Nuffield Health

Nuffield Health North Staffordshire Hospital

Inspection report

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Date of inspection visit: 23 November 2021
Date of publication: 31/01/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

We only inspected the surgical core service this time. We rated surgery as good because:

- Managers regularly reviewed and adjusted staffing levels and skill mix to keep patients safe from avoidable harm and to provide the right care and treatment. The service used agency staff and bank staff and gave staff a full induction.
- Staff had access to training in key skills however compliance levels were low due to a pause in training due to the COVD-19 pandemic, staff understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and mainly kept good care records. They mainly managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Compliance with mandatory training was low in some areas due to a pause in training due to COVID-19.
- Recruitment and retention of staff remained a challenge for the service.
- Staff did not always keep accurate records around the prescribing and administration of patients' medicines.
- Patient records were not always stored securely.
- Policies such as the safeguarding adults and children's policy and the medicines management policy did not always have enough detail or contain any local adjustments.
- Ward areas did not display details for patients on how to make a complaint.
- All Nursing staff should be confident and competent to assess a patients' capacity.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of surgery stayed the same. We rated it as good see the overall summary above for details.

Summary of findings

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Summary of this inspection

Background to Nuffield Health North Staffordshire Hospital

Nuffield Health North Staffordshire Hospital is operated by Nuffield Health. The hospital opened in 1978 and is located in Newcastle Under Lyme in Staffordshire. The hospital primarily serves the communities of Staffordshire but also accepts patient referrals from outside the area. The hospital provides the following regulated activities: -

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

The hospital does not carry out any surgical procedures on children. The hospital carried out 6,001 surgical procedures from November 2020 to October 2021 and has both NHS and private patients.

We have inspected the hospital three times since 2016. The last inspection took place in August 2019 when the Outpatients and Diagnostic imaging core services were inspected and rated as good overall.

We inspected the Surgery core service on 23 November 2021 and have rated the service as good overall. We did not inspect the medical core service, outpatients or diagnostic services as part of this inspection.

How we carried out this inspection

We carried out an unannounced comprehensive inspection of the surgery core service. We looked at all key questions including if the service was safe, effective, caring, responsive and well led.

The inspection team included a CQC lead inspector, a special adviser with expertise in surgery and a CQC pharmacist. The inspection team was overseen by Sarah Dunnett, Head of Hospital Inspection.

As part of the inspection we spoke with 25 staff including ward and theatre staff, the cancer lead, housekeeping staff, hostess staff, pharmacy and physiotherapy staff. We also spoke with three patients and reviewed 10 sets of patient records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that staff complete mandatory training including safeguarding training.
- The service should continue their ongoing work around staff retention and recruitment.

Summary of this inspection

- The service should ensure that accurate records are maintained around the prescribing and administration of patients' medicines.
- The service should ensure patient records are stored securely when not in use.
- The service should consider how details regarding the complaints process can be easily available for patients in ward areas.
- The service should consider if appropriate local policies are in place and that they contain sufficient detail for staff to follow.
- The service should ensure Information on how to make a complaint is clearly displayed for patients to see.
- The service should ensure all Nursing staff are confident and competent to assess a patients' capacity in every aspect of care if required.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Overall	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated

Good

Surgery

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

Are Surgery safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff, however due to the impact of COVID-19 some modules, especially those requiring face to face contact had not been completed by all staff. Leaders were working towards compliance and had an action plan in place.

Ward and theatre staff received mandatory training, however due to the impact of COVID-19 not all staff were up to date with all modules. The hospital had a programme of mandatory training in place and could run a report to monitor compliance levels. We reviewed the reports and found training figures for permanent staff fell slightly below the hospital's overall target rate of 90% on the ward (82%) and in the theatres (84%). Leaders reminded staff to complete mandatory training within staff meetings.

Reports showed eight out of 20 of theatre staff were not up to date with their immediate life support training (ILS) and five out of 18 staff on the ward. Other areas that fell below the hospital target included basic life support (BLS) in theatres (40%). Each morning a daily huddle took place within theatres which highlighted any staffing issues or requirements. Leaders told us there had not been any recent incidents where suitable skill mix was not available.

There were six staff trained in advanced life support (ALS). These included two resident medical officers (RM0's), the recovery lead, the anaesthetic lead, the resus lead and a theatre practitioner.

Leaders told us how all mandatory training had ceased during the height of the COVID-19 pandemic. Mandatory training and increasing compliance was a key focus for 2022. Leaders in theatre had implemented an action plan to improve compliance heads of departments will be reviewed in one to one meetings.

The mandatory training was comprehensive and met the needs of patients and staff. Staff used software for eLearning courses; staff training was also tailored to role. Staff spoke of good opportunities for education and a good leadership academy where individualised opportunities existed for everyone.

Good

Surgery

Managers monitored mandatory training and alerted staff when they needed to update their training. There were processes in place when staff were not up to date with their training. This included a daily email to staff and their manager. The matron and the training co ordinator also monitored compliance. Leaders told us staff nonattendance at training was reported into the senior management team.

Safeguarding

Staff understood how to protect patients from abuse. Staff had access to training on how to recognise and report abuse and they knew how to apply it, however safeguarding training figures were low due to COVID-19.

Staff received training specific for their role on how to recognise and report abuse. However, at the time of the inspection compliance with safeguarding training level 2 was low due to a pause in training due to COVID-19. The ward and theatres compliance with safeguarding level 2 Adults was 40%.

The Nuffield safeguarding training matrix stated all registered nurses required level three safeguarding adults training. Additionally, the 'Adult Safeguarding: Roles and Competencies for Health Care Staff, intercollegiate document (August 2018)' states level three is applicable to registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns. We asked leaders to provide us with information on how many staff had completed their adult safeguarding training level three. Leaders told us some members of the senior management team including the matron and the head of the department had completed this training and some nurses had started to complete this. Leaders confirmed the plan was for all registered nurses to be trained to level three within two years.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff told us they would raise any concerns around safeguarding with their manager and could detail the steps they would take.

Staff knew who to inform if they had concerns. All staff including senior staff told us they would raise any safeguarding concerns with their manager, or the safeguarding lead. Leaders told us safeguarding concerns were reported to the safeguarding lead (matron) and the matron would allocate a deputy in their absence. However, the name of the hospital safeguarding lead, the deputy or what to do in their absence was not clearly visible within the policy or in the ward area.

There was a joint safeguarding adults and children policy in place, this was version controlled, in date and due for review in 2024. However, as the policy was central for all Nuffield hospitals it did not contain the details of the local authority or the name of the hospitals safeguarding lead.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Staff took measures to protect patients, visitors and staff from COVID-19. Measures included patient screening, blue and green areas and a one-way flow through the hospital. Leaders encouraged staff to take two lateral flow tests a week.

Staff completed a COVID-19 risk assessment tool and placed this in the patients notes. Information such as if the patient had been vaccinated, if they had a previous diagnosis of COVID-19 and if they had any symptoms was included in the tool. The hospital employed a team of housekeeping staff who were highly visible on the day of the inspection.

Staff used records to identify how well the service prevented infections. Patients were screened by for MRSA prior to hospital admission, this was clearly recorded in the patients notes. We also saw risk assessments for Carbapenemase Producing Enterobacteriaceae (CPE).

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore PPE such as face masks, gloves and aprons and disposed of them appropriately. The hospital standard precautions policy required staff to wear eye protection during aerosol generating procedures (AGP), eye protection was available for all staff to use at any time. Staff washed their hands and used hand gel following patient contact; hand gel was readily available to patients and staff.

The hospital has an infection prevention link nurse in each area who linked in with the hospital infection prevention nurse. The infection control lead linked in with the microbiologist at the local NHS hospital. The microbiologist oversaw the infection control lead and their practice. Staff had access to infection prevention control policies which included policies on an infection outbreak, decontamination and antimicrobial stewardship.

Leaders assessed compliance with hand hygiene using the five moments of hand hygiene approach. We reviewed the infection prevention control (IPC) action log and noted the compliance rate for surgical scrub was 79% in January 2021 and 82% in June 2021. An action plan was in place which noted leaders had undertaken staff training using a glow box to improve compliance. Leaders were planning a further audit in December 2021.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used I am clean stickers to show when staff had cleaned items and they were ready for use. In theatres there was a dedicated clean area for returned processed equipment and a dirty area for used equipment. Housekeeping staff kept records of when they completed specific cleaning tasks such as completing deep cleans and preparing patients rooms for admission.

Theatre staff ensured all instruments were decontaminating in line with national guidance. An external company processed all instruments, staff felt this worked well.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital had six surgical site infections within the last year. Leaders individually checked surgical infection reports every Monday and root cause analysis (RCA's) were completed as required. We reviewed the minutes from an infection prevention meeting in November 2021 and a ward departmental meeting in August 2021 and found leaders had discussed infections. The infection control doctor/ microbiologist attended the meeting quarterly; leaders told us the meeting was usually well attended. Infection prevention control policies were in place.

Leaders in infection prevention control completed reports in relation to the North Staffordshire Hospital. The report dated January to December 2020 included an infection prevention dashboard, infection rates, risks and recommendations. The hospital submitted quarterly data on surgical site infections relating to hips and knees to Public Health England (PHE) via an online reporting system.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Two out of three patients we spoke with felt staff answered their call bells quickly.

Good

Surgery

The service had suitable facilities to meet the needs of patients' families. The hospital facilities and surgical equipment was readily available and fit for purpose. The hospital had three operating theatres, two with ultra clean air flow systems and one general theatre.

The hospital had an on-site estates team who staff felt provided a good response. Quarterly meetings were held with estates to discuss any maintenance requirements. The surgical ward was on a separate floor from the theatres with lift access. All rooms were en-suite with a toilet and walk in shower facilities. Rooms had storage facilities with key code access for patients to store belongings safely.

The hospital used an external company in relation to medical devices. The company held the asset register and attended the hospital to service equipment. If there was an urgent requirement there was a hotline staff could telephone and the company would attend the same day or within 24 hours. An external company tested electrical equipment for safety; the company had serviced the equipment within the recommended timescale of one year.

Staff checked resuscitation trolleys daily and used tamperproof tags. However, on the day of the inspection we found the tamperproof tag on the ward trolley, opposite the nurse's station was broken and had not been replaced. However, on the day of the inspection we found the tamperproof tag on the ward's resuscitation trolley had been broken and not replaced; the trolley contained consumables but also contained emergency medicines. We raised this with senior staff on the ward, leaders later confirmed the tag appeared to have been broken accidentally and all contents were in place as in the previous check. We reviewed a sample of consumable items and found them to be in date. The resuscitation policy did not specify staff needed to lock the trolley, only that staff needed to check it daily.

Following the inspection leaders provided us with details of an environmental audit completed in December 2021. Areas to address included chipped paintwork, holes in walls, limescale on taps and damage to doors.

Staff disposed of clinical waste safely. Staff disposed of clinical waste appropriately using coloured clinical waste bags. An external company collected any waste; staff ensured they did not overfill sharps containers and they had dated them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff had processes in place to identify and quickly act upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and knew how to escalate them appropriately. Staff understood the risks around sepsis and told us they could access sepsis training online. Staff were aware of the sepsis six and the sepsis checklist. Staff kept a sepsis box in the clinical room. The box had a sepsis screening and action tool and other items staff may need if sepsis was a concern and was checked daily. There was a standard operating procedure available on the intranet for the initial management of sepsis.

Staff working with cancer patients and involved in giving advice used the UK Oncology Nurses Society (UKONS) triage tool. The society developed the tool for staff who man 24-hour advice lines for patients receiving specific therapies and treatment.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly. Staff completed a pre-operative assessment for patients undergoing a surgical procedure. This helped staff identify risks to the patient, leaders told us they only accepted patients if they felt they could do so safely.

Good

Surgery

Staff completed patient observations and used a National Early Warning Score (NEWS2) to detect and respond to patient deterioration. Staff kept discharge criteria and escalation protocols with the chart. Staff we spoke with understood the discharge and escalation criteria. Leaders completed audits around NEWS2 documentation (June 2021) and found good compliance in most areas. We reviewed the departmental meeting minutes dated September 2021 and saw a compliance rate of 91%. Actions included ensuring staff were documenting the correct monitoring frequency and following it.

We observed a daily team brief and debrief in theatre and found all staff engaged. In the debrief leaders discussed theatre lists on the day, any issues that needed addressing and the meeting was attended by all theatre staff. Both the team brief and the debrief were well documented.

Staff completed the World Health Organisation (WHO) surgical checklist for each patient undergoing a surgical procedure. The safety checklists are designed to identify a potential error before it results in harm. We reviewed ten copies of the checklist and found staff had completed them appropriately.

Leaders completed a patient risk assessment audit. Ward departmental meeting minutes dated September 2021 noted areas for improvement as recording of skin inspection on admission or daily. Actions included ensuring staff provided patients with an explanation around risk assessments and that staff completed them daily.

Staff knew about and dealt with any specific risk issues. Staff completed patient risk assessments on admission to the hospital. Patient notes had risk assessments around COVID-19, Venous thromboembolism (VTE), malnutrition, skin integrity, nutrition and falls. A VTE prevention policy was in place and due for review in 2024. The hospital had processes and pathways in place for patients who were neutropenic; they also had alert cards for cancer patients who required them.

The hospital had a resident medical officer (RMO) on site 24 hours a day. This ensured there was always access to consultant medical input.

The hospital had a critical care transfer memorandum of intent in place. The document set out the guidelines for the transfer of patients who become critically ill and required a transfer to the local NHS trust.

The service provided 24-hour support to patients following their discharge. Staff gave patients a discharge pack which had the contact details of the outpatient's department, the ward and the pharmacy. The pack also provided patients with information on wound care, getting up and about after surgery, pain relief and complications; risks post-surgery were included such as blood clots, infection and chest pain, it also covered pressure ulcers.

Nurse staffing

Managers regularly reviewed and adjusted staffing levels and skill mix to keep patients safe from avoidable harm and to provide the right care and treatment. The service used agency staff and bank staff and gave staff a full induction. However staffing recruitment and retention remained a challenge.

The service did not always have enough nursing staff, recruitment was ongoing. The hospital had a standard operating procedure (LocSSIP) for safer staffing in place. The document outlined requirements for staff levels and competence to support the establishment of a safe workforce.

At the time of the inspection there was five full time theatre practitioner vacancies and three full time ward vacancies. The theatre staffing standard operating procedure (SOP) set out the agreed staffing levels for theatre lists which reflected

recommendations by the Association for Perioperative Practice (AFPP) and clearly states a procedure can only begin with the agreed number of staff and skill mix. We observed three surgical procedures on the day of the inspection and four anaesthetics and noted theatre staffing was within recommended guidelines. Leaders told us how some theatre staff were multi skilled; this meant they could step into different roles if required

The theatre staffing SOP noted how there would be times when the identified level of staffing was not required or when it was possible to run a list safely with less than optimum staffing levels. It also noted on such occasions this should be risk assessed taking into account the complexity of the cases, the experience of the staff and the location on the list. There was always a member of the senior leadership team on call as well as a theatre on call rota with staff on call from 9pm until 8am each day.

On the day of the inspection the ward area was two staff short due to staff sickness. However senior staff stepped up into role by having their own patients to look after. We saw staffing to be the biggest site risk cited in board meeting minutes dated November 2021.

Leaders were in the process of developing a ward dependency tool to identify the staff required versus the dependency of the patient cohort, the tool was colour coded and identified categories of risk such as two or more co-morbidities, complex medical histories and falls risks.

Leaders had been working hard to recruit new staff into the role but were finding this a challenge for a variety of reasons. Leaders had taken steps to recruit such as advertising on job boards at universities, recruitment days, recruiting internationally and offering a golden handshake. Leaders told us they had also done a lot of work around the retention of staff.

Leaders were undertaking Interviews for a variety of roles including a deputy ward manager, senior staff nurses, bank staff nurses and health care assistants. Two health care assistants had enrolled in a nursing associate course. Leaders told us they would cancel surgical procedures or reduce them if staffing levels were not safe.

The hospital had a clinical lead nurse for oncology and had appointed a breast care nurse clinical nurse specialist. Recruitment was ongoing for an additional staff member.

The ward manager could adjust staffing levels daily according to the needs of patients. Leaders in theatre held a daily capacity meeting to discuss the next three weeks theatre lists. This ensured leaders considered staffing requirements and skill mix ahead of time. The hospital had its own bank on staff alongside the use of a regular agency. Clinical sickness absence for the whole hospital in October 2021 was six percent.

The service used bank and agency nurses to cover vacant shifts or increase in workload. Agency/bank usage in theatres and recovery between 8 November 2021 and 22 November 2021 varied between 13% and 26%. The ward used agency staff on 24 occasions between the 3 November 2021 and the 28 November 2021. The hospital strived to use the same agency staff where possible.

Managers made sure all staff including bank and agency staff had a full induction and understood the service. All staff including agency had induction documentation completed. Permanent and bank staff completed a preceptorship documentation. The hospital offered new staff a comprehensive induction programme. All new staff had up to six weeks where they would spend time in different areas of the hospital. This provided new staff with an understanding of how each area of the hospital worked, how the business worked and to get to know the site.

Good

Surgery

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Consultants at the hospital worked on a practicing privilege basis so were not employed by the hospital. Leaders told us any gaps were managed accordingly and alternative specialities would be used if the planned consultant was not available.

The hospital contracted two registered medical officers (RMO's) through an external company. The RMO's covered 24 hours a day 365 days a year. There had not been any gaps in provision and the two current RMO's had been with the hospital several months to ensure consistency.

Anaesthetists were governed by practicing privileges which were undergoing review. There had not been any incidents recorded of an anaesthetist being unavailable.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However patient records were not always secured securely.

Patient notes were comprehensive, and all staff could access them easily. All patient care records were in paper format and kept in patient rooms. The Nuffield Health Electronic Record (NEPR) programme was likely to go live in April 2022.

We looked at ten patient records and found them to include the information needed to deliver safe care and treatment in a timely and accessible way. Patient notes included imaging results, care and risk assessments and case notes.

Leaders completed audits of care records. The ward departmental meeting minutes for September 2021 showed a compliance rate of 83%. Leaders advised staff to ensure they continued to take the patients temperature within the last hour when taking them to theatre and to ensure staff signed recovery handovers when patients returned to the ward.

Staff did not always store records securely. On the day of the inspection staff left patient records unattended for short periods on the desk at the nurse's station. Following the inspection leaders told us they had raised this with the team.

Medicines

The service mostly followed systems and processes to safely prescribe, administer, record and store medicines.

Staff mostly followed systems and processes to prescribe, administer and record medicines safely. However, on the day of the inspection we found that in three out of five charts two different routes were prescribed on the medicine charts for pain relief. The records did not have evidence as to which route staff had used for administration. We raised this with the pharmacy manager who advised it should not be recorded in this way, however the medicines management policy did not specify they should be separated. Other recording issues included a missing date, crossings out on charts and a medicine not specifying a maximum dose. This meant we were unable to tell what medicine had been administered and at which dose.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacy staff discussed patients prescribed medicines and provided advice.

Good

Surgery

Staff mostly stored medicine securely and managed all medicines and prescribing documents safely. Staff completed fridge and room temperatures checks and recorded this electronically. The hospital pharmacy service managed the disposal of medicines. All medicines checked were in date with opening dates recorded where appropriate. Staff always locked the controlled drugs cupboard and completed controlled drugs checks appropriately.

There were four controlled drugs registers in place; having more than one book can lead to confusion on where staff enter the medicine, however there were no recent incidents around this.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Staff in the pharmacy department began medicine reconciliation at pre assessment; they resolved any discrepancies by contacting the patients GP. We reviewed the medicines management policy and found it did not contain specific reference to writing a prescription and the use of multiple routes on the same prescription. Nurses were responsible for the safe administration of medicine and record keeping but there were no specifics in the policy regarding the route.

Staff learned from safety alerts and incidents to improve practice. There had been four medicine incidents between the 23 September 2021 and the 23 November 2021. Leaders documented these in an action plan with actions taken and lessons learnt.

Pharmacy leaders discussed two incidents around VTE prescribing; as a result of this the hospital were looking at a business case for additional pharmacy input on the surgical ward.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. We reviewed a presentation from the quarterly quality and safety meeting dated September 2021. The overall hospital top clinical trends included cancelations to surgery, unexpected medical events and delayed discharges, all had been reported to the hospitals electronic recording system; there were no specific trends within.

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses; all incidents were recorded on an electronic recording system. The matron reviewed the incidents on a daily basis, root cause analysis (RCA's) were then completed if relevant. The matron reviewed RCA's before they were closed.

The service had not had any recent never events within the surgical core service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff understood the principles of duty of candour and the importance of being open and honest. The duty of candour is a regulatory duty that relates to openness and transparency and requires the providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support for that person. The hospital had an open and duty of candour policy in place. The hospital manager apologised to patients when care and treatment fell below the expected standards and provided an explanation of events.

Good

Surgery

Staff received feedback from investigation of incidents. We reviewed the ward departmental meeting minutes for August 2021 and November 2021 and saw incidents were on the agenda. Leaders discussed incidents in daily (whole hospital) huddles to ensure they shared any learning.

Safety Thermometer

Leaders told us they did not routinely use safety thermometer as in the NHS. Staff recorded all incidents via an electronic system. Falls, venous thromboembolism (VTE's) and pressure ulcers were always reviewed as a root cause analysis (RCA). The RCA was then reviewed and approved locally at the hospital governance committee with any actions recorded as an action from the meeting. Once approved this was attached to the incident on the electronic recording system. For NHS patients staff recorded these on the electronic system and reported them monthly via the contract with the local trust; leaders also discussed them at contract review meetings with the Clinical Commissioning Group (CCG).

Are Surgery effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The hospital had policies and procedures in place to ensure care and treatment was in line with national guidance. Staff were able to access policies on the intranet and knew where to find them. Leaders ensured care was provided in line with national guidance and standards by completing various audits. Leaders discussed audits in quarterly quality and safety meetings.

We reviewed the meeting minutes from the ward departmental meeting November 2021 and noted the resuscitation council guidelines and algorithms were discussed.

The hospital had a policy for the recognition and initial management of sepsis. The policy signposted clinical staff to the most recent guidance in the recognition and management of sepsis and included information on the sepsis six. Staff told us they were able to access online training in relation to sepsis.

The cosmetic surgeon told us how preoperative assessments for cosmetic surgery included appropriate psychiatric history and discussion about body image in line with Royal College Surgeons (RCS). At the time of the consultation the cosmetic surgeon told us they ask specific questions to gain an understanding of the patients' mental health status and psychiatric history and focused on specific psychological and psychiatric disorders such as body dysmorphic disorder.

The hospital had a team of physiotherapists on site who were able to give staff and patients advice following surgery. Staff provided patients with a discharge booklet with telephone numbers of who to contact if they had any concerns after discharge.

Good

Surgery

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients meals were prepared on site, this meant kitchen staff could cater for any special diets or religious requirements. The hospital had specific staff who acted as hosts and gathered information from patients around dietary or religious needs. There was a notice board in the kitchen area which detailed any special requirements, in addition to laminated menu cards. Patient comments on the food included it was ok and there was a good choice of food.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patient notes contained information on the patients nutritional score which staff assessed using a nationally recognised tool. Nursing staff could tell us the steps they would take if patients were suffering from nausea and vomiting.

Staff made referrals for specialist dietary support. The hospital did not have its own dietitian; however, staff made appropriate referrals if needed. In relation to oncology patients' leaders told us they had close links with cancer supports services who could provide menus and local hospice support was available if needed. The cancer lead told us how they linked in with kitchen staff to support any specific needs.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff sent patients a letter to advise of any fasting requirements for surgery. We reviewed a letter sent to a patient and found recommended fasting was within fasting guidelines; fasting details were recorded in patients notes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff did not use pain medicine core standards but worked within the National Institute for Health and Care Excellence (NICE) guidance for pain management.

The hospital had three staff (physiotherapist, pharmacy staff member and a nurse) who had completed a course in pain management. Staff could also seek advice on pain management from two anaesthetists who ran pain management clinics.

The ward had a communication picture and photo toolkit in place which included a communication tool around pain. Staff recorded pain scores in patient notes.

Patients received pain relief soon after requesting it. Patients felt their pain was well controlled, pharmacy staff telephoned patients preoperatively to talk about pain management.

Staff prescribed, administered and recorded pain relief accurately. Staff prescribed and recorded any medicines in medication administration charts. Leaders reviewed recording around pain in patient records when completing their notes audits. We reviewed the ward departmental meeting minutes from September 2021 and noted the pain audit score was 89%. Leaders reminded staff to follow up pain scores and pain relief given with documentation, including if the pain relief given was effective or if patients had refused.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for patients.

Managers used information from the audits to improve care and treatment. Leaders completed audits to monitor how staff cared for people and to identify any learning needs. Staff completed audits around pain relief, infection prevention control, NEWS2, the environment and consent. Staff meeting minutes demonstrated key learning from audit results.

The service participated in relevant national clinical audits. The hospital collected surgical Patient Reported Outcome Measures (PROM's) data. PROM's are condition specific questionnaires that measure the severity of the condition from the perspective of the patient. For NHS funded patients, PROMs were mandated for patients undergoing either hip or knee replacement surgery (primary and revisions). For privately funded patients, PROMs were mandated for 13 surgical procedures by the Competition and Markets Authority.

We reviewed the latest provisional NHS Surgical PROMS data from April 2019 to March 2020 on NHS digital and found that the service had higher than the England average health gain on the EQ-5D, EQ-VAS index and Oxford hip score and was similar to the England average on the Oxford knee score.

In relation to private patient surgical PROMS collected under the private healthcare information order leaders told us 100% of hip replacements and 82% of knee replacement patients had improved six months following surgery. This was 2% above average independent sector averages for hip replacements and 12% below independent sector averages for knee replacements. Leaders told us PROMS data was discussed at medical assurance meetings attended by the medical director and the chief medical officer.

PROMS data was analysed using a statistical approach. The process when outliers were identified was to instigate investigation methology detailed within the surgical PROMS policy. Leaders told us how they had commissioned a research project into surgical PROMS and what factors predicted an unsuccessful outcome and how they were working closely with a university to conduct this research.

Staff documented all implants in patients notes and completed the National Joint Registry (NJR) form. The NJR was set up by the Department of Health and Welsh Government to collect information in England and Wales on joint replacement operations and to monitor the performance of implants, hospitals and surgeons. Staff uploaded details of joint replacements were onto the system, they had time out of their usual duties to do this. One of the staff were also a point of contact for the NJR.

Managers and staff used the results to improve patients' outcomes. Leaders told us how an internal theatre review had taken place and the quality manager had not raised any concerns; all policies and procedures were in place and resolved. Leaders benchmarked theatre utilisation against other hospitals and discussed in monthly reviews.

Leaders told us they had implemented a variety of quality improvement initiatives these included leadership changes, developing a ward dependency tool to identify the staff required versus the dependency of the patient cohort (in draft), developing a standard operating procedure (SOP) for all staff to work with, ensuring safe staffing and the process of escalation and the development of the whole hospital safety huddle.

Competent staff

The service made sure staff were competent for their roles, however information on staff appraisal rates was not available.

Managers supported staff to develop through yearly appraisals, however information was not available on how many staff had completed their appraisal. Staff had the opportunity to develop; we heard of examples where staff had progressed into senior roles. Leaders told us they postponed routine appraisals due to COVID-19. They also told us they had implemented a new system and as such were unable to provide the current staff appraisal rates.

Staff were positive about development opportunities and gave examples of where they had progressed or when they had the opportunity to.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Leaders told us they identified staff learning needs in a variety of ways including through the electronic recording system (incidents), one to one conversation and through yearly performance excellence reviews.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The registered manager received and signed off consultant surgeon appraisals (including consultants completing cosmetic surgery). Leaders told us the process covered continuing professional development, clinical competencies and training requirements.

Surgeons were part of the Private Healthcare Information Network (PHIN) network, details were uploaded of any complaints and infections. The organisation provides unbiased information on all private hospitals and consultants for everyone in the UK to access.

Staff completed competency documents relating to their role. These included different anaesthesia techniques such as local anaesthetic, general anaesthetic and sedation, equipment competencies and orientation to the environment. They also had preceptors allocated to each new staff member.

Multidisciplinary working

Consultants, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All necessary staff including those in different teams and departments were involved in assessing, planning and delivering care and treatment. Each morning the matron held a daily whole hospital safety huddle. The huddle was well attended and included representatives from each hospital department. The agenda included the opportunity discuss any patient related issues and other areas of risk such as staffing and supplies.

During our inspection we observed effective multidisciplinary working between different teams while carrying put patient care. We saw all staff including physiotherapy and pharmacy staff and ward and theatre staff working well together.

Good

Surgery

Multi-Disciplinary team (MDT) processes were in place in relation to cancer and histology services. The hospital audited compliance with Cancer MDT, compliance was 100% in October, November and December 2021. MDT audits were discussed in oncology team meetings.

Cancer service committee meetings were held quarterly with membership including the lead cancer nurse, pathology, radiology, pharmacy, matron, infection prevention control representative and a governance representative. Terms of reference were in place which included details of responsibilities and objectives.

The oncology team had monthly meetings and completed daily safety huddles for the hospital in addition to meetings with the pharmacy team on the days they treated patients.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards. Consultants reviewed patients depending on their care pathway. Consultants visited patients in their rooms following surgical procedures.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Surgical procedures took place on weekdays only between 8.30 am and 8pm, theatre staff worked until 9pm. There was a theatre on call rota in place which noted the staff on call from 9pm until 8am each day.

There were two registered medical officers (RMO's) who rotated on the hospital site 24 hours a day seven days a week, 365 days a year. This meant staff could access medical advice when they needed it throughout the day and night.

Physiotherapy services were available seven days a week with a reduced service at the weekend. Physio working hours were flexible and dependent on surgical lists. This meant they could accommodate later theatre lists and see all the patients on the day. Diagnostic services ran from Monday to Friday with minimal staff available on a Saturday and an on-call system on a Sunday.

Pharmacy opening hours were from 8.45 am to 6pm Monday to Thursday and from 9am to 5pm on a Friday. From 5pm on a Friday this switched to RMO cover and the service level agreement with the local NHS trust.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff at the service would signpost patients to relevant services to promote a healthy lifestyle. Staff signposted patients to other services if needed but told us they gave patients advice in the pre op stage of their journey. COVID-19 measures remained in place at the time of the inspection so patient information leaflets were not on display in the communal areas of the ward.

Staff assessed each patient's health prior to being admitted and provided support for any individual needs to live a healthier lifestyle. Each patient had an in-depth health assessment as part of their pre assessment, the assessment including key health questions and the patients' health status. The hospital offered a 30 day gym pass to private patients as part of a recovery plus initiative.

Good

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, nursing staff were not confident to assess a patients' capacity if the situation arose.

Staff understood the concept of mental capacity however did not feel confident to assess this. Nursing staff told us they did not feel confident to assess patient's capacity if the situation arose. However, leaders told us they would most likely identify and act on concerns around a patient's capacity at the pre assessment stage and provided an example of this. Leaders told us the process was for nursing staff to raise concerns around mental capacity with the matron. The matron together with the consultant would then complete a mental capacity assessment if required.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly documented consent within patients' medical records. Leaders had recently completed a consent for review audit and action plan. The audit had an overall result of 85% and was given an amber rating in relation to risk. Actions from the audit included discussing the audit in ward meetings and with individual staff groups.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The hospital provided staff with mandatory training around the Mental Capacity Act 2005 and Deprivation of Liberty and met the hospitals compliance rate of 90%.

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us how they supported patients pre and post op. Staff recognised patients' individual needs such as the need to pray or to eat a specific diet.

Patients said staff treated them well and with kindness. Patients told us staff treated them with respect, knocked on their doors before they entered and their privacy and dignity was respected. The hospital monitored patient feedback from their patient satisfaction survey. Results showed 80% of patients were likely to recommend the hospital to friends and family if they need similar care or treatment in November 2021. We observed staff using private areas to have discussions with patients treat patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Good

Surgery

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff made up pre-and post-operative packs for oncology patients using the service. Staff told us they would also print of information from specialist charitable cancer services if required. We noted the Nuffield Heath internet site had advice hubs where patients could find information on a variety of subjects including lifestyle management and emotional wellbeing.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave an example of when a patient had been distressed and the steps, they had taken to support the patient. Staff told us they helped to reassure patients by keeping them informed, up to date and discussing any expectations.

Leaders providing cancer services told us staff offered patients living with cancer psychologist support if required; staff completed this via a referral. Support groups were currently on hold due to COVID-19.

The hospital had achieved the Macmillan Quality Environment Mark (MQEM) following a visit in December 2020.The MQEM award champions cancer environments that go above and beyond to create a welcoming and friendly spaces for patients.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff provided patients with a copy of the paying for yourself: terms & Conditions leaflet. The leaflet covered general terms, cancelation charges and what was included in any treatment. Detailed information on costs were also available on the main Nuffield Health hospital website. Staff provided patients with Information on costs and the surgical procedure was discussed at the pre operative stage; patients felt they were kept informed about the processes.

Staff talked with patients, families and carers in a way they could understand. Patients told us staff gave them transparent information prior to admission and they explained any costs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff gave patients the opportunity to provide feedback on the care and treatment they received. Leaders discussed patient journeys in hospital board meetings as well as patient satisfaction survey results.

Staff provided patients with a going home booklet on discharge. The booklet reminded patients they could contact staff if they had any concerns or if they noticed anything unusual. Patients could contact someone at the hospital 24 hours a day.

Are Surgery responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Good

Surgery

Managers planned and organised services, so they met the needs of the local population. The hospital had supported the local NHS throughout the COVID-19 pandemic. This helped to relieve pressure on local services. The hospital also provided cancer services for patients. Staff told us if a patient had a learning disability, they would welcome their carers to support them throughout their stay. The hospital had a mixture of NHS and private patients and was flexible with operation dates if needed.

Facilities and premises were appropriate for the services being delivered. The hospital had three theatres; two with air flow systems and one general theatre; appropriate facilities were also in place for post anaesthesia care.

All areas were large enough to accommodate wheelchairs and patients with mobility issues. Patient toilets were disability friendly and the car park has disabled access. All the rooms were en-suite and had walk in shower facilities, they also had long call bells and toilet raisers in some instances. There was a lift available to all floors and the ward areas, theatres and diagnostic services were all within easy reach.

Managers monitored and took action to minimise missed appointments. The hospital policy for missed appointments was they would telephone patients who did not attend (DNA) to ascertain the reason for non-attendance. In the event the patient was not contactable by telephone, the surgeon's secretary would be informed to manage accordingly.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they would contact an interpreter if required, however this would usually be identified and organised as part of the preoperative process. We did not meet anyone who required the use of an interpreter on the day of the inspection.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The hospital had its own kitchen staff so were able to cater for any dietary requirements.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to a communication toolkit they could use to communicate. Staff did not have access to a hearing loop. The hospital did not have a lead for people living with dementia or a learning disability.

Staff providing support to patients living with cancer told us how they were able to offer patients scalp cooling treatments. They told us this could support in preventing hair loss and how they had achieved some good results around this.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. At the time of the inspection there was no waiting time for private patients waiting for surgical procedures. Staff had carried out 6,001 surgical procedures between November 2020 and October 2021.

Good

Surgery

The hospital followed 14-day guidance for pre assessment unless considered clinically urgent and a date was formatted from this; private patients could be booked within three to four weeks. The same applied to NHS patients, however the waiting time for NHS patients was eight to 10 weeks unless deemed as clinically urgent.

The hospital used a national priority score to ensure people with the most urgent needs were prioritised. They did not have any waiting lists for patients considered urgent with a cancer diagnosis and these were actioned immediately in line with consultant and theatre availability.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff reported cancelations to surgery on the incident reporting system. We reviewed several incidents when surgical procedures had been cancelled and saw staff made arrangements to book patient on the next theatre list when it was appropriate to do so. The hospital had an on-call theatre team who were available out of hours if needed.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff started discharge planning at the pre assessment stage of the patient's journey. Staff asked patients for information on their support network; staff told us they spoke to the patient again on admission.

Managers checked the number of delayed discharges and took action to prevent them. Leaders discussed delayed discharges at quarterly quality and safety meetings. Staff reported delayed discharges as incidents and recorded the reasons for the delay, this meant any learning was identified and shared with the senior management teams.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Staff understood the policy on complaints and knew how to handle them. There was a complaints policy in place. Staff knew what to do if a patient raised a complaint such as speaking to the patient, trying to resolve on a local level and escalating to the ward manager.

Managers investigated complaints and identified themes. We reviewed two complaints response letters. We found leaders investigated the complaint and offered an apology where learning was identified.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints went into a central system and onto the corporate complaints team and were discussed in quarterly quality and safety meetings; timescales were in place monitored via key performance indicators. We noted leaders discussed complaints in ward departmental meetings. We reviewed the board meeting minutes from October 2021 and saw leaders shared a complaints tracker. The tracker had details of the complaint and the actions taken as a result and helped to identify any themes and trends.

The service did not clearly display information about how to raise a complaint in ward areas. However, staff told us how a lot of information had been removed due to COVID-19.

Are Surgery well-led?

Good

Surgery

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a clear leadership structure in place. The leadership team included the hospital director, a matron, a theatre manager and a ward sister. Leadership roles were clearly identified in the North Staffordshire Hospital organisational structure. Staff told us leaders were visible and approachable.

The matron was new in post and had brought in a new initiative of whole hospital huddles which took place each morning, the huddle was well attended, and staff were positive about the change.

Leaders encouraged staff to take on senior roles; staff gave examples of being promoted and having the opportunity to apply for senior positions.

Leaders were able to identify the priorities and verbalise the issues they faced. Leaders identified workforce challenges within staff, quality and board meetings. Priorities at the time of the inspection included recruitment and improving compliance around mandatory training which leaders had paused due to COVID-19.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Nuffield Health had a strategy in place to ensure continued success through to 2030. The hospital had been working closely with the local NHS trust throughout the COVID-19 pandemic and treating NHS patients' therefore supporting the wider health economy.

The hospitals strategic intent was to build a healthier nation by supporting individuals who need them and the communities they were part of to achieve, maintain and recover to the level of wellbeing they aspired to by designing and providing connected health and wellbeing services with superior health outcomes, expanding flagship programme and influencing wider practice by sharing expertise.

Guiding principles identified within the strategy including being purpose led, beneficiary first, outcomes driven, sustainable, empowered teams and collaborating with partners. Various strands were also identified such as charitable purpose, strategic intent, guiding principles, strategic aims and organisation enablers. The strategy was an agenda item within the Nuffield Health North Staffordshire board meetings.

There was a Nuffield Health infection prevention annual report dated 2020. The report contained information on achievements, risks, challenges and the programme throughout 2021.

Good

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt supported, respected and valued by their leaders. Staff commented how the hospital was a lovely place to work, a good environment to work in, how staff worked well as a team and how their opinions were listened to. We saw a feedback card to staff thanking them for being so responsive and flexible with shifts throughout the pandemic.

There was a strong emphasis on staff wellbeing. Staff had access to the occupational health service. The hospital completed regular pulse surveys to find out how staff were feeling. Staff were able to express an emotion and make a comment on the reason they were feeling that way. Leaders thanked staff for taking the time to complete surveys and advised them of the results. Equality and diversity were written into the Nuffield Policies. We saw there was a suggestion box in place at the nurses' station.

We saw good news/success stories were shared in staff meetings. We reviewed the theatre staff meeting minutes dated November 2021 and saw positive feedback was shared and staff were thanked for their continued support and hard work.

Leaders spoke of staff incentives such as raffle tickets to win a monthly prize, we care awards, working with staff around the leadership structure as well as offering financial incentives to new staff (golden handshake).During COVID-19 leaders implemented a silver cloud programme to support the emotional wellbeing of staff. The human resources team had a wellbeing champion from an independent point of view.

The Competition & Markets Authority governed the hospital. The competition and market authority declaration on the online advice hub detailed the services offered to consultant partners. Leaders told us they ensured they complied with the market authorities' requirements around surgeon's performance.

The hospital was actively involved with The Private Healthcare Information Network (PHIN) and encouraged its consultants to do so. At the time of the inspection the hospital was working with the oncology team to ensure profiles were actioned; details of training days had been sent to relevant staff to accommodate any queries they may have.

Staff submitted relevant data to PHIN monthly, the information sent included inpatient and day case activity, satisfaction questions, outcomes and adverse events. Locally each hospital had access to the PHIN portal to view and encourage consultant engagement with PHIN.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a hospital board in place who held monthly meetings. The registered manager/chair attended the meetings in addition to the hospital matron and other committee members. Areas covered at board meetings included quality and safety governance, finance, complaints, compliance, partners improvement planning and governance and information security.

The hospital held several meetings for relevant staff to meet, discuss and learn from performance. This included the medical advisory committee (MAC) which met on a quarterly basis and quarterly quality and safety meetings.

We saw regular ward departmental meetings took place. Leaders discussed areas of governance such as new policies and procedures, audits, costs and revenues.

Surgeons were governed by their activity. The registered manager reviewed all of the surgeon's activity including any trends and incidents and was able to filter to individual consultants. The registered manager told us they would raise any concerns with the hospital's Medical Advisory Committee (MAC). Leaders told us if a consultant was suspended, they would contact the hospital they worked at and notify them of any suspensions.

Robust arrangements were in place for granting and reviewing practicing privileges; this included a monthly compliance report, initial meetings with the consultant when the registered manager formally discusses areas such as governance, complaints, behaviours and the working of the hospital. Consultants were then inducted and assigned to a member of staff. There was a formal review process every two years. As part of the review the registered manager reviewed the consultant's activity, complaints, trends and ensure they understood any policies. A practicing privileges policy was in place. Leaders told us consultants were responsible for their own indemnity insurance and they always obtained proof of this.

Policies were devised at a corporate level and did not always reflect the local areas or define some important details. For example, the safeguarding policy did not have the contact details of the local authority, the resuscitation policy did not specify the trolley needed to be tamperproof. Policies seen were both very high level and corporate or senior management documents. The medicines management policy did not give detail around actual processes needed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The hospital had a systematic programme of clinical and internal audit in place to monitor quality, operational and financial processes, and systems to identify where action should be taken. We saw staff completed audits around infection prevention control, NEWS2, records, the environment and pain.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Leaders identified risks in staff meeting minutes, quality and safety meetings and in board meetings; there was a whole hospital risk register in place. Leaders also discussed risks in daily departmental or whole hospital huddles.

Leaders told us due to being an independent hospital they were able to have much greater control over any fluctuation in demand, for example allocating to the resources they had available. The hospital had emergency generators in place in case of failure in essential services.

The hospital was registered with the MHRA Central Alerting System (CAS). This ensured the hospital received medical device and medicine alerts relent to the services being provided.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Good

Surgery

The hospital submitted information to external bodies such as the National Joint Register (NJR), The Private Healthcare Information Network (PHIN) and Patient reported Outcome measures (PROMS). The hospital allocated specific staff to input data into the system and ensure a point of contact.

Leaders had proposed the Nuffield Health Electronic Patient record (NEPR) programme due to COVID -19. The programme was likely to commence shortly with a go live date of April 2022.The hospital ensured surgical cosmetic procedures were coded in accordance with SNOMED-CT.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders ensured people's views and experiences were gathered and acted upon to shape and improve the services and culture. We saw leaders collated patient experience and compiled them into reports; patient journeys were an agenda item in board meetings.

Patient satisfaction surveys looked at many areas of the patient's journey and trends over time. Leaders designed questions to cover different areas of the journey such as from arrival at the hospital, the treatment by the consultant, COVID-19 safety and staff and treatment experience.

The hospital had regular communication with clinical commissioning groups (CCG) and the local NHS trust. The hospital held meetings with third party providers as a way of monitoring any service level agreements. The registered manger attended these meetings and the minutes of the meetings were retained.

Nuffield Health produced and shared quality reports with data on individual hospital performance. The reports included information on medical governance, incidents, patient experience and complaints.

There was a national speak up guardian in place and the hospital had two people undergoing the training to be speak up champions.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff spoke positively about improving services. Quality improvement was embedded in the culture of the service as evident in the meeting minutes reviewed.

We saw examples of quality improvement leaders had implemented throughout the service. Examples included the implementation of a whole hospital huddle and a ward dependency tool to identify staff versus the dependency of the patient cohort. Leaders also spoke of a new theatre standard operating procedure to ensure safer staffing and a process of escalation.