lead ran training days each month.
- A band five nurse on the ward showed us the flowchart for escalating safeguarding concerns which was within the safeguarding folder on the ward and also accessible on the intranet.
- All surgery staff were up-to-date with safeguarding training levels one and two at the time of our inspection.
- The safeguarding lead,all heads of departments, hospital director, matron, ward manager and consultants involved in children and young people, were trained to level three in safeguarding and this was reviewed on a monthly basis to ensure it did not expire.
- Safeguarding training levels one and two were online modules; however, the training also included face-to-face sessions with a police officer.
- Training included 'Prevent' training to help staff identify individuals at risk of radicalisation and female genital mutilation (FGM) awareness.

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

- At the time of our announced inspection all staff in theatres and on the ward were up-to-date with mandatory training.
- On the day of our unannounced inspection we were shown the most up-to-date mandatory training records which showed a current compliance rate of 97% overall for the whole hospital.
- Mandatory training compliance was managed by the HR department. Reports came through from the provider's head office on a weekly basis highlighting compliance rates so that individual members of staff could be booked onto refresher training in a timely way. The HR manager also showed us the training calendar which was pre-planned for the year ahead.
- Mandatory training was a combination of online learning and classroom modules and included, but was not limited to, manual handling, safeguarding levels one and two, infection prevention and control and fire safety.
- There was an up-to-date mandatory training policy which set out roles and responsibilities and the process for signing off training.

Assessing and responding to patient risk

- The service had an admission citeria in place with a clear inclusion and exclusion criteria.
- We assessed the use of the World Health Organization (WHO) 'Five Steps to Safer Surgery' checklist in the theatre case we observed and saw the theatre team were compliant with this and completed the required three checks (anaesthetic room, admission to theatre and final check).
- Within endoscopy, there was a specialised endoscopy safety checklist taken from NHS guidance from 2015.
- Nursing staff reported they had easy and quick access to medical input as required if they had concerns about a patient's condition. The band five nurse we spoke with on the ward clearly explained how they would escalate a case of a deteriorating patient.

- There was 24-hour access to medical input in the event of an emergency as there was always a resident medical officer (RMO) on site. Treating consultants were also required to remain within a 30-minute travel time for the duration of their patient's stay so they could attend in the event of patient risk or deterioration.
- There was a comprehensive on call system throughout the hospital which included senior management team, theatre team, pharmacy, pathology and radiology.
- The RMO reviewed patient drug charts twice a day as a minimum, with the ward manager or nurse in charge,so that if they were called to a deteriorating patient they would be able to respond quickly and appropriately.
- There were up-to-date service level agreements (SLAs) in place with three local NHS trusts and there was an up-to-date transfer out folder setting out potential situations of patient risk and the appropriate transfer out pathway to take. The ward manager told us that if a transfer to a local A&E was required, a nurse from the ward would always escort the patient on this transfer.
- The "Situation, Background, Assessment and Recommendation" (SBAR) tool was used to support staff in communicating important information, such as when a patient was deteriorating. This ensured consistent and concise information was passed between health professionals. In October 2016 19 staff had attended one of the three sessions that were run throughout the year.
- The service used modified early warning scores (MEWS) to review each patient's condition and adjusted staffing levels accordingly if required owing to increased risk or acuity. This scoring was carried out alongside regular recording of clinical observations. The Hospital was planning to move to the National Early Warning Score (NEWS) by April 2017, in line with Royal College of Physicians recomendations.

Nursing and support staffing

- There were 22.7 full time equivalent (FTE) registered nurses working within surgery services and 5.2 FTE health care assistants (HCAs), as of October 2016.
- At the time of our inspection there were two vacancies for nursing staff within theatres; however, the theatre manager had just recruited to fill these posts taking the department to full establishment. On the ward there were no nursing vacancies at the time of our inspection.
- Theatres used a small core group of agency nurses occasionally. There was use of bank health care assistants (HCAs) on the ward but they had recently recruited to fill these posts. Agency and bank staff received full local inductions before commencing their work there and only one agency nurse per theatre was permitted. The use of bank and agency nurses and HCAs was lower than the average for independent acute hospitals.
- On the ward the registered nurse to patient ratio was at least one to six and rotas were planned two months in advance to accommodate this. We reviewed rotas and saw that actual nurse staffing was in line with planned staffing levels and was sufficient to meet patient acuity. The nurse in charge was always supernumerary.
- Staffing levels were assessed on a daily basis using the 'professional judgement' model and Nuffield Health at provider level was assessing the most appropriate acuity tool to use at the time of our inspection. Staff were allocated according to patient numbers, acuity, number of discharges, theatre cases and number of admissions.
- Shift patterns for nurses were as follows:
- 7am to 3pm (early shift)
- 1pm to 9pm (late shift)
- 8.30pm to 8am (night shift)
- Full nursing handovers took place between each shift.
- Sickness rates for registered nurses within the theatres department were zero per cent, or lower than average for independent acute hospitals between October 2015 and September 2016 except for August 2016. For ODPs and HCAs in theatres the rate was also zero per cent except in March 2016.
- Sickness rates for registered nurses on the ward were zero per cent, or lower than average for independent acute hospitals between October 2015 and September 2016 except for October and November 2015. For HCAs on the ward sickness rates were variable. They were slightly higher than the average on six of the 12 months in the same reporting period.

Medical staffing

- The hospital overall employed 298 doctors under practising privileges.
- At the time of our inspection we saw that medical staffing in theatres and on the ward was sufficient to meet patients' needs.
- The service employed three resident medical officers (RMOs) who each worked on a week on, week off

rotation. If a need was identified for the RMO to work over an extended period, the service would request a second RMO from the service that was subcontracted to provide this.

- Surgeons and anaesthetists were required to be available and remain within a 30-minute travel time for the duration of their patient's stay to ensure sufficient out-of-hours cover, as a condition of their practising privileges. If this was not possible they were required to arrange alternative, suitable cover.
- The resident medical officer (RMO) attended each nurse handover which took place three times a day, between shifts, to ensure they were informed about patient conditions and progress.

Emergency awareness and training

- There was an up-to-date hospital-wide major incident plan (ratified May 2016) and staff confirmed they knew how to access this.This included a back up oil powered generator to provide essential power in the event of loss of electricity.
- There was an additional hospital policy for evacuation in the event of a fire, which had recently been updated to make it more tailored to the specific environment of the service.
- The deputy theatre manager explained clearly the process that would happen in the event of a fire, such as radio communication between departments and the additional equipment available such as foil blankets and oxygen near the exit of each theatre.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We observed a theatre case from admission to recovery and saw that care was provided in line with clinical guidance from the National Institute for Health and Care Excellence (NICE).
- Staff showed us how they were able to access up-to-date policies via the intranet and also hard copies. They were updated of any changes to policies.
- There was a comprehensive local audit schedule for the service, including monthly mattress audits on the ward; internal cleanliness audits and medicines storage audits. We saw that audits identified areas for improvement and had action plans , target dates and named responsible members of staff to achieve this.
- Policies were updated in line with national guidance and best practice and shared at provider level. New or updated guidelines from NICE were sent to the hospital monthly by the Nuffield Health Quality Care Team and assessed locally for their relevance before being shared with staff (including with consultants working under practising privileges).

Pain relief

- The ward completed acute pain management audits every month. We reviewed the pain audits from September 2016, January 2017 and February 2017 and saw they had been completed and signed off appropriately. These audits consisted of a review of 10 patient records and identifying any actions where appropriate. For example in September 2016 the service scored 60% for the reported measure 'post operative analgesia prescribed before discharge from recovery'.
- The action from the audit, identified a need to implement additional education and teaching to all recovery nursing staff to ensure that all consultant anaesthetists and admitting consultants had a post discharge plan surrounding analgesia. There were also owners and target dates allocated to any actions to effectively track progress. In the audit from February 2016 the service had scored 100% on all reported measures.
- We were told there had previously been some concerns around effective pain management on the ward. As part of the actions for improving this, one nurse had completed a university course on pain management and was now leading teaching sessions for other staff.
- Nursing staff reported that anaesthetists were accessible for guidance on pain relief.
- Pain scores were documented appropriately in the patient notes we reviewed. Patients were asked to score their pain on a zero to ten scale each time clinical observations were recorded.
- Pain relief advice sheets were given to patients following their procedure, and provided information on a range of pain relief and contact numbers for the ward and pharmacy.

Nutrition and hydration

- There was a menu which varied daily and was assessed for nutritional value. Menu choices were varied and included hot and cold food. Patient dietary requirements were taken into account, for example halal, kosher and vegetarian options were available, and patients could request food at any time.
- The service did not have a dedicated dietician; however, the ward manager told us they could access nutritionists from the community where more specialist advice or input was required. The service also worked with patients' GPs to manage any specific nutritional plans.
- Within the theatres department the standard starve time of six hours was used. The service had separate morning and afternoon theatre lists to minimise longer than expected fasting times for patients.

Patient outcomes

- Between October 2015 and September 2016 there were 16 unplanned returns to theatre.
- Between October 2015 and September 2016 there were eight unplanned transfers of inpatients to other hospitals and 18 unplanned readmissions within 28 days of discharge. This was within the estimated variance for independent acute hospitals.
- The service participated in national audits including the National Joint Registry; the NHS Medication Safety Thermometer and the Patient-Led Assessment of the Care Environment (PLACE). NHS patients undergoing hip and knee replacement surgery were also invited to participate in Patient Reported Outcome Measures (PROMs). These were sent from the corporate team and cascaded by the hospital team.
- PROMs results from November 2016 for NHS-funded patients receiving a primary knee replacement showed the service was within the estimated range of the England average. This included results of the Oxford Knee Score showing that out of 59 modelled records, 98.3% were reported as improved and 1.7% as worsened.
- PROMs results from November 2016 for NHS-funded patients receiving a primary hip replacement showed the service was within the estimated range of the England average.This included results of the Oxford Hip Score showing that out of 68 modelled records, 98.5% were reported as improved and 1.5% as worsened.
- The service was part of the Private Healthcare Information Network (PHIN) and submitted data in accordance with legal requirements regulated by the Competition Markets Authority (CMA). The service was represented at both the PHIN monthly implementation forum and the expert advisory working groups. Coded episode data had been submitted to PHIN as required by the CMA Order in advance of 1 September 2016 and other member agreed data requirements by agreed due dates.

Competent Staff

- There was a focus on maintaining and developing staff competencies both on the ward and in theatres. For example, theatres were currently running a surgical first assistant course for nursing staff. Two members of staff had already completed the course and the service was hoping that all staff would undertake it by the end of the year. One endoscopy HCA told us they were doing their first aid course, supported by their manager and the service and they were looking to develop their competencies further by completing a decontamination course.
- The ward ran teaching sessions for nursing staff every Tuesday on different topics to ensure staff competencies were maintained and developed.
- Upon commencing employment, staff received a full induction to ensure competence. This included being shown how to report an incident, how to complete online training and an introduction to local policies and procedures.
- All registered nurses completed an administration of medication competency workbook and a controlled drug competencies worksheet, prior to being able to administered medications or controlled drugs.
- Data provided prior to inspection showed that in the appraisal year so far (between January and December 2016), 94% of registered nurses and 95% of operating department practitioners (ODPs) and HCAs in theatres had completed appraisals. On the ward, 92% of registered nurses, 80% of HCAs and 96% of other staff had completed appraisals during this time.
- By the time of our inspection in February 2017, all staff were up to date with appraisals and reported they had clear action plans and appropriate support from managers to develop.
- Consultant practising privileges were governed under the Nuffield Practising Privileges Policy, and Revalidation and Appraisal Policy. We found these policies to be up-to-date and appropriate to ensure

consultant competence and define the limits of practice. Practising privileges were reviewed bi-annually by the Medical Advisory Committee (MAC) and Hospital Director; or on an individual basis if there were concerns raised or changes to the consultant's scope of practice.

Multidisciplinary working

- We saw evidence of effective multidisciplinary team (MDT) working both in theatres and on the ward, including in the theatre case we observed, with good communication between staff at all levels. This was confirmed by staff we spoke with on the day of our inspection; for example the ward manager spoke very positively of the support from the lead pharmacist and from allied health professionals (AHPs).
- Nursing staff reported they had good working links with and access to the medical team including resident medical officer (RMO).
- Physiotherapists attended handovers every day to give their input to the patient's care plan.
- The hospital did not employ any in-house occupational therapists but the ward manager told us they had access to occupational therapists in the community if required.
- We asked how patients were referred to MDT meetings and the ward manager told us they would make this decision dependent on individual patient care needs, with input and advice from the consultant if required.
- The service had access to external microbiology support if needed,through a sevice level agreement with a local NHS trust.

Seven-day services

- The ward had access to an on-call radiographer who was also required to remain within 30 minutes of the hospital to ensure the availability of diagnostic and imaging services.
- Physiotherapy was available Monday to Thursday from 7.30am to 7pm and Friday 7.30am to 4pm. Post-operative physiotherapy was available on Saturday if required.

Access to information

- We were shown the electronic notes system and staff confirmed they were able to access records and all the information required. Consultants had individual secure log ins so they could view and update notes for their patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff showed awareness of the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We were told there was an emphasis on involving the patient in the discussion even if they had been assessed as lacking capacity.
- The hospital's policy on consent to examination or treatment was comprehensive, in date and compliant with national guidance. Staff were familiar with the policy.Consent to examination or treatment audits were carried out to ensure that the consent process and records were recorded accurately. We reviewed the audit data for February 2017 and found out of five sets of notes audited, all were compliant.
- We were shown the electronic step-by-step system where staff were prompted to consent the patient before moving onto the next step which was good practice for ensuring consent was appropriately taken and documented.
- A consent form "4" was used for patients living with dementia, which highlighted the consideration of needs of the person, and assessment of the persons capacity in line with the Mental Capacity Act.
- In the case of cosmetic surgery there was a two-week 'cooling off' period for the patient to have enough time to consider the surgery.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Between April 2016 and September 2016, monthly Friends and Family test results were between 97% and 100%. Response rates were 100% for each month except June where they were 95%, which was significantly higher than the England average for independent acute hospitals.
- All interactions we saw between staff and patients or families were positive and showed compassionate care.
- The patient we spoke with described their experience of staff as being "engaging" "helpful" and "respectful".

Good

Surgery

- We were told of an example of a patient who missed their cat during their stay in hospital. Staff on the ward enlarged a photo of the patient's cat and stuck it to the wall in his room which we were told the patient appreciated.

Understanding and involvement of patients and those close to them

- A patient we spoke with on the ward told us they had been kept fully informed about their procedure and admission and discharge plans.
- Within the bedrooms on the ward there were 'self-medication boxes' which allowed patients to administer their own medicines as long as it was safe and they were assessed as having capacity to do so. The ward manager told us they had received positive feedback from patients about this as it allowed patients to retain independence during their stay on the ward and be involved in their own care.
- In January 2017 "Think Like a Customer" (TLC), was rolled out across the hospital and was part of the Nuffield organisations aspiration to become "one Nuffield" , with an aim to improving patient experience. There was a monthly newsletter published which included results from quality indicators, complaints and net promoter score, and also reviewed feedback from patients and initiatives to improve the overall patient experience.

Emotional support

- The service did not have in-house counselling services; however, we were told that they would help patients access counselling and support services where required. The theatre manager gave an example of where the service had arranged psychological support for a patient and had ongoing contact with the patient to support their longer-term psychological and emotional needs.
- A "show and tell" meeting was held bi monthly for women who had undergone breast reconstruction, to share their experiences of the hospital, the care they received and the patient journey, which provided support to other women who were due to come into hospital for surgery.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Surgery services were planned and delivered to meet individual patient needs and the needs of the community. The service worked closely with the local clinical commissioning group (CCG) and local NHS trusts to meet those needs.
- Patient assessment were carried out prior to surgery to assess individual medical, social, psychological and physical needs. As part of this assessment, the service offered a 'patient health MOT' to all patients.
- Theatre sessions were planned on five-week schedules. We saw the schedule for the month ahead and the theatre manager showed how it was planned according to effective utilisation of all the areas, patient priority and demand; and consultants' hours.
- We were shown the online booking system whereby theatre bookings were made via the bookings team in conjunction with the theatre manager. Endoscopy bookings were made through the Endoscopy Management System (EMS).
- Theatres ran from 8am to 6pm from Monday to Friday, and 8am to 5pm on Saturdays. The department did not routinely schedule surgery after 6pm, except ophthalmic surgery, as this type of surgery was lower risk with quicker recovery time so was assessed as safe at a later time.
- Within endoscopy there was a mixture of ad-hoc consultants and consultants who worked at the service on a weekly or fortnightly schedule.
- We were told that one endoscopy consultant had regularly been late causing delays to endoscopy lists; however the team had recently had a discussion with him and reported that timeliness had now improved.

Access and flow

- Data provided by the hospital prior to inspection showed that between October 2015 and September 2016, 29 procedures in total across the hospital were

cancelled for non-clinical reasons, such as the patient choosing a more convenient time for them. Of these patients, 26 had been offered another appointment within the next 28 days.

- The theatre manager told us there had been two occasions in the previous six months where they had to cancel operations because theatre lists had ran over. In both instances, the operations were rescheduled for within the next 48 hours.
- Within endoscopy, the service had on occasion had to cancel appointments because of faults with the endoscope washer which was a recognised issue for the service. However, they had always been able to notify the patient in advance of their arrival at the hospital and schedule an alternative appointment in a timely manner.This was on the risk register.
- The service monitored waiting times for surgical patients referred via the e-referral system and reported compliance with waiting time targets for NHS patients to the clinical commissioning group (CCG) at quarterly contract review meetings. Private patients booked their procedures with individual consultants according to the patient's convenience.
- Admission to endoscopy was done on the ward as the department was small and they did not have the space or staff to facilitate this. One member of nursing staff said it was a frustration that they were unable to meet all patients before their procedures, only those in the morning list, as they did not usually have the time or staffing cover to go to the ward between lists to see patients prior to admission to the endoscopy theatre. We reviewed the admission process for endoscopy with staff and were satisfied that actions were taken to make admission as smooth as possible. Funding that had recently been secured to expand the endoscopy department.
- The service was compliant with referral to treatment (RTT) times for NHS patients admitted within 18 weeks of referral, with over 90% of patients admitted within this timeframe between October 2015 and September 2016, except in September when the rate was 87%.
- We spoke with staff in the bookings department who managed RTT and showed us the system used to oversee it and identify patients who were approaching the 18-week breach period and the reasons for this. In January 2017, for example, there were 13 episodes of exceeding the 18-week period but all of these were recorded as being down to the patient's choice. This showed good oversight of RTT in the service.
- Any cancellation or case where the patient did not attend their appointment was recorded as an incident . These were then raised and discussed at monthly Quality and Safety meetings led by the matron. We saw evidence of this in the Quality and Safety report from January 2017.

Meeting people's individual needs

- The servicehad introduced a 'blue pillowcase' system to indicate where a patient was living with dementia so that staff knew that they may have different or more complex needs.
- Staff had undergone an on line dementia friends and family training, as well as dementia training days. We reviewed the attendance record for the dementia training day in September 2016 in which 29 members of staff attended and included nursing, kitchen, imaging and pathology staff.
- The "This is me" leaflet (a form that provides information about the individual including events, culture, preferences, routines and personality), was used to support staff in caring for patients living with dementia.
- There used a "hospital communication book", which had been developed on behalf of a local learning disability board. This provided staff with information on how to help patients who may have had a difficulty in communicating or understanding, including some basic sign language signs and the use of pictures and symbols.
- There was a "medical encounter" communication boards , which incorporated a range of symbols and questions for general questions or questions specifically for the doctor, which would assist patients who were not able to communicate effectively.
- Fitness programmes were available to orthopaedic and women health patients to aid them in their recovery following surgery.
- Patients undergoing cosmetic surgery had supportive garments (which would be used post operatively) ordered in advance of their admission to ensure that were available immediatetly following surgery.
- We spoke with a band five nurse on the ward who reported they received support from the ward manager

in treating and communicating with patients living with dementia or learning difficulties and there were plans for this nurse to become a dementia champion for the hospital.

- The ward manager told us that under the service level agreement (SLA) with the local NHS trust, they had access to nurse specialists to meet any specific or complex needs, such as in the case of patients living with dementia or with a learning disability.
- The service used had access to two different translation services for patients whose first language was not English.
- Dignity audits were completed every six months, and included ensuring the hospital had dedicated dignity champions, as well as completing observations in clinical areas to ensure people were treated with dignity and respect. We reviewed audit data from February 2017 and found that the target of above 90% had been met.

Learning from complaints and concerns

- Data provided by the service showed there were 17 complaints to the service overall between October 2015 and September 2016; these were not broken down further so we could not see how many related directly to surgery. This was significantly fewer than the previous year (44 complaints) and was similar to other independent acute hospitals. None of these complaints were referred to the Ombudsman or to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- There was an appropriate and up-to-date complaints policy, which included a timescale for responding to complaints. All complaints were acknowledged in writing within two working days with a full written response to be provided within 20 working days. If a longer investigation period was required, for example because of complex issues or a relevant member of staff being on leave, the complainant would be informed and a new response date given. The complaints data that we reviewed showed that the service was compliant with these timescales.
- The matron led investigations into any complaints relating to clinical care. Non-clinical complaints involved the relevant head of department alongside the hospital director. If a complaint involved an individual consultant the hospital director and/or matron would meet with the consultant involving the MAC Chair if appropriate.
- There was evidence of learning from complaints and concerns in order to improve services. The ward manager told us that complaints were collated on a monthly basis and the customer service lead for the hospital produced five key learning points from these which were shared at team meetings.
- The ward manager followed up patient complaints with a phone call to discuss it and obtain further details so that action could be taken to make improvements where possible.

Are surgery services well-led?

Good

We rated well-led as Good .

Leadership / culture of service related to this core service

- Surgery was overseen at a local level by a lead in theatres and a lead on the ward. Service leads displayed strong leadership and management and there was a drive to promote a positive, open and transparent culture. Staff described the culture as “supportive” and “like family”.
- A “daily brief” was led each morning by the senior management team, and provided an opportunity to share daily operational information as well as training opportunities and external visits. We attended a “daily brief” during our inspection, and found it well attended with a range of staff in attendance. A memo was produced after the meeting and shared with staff via the intranet, and displayed in the canteen for staff who may not have been able to attend.
- The hospital ran annual staff satisfaction surveys under the heading of “leadership MOT”. There was evidence in the Team Brief document that showed actions following the results from the survey, had been communicated to staff, action plan in place and a dedicated “how we are doing board” for all staff to see.
- Monthly session were run for all staff named “Have your say make a difference”. We reviewed the minutes from September and November 2016.This covered a wide range of issues, including staff requesting a dedicated room that could be used as a prayer/reflection room. At the time of our inspection this was being taken forward.

- All staff we spoke to reported the senior management team were accessible and approachable; the ward manager told us that the hospital director visited the ward every day and that the hospital director and matron spent time talking to patients and families.
- There was an open and transparent culture within the hospital and staff felt said that they felt confident to raise concerns or issues.

Vision and strategy for this this core service

- The hospital was part of the Nuffield health organisation and shared in the organisations four values, to be enterprising, passionate, independent and caring.
- The ward manager told us that over the past 12 months they had focused on improving the culture with better learning, communications and stability within the surgery team. They were now focusing on embedding this work.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The service had a structured process in place for the medical advisory committee (MAC).We reviewed the meeting minutes from May, July and October 2016. These were detailed, comprehensive and covered all services within the hospital. Topics included appraisals, unplanned transfers, children and young people, practising privileges , complaints and quality dashboards.
- The hospital produced a "Mac update", which was sent out to all consultants following a MAC meeting to ensure that updates and general information was shared. We reviewed the MAC update from December 2016, which covered topics such as pharmacy updates and lessons learnt from clinical incidents.
- At the time of our inspection the MAC chair had been in post for six years and was in the process of handing over to a new MAC chair, however was still going to support the hospital in the overseeing of governance arrangements and supporting the matron on investigations.
- Practising privileges were routinely discussed as part of the MAC. Privileges were renewed and reviewed every three years as a minimum. There was a comprehensive database in which weekly reports would be generated to identify where consultants had not adhered to the requirement of practising privileges. We were shown examples of where practising privileges had been suspended for the non-production of required documentation.
- The hospital had an overarching risk register which was detailed with updates, progression dates and actions to mitigate risks, however local risk registers were not held within each department. The risk register was a standing agenda item on the Head of Department (HOD) meetings and the MAC meetings. We reviewed two sets of minutes from the HOD meetings in October and November 2016, and could see where it was recorded when additional risks had been entered onto the register.
- The endoscopy washer was a recognised issue for the department as it regularly broke down and the service had to call out engineers for repair. This was on the service's risk register and the two endoscopy staff we spoke with told us they received good support from senior management in minimising this risk and working around it.
- The ward manager and theatre manager were both able to explain the risks in their respective departments and actions taken to mitigate these risks. These were documented in the risk register. For example, on the ward, emergency call bells were a known risk because, owing to the layout of the ward they could not be heard from one end to the other. This was being addressed at the time of our inspection with plans for new call bells to be introduced.
- The hospital took part in an annual Quality Assurance Review, in which staff from other sites, as well as the regional quality care partner undertook a three part review, based on the CQC key lines of enquires. We reviewed the findings from the January 2016 review and action plan. There was clear evidence of where changes had occurred, for example the process of updating policies. There were no actions outstanding, and all recommendations had been completed.

Public and staff engagement (local and service level if this is the main core service)

- There was a focus on promotion and development from within; for example the theatre manager told us they had been supported by both other staff in the department and the senior management team to progress into this role.
- There was a staff suggestion box in the canteen area.

Good

Surgery

- There was a monthly staff forum. We reviewed the minutes from the meetings in February, August and November 2016.These meeting provided an opportunity for staff to raise issues that mattered to them, and there was evidence of senior managers following requests up.
- Staff told us about 'therapy days' where staff could have 15-minute massage treatments or meditation sessions after their shift or during their break.
- The hospital was in process of setting up a patient forum, and this was expected to be in place by August 2017.
- A yearly awareness day for breast cancer was held in the hospital, which provided opportunity for staff and patients to gain information into the disease as well as raising funds.
- A part of the quality assurance review (referenced in the Governance, risk management and quality measurement section), patient interviews were completed to gain feedback about the service and improvements that could be made. Overall the comments were positive and patients were satisfied with the service.

Innovation, improvement and sustainability

- The service had recently refurbished their theatres department, including a development of a new digital theatre of which they were proud
- The endoscopy unit had, in February 2017, secured funding to develop the endoscopy unit and improve these facilities. They were also working towards (JAG) accreditation in 2018.

Outstanding ☆

Services for children and young people

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

Are services for children and young people safe?

Outstanding ☆

We rated safe as **Outstanding.**

Incidents

- The hospital reported no never events in 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.
- One serious incident was reported in August 2016 in a child following surgery, and whilst in recovery. The root cause analysis investigation confirmed further staff development was required and changes in practice were implemented which included ensuring that children were not anaesthetised until the previous child was fully recovered. This ensured the availability of the anaesthetists in emergency situations.
- From October 2015 to September 2016, the hospital reported nine incidents within the children and young peoples services (CYP) with five incidents reported had no patient harm, three had low patient harm and one had moderate patient harm. These incidents all had clear improvement plans to avoid future reoccurrence.
- Staff knew what incidents to report and how to report them. Managers investigated incidents and shared the lessons learned with all staff in this hospital. Managers made changes to practice to make sure incidents did not happen again. An example discussed with staff described lessons learnt from an incident reported at another hospital, when a child had accessed the lift to the ground floor. Managers installed a digital access pad on the first floor lift to prevent unaccompanied children accessing the lift , to ensure an incident like this would not occur at the hospital.

Cleanliness, infection control and hygiene

- The hospital reported no cases of clostridium difficile, methicillin resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA) or E-coli in the period between Oct 2015 and Sept 2016.
- The Infection Contol and Prevention team (IPC team) consisted of a lead nurse and matron who was the responsible director of infection prevention control and an identified link nurse for the service who monitored the completed audits. The IPC audit results were reviewed and clearly displayed within the service.
- The department had cleaning checklists audit results that showed compliance at 98% or above for IP&C practices e.g. bare below the elbows, hand hygiene, decontamination of patient care reusable equipment, standard precautions (waste, laundry and sharps) and isolation precautions. The hand hygiene compliance for CYP was 100%.
- Actions taken by the hospital to maintain compliance included IPC being a regular agenda item on the CYP service meeting.

Environment and equipment

- The C&YP service was a secure environment appropriate for the service. All areas across the hospital where C&YP attended had been decorated in a themed child friendly way (trees, butterflies and animals) which identified the dedicated areas for C&YP.
- There was a lift with a security digital pad requiring an access code on the lift door that prevented children leaving the ward area unaccompanied.

Services for children and young people

- The C&YP wards were secure with anyone needing access to the hospital required to sign in at the main reception when they arrived and again when they left.
- The service made sure all patients were protected from harm by installing window restrictors in line with the Management of Health and Safety Act at Work Regulations (1999) to prevent windows opening beyond 10 centimetres wide. All windows were fitted with blinds for privacy and dignity with a short length of blind cord that was fixed to the wall out of the reach of children.
- Staff changed privacy curtains on a four-month cycle. Curtains across the service were child friendly and dated. Staff confirmed that they could get curtains changed if dirty and changed immediately.
- All ward areas had easily wipe able floor covering as carpets had been removed in line with infection and prevention recommendations. The one area used by this service that still had carpet was the CYP pre assessment room and staff confirmed plans for this to be removed within the next month as part of the refurbishment of this area.
- All patient care monitoring equipment reviewed had electrical checks within date and had a planned prevention maintenance programme.
- Staff confirmed they received training when new equipment was purchased and knew how to access training for unfamiliar equipment.
- All areas across the hospital that included C&YP had access to appropriate equipment and easily identified (blue) C&YP resuscitation trolleys with butterfly stickers on the front of each trolley. Two staff checked all C&YP resuscitation and difficult intubation trolleys daily and a monthly check had been completed and signed off by senior staff.
- The resuscitation trolleys were seen and checked with one trolley found in the ward area, one on the ground floor outpatients department and one trolley between x-ray and therapy department. There was one trolley reviewed in the recovery area within theatres. All new trolleys had been in place since February 2016 and had completed Nuffield check lists.
- We reviewed the resuscitation trolly audit data from May 2016 and found overall 100% compliance with checking. However on two ocassions the top of the trolley had not been checked, and this had been fed back to staff to action.
- The outpatient department had a television and toys to provide entertainment whilst patients were waiting for appointments.

Medicines

- There had been one medication incident recorded within CYP service between January 2016 to February 2017.
- Senior staff discussed an incident that had occurred which involved administration of a sedative to a child in an emergency situation . Staff had not followed procedure or signed document when the medication was given. Additional staff training and changes had been made following the incident in line with the hospital policy to ensure the risk of reoccurrence was mitigated. There had been no further medication incidents reported.
- The ward manager held the medication and controlled drug cupboard keys. Medications were kept in a secured trolley within a secured room or in a locked medication fridge within the same room.
- Staff checked controlled drugs and medicine storage in line with hospital policy and included daily temperature recordings of the fridge. The controlled drug register was also checked daily with both checklists correct and completed when reviewed.
- The hospital had an identified antibiotic steward led by the pharmacist to support staff within this service.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Records

- Staff name and designation were clearly documented at the beginning of all the patient records, counter-signatories were in place where needed.
- Quarterly documentation audits were completed to ensure high standards of record keeping. We reviewed the audit results from April 2016. 10 sets of notes had been reviewed against six key performance indicators. Four indicators had achieved 100% compliance, with the remaining two 90%. Those not meeting 100% had clear actions in place and when they would be reviewed. Staff confirmed their awareness of Caldicott (protecting patient information) and the Caldicott guardian and spoke about processes in place to support

confidentiality which included the secure storage of medical notes within the ward reception area. The CYP service adhered to data protection and Caldecott handling principles.
- This hospital group had commenced work towards all aspects of patient information becoming digital in the future.

Safeguarding

- Staff followed patient assessments and safeguarding procedures to prevent children and young people from harm.
- The hospital matron was the lead for safeguarding supported by the CYP lead nurse and registered manager.
- A named consultant paediatrician for Nuffield Health Brentwood Hospital ran regular outpatient clinics and monthly endoscopy lists (in theatre) and staff confirmed they are easily accessible directly or via their secretary.
- The CYP lead nurse had established a professional relationship with the medical lead, enabling access to advice, information and support where necessary in relation to safeguarding.
- The paediatric nurse lead attended the external named professionals quarterly meeting (held at a local provider), as well as having a good relationship with the peadiatric lead at the neighbouring trust. This ensured that learning was shared, and advice could be sought from a range of experts.
- The hospital medical lead chaired the CYP committee and sat on the medical advisory committee, representing CYP services.
- Level three children's training was held by the matron and ward manager, CYP lead nurse and the hospital director. All consultants and staff involved in the care of children and young people had also undergone level three training. Training was monitored by human resources and reviewed on a monthly basis.
- PREVENT(Government's counter terrorism strategy) training was completed by all staff and the lead nurse was undertaking training to facilitate this training to ensure staff were aware of their professional responsibilities in relation to the safeguarding of CYP from radicalisation and acts of terrorism.
- Staff confirmed they followed the intercollegiate document: Safeguarding children and young people, roles and competences for health care staff third edition: March 2014.

Mandatory training

- All staff had completed children's speciality training and had relevant skills for their role. All staff spoken with confirmed they felt supported to undertake training in their area of speciality.
- Staff completed blood administration and returns system (BARS) training as part of the induction and mandatory training. This included training in the new system being introduced which included a barcode and finger print recognition process to track blood removal and usage, wastage and returns.
- Staff confirmed that many of the training opportunities were available on the electronic learning system which they could access outside of work, for example medicines management which they updated yearly.
- The situation, background, assessment and recommendation (SBAR) tool introduced by the National Health Service (NHS) institute of innovation and improvement was used as part of the day to day care within CYP. Mandatory training included this communication tool which was used as part of the hospital communication process to ensure key patient information is communicated correctly and understood.

Nursing staffing

- Staffing was planned by the CYP lead nurse who confirmed she continually monitored staff requirements to meet the needs of the service with bank or agency staff employed as required. There were two whole time equivalent staff (three staff members) within the service who are registered sick children or children's speciality trained nurses.
- The service was supported by three registered nurses (children's) regular paediatric bank staff. There were four shifts in the last twelve months that required agency cover and one agency staff completed the four shifts to ensure the paediatric operating sessions one to two per week were covered. There was currently a recruitment advert for bank registered children's nurses.
- CYP champions were identified in all departments to ensure engagement and understanding of CYP issues across the hospital.
- If a child or young person required transfer we were assured that a registered children's nurse accompanied them during the transfer and that staff would be flexed to cover the inpatient area.

- The staffing for inpatients within CYP service reflected the reviewed CYP policy set at one registered nurse to three patients.

Medical staffing

- Services were planned and a service level agreement with the local NHS trust gave 24 hour consultant support with patients transferred as their condition necessitated.
- Staff caring for children and young people confirmed that consultants were approachable and easily contactable by telephone should advice be required.
- Consultants clearly documented their contact details in the six medical records we examined.
- We found no reports of consultants attending late for clinics or theatres.
- All surgeons as a condition of their practising privileges are required to be available 24/7 and remain within a 30 minute travel time of the hospital for the duration of their patient's stay in hospital. Alternatively they must arrange suitable formal cover. The out of hours occurrences that needed medical intervention from consultants are minimal but we were assured that the team works well together to cover as required.
- Medical staff in the ward and theatre areas easily accessed electronic and paper based policies and policies reflected national guidance. For example, we reviewed the safeguarding children and consent policies and found these up to date and ratified.

Emergency awareness and training

- Staff knew of the hospital's major incident business plan which was reviewed in June 2016 and staff we spoke with described their responsibilities.
- All emergency equipment for children and young was available and checked.

Are services for children and young people effective?

Good

We rated effective as good

Evidence-based care and treatment

- CYP received care and treatment that was planned and delivered in line with evidence based guidance and standards. The CYP lead nurse completed and managed audits to evidence practice was in line with best practice and latest guidance. For example, we saw the latest guidance from the Royal College of Anaesthetists that confirmed that children under 15kgs were not suitable for tonsillectomy surgery. This was due to the risk of peri-operative and post-operative bleeding and potential respiratory difficulties.
- Electronic and paper based policies were easily accessible by staff, we observed staff accessing them from on the hospital internet. Staff described channels of communication used to inform them when policy updates had taken place. We saw the safeguarding, medicines management and consent policies, which were all up to date and ratified.
- Paediatric care pathways reflected that evidenced based practice was used, and the paediatric early warning score (PEWS) with relevant risk assessments was embedded in the pathway.
- The service undertook local audits.. Examples of local scheduled audits completed assured us of the compliance with Nuffield hospital policies and included allergies in children and early onset of diabeted mellitus in children.
- We reviewed the audit completed in November 2016 to ensure compliance with The National Institute for Health and Care Excellence (NICE) administration of intravenous therapy to children. All criteria was found to be met, for example updated algorithms in all emergency trolleys.
- Systems were in place that reflected national, professional guidance and legislation to keep CYP safe and included, for example, the weight related criteria for tonsillectomies and adenoidectomies patients admitted to this service.
- We saw the 'World Health Organisation (WHO) safe surgery checklist, "five steps to safer surgery" tool was used to ensure patient safety during surgical procedures. The CYP lead nurse confirmed she attended the WHO briefing session in theatres when CYP were included on the theatre list.

Pain relief

- We reviewed six CYP records and found an age appropriate pain tool completed in each record. We found two pain tool methods used which included the Wong-Baker face pain rating scale for younger children

or those with learning difficulties who could not identify a numbers scale. The older children used a numerical scale of one to ten (with ten being extreme pain and one no pain) to confirm their current experience of pain.
- Staff reported that the child friendly pain charts were embedded into the paediatric early warning system (PEWS) tool to support children and young people to express their pain.
- We reviewed a pain assessment being undertaken on a child post operatively. Their parent confirmed that staff had completed 30-minute assessments on the child following surgery and offered pain relief appropriately and timely.
- Two additional patients confirmed they felt confident in assessing their own pain with staff and the tool given to them was clearly explained.
- The second set of parents we spoke with stated that pain assessments were completed regularly and pain relief was given in a timely manner.
- Staff completed pain scores in all of the records that we reviewed.
- The service completes a quarterly paediatric inpatient survey. Questions were asked in relation to pain management and outcomes were positive.
- Local patient survey results showed that 100% of nurses always asked about a patient's pain and 100% of patients reported to receiving medicine to make pain better.
- The service provided a child friendly information leaflet on discharge which included pain relief and a contact number if pain is experienced. Staff followed this up 48 hours after of discharge via a telephone call including the question about pain management.
- When we reviewed the information given to patients and families at discharge we found it included, what to expect after a procedure and offered advice on pain relief at home.

Nutrition and hydration

- The six CYP records reviewed all showed that children's and young people's dietary needs were assessed, met and recorded.
- The food menus encouraged children and young people to eat as appropriate.
- The house keeper for the ward area was seen distributing fresh drinks and food as appropriate throughout the day to children and young people and their families.
- Three parents confirmed that food was offered to them at mealtimes and snacks outside of those times throughout the day. Their feedback included praise for the housekeeper and the kitchen staff for being so accommodating in delivering food better than they expected during their child's stay. The menu choices offered to parents gave an extensive and varied style of food which met all dietary and religious requirements.
- There was no dedicated dietician within this service but senior staff told us that the consultant could make a referral when specialist advice was required.
- All parents spoken with confirmed they received adequate information about the need for their child to fast prior surgery.
- Staff arranged theatre lists to start with the youngest or high priority child first, to ensure that children did not go longer than necessary without food and drink.
- Staff offered children and young people food and drink following surgery once water had been tolerated. One child we saw complained of feeling sick after eating a full meal and staff gave prescribed anti-sickness tablets promptly with good effect.
- The outpatient department had access to fresh drinking water, hot drinks for parents and snacks if required.

Patient outcomes

- CYP had a dedicated pathway for surgery and overnight stays and the CYP lead confirmed the process for staff during the night to cover any unplanned overnight stays.
- Between the months of October 2015 and September 2016,there were no cases of unplanned returns to theatre for children and young people occurred.
- No unplanned readmissions occurred from October 2015 to January 2017.The service admitted day case patients only and should readmission be required, this would be to the local NHS trust. Senior staff told us that this information was made clear to patients and their families on admission and prior to discharge.
- Locally, the service carried out inpatient paediatric audits, for example in pain relief. Results from the most recent audit had led to changes in the information provided to children and their families prior to admission.
- Following day case admisions a follow up telephone call would be made after 48 hours to the parent/carer to

assess the childs recovery, for example in relation to pain management and any post operative complications. We reviewed responses from January 2016 to December 2016.
- There was evidence of changes made following the post-operative call assessment. For example additional information given to parents and carers in relation to fasting times and updating post-operative information given.
- In addition, a paediatric nurse would carry out a follow up telephone call on the day after discharge to ensure that the child was recovering well. There was evidence of telephone follow up calls in medical records that we reviewed.

Competent staff

- Staff we spoke with confirmed they had access to education and training courses completed in face-to-face sessions or via the electronic learning training programme.
- The training programme included caring for children with learning disabilities and Paediatric Basic Life Support (BLS) or Immediate Life Support (PILS) which had been completed by all staff. All paediatric bank nurses used within the service completed the PILS qualification.
- The resident medical officer (RMO) held the Advanced Paediatric Life Support qualification to provide cover across the service.
- The hospital had an RMO policy framework in place, which clearly defined the roles and responsibilities of RMO's working at the hospital.
- All consultants are required to provide evidence on an annual basis to the number of paediatric cases seen, evidence of continued professional development and evidence of relevant training. This was to ensure that all consultants were regularly practising in their field of specialisms.We saw evidence of this on the database held. For further information on bank and agency staff induction and, practising privileges please see the surgery section of this report.
- Staff confirmed they had an annual appraisal and 100% was achieved for CYP service in the current year to date (April 2016 to January 2017).
- All staff had recently completed or were currently completing revalidation (a process that all registered health professionals follow to maintain their registration), and confirmed they felt supported during this process.
- All bank and agency staff employed within the service completed a hospital and local induction to ensure they were familiar with fire points, the local environment and where to access appropriate resources whilst caring for children and young people.
- The CYP lead nurse was accessible to all departments within the hospital should they require additional access to support, advice or information in relation to the children and young people that they see.
- There was a transfer policy for children and young people and when a registered children's nurse should be present which included the Standard Operating Procedure for every phase of the patient journey.
- All children and young people admitted for surgical treatment are `pre-assessed` by a registered nurse (children's) to evaluate their suitability for the proposed treatment(s). This assessment identified any individual risk for that child or young person and ensured that their safety remained paramount at all times.
- Managers held quarterly scenario training meetings with staff where any situation that had a possible incident or concern were reviewed and staff reflected on how they could improve in the future.

Multidisciplinary working

- The submitted service level agreement confirmed access to consultants including paediatric consultants from the local NHS trust should they require support.
- The CYP service meeting minutes for January 2017 showed a good attendance across all professional groups and included representation from phlebotomy, physiotherapy and radiology departments.
- Staff we spoke with confirmed twice daily medical staff ward rounds are completed and more often if required.
- We were shown a variety of communication methods that were in place between ward staff, outpatients, surgery, radiology, phlebotomy and physiotherapy departments. For example, ward boards, "10 at 10" feedback notes and CYP meetings.

Seven-day services

Outstanding ☆

Services for children and young people

- The hospital's RMO was accessible 24 hours a day, seven days a week to respond to children and young people should the need arise.
- The service provided day case surgery only for children and young people between Monday and Saturday but staff explained a Sunday would not be dismissed if requested. Children aged three to 16 years of age were accepted for day case surgery.
- Children aged from birth to 16 years of age were seen in the outpatient department between Monday and Saturday.
- In addition, children and young people had access to diagnostic imaging and physiotherapy services between Monday and Saturday.
- For more information relating to the availability of clinics and opening times, please see the outpatient and diagnostic imaging and surgery sections of this report.

Access to information

- Hospital policies are available electronically and paper based policies in place in the ward areas.
- Paper medical records are held securely onsite and once a patient is discharged staff scanned the records into the secure electronic database.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms had a specific section to allow the child to consent if appropriate to do so.
- Quarterly audits were completed in relation to consent, examination or treatment. The audits included records ensuring that person giving the consent on behalf of the child had parental responsibility, and the correct consent form used. Data from September and November 2016 showed 100% compliance.
- Documentation showed that Gillick competence assessment had been considered and when it was required. We spoke to staff who gave us assurance that they understood and had considered this assessment. Gillick competencies are considered for children under 16 to assess if they are 'Gillick competent' to make treatment decisions.
- The hospital had a policy detailing consent. We reviewed this document and it had clear guidance for staff in relation to obtaining consent from children up to the age of 16 years and young people aged from 16 to17 years of age. The policy clearly referenced the 'Gillick' competence which is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.
- We reviewed six sets of paediatric medical records. We found that consent was clearly documented in all records. Consent forms had a specific section to allow the child to consent if appropriate to do so.
- We saw that consent was discussed at a C&YP meeting and showed key points around the gaining of consent in children and young people, referring to the Gillick competence.

Are services for children and young people caring?

Outstanding ☆

We rated caring as Outstanding :

Compassionate care

- The hospital undertook a weekly inpatient survey dedicated to gain feedback from children and young people, which was collated monthly. Survey responses were from both children and young people or their parents/carers. We looked at data from the July 2016 to September 2016 survey, which described nurses and doctors within this service as 'excellent'.
- In 2016, feedback from the inpatient survey showed 98% of patients said they would be 'extremely likely' to recommend the hospital to other people and 99% of patients felt 'very well' looked after.
- Friends and family test responses from January 2016 to December 2016 showed that 99% of patients were extremely likely or likely to recommend this service.
- Staff were observed communicating appropriately with children and young people, with dignity and respect while being caring and compassionate to parents who were anxious about their children's condition.
- All staff seen entering a child's room knocked prior to entering to protect the privacy of children and young people. All single rooms had doors closed and had signs to indicate when the room was occupied.

Outstanding ☆

Services for children and young people

- We spoke with two families who had accompanied their children to the ward for surgery. Both sets of parents told us that the service had been fantastic and had one nurse treating the child for the duration of the inpatient stay.
- One parent confirmed that she felt her child had been very well cared for and wished she had known about this service previously.
- Another parent said 'I wouldn't change anything it is above what I was expecting and everyone has looked after me as much as they have looked after my child. The staff are professional but so friendly and caring.

Understanding and involvement of patients and those close to them

- The paediatric inpatient survey showed that 100% of patients felt that the pre-assessment stage of their care was helpful and that 100% of patients were told what to expect in relation to their care and treatment. There was evidence to support 100% of patients had received written information relating to their care or treatment prior to attending the hospital.
- Parents confirmed they knew the name of the nurse who had looked after them and their child during their hospital stay.Staff used "my name is" when introducing themselves to patients.
- The preadmission pack included leaflets that advised parents on how to prepare their children for their stay in hospital, they were age appropriate and gave children and parents an understanding of what to expect.

Emotional support

- All children and young people had access to a specialist nurse if required who worked with the registered children's nurses.
- Counselling services were accessible following referral for patients and parents.
- We saw distraction techniques used before and after surgery involving IT tablets and music therapy aiding the child emotionally during their stay or during investigations.
- At the pre assessment meeting a "driving licence" was given to younger children to take home and bring back on the day of their surgery. This then enabled them to drive a pedal car to theatre. This aimed to reduce anxiety in younger children and was a method of distraction.

Are services for children and young people responsive?

Outstanding ☆

We rated responsive as Outstanding

Service planning and delivery to meet the needs of local people

- CYP services confirmed that there was a 94% private to 6% NHS funded service in 2016.
- The hospital received NHS referrals from acute NHS trusts for day case surgery only. The children and young persons' lead told us that surgery mainly took place from Monday to Friday (9am – 5pm) but surgery could be planned on Saturday mornings to meet the family needs.
- The children and young people's outpatient clinics took place from Monday to Saturday, 8am to 5pm. Evening clinics were available to minimise disruption with schooling and to aid parents who were unable to attend appointments during the day. Although we saw no supporting data for when this occurred, staff described the Saturday morning clinic for children with attention deficit hyperactivity disorder (ADHD) held at a quieter time to reduce anxiety.
- NHS surgical referrals were accepted via an electronic database. Staff told us that a variety of appointment times and surgery dates could be offered to meet people's individual needs.

Access and flow

- All admissions were screened for suitability by the children and young people's lead on a face to face pre assessment appointment.
- The paediatric consultant clinic ran during the week Monday to Friday 8am to 6pm and 8am to 5pm on a Saturday.
- CYP were prioritised for theatre list with the youngest or highest priority child first on the theatre list. Should other staff challenge this decision a discussion would be held by the lead for CYP services.
- All staff spoken with confirmed that all children and young people admissions were reviewed and agreed by the consultant and CYP lead nurse to ensure they met this service's admission criteria.

- Surgery was planned in advance but had the flexibility for change to meet the individual's requirements if the child or young person has been assessed as suitable in meeting the criteria for admission.
- Bed occupancy was 54.5% for quarter four from January to February 2017 within the ward area.
- One case within CYP surgery was cancelled between October 2015 and September 2016.Data submitted by the hospital confirmed this case was reported as an incident when a child presented pre-operatively with a chest infection.
- No children or young people were seen waiting for extended periods of time during our attendance in the out patients department.

Meeting people's individual needs

- Staff all wore identification badges and use "my name is "when introducing themselves to patients in an age appropriate manner.
- Childrens individual needs were discussed at the face to face pre assessment appointment, and children were able to visit the hospital for a tour prior to admission. Staff spoken with told us this process was particularly useful if the child was anxious regarding their upcoming admission to hospital.
- The children and young people's lead nurse told us that any complex needs would be highlighted during the pre-assessment stage and if additional advice was required this would be obtained from the multidisciplinary team or other professionals external to the hospital, for example dietician.
- A "hospital passport" was available for children with learning difficulties, and allowed the child, family and carer to document likes and dislikes, communication needs and interests. This provided helpful information to staff to ensure the child was comfortable and their needs were met during their stay.
- Staff had access to language line for translation services for patients whose first language was not English. In addition, interpreters were available for face-to-face translations when required.
- A communication board was available to use to assist children when communicating. This included pictures depicting if a child was unwell, or shy, as well as large letters which could be used to spell words.
- At the pre assessment visits, booklets on anaesthetic was given to the child and parent or carers, as to what to expect and information regarding the hospital. The booklets were designed for two different age groups, "Rees bear" for young children and "David the detective" for older children.
- Leaflets for parents and carers were available throughout the hospital and provided in a pre-admission pack and at discharge additional leaflets were distributed as appropriate. Leaflets included information on children's blood tests, preparing for a stay in hospital and advice once discharged from hospital.
- The discharge leaflet contained information on postoperative care, pain relief and how to contact the hospital if required. The leaflet had space for hospital staff to write down when the child had their last received medication or pain relief.
- Children and young people with learning difficulties were assessed and their individual requirements were identified to meet the individual's best interests.
- All children and young people were admitted to the ward for day case surgery only. Patient rooms were single occupancy, but could accommodate parents with en-suite facilities, Wi-Fi access and a television.
- The recovery area had a separate area for children and young people. Staff showed us the specific bay used for children. Child friendly curtains separated children from adult patients. This area had themed coloured artwork on the wall to appeal to all children and young people.
- The children and young people's lead nurse showed us the Nuffield teddy bear offered to all children who attended the hospital for surgery. In addition, there were certificates, stickers, and toys for varying age ranges as well as water bottles and gym bags for older children.
- The ward had a variety of leaflets and books that described, going to hospital, going for tests and going to surgery, to explain and reassure children when anxious. Methods of distraction to support children during their any investigations included access to Wi-Fi and music therapy.

Learning from complaints and concerns

- The hospital had no complaints between January 2016 and February 2017 for CYP services.
- Patients and their families had access to information on how to make a complaint. Patient feedback questionnaires and boxes were located in all areas where children and young people were seen and treated.

- Staff had access to the Nuffield hospitals complaints policy which had clear guidelines relating to the timeframes for acknowledging and dealing with a complaint. In addition, the document outlined and referenced who was responsible for dealing with complaints relating to children and young people, and for how long documentation should be retained.

Are services for children and young people well-led?

Outstanding ☆

We rated well-led as Outstanding

Leadership and culture of service

- The CYP service was managed by a senior consultant and lead nurse that was frequently visible and approachable. The senior consultant attended the medical advisory meetings, whilst the lead nurse was represented by the hospital matron.
- Staff felt confident to raise concerns, and there was an open culture within the hospital.
- All staff we spoke with during the inspection explained the open and transparent way they discussed when incidents occurred and how they had learnt from those incidents.
- Staff had access to leadership skills and development opportunities and senior staff told us the workforce race equality standard (WRES) was included on electronic -learning training.
- Staff informed us of their job satisfaction and stated that managers supported them. One nurse told us she travelled from outside the area to work by choice.
- The Nuffield Health Group had a whistleblowing policy which was last reviewed in April 2016. Staff confirmed they felt confident to follow and escalate the process if required and felt happy about raising concerns directly to managers if they were not happy.
- The hospital had a dedicated children's and young person's lead nurse. We spoke with this lead nurse who was passionate about the service offered to children and young people. Another registered staff said 'we treat everyone as they are one of our own family'.
- We spoke with one paediatric nurse who said the hospital's matron was 'very approachable and welcomed and listened to suggestions for improvements'. The staff member also said they felt supported in their role by senior management to care for children.
- A member of paediatric nursing staff said 'I enjoy working here I could go elsewhere but I feel well supported and enjoy coming to work".
- Two student nurses worked within this service and one confirmed they had already applied to work on the bank staff at this hospital as they felt so supported by this service.

Vision and strategy for this this core service

- Nuffield Hospital's vision and strategy for 2017 had clear goals which included the vision of the CYP service.
- The lead CYP nurse told us that there were plans to continue to develop the service, for example in increasing day surgery offered to children and young people.
- The service's mission was 'to provide first-class independent healthcare for children and young people in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families'. We spoke with three staff who care for children and young people, all knew of the mission statement.
- Managers had displayed the Nuffield Hospital's mission statement in the ward area and in areas were children attended at this hospital.

Governance, risk management and quality measurement

- The hospital had a governance structure for CYP services and a clear mechanism for effective communication via the CYP service meeting which was held monthly. The matron and lead nurse for CYP were members on the CYP service meeting with representation from across all services. The CYP service meeting reported to the hospital wide quality and safety committee and the medical advisory group.
- We reviewed the risk register for the CYP service and found no current risks identified for this service.
- We asked for examples of risks closed from 2016 and changes that had been implemented to close the risk. We were informed of updates following the PLACE inspection when carpet remained in clinical area's and saw only one remaining area had carpet which was in the pre- assessment room. This was to be removed after the inspection as part of the refurbishment process.

Services for children and young people

- The CYP forum and quality performance meetings included the risk register on the agenda and any staff not attending the meeting were referred to minutes or given a handover as part of the CYP staff handover which is held weekly.
- A CYP service plan was in place which captured areas of improvements required following CYP meetings on a monthly basis and included actions, leads and dates of completion. We reviewed the service plan and saw evidence of actions completed, such as specific paediatric training rolled out in recovery staff and the purchase of new equipment such as baby changing mats.
- Staff audited CYP services in line with the Nuffield Hospital audit policy and the lead nurse explained the ongoing development of an individualised audit program reflective of the services offered at Nuffield Health Brentwood Hospital. This would allow for continuous monitoring and enhancement of the quality of care delivered.
- The medical advisory committee had a named representative for children and young people who attended quarterly MAC meeting minutes, which showed that staff discussed services for children and young people. In particular, one meeting had discussed the general requirements for all paediatric anaesthetists and surgeons who undertook work at the hospital.
- We looked at the quarterly quality and review governance committee meeting minutes for January 2016 and January 2017 which showed the improvements and changes in those twelve months.
- Quarterly paediatric themes were collated and reviewed. The review comprised of data gathered from patient feedback, incidents and investigations. We reviewed the data from January 2016 to December 2016.This showed that changes were made, in response the thematic reviews. For example in January 2016 a dedicated peadiatric pre admission area had been designated.
- We reviewed the annual safeguarding childrens report dated February 2016. This set out clear objectives and action for CYP services moving forward into the year 2017, which included the safeguarding lead to attend the external named professionals quarterly meetings, rolling safeguarding training and additional training for human resources department to ensure safe recruitment of staff.
- We spoke with three members of staff who cared for inpatient children and young people. All could clearly articulate and describe the senior management structure at the hospital and clear about their specific roles and responsibilities.
- Data provided by the hospital showed that between October 2015 and September 2016, 100% of inpatient nurses completed validation of professional registration.
- The governance arrangements were the same throughout the hospital. For more information relating to governance processes please see the surgery section of this report.

Public and staff engagement

- We were informed by nursing staff that regular staff meetings were held to share information and we reviewed minutes from meetings held in this service from December 2016 to February 2017 .
- Patient satisfaction survey cards were available to ensure feedback from all children and young people, and specific forms were used for three to seven year olds and eight to 15 year olds.
- Feedback was recorded weekly and collated monthly and shared at CYP meetings as well as the CYP committee. We reviewed minute meetings from February 2016, which reflected positive feedback from parents/carers regarding the introduction of child friendly duvet covers and the introduction of “Nuffy Bear”.
- Two nursing staff informed us that any public or staff concerns were dealt with by matron and discussed at the CYP meetings
- The matron and director held daily drop in sessions called “10 at 10”. This enabled staff from children and young people’s services to discuss issues of importance or raise any other issues. Staff shared ideas, opinions and feedback. If staff did not attend the meeting they received a feedback sheet outlining discussion points.
- Public feedback was sought through a variety of methods. The hospital accessed social media to gain feedback from patients, including from parents of children and young people.

Innovation, improvement and sustainability

- Plans included representation on the local NHS Essex safeguarding board network which would support updated knowledge.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Outstanding ☆

We rated safe as Outstanding :

Incidents

- The hospital reported 93 clinical incidents within outpatient and diagnostic imaging services between October 2015 and September 2016. This is more than the number reported by other independent acute health providers that we hold this data for.
- There had been no never events or serious incidents reported within the outpatient and diagnostic imaging services from October 2015 to the time of our inspection. Never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available, at a national level, and should have been implemented by all healthcare providers.
- The hospital reported six non-clinical incidents within outpatient and diagnostic imaging services between October 2015 and September 2016. This is less than the number reported by other independent acute providers that we hold this information for.
- All nursing staff, radiographers, and health care assistants we spoke with knew how to report incidents using the hospital electronic reporting system. One member of staff gave an example of using the system to report a patient fall in the waiting area.
- Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2000) IR(ME)R. Diagnostic imaging services had procedures in place to report incidents to the correct regulators, for example the Care Quality Commission (CQC). There had been two reportable IR(ME)R incidents at this hospital in the past 12 months.
- We reviewed an incident on the hospital electronic recording and reporting system. The hospital had thoroughly investigated the incident following a route cause analysis (RCA) approach and feedback was provided to staff and the patient involved.
- We reviewed diagnostic imaging team meeting minutes dated November 2016, and noted the reportable radiation incident had been shared with the team and actions discussed and taken to reduce incidents reoccurring.
- We reviewed outpatient team meeting minutes for 8 November 2016, 13 December 2016 and 21 February 2017 and saw that discussion around incidents was a regular agenda item.
- All staff we spoke with within outpatients and radiology knew their responsibility and the process relating to Duty of Candour. The Duty of Candour is a legal duty on services such as hospitals to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.
- The outpatient manager met quarterly with other outpatient managers across the Nuffield group. This was an opportunity for shared learning. They gave an example where another hospital had identified a concern around scalpel blades and needles being kept on trolleys in consulting rooms. This had been shared and sharps are now kept in locked cupboards in the treatment rooms.

Cleanliness, infection control and hygiene

Good

Outpatients and diagnostic imaging

- We spoke with a member of staff who explained the protocol for patients with possible infectious disease. They had good understanding of infection, prevention, and control. Staff assessed patients to address any infection risk prior to admission.
- Staff adhered to the hospital's hand hygiene and "bare below the elbow" policy. Personal protective equipment such as gloves and aprons were available to wear during care and treatment.
- The reception area, consulting rooms and treatment rooms were tidy and appeared visibly clean. We reviewed daily cleaning schedules between January 2017 and February 2017 for the outpatients department. The schedules were complete and signed by staff with no omissions. We reviewed the daily cleaning schedules for the radiology department between January 2017 and February 2017 and found these were also complete. Results from the hospital cleaning audits during 2016 showed 97% compliance in quarter one, 95% in quarter two, 100% in quarter three and 100% in quarter four.
- The outpatient department and imaging department had representatives on the infection prevention expert advisory group that provided support and guidance to staff on all issues relating to infection prevention and control.
- Clinical waste was disposed of appropriately and in line with the hospital's waste disposal procedures. Staff used orange clinical waste bags, with foot-operated waste bins. Sharps bins were correctly assembled, signed, dated, and not over-filled.

Environment and equipment

- We checked equipment in three treatment rooms. All equipment was routinely checked and within their respective service or equipment renewal dates. Equipment also displayed "I am clean" stickers to show that staff recently cleaned equipment.
- Signage around the hospital, outpatients, and radiology areas were clear and easy to follow.
- Controlled areas within the x-ray department had light boxes outside indicating that it was a controlled area and when it was not safe to enter.
- Equipment stored in cupboards was stored safely. Staff explained the methods used to maintain and rotate stock to ensure it was within date and ready for use.
- Diagnostic imaging staff used lead aprons to protect themselves against radiation exposure. Lead aprons were in good condition and were checked on a regular basis and replaced when not fit for purpose. Thyroid protection shields were available in theatres and the fluoroscopy room in line with IR(ME)R recommendations.
- An external supplier serviced and maintained diagnostic imaging equipment for the hospital. The service schedule showed that all imaging equipment received either a four monthly, six monthly or yearly service depending on the complexity or use of the equipment.
- Radiographers wore film badges to measure radiation doses and the hospital monitored these quarterly to ensure radiation exposure remained within acceptable limits.
- The diagnostic imaging department had a quality assurance programme to ensure regular equipment safety tests. Records showed that staff conducted daily, weekly and monthly equipment tests.
- The outpatient department was based in two locations on the first and second floor. There was a reception and waiting area at each location. The outpatient department had ten consultation clinic rooms with half carpet and half vinyl flooring. The three treatment rooms had vinyl flooring which is in accordance with best practice guidelines.
- One gynaecology consultant provided their own scanning equipment. The servicing of this piece of equipment was the responsibility of the consultant but was overseen by the outpatient manager who kept the documentation and ensured that servicing was up to date.

Medicines

- In the outpatient treatment areas, medicines were stored appropriately in locked cabinets and the keys held in a cabinet with a key code lock. Staff completed temperature checks in both the room and fridge used to store medication. We saw the record of daily checks between January 2017 to February 2017 and they were completed with no omissions.
- Medication and contrast media within diagnostic imaging was stored in locked cupboards. Medication keys were kept in a cabinet with a key code lock. We checked temperature records in the computed tomography (CT) suite and saw that staff had carried out daily checks between January 2017 and February 2017.

- Emergency drugs were available within the CT suite. These were kept in a tamper proof bag provided and restocked by the pharmacy staff. The bag was kept in a locked cupboard in the scanning area.
- Prescription forms were kept in a locked drawer in the outpatient manager's office. The key to the drawer was kept in a cabinet with a key code lock. When a consultant required a prescription the book was checked out, the next prescription number recorded along with the consultant name. The return of the forms was also recorded.

Records

- We reviewed the healthcare records of four people who attended outpatient department. The records were accurate, complete, legible and up to date. These records were stored securely by the hospital medical records. During outpatient clinic the records were kept in a secure cabinet in the nurses office.
- Information prior to our inspection stated that 60% of patients attended appointments without medical records being available. Staff confirmed that this happened on a regular basis. At the time of our inspection the hospital did not have a process in place to address this problem and were not recording the number of incidents of patient attending without medical records on the electronic reporting system. We bought this to the attention of the hospital. When we returned for our unannounced inspection a process had been implemented whereby patients attending without medical records were logged on arrival in outpatients. New temporary notes were made up and then merged to existing notes if applicable. Incidents were logged and recorded on the electronic reporting system.
- Staff recorded diagnostic imaging details on the radiology department information system (RIS). A radiology information system (RIS) is the core system for the electronic management of imaging departments. Information recorded on the RIS included the examination carried out, the patient identification checked, the radiation exposure, and who carried out the examination.

Safeguarding

- The hospital had a policy and procedures in place for safeguarding adults and children which was reviewed and up to date. Staff had access to these policies and procedures.
- The hospital matron was the hospital lead for safeguarding supported by the children and young people's lead nurse and the registered manager.
- All radiography staff and outpatient staff were trained in level two safeguarding for adults and children. The outpatient department manager was trained to level three safeguarding. Mandatory training compliance was 100%.
- Training included prevent training to help staff identify individuals at risk of radicalisation. Training also included female genital mutilation (FGM) awareness. The registered nurse (children's branch) who worked on a Friday in the outpatient department for children's clinics was up-to-date with level three children's safeguarding training.
- The hospital had a flow chart to guide staff through raising a safeguarding concern. We saw this displayed on notice boards across the hospital during our inspection.
- We spoke with three members of staff and all knew how to raise a safeguarding concern and who the hospital safeguarding lead was.
- The hospital had an up-to-date chaperoning policy in place and there were notices throughout the department offering a chaperoning service. Staff told us that they were required to explain the chaperoning procedure to all patients attending appointments and ask them if they would like a chaperone with them.

Mandatory training

- Two members of staff told us they had completed mandatory training via e-Learning and face-to-face training sessions. Subjects included health and safety, fire safety moving and handling, infection control, safeguarding adults and children and basic life support.
- We saw that 100% of staff in outpatients and diagnostic imaging were up to date with their mandatory training.

Assessing and responding to risk

- The imaging department had implemented a pause and check process before every patient examination started. We saw that each diagnostic imaging room displayed a pause and stop poster to support staff whilst delivering safe and effective patient care as part of clinical imaging services using ionising radiations.

Good

Outpatients and diagnostic imaging

- Within diagnostic imaging, radiographers were trained in both basic life support (BLS) and immediate life support (ILS). Records showed all staff were up to date with the necessary life support training according to their job role.
- We reviewed a list of non-medical referrers who were entitled to make a referral request for diagnostic imaging. This was compiled centrally by Nuffield Healthcare. Details included the referrer name, job title, and signature and the examinations they were entitled to request. There was evidence that the referrer had attended training in Ionising Radiation (Medical Exposure) Regulations (2000) IR(ME)R. Non-medical referrers included physiotherapists, podiatrists and advanced nurse practitioners.
- The hospital used the "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" for minor operations in outpatients and interventional radiological procedures. This reflected evidence-based practice to ensure safety for surgical procedures.
- The diagnostic imaging team checked the pregnancy status of female patients prior to having a diagnostic image examination. This process was in in line with Royal College of Radiographers (RCR) guidelines. Radiographers we spoke with understood the process and explained its application.
- The hospital had local policies in place for the risk assessment and prevention of contrast induced nephropathy. We viewed the policy and saw that it was up to date and in line with The National Institute for Health and Care Excellence (NICE) acute kidney injury (AKI) guidelines and the Royal College of Radiologists (RCR) standards for intravascular contrast agent administration.
- Radiation protection advisor (RPA) support was provided by an NHS trust to the Nuffield group as part of a service level agreement (SLA). Staff told us the trust were very responsive and accessible for help and advice.
- Staff knew how to manage a patient who suddenly became unwell. This included basic observations, contacting the resident medical officer (RMO) and emergency treatment as required.
- Diagnostic imaging staff reviewed previous patient images as well as asking patients if they had undergone a recent x-ray to reduce the risk of patients having unnecessary repeat examinations. When a patient attended radiology for imaging the radiographers completed an eight point check to ensure that the correct patient received the correct diagnostic imaging. The check included name, date of birth, postcode, imaging modality, site of imaging, previous x-rays, clinical information and timing of the examination.

Nursing staffing

- The outpatient manager told us that staffing was calculated to meet clinic workload and if this increased staffing would be arranged accordingly. The clinic lists were reviewed a week in advance and a day before the clinic staffing number confirmed.
- The hospital employed a mix of registered nurses (RN) and health care assistants (HCA). Data supplied by the hospital showed the outpatients department had 6.9 full time equivalent (FTE) RN's and four FTE HCA's.
- In addition to the service manager the radiology department employed four FTE radiographers, one mammographer, one FTE imaging assistant and one FTE assistant practitioner.
- Diagnostic imaging used bank and agency staff to cover staff shortfall. The manager told us that they used staff from the bank with previous experience of working in the department. The department employed one agency staff member who was covering maternity leave. Bank and agency staff in diagnostic imaging had a local induction and completed a competency assessment to demonstrate that they were competent to use the diagnostic imaging equipment and the range of examinations they could complete.
- Between October 2015 and September 2016, the use of bank RNs working in the outpatient department was lower than the average of other independent acute hospitals. This ranged between 7% in November 2015 and 15% in May 2016. No agency nurses were used.
- Between October 2015 and September 2016, the use of bank staffworking in the outpatients was lower than the average of other independent acute hospitals. This ranged between 0% in December 2015 and 4% in August 2016.

Medical staffing

- Medical staff were predominantly employed by other NHS organisations in substantive posts and had practising privileges to work at the Nuffield Brentwood Hospital. The hospital employed 298 consultants under practising privileges. A practising privilege is defined as 'permission to practise as a medical practitioner in that hospital' (Health and Social Care Act, 2008).

Good

Outpatients and diagnostic imaging

- Staff we spoke with told us that the resident medical officers were supportive and available to offer medical support when required.
- As part of the practising privileges, consultants were required to be contactable by the telephone or in person out of hours. Consultants were required to arrange cover if unavailable due to other commitments or annual leave. Staff told us that when consultants were not in the department, they could be accessed via the consultants' secretary and access to consultants was never an issue.

Emergency awareness and training

- The hospital had business continuity and a major incident plan policy in place. The plans covered the loss of information technology systems, communication systems, flood, fire and bomb threats.
- Senior staff in the outpatient and diagnostic imaging department were familiar with the business continuity plan document and could access it via the intranet, as well as in folders located in the departments. The radiology manager advised us that the business continuity plan had recently been reviewed to add contingency plans in the case of adverse weather.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effective:

Evidence-based care and treatment

- The hospital had policies and guidelines for the diagnostic imaging department, which included details on 'Local rules', radiation protection supervisor (RPS) and radiation protection advisor (RPA) in line with ionising radiation (medical exposure) regulations (IR(ME)R.
- Staff audited radiation dose levels for diagnostic imaging examinations. These were checked to ensure that radiation doses were in line with national reference levels (NRL) .Where local doses exceeded the NRL adjustments were made to equipment or protocol to bring the dose to within acceptable limits.
- Radiographers carried out daily checks to ensure that diagnostic images had been reported. Radiographers checked the report to ensure that any unexepected findings had been acted on appropriately in line with NICE guidelines.
- The hospital participated in various audits including the National Patient Reported Outcomes Measures (PROMS), and local hospital based audits for example, infection prevention, protection and control, hand hygiene and medicines management amongst others. We have reported fully on these audits under the surgery core service within this report.
- The outpatient department carried out local audits of outpatient care records and compliance with the chaperone policy. Results of the chaperone audit for December 2016, January 2017 and February 2017 showed 100% compliance. Results for the care record audit for October 2016 was 95% and for January 2017 99%. Results below 85% required a formal action plan to be implemented.
- The diagnostic imaging department completed local audits. We saw the radiology monthly audit tracker and saw audits included reject analysis, Infection prevention, CCG reporting audit and WHO check audit. All audit results appeared in green showing that they were compliant.
- The hospital had a nurse with a specific interest in breast care as part of the outpatient team. The nurse was available to support patients whilst making or attending an appointment. This complied with the Royal College of Nursing (RCN) clinical standard for breast care.

Pain relief

- The clinical team assessed patients who reported pain during a procedure and offered pain relief where appropriate.
- Staff used an assessment tool to assess patient pain using a pain scale.

Nutrition and hydration

- Tea, coffee and water were available in the outpatient and diagnostic imaging waiting areas.

Patient outcomes

- The hospital conducted an annual audit of radiation dose levels for diagnostic imaging examinations to

ensure that radiation doses were in line with national reference levels (NRL). Where local doses exceeded the NRL, staff adjusted equipment or protocol to bring the dose to within acceptable limits.
- Patients undergoing a joint replacement and who had consented had their prosthesis registered on the National Joint Registry (NJR). These patients were followed up in outpatient clinic and clinical outcomes recorded.

Competent staff

- Outpatient and diagnostic imaging staff achieved 100% compliance with their appraisals during the past year. Training needs were discussed and actions set during appraisals and reviewed in monthly one to one meetings.
- The outpatient and diagnostic imaging departments had a local staff induction folder that provided local information on clinical policies and processes for any new staff entering the hospital. Permanent, bank and agency staff in diagnostic imaging completed competency folders to demonstrate that they were competent to use the diagnostic imaging equipment and the range of examinations they could complete.
- Staff told us that their managers were very supportive of their training and development needs and that they were given time to attend necessary training updates.
- Revalidation formed part of staff's annual appraisal for those who required revalidation of professional registration. Human resources monitored revalidation and staff we spoke with said that they were supported in the process.
- Consultant practicing privileges (PPs) were reviewed bi-annually by the medical advisory committee and the hospital director. PPs were reviewed on an ad-hoc basis if the consultant changed scope of practice, concerns were raised about a consultant's practice or if a consultant failed to meet the requirements of the PPs policy. The hospital director sought the advice at group level from the responsible officer, chief nurse and medical director if a matter required referral to the GMC or other professional body.

Multidisciplinary working

- Staff reported good multidisciplinary working with the ward staff, outpatients, theatres, and physiotherapy.
- Radiology staff worked with consultants to develop a list of their preferred protocol for each diagnostic image to create the correct image on the first occasion reducing the need for repeat radiation exposures.
- Outpatient staff told us that they had a very good working relationship with the consultants and everyone worked as a team to provide the best care for the patients.

Seven- day service

- Diagnostic imaging was available Monday to Friday 8am to 8pm and Saturday 8am to 1pm.
- The hospital had access to out of hours on call x-ray imaging twenty-four hours a day seven days a week.
- Physiotherapy was available Monday to Thursday 7.30am to 7.00pm and Friday 7.30am to 4pm. Post-operative physiotherapy was available on Saturday if required.

Access to information

- Staff had access to a wide range of policies and guidance via the hospital intranet. Staff had hard copies of policies in various work areas as a quick reference guide to assist them in their practice. However we asked to see the chaperone policy and the hard copy version was out of date. Therefore staff referring to the hard copy document may not have the most up to date guidance. An updated version was available on the intranet. The hard copy was disposed of and replaced with the latest version.
- Staff had access to computerised diagnostic images and imaging reports via the picture archiving and communication system (PACs). The hospital could transfer diagnostic images taken at other healthcare providers via the image exchange portal (IEP) and make these available to view on PACs.
- Discharge information was given to the patient to pass on to their GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the hospital policy on consent to examination or treatment policy V8 due to be reviewed by July 2018. The policy was comprehensive, in date and compliant with national guidance.

Good

Outpatients and diagnostic imaging

- Consultants were responsible for gaining patient consent for procedures and treatment. We reviewed three consent forms and noted these were completed appropriately within patient records.
- We observed a member of the radiography staff discuss a CT procedure with a patient and obtain the patient's verbal consent to proceed with the examination.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate care

- The results from the outpatient Friends and Family Test (FFT) between August 2016 and January 2017 showed that 98% of respondents were extremely likely or likely to recommend the service.
- Staff interactions with patients and visitors were friendly and respectful at all times during our inspection.
- Three staff members told us that they explained the chaperoning procedure to patients when attending appointments and asked them if they would like a chaperone during their appointment. We observed staff and patients using this process when attending for an x-ray procedure.
- Within diagnostic imaging, staff treated patients with respect and dignity. There was a separate waiting area for patients who were changed into hospital gowns prior to their appointment to protect the patient's privacy. Staff interacted with patients in a polite and respectful manner. During the inspection, inspectors were only allowed to access patient areas once the radiographers had checked that the patient was comfortable for us to do so.
- Reception staff greeted patients courteously as they arrived for an outpatient or diagnostic imaging appointment.

Understanding and involvement of patients and those close to them

- We observed a member of staff helping a patient to access a treatment room. The nurse was courteous and took time to explain what was happening and checked that the patient fully understood what was going to happen to them.
- We observed a patient being prepared for a computed tomography (CT) scan. The radiographer explained the procedure very clearly and gave plenty of time for the patient to ask questions. The patient was told when their result would be available and how to access the results.

Emotional support

- We observed a patient having an CT scan supported by the radiographer to ensure that they remained calm and supportive throughout their examination.
- Staff enabled patients that were anxious about their examination the opportunity to see the scanner prior to their appointment. Staff offered support and answered questions to address any patient concerns in relation to their care or treatment.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The hospital worked closely with the local Clinical Commissioning Group (CCG) and the local NHS Trusts in order to understand the local community and deliver the services required by the local population.
- Appointments were available in the evenings and on Saturdays to enable patients to access the service outside of working and school hours.
- Patient car parking was available although space was limited. The hospital told us that to alleviate parking issues they engaged with the local school and cricket club for additional parking as well as ensuring that all staff parked in the appropriate area.

Access and flow

Good

Outpatients and diagnostic imaging

- The outpatients department exceeded its target of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for the period October 2015 to September 2016 for incomplete patient pathways. These figures were for NHS funded patients only.
- Targets for non-admitted patients' treatment beginning within 18 weeks were abolished in June 2015. It is however positive to note that for the period October 2015 to September 2016, the outpatients department exceeded its 95% target on a consistent basis, reaching 100% in five months, 99% in six months and 98% in September 2016.
- The hospital provided data in relation to NHS funded patients' and diagnostic waiting times. Between October 2015 and September 2016, no patients waited six weeks or longer from referral for CT or MRI scan, and all patients were offered an appointment within one week.
- Between October 2015 and September 2016, nine patients had waited longer than six weeks for non-obstetric ultrasound, one patient for Urodynamic and two patients for cystoscopy.Patients delays were based on consultant decision, or at the patients request.
- The diagnostic imaging department provided a walk in x-ray service for patients attending outpatient clinics so that the patient could have their x-ray in conjunction with their appointment meaning that the patient's x-ray images were available for immediate consultant review.
- The outpatients department had good oversight of waiting times for patients attending appointments and demonstrated that they were able to identify why delays had occurred and look at ways of preventing delays of a similar nature occurring in the future. The outpatient manager gave an example of a consultant clinic which regularly ran late. The department took the decision to extend the appointment times for this consultant meaning that his clinic now ran on time.
- Patient leaflets were available explaining to patients how to prepare for their diagnostic imaging examination and explaining the procedure. These were sent out with appointment letters.
- Patients could choose an outpatient appointment to suit their needs, as far as reasonably practicable. Appointments could be made by contacting the hospital directly.
- Patients were given a discharge summary to pass on to their GP.

Meeting people's individual needs

- The outpatients and diagnostic imaging department had access to translation services for patients whose first language was not English. When booked in advance face-to-face interpreters were available to attend the hospital appointment with the patient to give them direct support. Staff could also use a telephone service where an interpreter supported patients via the telephone.
- Interpreters for deaf patients could be accessed from the royal association for deaf people to offer a translation services for a patient's consultations.
- The hospital had access to a specialist dementia nurse, who could provide guidance and support to staff in order to meet the needs of patients and their families living with dementia.
- The outpatients department had two treatment couches for bariatric patient use. Staff said they had access to a dietician when supporting bariatric patients in order to provide support and meet their individual needs.
- The hospital patient health questionnaire specifically asked patients questions to identify a patient with any specific needs, for example, special learning needs, dementia, or allergy. This meant that staff could quickly identify specific needs and plan the patient's care and treatment accordingly.
- Patient information leaflets were available in all languages via the computer system. A member of staff showed us the example of a leaflet explaining after care following a minor operation. Staff selected the leaflet and language required and the leaflet was then printed for the patient.
- Consulting rooms had signage demonstrating if a room was in use or not to ensure the privacy and dignity of patients during consultation and procedures.

Learning from complaints and concerns

- The hospital had a complaints policy in place to guide staff how to respond to complaints and patient concerns. The hospital director and matron reviewed complaints initially. Matron or the appropriate head of department investigated the complaint and their findings were sent to the general manager to draft a

complaint response. The hospital director's personal assistant (PA) uploaded complaints, investigations, statements, files notes and final responses onto the electronic reporting system.

- The hospital had received 17 complaints between October 2015 and September 2017. Three complaints related to diagnostic imaging and one related to outpatients. They included a patient distressed about pain during a biopsy, additional costs for an ultrasound scan and sharing of information. We saw that the complaints had been investigated, learning shared and feedback given to the complainants. In the radiology department we saw a flow chart to help staff deal with complaints using an acronym LEARN: Listen, empathise, apologise, react and notify.
- Staff discussed complaints at team meetings and had the opportunity to reflect on what went wrong in order to prevent repeated issues in the future. The hospital senior management team discussed the complaints activity at their weekly meetings and meeting minutes provided by the hospital demonstrated this.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good

Leadership and culture of service

- The outpatients department and radiology department had dedicated managers who reported to the hospital matron. Both managers described the matron as a good manager who was supportive and approachable.
- All staff we spoke with thought highly of their managers. They told us that managers promoted a positive team culture that created a lovely place to work. Managers worked hard to make the department an effective and safe place for patients, visitors and staff.
- Staff said they felt able to raise issues or concerns. They described the hospital as professional, patient focused and staff centred to ensure that they had what they needed to do their jobs to the best of their ability.
- Senior management team described two way communication as a priority and took a "ward to board, board to ward approach". Board meeting minutes were published to keep staff informed of issues affecting the hospital. There was a daily "10 at 10" meeting which staff told us they were encouraged to attend, where issues were discussed and concerns addressed.
- Senior hospital managers were visible within the department. Staff felt that senior managers were approachable and easily accessible and helpful when they needed support.
- Meeting records showed that the team discussed issues relevant to the safe management and effective leadership of the department, including staffing levels, absence management, patient needs, and shift patterns.
- The radiology manager and outpatient manager told us there was a good relationship between all departments and the heads of department supported each other to address concerns and share learning.

Vision and strategy for this this core service

- The hospital adopted Nuffield Health's strategy which is to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner".

Governance, risk management and quality measurement

- Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.
- The hospital had a clear governance structure in place with committees such as clinical governance, senior management, and heads of department feeding into the medical advisory committee (MAC) and hospital senior management team.
- There were no local risk registers for outpatients and radiology. All risks were held on the central hospital risk register, and fed into the radiology group if approporiate.The hospital top five risks were highlighted on notice boards in both areas. For example the radiology manager told us that a risk within radiology was the need for replacement of some equipment. We saw that capital replacement of radiology equipment was on the hospital risk register.

Public and staff engagement

- Where our findings on surgery also apply the outpatient and diagnostic services, including how public and staff

engagement was managed, we do not repeat the information but cross-refer to the surgery section. We identified no concerns regarding public or staff engagement of the outpatients or radiology services.

- The outpatient manager met quarterly with other outpatient managers across the Nuffield group. They said the meeting was an opportunity to meet with colleagues to share learning, and exchange ideas.
- There was a staff forum which was organised by human resources. The forum met once a month to share ideas to improve the work environment.
- The Nuffield group produced a quarterly group newsletter sharing information and learning across the wider organisation.
- The hospital organised social events for staff. One member of staff told us about a social event held to present long service awards.

Innovation, improvement and sustainability

- Please refer to this section under Surgery for information on innovation, improvement and sustainability.

Outstanding practice and areas for improvement

Outstanding practice

- We saw evidence of the application of "Human Factors" approach, when the hospital investigated incidents. For example we reviewed one investigation which considered the training and competency of staff as well as custom and practice, as part of the review process.
- There was evidence of innovative work to improve and engage all staff in infection prevention and control, such as running lab experiments with staff to show the difference in bacteria levels with good hand hygiene practice, and an anti-microbial awareness week.
- In January 2017 "Think Like a Customer" (TLC), was rolled out across the hospital and was part of the Nuffield organisations aspiration to become "One Nuffield" , with an aim to improving patient experience. There was a monthly newsletter published which included results from quality indicators, complaints and net promoter score, and also reviewed feedback from patients to improve the overall patient experience.
- The Senior Management Team ran a number of staff engagement strategies in the hospital to improve patient experience, to engage staff and to consistently review the leadership of the service. These included the "have you say make a difference" monthly meetings, and the annual "leadership MOT" review.