Nuffield Health Tunbridge Wells Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Tunbridge Wells Hospital is operated by Nuffield Health. It is an independent hospital and has 36 beds, three of which are paediatric beds, which can be increased to six if necessary. The hospital has three operating theatres, one recovery area with three beds which can be extended to four if required and a dedicated paediatric recovery bed. The outpatient department, located on the ground floor of the hospital, has 10 consultant rooms, two treatment rooms, one phlebotomy room and one designated gynaecology and urology room. The diagnostic imaging department offers services including general x-ray, ultrasound, CT, MRI, bone densitometry, mammography, mobile x-ray and image intensifier, and fluoroscopy. The physiotherapy department provides inpatient and outpatient care.

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

The main service this hospital provides is surgery. The hospital offers a range of private and NHS elective surgical procedures for a range of specialities, including, orthopaedics (hip and knee arthoplasty), general surgery, urological and gynaecological surgery, ear, nose and throat and cosmetic and plastic surgery. It provides elective surgery for children aged three to 18 years old. The hospital provides care for children and young people in a range of specialties. The primary specialties include ear, nose and throat, orthopaedic, musculoskeletal and cosmetic surgery such as pinnaplasty. The hospital provides outpatient services to adults, children and young people (CYP) from birth to 18 years old. The hospital has a small medical care service, which consists of medical inpatient care, endoscopy and oncology day care.

Where our findings on surgery for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 and 7 February 2017 and an unannounced visit on 17 February 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.

We rated this hospital as good overall because,

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.
- Lessons learnt from incidents were regularly communicated through handovers and staff meetings. We reviewed the ward meeting minutes for December 2016 and January 2017 and saw that incidents were discussed with actions to be taken to prevent similar incidents happening in the future.
- Policies and procedures used within the surgical department and the hospital, followed evidence based practice.
- The hospital planned, implemented and reviewed staffing levels to keep people safe at all times at the hospital.
- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice.
- The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. The hospital benchmarked their findings against other providers and used this information to improve care.
- Overall, feedback from people who used the service and those who are close to them was positive about the way staff treated people and the care received.

Summary of findings

- Staff treated people with dignity, respect and kindness. Patients felt supported and cared for by staff.
- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately and kept patients informed.
- The hospital had consistently high levels of constructive engagement with staff at all levels. Leaders listened to staff and valued their input.
- The hospital had robust governance arrangements. Governance and performance management arrangements were proactively reviewed and reflected best practice.

We found areas of outstanding practice :

- The chemotherapy nurses constantly sought funding from outside organisations and charities that enabled service improvements for oncology patients. For example, sourcing items from various organisations to include in a welcome “goody bag” given to all new oncology patients on arrival.
- A chemotherapy nurse initiated and led a monthly support group for oncology patients, relatives, friends and carers called the “Nuffield Cancer Support Group”. The group met monthly and welcomed all NHS and private patients.
- The hospital's orthopaedic service offered a service to all private patients to include Nuffield Health recovery plus programme. This included an extended membership at a fitness and wellbeing centre supported by a personalised programme post-operatively to improve outcomes and provided patients with the support they needed to get well and stay healthy after their procedure.
- We saw that the hospital used technology to improve the experience of care for children and young people. For instance, the diagnostic imaging department used technology to project child friendly images including a rainbow, and night sky during procedures. The surgery department used a tablet to provide distraction to children before and after procedures.
- The diagnostic imaging department’s consultant survey and proactive response to the rejection rate audit reflected outstanding practice.
- The outpatient department’s risk assessment and action in response to low permanent staff levels reflected outstanding practice.

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

- The provider should take action to replace carpets. Flooring in the majority of the patient bedrooms on Abergavenny Ward was carpets. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages contrary to the Department of Health’s Health Building Note 00-09.
- The provider should take action to upgrade clinical hand washing provision as there were no dedicated clinical hand wash basins in patient's bedrooms. This meant staff had to wash their hands in the basins in patient’s en-suite bathrooms contrary to the Department of Health’s Health Building Note 00-09: infection control in the built environment.
- The provider should ensure that staff in theatre are effectively trained in surgical scrub techniques. We observed a scrub practitioner undertaking poor surgical scrub technique. This was raised with the theatre manager during the inspection and further training has been arranged for staff.
- The provider should improve the appraisal rates for theatre and in patient nurses.
- The provider should improve training rates for adult and paediatric intermediate life support.
- The provider should fully embed the WHO surgical checklist.
- The provider should ensure processes around CD checking are consistent in theatres.
- The provider should ensure learning from incidents is recorded in the outpatient department.
- The provider should ensure outpatient staff have completed their competencies and training tracker is accurate.

Summary of findings

- The provider should review areas of outpatient records audits that were consistently low to confirm additional training has been successful.
- The provider should consider implementing standardised methods to measure pain levels in outpatients.
- The provider should ensure that there is a private area at reception where patients can speak to staff.
- The provider should ensure patients receive cost information, about their care and treatment.
- The provider should review clinics cancelled by the hospital to assess whether cancellations can be minimised.
- The provider should ensure the hospital meets its internal timeliness targets with regard to complaints.
- The provider should consider providing dedicated waiting areas for children.
- The provider should consider providing dedicated CYP clinics and surgery lists in line with Royal College of Surgeons recommendations as outlined in Standards for Children's Surgery, Children's Surgical Forum, 2013.

Following this inspection, we told the provider that they should take some actions even though a regulation had not been breached, to help the service improve.

Professor Edward Baker
Deputy Chief Inspector of Hospitals London and South East

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	We rated this service as good because it was safe, effective, caring, responsive and well led. Staff understood and fulfilled their responsibilities to report incidents and near misses. The hospital fully investigated incidents and shared learning from them to prevent recurrences. The hospital planned, implemented and reviewed staffing levels to keep people safe at all times and the hospital responded to any staff shortages quickly and effectively. Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice. The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. The hospital benchmarked their findings against other providers and used this information to improve care. Overall, feedback from people who used the service and those close to them was positive about the way staff treated people and the care they received. The hospital coordinated the care and treatment it provided with other services and other providers. There were high levels of satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture. However: The hospital did not have a clear process for managing patients who were acutely ill within oncology. There was no strategic leadership within the oncology unit. This meant that oncology staff did not receive clear leadership. However, they clearly demonstrated passion, dedication and commitment to their roles.
Surgery	Good	We rated this service as good for effective, caring, responsive and well led. We rated it as requires improvement for safe. Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.

Summary of findings

Policies and procedures used within the surgical department at the hospital, followed evidence based practice.
We observed the staff on Abergavenny ward being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us staff always introduced themselves, were polite, and treated them well.
All surgery carried out at the hospital was elective. Patients could select times and dates to suit their family and work commitments.
Services were planned and delivered to take into account the individual needs of its patients, for example, age, disability, gender, religion or belief.
There was a clear governance structure in place with committees for medicines management, infection control and prevention and health and safety, which fed into the clinical governance committee.
The hospital was led by a senior leadership team that included the hospital director, the finance director and the matron. Staff spoke positively about the senior management team and felt they were listened to with actions being followed through.
However:
Flooring in the majority of the patient bedrooms on Abergavenny Ward was carpet. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages contrary to the Department of Health's Health Building Note 00-09: infection control in the built environment.
There were no dedicated clinical hand wash basins in patients' bedrooms. This meant staff had to wash their hands in the basins in patients' en-suite bathrooms, which was contrary to the Department of Health's Health Building Note 00-09: infection control in the built environment.
We observed a scrub practitioner undertaking poor surgical scrub technique. This was raised with the theatre manager during the inspection and further training had been arranged for staff.

Services for children and young people — **Good**

We rated this service as good because it was safe, effective, caring, responsive and well led.

Summary of findings

The service had a good track record on safety.
Openness about incidents was encouraged and learning was shared. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
The service gave priority to safeguarding CYP and most staff had completed their safeguarding training.
The service planned and delivered CYP care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
Staff were qualified with the skills and experience they needed to carry out their roles effectively and in line with current legislation and best practice. The service had an induction process for new staff that included an assessment of CYP competencies.
Children's nurses were able to build relationships with patients and their families. This allowed nurses to provide reassurance, information and support to patients and families.
Staff provided emotional support to patients and their families.
The service was flexible in meeting the needs specific to CYP. For instance, the service offered outpatient appointments for CYP during the afternoon, and holidays so that families could attend out of school hours.
The setting was responsive to children's needs. Outpatient and inpatient rooms were decorated in child friendly motifs.
The CYP team was going through changes when we visited the site. The CYP lead was in an interim role. Staff expected a permanent CYP lead to take over later in February 2017.
The future aim for CYP was to grow the department. However, at the time of inspection this had not started.

Outpatients and diagnostic imaging

Good

We rated this service as good because it was safe, caring, responsive and well led. We do not rate effective for the outpatient and diagnostic imaging departments as there is currently not sufficient evidence to rate.
Patients received harm free care in the outpatient and diagnostic imaging departments.
The outpatient department and diagnostic imaging departments was compliant with relevant legislation including ionising radiation regulations.

Summary of findings

Records were stored and transported securely.
The outpatient and diagnostic imaging departments provided care based on current, evidence based guidance.
We saw evidence of multi disciplinary work between departments.
Staff had a supportive and encouraging manner with their patients and took the time to listen to and understand their needs.
The outpatient and diagnostic imaging departments were open evenings and weekends.
Patients could schedule appointments at times convenient for them and found the scheduling process to be easy and flexible.
Staff were able to provide services to patients and family members who were living with dementia or had other diverse needs.
Many members of the senior management team and the outpatient department manager were new in post.
The implementation of new visions and plans for the service was still in progress and their full impact could not be measured at the time inspection.

Summary of findings

Contents

Good

Nuffield Health Tunbridge Wells Hospital

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

Summary of this inspection

Background to Nuffield Health Tunbridge Wells Hospital

Nuffield Health Tunbridge Wells Hospital is operated by Nuffield Health. It is a private hospital in Tunbridge Wells, Kent and has been open since 1968. The hospital primarily serves the communities of the Tunbridge Wells area. It also accepts patient referrals from outside this area.

The registered manager had been in post since October 2016.

The accountable officer for controlled drugs (CDs) was the registered manager.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, Sheona Keeler, CQC inspectors, a theatre nurse, a surgery nurse team lead, a medical nurse team lead, a medical nurse, an outpatient lead nurse and a radiographer . The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Information about Nuffield Health Tunbridge Wells Hospital

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

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

During the inspection we visited the ward, theatres, outpatients, radiology and the chemotherapy unit. We spoke with over 30 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, radiography staff and senior managers. We spoke with eight patients and their relatives. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection. The hospital's the most recent inspection took place in February 2015, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (October 2015 to September 2016);

There were 7,150 inpatient and day case episodes of care recorded at the hospital in the reporting period (Oct 15 to Sep 16); of these 18% were NHS funded and 82% were other funded.

The main service provided by this hospital was surgery. The hospital offers a range of private and NHS elective surgical procedures for a range of specialities, including, orthopaedics (hip and knee arthoplasty), general surgery, urological and gynaecological surgery, ear, nose and throat and cosmetic and plastic surgery.

Eighteen percent of all NHS funded patients and 15% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 10,374 outpatient total attendances in the reporting period (October 2015 to September 2016); of these 28% were NHS funded and 72% were other funded.

Track record on safety;

In the reporting period (October 2015 to September 2016) there has been one Never Event. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them.

Summary of this inspection

There were 488 clinical incidents in the same period. Of these incidents 367 were categorised as no harm, 108 were categorised as low harm, 12 were categorised as moderate, one was categorised as severe.

There were:

- no inpatient deaths.
- no incidents of hospital acquired MRSA. and no incidents of hospital acquired MSSA.
- no incidents of hospital acquired C.diff. and no incidents of hospital acquired E-Coli.

In the reporting period (October 2015 to September 2016) the percentage of patients risk-assessed for VTE was 93.75%. The number of cases of hospital acquired venous thrombosis and pulmonary embolism was two.

There were 128 doctors employed or practicing under rules and privileges for the provider of which 125 have had their registration validated in the reporting period (October 2015 to September 2016).

There were 29.7 whole time equivalent (WTE) registered nurses and 13.1 (WTE) healthcare and operating department assistants.

Services Accredited by national bodies

- Oncology service has a Macmillan Quality Environment Mark (MQEM).
- Pathology has United Kingdom Accreditation Service (UKAS) accreditation.

Outsourced Services

- Catering.
- Estates management.
- Medical equipment servicing.
- Mobile CT service.
- Resident Medical Officer.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff understood and fulfilled their responsibilities to report incidents and near misses. The hospital fully investigated incidents and shared learning from them to prevent recurrences.
- The hospital planned, implemented and reviewed staffing levels to keep people safe at all times and the hospital responded to any staff shortages quickly and effectively.
- The hospital had effective systems to assess and respond to patient risk.
- There was sufficient emergency resuscitation equipment available and evidence of assurance that this was safe and fit for purpose.
- Staff received up-to-date mandatory training in safety systems including fire training and infection prevention and control to enable them to keep patients safe.
- The hospital stored and checked medicines appropriately in line with legal requirements.

However:

- Flooring in the majority of the patient bedrooms on Abergavenny Ward was carpet. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages contrary to the Department of Health's Health Building Note 00-09, infection control in the built environment.
- There were no dedicated clinical hand wash basins in patient's bedrooms. This meant staff had to wash their hands in the basins in patient's en-suite bathrooms, which was contrary to the Department of Health's Health Building Note 00-09, infection control in the built environment.
- We observed a scrub practitioner undertaking poor surgical scrub technique. This was raised with the theatre manager during the inspection and further training had been arranged for staff.
- We saw evidence of a leak below one of the sinks in theatre and there was visible mould damage which could have given rise to an infection control risk.

Summary of this inspection

Are services effective?

Good

- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice.
- The hospital routinely collected and monitored information about people's care and treatment and their outcomes. The hospital benchmarked their findings against other providers and used this information to improve care.
- Staff received meaningful and timely supervision and appraisals. We saw evidence of an appropriate approach for supporting and managing staff when learning and development were required.
- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Staff could access the information they needed to assess, plan and deliver care to people in a timely way.

However:

- The hospital did not have a clear process for managing patients who were acutely ill within the oncology service.

Are services caring?

Good

- Overall, feedback from people who used the service and those who were close to them was positive about the way staff treated people and the care received.
- Staff treated people with dignity, respect and kindness. Patients felt supported and cared for by staff.
- Staff encouraged patients and their loved ones to be partners in their care.
- Staff respected people's privacy and confidentiality at all times.
- The service had links with other services to help patients living with cancer and those close to them cope emotionally with their care and treatment.

Are services responsive?

Good

- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately and kept patients informed.
- The hospital coordinated the care and treatment it provided with other services and other providers.
- The hospital made positive improvements to make the service more accessible for patients living with dementia, and wheelchair users had easy access to the ward.

Summary of this inspection

- The hospital dealt with complaints appropriately and responded to them within the time frame set in the complaint's policy.

Are services well-led?

Good

- There were high levels of satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The hospital had consistently high levels of constructive engagement with staff at all levels. Leaders listened to staff and valued their input.
- The hospital had robust governance arrangements. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- Leaders drove continuous improvement and organisational growth.
- We saw strong collaboration and support across all staff groups and a common focus on improving the quality of care.
- The vision and values were well embedded amongst staff.
- Leaders actively encouraged staff to raise concerns. There was a culture of openness, and all staff we spoke to could describe their responsibilities relating to Duty of Candour.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care

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

Are medical care services safe?

Good

We rated safe as good.

Incidents

- In the reporting period October 2015 to September 2016, there were no never events related to medical care services. 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.
- In the reporting period October 2015 to September 2016, there were no serious injuries related to medical care services reported to the Strategic Executive Information System (STEIS). STEIS is a web-based serious incident management system, through which providers record serious incidents provided by NHS England.
- An up to date corporate incident reporting policy was in place. The incident reporting system was electronic based. Staff had a good understanding of how to use the system and were able to describe examples of incidents they had reported. Staff were able to describe examples of changes in practice following an incident. We saw evidence of incidents discussed at the clinical governance and head of departments meetings, and learning disseminated at ward meetings.
- Data received from the hospital showed between October 2015 and September 2016 there had been 488 clinical incidents reported across the hospital, and 376 incidents (77%) occurred within surgery or inpatients. The hospital were unable to separate the information by medical or surgical incidents. The rate of clinical incidents for the hospital was higher than the rate of other independent acute hospitals we hold this type of data for in the same reporting period. The high rate of incident reporting and low rate of serious incidents indicated that the hospital had an open and honest reporting culture and learned from low harm and near miss incidents. There were no apparent themes related to this service.
- There were 83 non-clinical incidents reported by the hospital between October 2015 and September 2016. Of these, 11% (nine incidents) occurred in surgery or inpatients. The hospital were unable to separate the information by medical or surgical incidents. The rate of non-clinical incidents for the hospital was similar to the rate of other independent acute hospitals we hold this type of data for in the same reporting period.
- Staff were able to describe the basis of Duty of Candour. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff gave us an example where an appropriate medication was not prescribed for a patient. Even though the patient did not experience significant harm, staff apologised and explained to the patient and relative what had gone wrong.
- The hospital reported no patient deaths in the period October 2015 to September 2016. Staff we spoke with described they would discuss mortality and morbidity at the clinical effectiveness and audit meetings, clinical

governance committee meetings and the medical advisory committee meetings. However, we did not see this in the meeting notes as there were no deaths in the same reporting period.

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

- The NHS safety thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and harm-free care. The tool allowed the proportion of patients who were kept "harm-free" from venous thromboembolisms (VTEs, or blood clots in veins), pressure ulcers, falls and catheter associated urine infections to be measured on a monthly basis.
- Patients identified at risk of developing pressure ulcers were placed on an appropriate care plan and were monitored more closely by staff. For example, the hospital provided a pressure relief mattress, which helped stop pressure ulcers occurring.
- Between October 2015 and September 2016, the hospital reported a 95% inpatient VTE screening rate. However, nurses we spoke with during the inspection showed us the hand-over sheets has been changed and now included a reminder to resident medical officers (RMOs) to complete VTE screening. The matron told us that the inpatient VTE screening rates had improved to 100% at the time of the follow up inspection.
- In the same reporting period, the hospital reported no falls. We saw this recorded as a standard agenda item of the clinical governance, clinical effectiveness and audit meetings held in November and December 2016, and in January 2017.

Cleanliness, infection control and hygiene

- To maintain registration with CQC, healthcare establishments must demonstrate compliance with infection prevention criteria as detailed in The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health 2015). We saw information provided by the hospital, which demonstrated detailed infection prevention, and control activities carried out yearly known as "clinical audit schedule". Activities carried out included having systems and policies in place to ensure the hospital met with infection, prevention and control of infection requirements.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment. Patients' representatives assess cleanliness as part of PLACE audits. The hospital's PLACE score for cleanliness for the period February to June 2016 was 99%. This was better than the England national average of 98% for the same period. The assessment of cleanliness covered areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.
- During the inspection, all the areas we visited looked visibly clean and tidy. We found equipment was visibly clean throughout the department. Staff demonstrated a good understanding of responsibilities in relation to cleaning and infection control. Staff used "I am clean" labels on equipment, which indicated the date the equipment had been cleaned. This provided assurances the equipment was clean and ready for use. All equipment we saw during inspection had a label.
- We saw completed cleaning checklists from October to December 2016 for Abergavenny Ward, the oncology unit and the endoscopy suite. These were all completed daily and included staff signatures, which showed that the areas were cleaned daily.
- The majority of the patient bedrooms on Abergavenny Ward had carpets. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages. The Department of Health's Health Building Note (HBN) 00-09 states, "Carpets should not be used in clinical areas." However, we saw carpets in patient bedrooms were visibly clean and free from stains. We also saw regular deep cleans of carpets had taken place. We did not see a carpet replacement schedule at the time of inspection. However, the senior management team told us all carpets in the bedrooms would be replaced within the next two years. Flooring in the oncology unit and endoscopy suite was compliant with HBN 00-09.
- Staff followed the corporate January 2015 "Standard Infection Prevention Precautions Policy," which was within its review date. The policy included areas such as hand hygiene and the use of personal protective

equipment such as gloves and aprons. In the event of spillages of blood and body fluids, the policy stated a step-by-step process. This meant that staff were able to follow clear processes.

- We saw personal protective equipment and hand-sanitising gel was available in all patients' bedrooms. We saw nurses used the gel at the time of inspection which was in accordance with the World Health Organisation (WHO) "Five moments for hand hygiene." Posters were displayed in ward offices, which explained the WHO "Five moments for hand hygiene". This meant that staff were reminded to follow the correct hand hygiene process. We saw these posters also displayed in the en-suite bathrooms of patient bedrooms.
- On Abergavenny Ward, there were no dedicated clinical hand hygiene sinks in patient bedrooms. Staff and visitors used the hand wash basins with lever-operated taps in the bedrooms' en-suite bathrooms or the hand washing facilities in the sluice and reception desk. This did not comply with HBN 00-09: infection control in the built environment, which states "healthcare providers should have policies in place ensuring that clinical wash hand basins are not used for other purposes." The hospital did not have a programme of works for installation of new dedicated hand wash sinks in the patient bedrooms.
- Hand hygiene audits, including bare below the elbow audits, showed 100% compliance for Abergavenny Ward and the oncology unit for the six months prior to our visit. We saw all staff on the ward were bare below the elbow to allow effective hand washing and followed the WHO "Five moments for hand hygiene" during our inspection.
- We saw staff separated waste into different colour coded bags to signify the different categories of waste. This was in accordance with Health Technical Memorandum (HTM): Safe Management of Healthcare Waste, control of substances hazardous to health (COSHH), and health and safety at work regulations. This meant staff also followed the corporate January 2015 "Standard Precautions Policy: colour coding procedure for clinical waste."
- We saw sharps bins were available in treatment and clinical areas where sharps were used and was compliant with Health and Safety Sharps Regulations 2013, 5 (1) d. The regulation requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. Staff fully completed labels on sharps bins, which ensured traceability of each container.
- The specialised ventilation revalidation results were reviewed against performance criteria as defined by HTM 03-01 2007. This HTM is a comprehensive guidance to providers on the legal requirements, maintenance and operation of specialised ventilation in all types of healthcare premises. The hospital showed us the recorded results together with the maintenance records provided for endoscopy, which indicated the presence of suitable maintenance regimes being employed.
- Staff in the endoscopy suite took monthly environmental mycobacterium samples. The most recent test showed out of range mycobacterium counts. Therefore, the chamber was not currently being used for sterile scopes until another test showed a negative result.
- In the endoscopy suite, we saw there were adequate systems to ensure that endoscopes were safely decontaminated. We saw staff used a tracking and tracing scanning system for endoscopes. There was a traceability book for each washer and the system tracked the endoscopes through each stage of the decontamination process and enabled patient identification. Staff placed traceability stickers in patient records as well as the drying cabinet storage record.
- We saw the current layout within endoscopy meant staff had to transport dirty instruments through a clean area to access the endoscopic washer. This meant that there was a risk of cross-contamination and was not in accordance with the corporate February 2015 "Decontamination of Flexible Endoscopes and Heat Labile Equipment Policy." The policy states, "The clean area should be operated in a manner which prevents possible re-contamination of the processed endoscopes before they are placed into storage or drying cabinets, taken for immediate use, or vacuum packed (where permitted)". However, we saw the hospital works programme included improvement of flow and re-configuration to the area. The infection prevention lead was involved in the development and design stages of the proposed new layout.

- Some chemotherapy drugs are harmful to patients and staff. We saw the oncology unit had spill kits readily available to deal with chemotherapy spills and staff were aware of how to use them.
- Chemotherapy was prepared in an sterile environment. This guarded against the risk of infection being introduced when the chemotherapy was administered. This ensured that oncology patients were kept safe from decontamination caused by harmful bacteria, viruses, or other microorganisms.

Environment and equipment

- The oncology unit has four individual rooms, a day room with three reclining chairs and a quiet room. The individual rooms were used for both consulting and counselling providing patients with privacy when needed. The day room was used for taking blood samples. The 'Health Building Note 02-01: Cancer treatment facilities' recommends a mixture of open-plan and individual treatment spaces, but states that the overall size of the treatment suite will depend on patient throughput.
- There was a resuscitation trolley each on Abergavenny Ward, the oncology unit and the endoscopy suite. The resuscitation trolleys were secure and we saw records of equipment and consumables checks were up to date. Staff ensured all trolleys were fully stocked with equipment needed in a resuscitation emergency. All consumables were in date. Staff checked the trolleys daily.
- Staff we spoke with said patients requiring end of life care (EOLC) were not admitted to the hospital. However, we were told that a patient would be referred to the local hospice if required. We saw the hospital had arrangements in place with the local hospice to receive patients requiring end of life care.
- We saw portable appliance testing (PAT) stickers on electrical equipment on Abergavenny Ward and the oncology unit, which showed electrical equipment had been tested and was safe to use. This complied with the Medicines and Healthcare Regulatory products Regulatory Agency (MHRA) "Managing Medical Devices" April 2015.
- On Abergavenny Ward, we looked at 12 pieces of equipment and all were within the date of service. Equipment we checked on the oncology unit and endoscopy suite was within the date of service. This provided assurances the hospital maintained equipment to keep it safe and fit for purpose.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of February to June 2016 showed the hospital scored 97% for condition, appearance, and maintenance of the environment. This was better than the England average of 93% for the same period. The assessment for condition, appearance, and maintenance covers areas such as decoration, the condition of fixtures and fittings, tidiness, signage, lighting (including access to natural light), linen, access to car parking, waste management, and the external appearance of buildings and maintenance of grounds. This aligned with what we saw during inspection and our follow up visit.

Medicines

- There was an up to date corporate policy on the safe management of medicines (medicine management policy dated October 2016). We saw evidence of two pharmacy standard operating procedures on Abergavenny Ward, which was developed specific to the ward.
- The pharmacy department carried out a number of audits related to medicines. These were carried out monthly and included the medicines management audit, pharmacy intervention audits and audit of time taken to dispense a prescription. The audits demonstrated 100% compliance. The medication safety thermometer audit carried out in October 2016 showed an issue with maximum doses not being documented on 30 prescription charts. However, these were all rectified and included documented maximum doses during our visit.
- On Abergavenny Ward and the oncology unit, staff securely stored medicines in a clinical room with keypad access and cupboards in the room were locked. Keys for those cupboards were kept in a coded key safe or were in the possession of a trained nurse.
- There were appropriate processes in place for staff to obtain medication from the pharmacy department out of hours. This meant the RMO can only access the pharmacy department when accompanied by the nurse in charge. The pharmacy door had two locks with one

key held by the RMO and one by the nurse in charge. This meant that staff followed the hospital's up-to-date standard operating procedure for "Out of Hours Access to Medicines".

- Medicines on Abergavenny Ward and the oncology unit were kept in temperature-controlled rooms and we saw evidence of ambient temperature records being kept. Medicines requiring refrigeration were stored in fridges and daily temperature checks were within range. We saw records of this for the five months prior to our visit.
- We completed a random check of 20 stock medicines on Abergavenny Ward and all were in date. This meant the safety and effectiveness of medicines on the ward was assured.
- We observed appropriate storage and record keeping of controlled drugs on Abergavenny Ward and the endoscopy unit as per the Misuse of Drugs Regulations, 2001. We saw evidence of daily balance checks and three-monthly pharmacy audits in the stock controlled drugs (CD) register on Abergavenny Ward.
- We checked the stock balance of two CDs in the cupboard on Abergavenny Ward and found these were correct and matched the CD register. All CDs we checked were in date. This provided assurances around the safety and effectiveness of CDs on the ward. Emergency drug packs for arrest, anaphylaxis and deteriorating patients were available and standardised across the service. Pharmacy staff kept records of locations and expiry dates of the emergency drug packs.
- Staff had access to appropriate resources related to medicines such as the British National Formulary Issue 72 which was the most up-to-date available version at the time of our inspection and online access to an intravenous medicines guide.
- We reviewed four prescription charts for patients on Abergavenny Ward. All prescriptions were signed and dated, allergies were documented and there were no missed doses.
- We saw two chemotherapy prescription sheets on the oncology unit were signed and dated, and were clear with copies of relevant protocols securely attached to the prescription.
- A member of the pharmacy team visited the ward daily to facilitate patient discharge, complete clinical reviews of inpatient prescriptions and checked patient's own medication to determine suitability of use. The pharmacy team also supported the multidisciplinary team with clinical decisions regarding patient's medication.
- A pharmacist attended the multidisciplinary team meeting held daily on Abergavenny Ward at 8:30am. Other attendees include nurses, business support and physiotherapists. Issues such as patients on high-risk medicines for example, insulin or oral anticoagulants (medicines to prevent blood clots), admissions and discharges were highlighted to the pharmacist at this time. This meant the pharmacy team could prioritise patients based on risk and reduce the risk of medication errors and delayed discharges.
- Staff kept a maximum of one private outpatient prescription pad in a locked medicines cupboard on Abergavenny Ward, which met the current demand. We saw a log, which showed when a prescription had been issued, to whom and what for. This was in line with NHS Protect, Security of Prescription Forms Guidance 2013.
- Pharmacy staff told us they provided patients with a medication record card if a need was identified. For example, if the patient had trouble remembering to take their medicines.
- The pharmacy department supplied patients with supporting information with their medication. For example, they supplied leaflets regarding unlicensed medicine advice, safe and effective use of antibiotics and alert cards for oral anticoagulants to appropriate patients.
- On the oncology unit, staff gave chemotherapy drugs directly into a patient's vein. A complication of this is a leakage of the drug from the vein in to the surrounding tissue. Staff kept an emergency pack of medicines in the clinical room in the event a patient had an anaphylactic reaction or a patient suffered leakage of bodily fluid. The pharmacy department maintained a log of expiry dates and replaced the pack once it was used or an item expired.
- The hospital did not use dose banding for chemotherapy. Dose banding is a national system introduced by NHS England to reduce variation and wastage in chemotherapy. A pharmacist told us patients received individually calculated doses of medicines.

- Chemotherapy drugs were delivered to the oncology unit in a sealed box. These medicines were not stored away as staff used them almost immediately upon delivery. This meant that these medicines were used straight after preparation. A nurse checked the medicines before transferring them to the patient's room, and two registered nurses before administration checked the medicines. This meant that nurses followed the Nursing and Midwifery Council (NMC) standards for medicines management.
- For detailed findings on medicines, please see the Safe section in the surgery service report.

Records

- The hospital used a variety of information technology systems that held patient data. Management required all staff to be compliant with information security and data protection with all services around patients. We saw 99% of hospital staff completed mandatory e-learning modules for information governance. This was better than the hospital target of 85%.
- An audit showed that 95% of adults who were admitted as inpatients from October 2015 to September 2016 had a VTE risk assessment. However, information provided by the hospital at the follow up inspection showed this had improved to 100% and staff had completed VTE risk assessments in all patient records we reviewed.
- The hospital audited medical records from June to August 2016 to monitor clinical documentation and staff compliance with policies and national guidelines. The audit showed compliance ranged from 95% to 100% in areas such as; patient, GP details and allergies were documented, fully completed consent forms, entries were dated, timed and signed. All entries were accurate which included risks and remedial actions, and had clear discharge pathways. The findings of the audit were presented to the clinical governance committee and medical advisory committee. Heads of departments disseminated results during team meetings. We reviewed four medical records and all of these showed 100% compliance.
- Staff in the endoscopy suite placed traceability stickers for endoscopes in patient records. There was also a record of storage in the drying cabinet. This enabled traceability of the source in the event there was any infections.
- Oncology patients carried record books, which indicated the chemotherapy type and frequency as well as the patient's most recent blood test results. This meant that patients were able to keep track of the treatments and were able to communicate to health professionals when unwell.
- The hospital used a personalised care plan for medical care patients. The care plan was to be used in conjunction with other risk assessments. For example, the Modified Early Warning Score (MEWS) chart, pain management and pain scale, patient handling, slips, trips and falls.
- The hospital had a medical records department on site. Staff tracked notes so their location was known. We saw records that were tracked to the ward and staff we spoke with said they were located promptly when required. The hospital therefore ensured staff had quick access to patients' medical information.
- We saw care pathway records and consultant notes for oncology patients were stored in the cancer nurse specialist's office. This office was locked when not in use to maintain record security and confidentiality. This meant that a full patient record was available at the time of the patient appointment.

Safeguarding

- There had been no safeguarding referrals made to the CQC from October 2015 to September 2016.
- There were corporate policies in place for safeguarding adults and children and these were accessible to staff. We saw a flow chart of how to raise a safeguarding concern in Abergavenny Ward for staff to refer to.
- Staff received mandatory training in the safeguarding of vulnerable adults via an online module, as part of their induction.
- Safeguarding vulnerable adults training was undertaken every year for level one. Data provided by the hospital showed that in February 2017, 96% of required staff had completed level one. This was better than the Nuffield Health target of 85%. This meant the hospital had assurance all staff had the necessary up-to-date training to keep patients safe.

Good

Medical care

- Staff had a good understanding of what a safeguarding concern might be and how to escalate a concern. They knew who the safeguarding lead was.
- The Matron was the hospital safeguarding lead and trained to safeguarding children level three and had access to the Nuffield regional safeguarding lead, trained to level four. This was in line with the intercollegiate document, "Safeguarding children and young people: role and competences for health care staff, March 2014".

Mandatory training

- The overall hospital completion rates for mandatory training (including bank staff) as of 16 February 2017 were 94%. This was better than the Nuffield Health target of 85% (including bank staff).
- Managers tailored the mandatory training programme to the requirements of each staff job role. Staff completed online training annually. Staff told us they had no problems completing online training and this was done during work time. Staff were also allocated time to complete mandatory training.
- Weekly reminders were emailed to line managers in order to monitor mandatory training. Staff were incentivised to complete mandatory training, as they were not eligible for a pay rise unless all mandatory training had been completed.

Assessing and responding to patient risk

- We looked at four records of medical inpatients and saw a range of risk assessments were used which used nationally recognised and validated tools. These included assessments for risk of pressure damage and malnutrition. We saw assessments were reviewed against score charts and there were clear escalation process as required by the hospitals care bundles. Other risk assessments included those concerned with falls, manual handling and the use of bed rails.
- Staff assessed the risks of VTE for each patient and used appropriate prophylactic measures where applicable, for example, the use of anti-coagulant medication. Between October 2015 and September 2016, the hospital reported no incidents of hospital acquired VTE or pulmonary embolism related to medical care.
- National Institute for Health and Care Excellence (NICE) guideline CG50: Acutely Ill Patients in Hospital recommends the use of an early warning scoring system to identify patients whose condition may be deteriorating. The hospital used the Modified Early Warning Score (MEWS) and we saw this was routinely used for inpatients where appropriate.
- The hospital employed two resident medical officers (RMOs) via an agency who were available on site 24 hours a day, seven days a week. The RMO was available to assist nursing staff and consultants by completing any necessary medical tests and writing prescriptions required by the lead consultant. The RMO gave us an example of a patient who had become unwell during the night, and transferred to the local NHS hospital. The RMO provided medical cover 24 hours a day, seven days a week. The RMO was able to give us examples of managing complex patients out of hours and said that consultants were happy to be contacted for advice if needed.
- Consultants were responsible for their own patients. It was a requirement of the corporate practising privileges policy, that consultants remained available (both by phone and, if required, in person) or arranged appropriate alternative named cover, via a buddy system if they were unavailable, when they had inpatients in the hospital.
- A senior nurse was available at the hospital as a contact point for both staff and patients, including to help resolve patient queries and to accept out of hours admissions. They were contactable via bleep or telephone.
- On discharge, staff provided patients in the oncology unit with telephone contact details for a 24-hour advice line. Staff documented advice they gave in patient records, and we saw evidence of this in the two chemotherapy records we reviewed.
- Staff told us that they would telephone for an ambulance if patients required transfer to the local NHS trust. We saw a service level agreement with the local NHS trust, which included the direct transfer of critically ill patients to the intensive care unit.

Nursing and support staffing

Good

Medical care

- Staffing levels were calculated using a nursing allocation tool adapted to the hospital. The nursing rota was completed monthly and adjustments made 24 hours in advance based on patient occupancy numbers and acuity.
- As of 1 October 2016, the hospital employed 16.8 whole time equivalent (WTE) inpatient nursing staff and 3.0 WTE health care assistants (HCAs) for inpatients. The inpatient departments had a ratio of nurse to health care assistant of 5.7 to 1.
- There was one WTE inpatient nurse vacancy as of 1 October 2016. The vacancy rate (6%) was better than the average of other independent acute hospitals that we hold this type of data for. Nursing staff we spoke with told us they considered there was sufficient nursing staff to meet the needs of patients.
- From October 2015 to September 2016, the use of bank and agency nurses in inpatient departments was worse than the average of other independent acute hospitals we hold this type of data for in all months except August and September 2016. The bank to agency ratio for inpatient nurses was 1.92 to 1.0 in the last three months of the reporting period.
- For the same reporting period, the use of bank and agency HCAs in inpatient departments was variable and the rates were worse than the average of other independent acute hospitals we hold this type of data for in November 2015 and January to May 2016. The bank to agency ratio for inpatient HCAs was 1.0 to 1.0 in the last three months of the reporting period.
- Bank and agency staff worked at the hospital regularly and were familiar with policies and procedures. This provided continuity of care for patients and ensured these staff could work safely as they were familiar with the systems and processes of the hospital.
- The oncology service employed a manager, two specialist oncology sisters and four chemotherapy nurses. The position for the oncology manager was vacant. However, the matron at the hospital and Nuffield regional oncology lead fulfilled this role until a manager was recruited.
- Two chemotherapy nurses staffed the oncology unit at all times. We observed nurses contact the ward to liaise with ward staff to cover breaks for staff in the unit during the day.

Medical staffing

- This service operated one inpatient ward, which was shared with surgical patients. The medical staffing arrangements are reported on under the surgery service within this report.
- Nursing staff on Abergavenny Ward and in the oncology unit could contact the RMO or consultant physician if medical advice was needed.

Major incident awareness and training

- For detailed findings on major incident awareness and training, please refer to the surgery service report.

Are medical care services effective?

Good

We rated effective as good.

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

- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example National Institute for Health and Care Excellence (NICE) guidance CG161: Falls in older people- assessing risk and prevention; and European Oncology Nursing Society (EONS) extravasation guidelines.
- The hospital had policies describing the management of neutropenic sepsis, which were compliant with NICE guideline CG151 (neutropenic sepsis: prevention and management in people with cancer). Neutropenic sepsis is a potentially fatal complication of anticancer treatment, particularly chemotherapy.
- Oncology nurses we spoke with told us a locally adapted acute oncology management pathway was used to assess patients who contacted for advice. We saw this pathway did not provide a clear process for staff to follow and could have the potential of resulting

in the wrong action being taken. An example of this was when a patient could have avoided admission with dehydration if the process for management was clear. We raised this with the oncology nurses and we were told that they would amend the pathway until they introduced the use of the UK Oncology Nursing Society (UKONS) triage tool. The UKONS tool would ensure that patients received reliable assessment every time they contact the hospital for advice. During the inspection, we saw the first training session commenced to ensure competency in the use of the tool.

- The endoscopy unit did not have Joint Advisory Group (JAG) accreditation at the time of inspection. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain JAG accreditation. JAG had not formally reviewed the hospital at the time of our visit and the hospital management had a detailed action plan working towards accreditation.
- The hospital had an audit programme throughout all clinical departments. Audits were completed and reported to the departments and through to the clinical governance meetings. Audits included hand hygiene, WHO checklist, pain and medicine management and patient health records.
- The hospital took part in national audits, for example the NHS safety thermometer, VTE, reviewed clinical practice and identified potential remedial factors.

Pain relief (medical care specific only)

- There was a pain assessment scale within the Modified Early Warning Score (MEWS) chart used within the hospital. We saw pain scores documented at appropriate intervals on all six MEWS charts we reviewed.
- Pain score and assessment prompts were included in the "Nursing Intentional Rounding" form used by staff, to ensure their patients were safe and comfortable. Staff made hourly intentional rounds for all medical care inpatients and day patients. Patients told us nurses routinely asked them about their pain levels part of these rounds.
- We spoke with four medical and oncology patients, who told us staff met their pain management needs.
- Nurses on the oncology unit told us they could contact the RMO to prescribe additional pain relief for a patient if it was required.
- The pharmacy team supported pain management at ward level by providing advice and support to patients and clinical teams.

Nutrition and hydration

- Staff screened all patients for malnutrition and the risk of malnutrition on admission, the Malnutrition Universal Screening Tool (MUST). We reviewed four medical records, all of which had been completed correctly.
- Patients on Abergavenny Ward and the oncology unit had access to a food and drinks menu. Patients on the ward were served meals for breakfast, lunch and dinner, and patients on the oncology unit could order food and drinks at any time during their treatment. Requests outside the menu were also offered to patients.
- Information on food allergens was also available to patients if required.
- Catering staff were aware of the side effects from treatments and recognised the importance of patients eating something they chose and to their liking. We saw the catering department also provided a menu specific for oncology patients, which had choices such as scrambled eggs and smoothies.
- Nutrition and hydration was included in the "patient needs" prompt on the "nursing intentional rounding" form used by staff, to ensure their patients were safe and comfortable. Intentional rounds were undertaken hourly for all inpatients and day patients. Patients told us nurses routinely offered them drinks as part of these rounds.

Patient outcomes (medical care specific only)

- The hospital measured its performance in a number of areas relevant to medical care. This included unplanned readmissions and unplanned transfers to hospitals with critical care facilities. Nuffield Health compared results from all hospitals across the group. This allowed the hospital to benchmark its performance against other hospitals.

Good

Medical care

- The hospital reported no unplanned re-admissions related to medical care between October 2015 and September 2016. This meant that patients who were discharged from the hospital did not require re-admission..
- The hospital contributed data to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) when this was applicable. However, the hospital reported no deaths between October 2015 and September 2016.
- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services at the time of our visit. JAG accreditation by the Royal College of Physicians was formal recognition that an endoscopy service was competent to deliver against defined measures in a global rating scale for endoscopy standards.
- The theatre manager and the Matron told us the hospital had significant work to do in order to qualify for JAG accreditation. This included improvements to the flow and layout of the endoscopy area. Due to the extent of the work required, the hospital director felt that a strategy of working towards JAG accreditation in 2018 was a realistic target.

Competent staff

- There was a corporate policy in place for granting and maintaining consultant practicing privileges. The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff and we saw evidence of this in the MAC meeting minutes.
- In the reporting period October 2015 to September 2016, 38 practising privileges were removed for surgeons who had not worked at the hospital for a period more than six months. These processes ensured doctors with practising privileges worked at the hospital regularly. This meant they were more likely to be familiar with the hospital's environment, staff, policies and ways of working.
- In the same period, one nurse and three doctors were suspended due to non-compliance with indemnity insurance and appraisal documents, and conduct.
- The hospital had systems in place for supporting staff with learning and development. In the year December 2015 to December 2016, the appraisal rate for staff in oncology was 88% (seven of eight staff). We saw evidence the one remaining oncology staff member was re-booked to have an appraisal in March 2017. Appraisal rates were 100% for inpatient staff and 100% for administrative staff. This meant that all staff had appraisals and this service was able to address any potential staff performance issues.
- Staff we spoke with told us they had a yearly and mid-year appraisal. They felt it was useful and managers discussed performance and opportunities for training and progression.
- There was 98% completion rate of validation of registration for doctors working at the hospital under practising privileges in the reporting period October 2015 to September 2016. This meant the hospital had assurances that all doctors met the practising requirements set by the General Medical Council (GMC).
- In the same reporting period, the completion rate of revalidation of professional registration for inpatient nursing staff was 100%. This meant that all inpatient nursing staff met the practising requirements set by the Nursing and Midwifery Council.
- Nurses we spoke with said they felt supported by their managers in regards to maintaining their registration with the Nursing and Midwifery Council (NMC). The hospital provided training and support sessions in person and online training related to revalidation for both Abergavenny Ward and the oncology unit.
- Staff told us they had could access training and gave us examples of training they had recently completed in addition to mandatory training. For example, we saw four oncology staff had recently completed a comprehensive systemic anti-cancer therapy course. A ward nurse told us she was in the process of receiving chemotherapy training.
- Bank and agency staff had access to the same on-line training modules as permanent hospital staff.

- We saw competency certificates for ward, oncology and endoscopy staff. Examples of these included cannulation and administration of chemotherapy, pain management and operation of specific equipment. This provided assurances staff were competent to carry out their roles.

Multidisciplinary working

- A multidisciplinary team meeting took place daily on Abergavenny Ward. We saw this during inspection and it was effective. It was attended by nurses, business support, pharmacists and physiotherapists.
- We saw evidence of input from the oncology specialist nurses, pharmacist and allied health professionals, for example physiotherapists, dieticians and speech and language therapists in patient records. Staff we spoke with told us they had good access to these teams in the hospital.
- We observed good multidisciplinary team working between the RMO, nursing staff, pharmacy staff and oncology staff during our inspection.
- The hospital had a good working relationship with the local hospice and staff were able to refer patients at an early stage, as the hospital did not provide end of life care.
- Nursing staff and the resident medical officer (RMO) described a good working relationship with pharmacy staff. We observed friendly and professional interactions between the pharmacist and nursing staff on the wards and the chemotherapy nurses.

Seven-day services

- Consultants were responsible for their own patients. It was a requirement of the corporate practising privileges policy that consultants remain available (both by telephone and, if required, in person). If they were unavailable, appropriate alternative arrangements such as named cover, via a buddy system, were in place at all times when they had inpatients in the hospital.
- There was always a senior nurse available at the hospital as part of an on-call rota. The senior nurse was a contact point for both staff and patients, including to help resolve patient queries and to accept out of hours admissions.
- Patients in the oncology unit were provided with a telephone number enabling them to have access to support from the hospital nursing staff and advice 24 hours a day, seven days a week.
- Hospital staff were able to access the pharmacist by telephone, 24 hours a day seven days a week.

Access to information (medical care only)

- Staff had appropriate access to the policies and procedures they needed to do their jobs. We saw examples of these included infection prevention and control, risk management, incident reporting and medicine management.
- We saw a range of information was available for patients. This included information published by recognised organisations such as Macmillan, as well as signposting to services such as complementary therapy providers.
- The hospital provided a welcome letter to patients admitted to the wards. The letter explained the process of admission, facilities on the ward and hospital, and provision of meals. It also explained the staff handover arrangements on the wards and medication rounds. We saw a folder included information such as the hospital layout, meal times and TV channels provided in every inpatient room.
- Endoscopy patients and inpatients received a letter on discharge. This included details of the procedure or treatments, changes to medication, findings and details of any follow up. Staff sent a copy of this letter to the patients' GP and a copy was kept at the hospital in the patients' medical records. This meant there was a continuity of service and all medical teams were kept informed.
- The hospital had a medical records department on site. Staff we spoke with told us that medical records were easy to access and NHS medical records were always returned securely to the relevant NHS Trust as soon as they were no longer required. Staff tracked notes so their location was known.
- The hospital was in the process of developing pain information leaflets to give to patients at

pre-assessment and on discharge to take home, which provided information on how to manage pain following discharge from hospital. We saw a draft format in progress.

- Staff included details of medications given on discharge in a letter to the patient's GP. This ensured that GPs were kept informed.

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

- The corporate policy for safeguarding adults was up to date and incorporated the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The policy had clear guidance that included the MCA 2005 legislation and set out procedures that staff should follow if a person lacked capacity. The policy included the process for consent, documentation, responsibilities regarding the consent process.
- Data provided by the hospital as of February 2017 showed that 98% of required staff had completed MCA training. This was better than the Nuffield Health target of 85%.
- Staff we spoke with could describe their responsibilities to ensure patients consented when they had capacity to do so or that decisions were taken in a patient's best interests when they lacked capacity. We did not see consent forms with best interests decision completed, as all the patients during our inspection had capacity.
- Patients signed their consent for chemotherapy agreements and we saw these in two patients' records. We saw recorded evidence that staff outlined the expected benefits and risks of treatment so patients could make an informed decision. This was in line with General Medical Council (GMC) guidance.
- The hospital carried out a quarterly audit of consent forms and documentation. Audit results showed 95% compliance between June and August 2016. We saw the hospital took action around non-compliance such as reminding staff at team meetings.

Are medical care services caring?

Good

We rated caring as good.

Compassionate care

- The patient-led assessments of the care environment (PLACE) assessment for privacy, dignity and wellbeing between February and June 2016 was 88%. This was better than the England national average of 83% for the same period. During inspection, we saw staff treating patients in a kind and considerate manner. We saw staff knock and wait before entering patients' rooms on the wards to respect their privacy. Patients told us staff always treated them with dignity and respect.
- We saw staff on Abergavenny Ward and the oncology unit introduced themselves to patients and their relatives.
- We saw staff respond quickly to patients' call bells, which had been activated on Abergavenny Ward.
- Staff asked all patients to complete a patient satisfaction questionnaire that incorporated questions of all aspects of their care and experience. The hospital measured national survey information, for example the NHS Friends and Family Test (FFT) for NHS-funded patients. The hospital used all patient feedback to guide investment plans, treatments offered and the overall patient experience.
- The hospital FFT scores for NHS patients from April to September 2016 were worse than the England national average of 98% in five of the six months, the scores ranged from 95% to 97% except in August 2016 when it was similar at 98%. The FFT response rate at the hospital was worse than the England average of 40% across all six months in that period, ranging from 16% to 32%. The senior management team told us that although improvements were made month on month since the reporting period, they aimed to achieve a level similar to, or better than, the England average. One of the hospital's action plans to help improve the FFT scores was to establish a patient focus group, which was at the time of inspection, was in it's infancy.

Good

Medical care

- We saw patients' comments displayed on notice boards on Abergavenny Ward and the oncology unit which included, "Excellent 5 star treatment", "Good communication from staff, always remember who I am and my needs, very reassuring", "Always listening and addressing concerns promptly" and "Staff are very attentive and caring at a difficult time of treatment."

Understanding and involvement of patients and those close to them

- We saw staff discussed the side effects of treatment with patients in a kind and considerate manner.
- Patients received full explanations and details about the procedures they were to have. We saw leaflets and booklets contained this information. For example, oncology patients were provided with an introductory pack, which contained information such as VTE and pulmonary embolism, physical activity and cancer treatment, therapy and well-being support groups.
- Patients we spoke with told us they were given information about the costs of treatment and the various methods of payment. The hospital website also published costs for treatments provided and different ways to pay. The information stated the costs were a guide only and was clear the consultant gave the final costs for the recommended treatment and tests.
- Oncology patients could ring a dedicated number if they felt unwell at home. They carried a record book with details of what to do if they felt unwell. This was in line with the Manual for Cancer Services: Department of Health, 2004.
- We spoke with two oncology patients who attended the oncology unit. They told us staff were caring and professional. They felt involved in their care and were given adequate information about their diagnosis and treatment. Staff gave patients the time to ask questions and answered questions in a way patients could understand.
- Staff told us relatives were encouraged to participate in the care of patients when this was appropriate. For example, relatives assisting with mouth care and personal care. However, we did not observe this, as the medical patients we spoke with did not have a visitor during inspection.
- Patients undergoing an endoscopic procedure attended a pre-assessment clinic to receive a full explanation of the planned procedure, as well as any necessary medicines.

Emotional support

- The oncology nurses provided specialist oncology support , to patients, their relatives and staff. They were contactable seven days a week.
- Staff we spoke with told us counselling services for staff and patients were provided by an outside agency. The service upheld confidentiality and staff felt they received emotional support in a safe environment. Relatives were signposted to the outside agencies that could support them. A patient told us they had been provided with information on who to contact if they required emotional support. Oncology patients were also provided counselling services by the local hospice if required.
- We saw staff interacted with patients in a supportive manner and provided empathy and reassurance.

Are medical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital provided a small number of medical care services. These mainly consisted of an elective endoscopy service and chemotherapy. However, the hospital was within three miles of a large NHS trust. Therefore, patients with more complex medical care needs had access to additional services in their local area.
- The executive team had regular meetings with local NHS care commissioning groups (CCGs). This enabled the service to regularly review their provision to NHS patients against the needs of the local population.
- Oncology patients accessed treatment through their insurance companies or privately.

- The oncology unit provided an average of 82 episodes of chemotherapy sessions per month, and this capacity met the current demand.
- Patients on the inpatient ward and oncology unit were offered en-suite single rooms with televisions and internet facilities for patients to use. Two oncology patients we spoke with said this provided them privacy and the facilities they needed to pass the time during treatment. The rooms were spacious and were able to accommodate an extra chair for relatives who wanted to stay overnight. However, relatives could stay overnight in a separate single room if this was available. Staff told us that not many relatives wanted to stay overnight, however the hospital had been able to accommodate all requests.
- Oncology patients could control the temperature in their rooms. Patients receiving chemotherapy can be very sensitive to temperature and all rooms had black out curtains for patients receiving treatment sensitive to light.
- Friends and family were able to visit the hospital from 9am to 9pm daily. Outside these hours, visiting was by agreement with nursing staff and patients. There was access to a quiet room where oncology patients and relatives could reflect and enjoy time together.
- The endoscopy unit was open daily Monday to Friday from 8am to 6pm. We were told that occasionally the unit would open beyond 6pm to accommodate for later sessions.
- The oncology unit was open Monday to Friday from 8am to 6pm and could open outside those hours when required. This gave patients a choice in the time or day of the week they had their treatment. Patients had access to advice 24 hours a day, seven days a week.
- The hospital had a pharmacy which provided both inpatient and outpatient services. The pharmacy was open from 9am to 5pm Monday to Friday. Staff could access a pharmacist by telephone 24 hours a day seven days a week. Food and drink facilities were available for patients and visitors at the hospital restaurant. Hot and cold drinks were available at any time on request.
- An external company provided catering at the hospital. The PLACE assessment between February and June 2016 showed the hospital had a score of 81% for food, 87% for organisational food and 74% for ward food. These were worse than the England averages of 91% for food and organisation food, and 92% for ward food. However, patients we spoke with told us they were happy with the food choices provided and were given a choice to order a food item outside the menu. The hospital told us they reviewed the scores in conjunction with patients' feedback regularly and worked to make improvements at every opportunity.

Access and flow

- Staff initially saw the majority of medical patients in outpatients, and planned their admission if required. All patients who were admitted were pre-assessed either face to face or by telephone. Staff conducted an interview via telephone for patients undergoing a minor procedure. Therefore, the hospital was responsive to sharing the patient pathways and ensured that all relevant information was given to the patients.
- Oncology patients received a pre-assessment clinic appointment where a doctor decided on the treatment regime, with a nurse in attendance. This determined how many days a week the patient attended for treatment.
- All oncology patients were non-NHS funded at this hospital. There were no waiting lists for oncology at this hospital. Patients reported that they did not have to wait long for chemotherapy treatment and they could choose a time and date that suited them best.
- Care pathways directed staff to consider all aspects of discharge planning for inpatients. We saw sections such as take home medication, equipment required, follow up appointment dates and key contact details had been completed. This meant patients were safely discharged from hospital.
- Nurses on the wards referred a patient to the community team if a patient required additional assistance when they returned home. For example, medication, palliative care and wound care.
- Staff in the endoscopy unit sent a copy of discharge letters to GPs on the same day as the procedure. They used the NHS secure email system in keeping with the hospital information governance best practice.

Meeting people's individual needs

Good

Medical care

- Oncology patients had access to a range of leaflets explaining their condition and treatment. Most of these were produced by recognised national charities. No leaflets were displayed in other languages. However, staff told us these could be obtained from the charity if required.
- Patients attending the oncology unit had access to a range of complementary therapies such as aromatherapy and reflexology. Therapies were provided by an outside charity and patients we spoke with valued them and felt they gained therapeutic benefit.
- We saw a range of information was available for patients. These included information published by charities regarding the different types of cancer, coping with the diagnosis, treatment and the future.
- The oncology unit was re-awarded the Macmillan Quality Environment Mark (MQEM) in 2017, which is valid for three years. This stipulates units must be welcoming and accessible to all; they are respectful of people's privacy and dignity; they are supportive to user's comfort and well-being and listen to the voice of the user. Patients we spoke with felt the hospital provided these things, and said they valued them.
- The oncology unit had four individual rooms where patients could have treatment as well as private conversations with their relatives and staff. Two oncology patients told us they could relax when they were having treatment. They gave examples of having treatment in an individual room, were able to listen to music, used the hospital Wi-Fi access to use smart devices and watch movies.
- The hospital also ran a support group "Nuffield Cancer Support Group" for oncology patients, their relatives, friends and carers. The group met monthly where everyone was welcome and refreshments were provided. A variety of topics was discussed such as the different types of cancers, treatments and the resources available. This gave patients, relatives and friends the opportunity to gain knowledge and enabled them to share experiences, and gain mutual strength. We saw the group's 2017 programme, which was scheduled through to December and included topics such as healthy eating during and after treatment, looking good and feeling better, complementary therapies, yoga, Easter ideas, Christmas coffee and mince pies. Feedback from the group showed positive feedback such as "Enables me to meet up with other people in a similar situation and chat in an informal social setting," "Excellent," "A sense of belonging," and "Fun and light-hearted."
- Staff told us how they accessed professional translation services for people who needed them. This was arranged at pre-assessment and the same translator followed the patient through the hospital, from admission to discharge. This supported patients to build trust with the translator and ensured effective communication. However, staff advised us translators were rarely needed.
- Staff told us they could access leaflets containing information about endoscopic procedures in other languages if required.
- We asked staff about arrangements to support people living with a learning disability or dementia. Staff identified the needs of these patients at the pre assessment appointment. The hospital used the "blue pillow case" initiative where staff could discreetly identify patients living with dementia and remind them that these patients may need more of their time and patience. The hospital also used the "This is me" tool developed by the Alzheimer's Society. This enabled staff to see the patient as an individual and deliver person-centred care tailored specifically to the person's needs. Staff told us they used dementia friendly crockery, toilet signage, clocks and shower curtains. The hospital also had facilities for carers to stay overnight when required. Staff told us of an example where two patients with Down's syndrome were offered to tour round the inpatient ward and have pre-assigned rooms before admission.
- PLACE assessment between February and June 2016 showed the hospital scored 83% for dementia. This was better than the England average of 80% for the same period. Dementia was included in PLACE assessments for the first time in 2015, and focused on key issues such as, flooring, decoration (for example contrasting colours on walls to help patients with a visual impairment), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia. The hospital had a dementia strategy to ensure they met the needs of people living with dementia.

Good

Medical care

- Staff assessed patients' weight before admission and arranged the availability of appropriate equipment when required. The hospital had equipment that could cater for bariatric patients up to a certain weight. Equipment was suitable for patients with a BMI of less than 40. They had a wider chair, appropriate beds and an adapted wheelchair.

Learning from complaints and concerns

- Staff encouraged patients who had concerns about any aspect of the service to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure.
- The Nuffield Health complaints policy set out the relevant timeframes associated with the complaint response process. An initial acknowledgement was required within two working days and a full response within 20 working days. If a complaint was escalated to a further stage, the complainant was given contact information for the health ombudsman. Private and NHS patients were signposted to ISCAS and the NHS Ombudsman respectively.
- We saw a patient information folder in all the patient bedrooms on Abergavenny Ward and the oncology unit that included a "How to make a comment or formal complaint" booklet. The booklets outlined a clear process including contact details. We saw these were also located throughout the hospital and contained information on how to raise any concerns. Staff gave patients the opportunity to provide feedback through the hospital's patient survey questionnaire.
- There were 16 complaints on the hospital complaints log between June and November 2016. Two of these were related to medical care services and included complaints related to staff behaviour, treatment completed late into the day and security of the hospital at night. The hospital investigated the two complaints and took appropriate actions to deal with the issues. All complaints were responded within the 20-day timeframe set in the corporate complaints policy.
- CQC directly received no complaints about the hospital in the reporting period October 2015 and September 2016. There were no complaints referred to the NHS Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS) in the same reporting period.
- Complaints were discussed at clinical governance meetings, the medical advisory committee and ward meetings. This showed learning was shared across the hospital and disseminated to all appropriate staff.
- All patients we spoke with said they knew how to complain but had not felt the need to as the care and treatment was of a very high standard.
- Staff at all levels were encouraged to address any concerns whilst the patient was on site and resolve any issues as soon as possible.
- The responsibility for all complaints rested with the hospital director who instructed the appropriate member(s) of staff to investigate. The matron, finance manager and sales and services manager were allocated to investigate complaints, depending on what the complaint involved.

Are medical care services well-led?

Good

We rated well-led as good.

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

- The hospital had a vision and clinical strategy that was made up of six key themes. Four key elements made up the hospital's values. These were to put patients, customers and colleagues at the heart of everything the staff did. Staff we spoke with demonstrated clear understanding that the patient was at the heart of what they did and worked together to achieve this.
- Staff from the oncology, endoscopy and inpatient wards had clear ambitions for the services they provided and were aware of the visions of the departments. The vision was to provide the highest standard of care and ensure patient experiences were as comfortable as possible. However, oncology staff we spoke with felt they lacked a strategic lead since the oncology manager's post had been vacant for a few months. This was evident in the delay in introducing and embedding the UK Oncology Nursing Society's triage tool. However, we saw the oncology staff were very passionate, committed and dedicated.

- The endoscopy team were working towards Joint Advisory Group (JAG) accreditation. Information provided by the hospital showed this and this was supported by the hospital action plan for JAG accreditation.

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

- A corporate governance strategy provided a framework for local governance procedures. The medical care service governance processes were the same as those throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- The hospital had a clinical effectiveness and audit group, which met monthly, and a clinical governance committee (CGC), which met quarterly. The committee governed all inpatient governance, risk management and quality measurements for medical care. The group linked with the hospital's Medical Advisory Committee (MAC) who met quarterly.
- There were a variety of monthly meetings that discussed risk, incidents and complaints. These included the senior management team and heads of department meetings. Management disseminated information from these meetings at ward meetings. In turn, information from departmental meetings was escalated up to the heads of department. This ensured there was good communication throughout the hospital and staff were aware of specific incidents and causes for concern. We saw examples of minutes that demonstrated departmental and other meetings fed into the CGC such as ward meetings, information governance meetings and the clinical effectiveness and audit group. Management discussed clinical quality and governance at the quarterly MAC. Attendance at these meetings included the hospital director, matron and the pathology manager.
- Abergavenny Ward had a clinical governance folder that contained recent minutes from the clinical governance committee, complaints log and incident reports. We saw staff had signed to confirm they had read the folder. This provided assurances staff received important information, including learning from incidents and complaints.
- Staff attended monthly ward meetings. We saw minutes that demonstrated a high level of attendance. Staff told us the meetings were useful and the minutes were circulated by email. This meant that staff unable to attend had access to discussions and information.
- The hospital management and the MAC managed consultant contracts, known as practising privileges, jointly. We saw evidence of discussion of new applications and outcomes in the October 2016 MAC minutes. There was also evidence of consultants suspended when they had not provided the required documentation requested by the hospital management. This demonstrated the hospital took action when consultants did not provide evidence of meeting the required standards of practice.
- There was a hospital risk register on the hospital intranet in respect of the whole organisation. The hospital director monitored the register in respect of this location.
- The hospital risk register was divided into categories such as quality and safety, operational, financial and reputation. The risk register detailed the risks, mitigations and actions for ensuring existing risk controls and actions were completed for the identified risks.
- The hospital risk register was for the whole hospital and this had clearly stated a clinical or non-clinical area and a department of the hospital within each risk description. This meant that staff in each department were able to identify which area a risk was related to. Staff we spoke with were able to tell us what was on the risk register.
- The risk register was reviewed monthly at 2016 and 2017 clinical effectiveness and audit groups and clinical governance meetings as a standard item to ensure that identified risks were on the register. If any risks changed, they were re-categorised. We saw evidence of this in the clinical governance meeting minutes from November 2016 to January 2017.

Leadership and culture of service

- There was a clear management structure which staff were aware of. This meant leadership and management responsibilities and accountabilities were explicit and clearly understood.

Good

Medical care

- The management structure for medical care service at the hospital was the hospital director and matron who were responsible for the ward manager and ward sisters. Heads of departments oversaw the running of their respective areas and reported to the matron and the hospital director.
- All staff we spoke with told us that the senior team at the hospital were visible and approachable. All staff knew who the senior team were. All staff told us they had seen change and improvement since the hospital director came into post in September 2016 and were very positive about working at the hospital. One comment we received in respect of the senior team was, “the culture has changed and the hospital feels like a small family”. Another member of staff said they felt “they had opportunities to grow within the hospital”.
- Nursing staff on Abergavenny Ward spoke highly of their line manager and felt able to raise issues with them. The oncology staff felt they were able to openly raise concerns direct with the matron given the vacancy of an oncology manager.
- All staff we spoke with described good team working within all clinical and non-clinical areas in the hospital.
- Ward staff told us that they all worked well together. Staff told us they regularly socialised together. Staff felt supported and felt there was a work-life balance.

Public and staff engagement

- The hospital monitored patient satisfaction in all areas of its service delivery. This was achieved through obtaining patient feedback and views through the forms they placed on the inpatient ward and the oncology unit. An external provider analysed this information. The hospital received a corporate monthly report, which showed response rates, rating within categories and ranking against all Nuffield Health hospitals. It also included all the freehand patient comments. This meant patients had an opportunity to provide feedback to help make improvements.
- The hospital encouraged social interaction for staff through a range of events organised specific to the hospital. For example, the inspiring people scheme, which lead to staff recognition awards.

Innovation, improvement and sustainability

- The chemotherapy staff were constantly seeking extra funding from outside organisations and charities to enable service improvements for oncology patients. For example, all oncology patients were provided with a welcome “goody bag” that contained items such as hand cream, a water bottle and toothpaste. Patients we spoke with told us, “What a lovely surprise” and “Small gestures go a long way."
- All staff were encouraged to be innovative. For example, a chemotherapy nurse initiated and led a support group for oncology patients, relatives, friends and carers called the “Nuffield Cancer Support Group." The group met monthly and welcomed all NHS and private patients.

Good

Surgery

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

Are surgery services safe?

Requires improvement

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 safe as requires improvement.

Incidents

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.
- The Nuffield Health hospital at Tunbridge Wells had reported no never events in the surgical services in the period October 2015 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. However, in October 2016, one never event was reported within the surgical directorate. We reviewed the root cause analysis (RCA) and saw a comprehensive investigation took place and recommendations in practice were made. An action plan was put in place to implement the recommendations into clinical practice. The action plan was being implemented at the time of the inspection.
- Nuffield Health incident reports for October 2015 to September 2016 consisted of 488 clinical incidents, 77% (376 incidents) occurred in surgery or inpatients. Out of 83 non-clinical incidents 11% (nine incidents) occurred in surgery or inpatients. The matron told us trend analysis took place each month and all moderate incidents were reviewed by the Nuffield Health quality care partner (QCP) and a RCA was completed. We saw robust systems were in place to investigate incidents with the learning from each incident discussed at departmental meetings.
- In the period October 2016 to December 2016 a total of 94 incidents were reported across the hospital. The majority were low harm/no harm incidents apart from one never event and one serious incident which were both investigated. The low harm/no harm incidents included extended lengths of stay, last minute bookings and no available nurse to escort patient back to theatre. We reviewed the children's surgical incidents and saw that between June 2016 and November 2016 eight incidents were reported. We saw the incidents were of low harm and no trends were identified. Incidents reported included post operative pain, delay due to patient having breakfast and a patient refusing an anaesthetic.
- Lessons learnt from incidents were regularly communicated through handovers and staff meetings. We reviewed the ward meeting minutes for December 2016 and January 2017 and saw that incidents were discussed with actions to be taken to prevent similar incidents happening in the future.
- Copies of the minutes of the clinical effectiveness meeting, medical devices meeting and the information governance meeting were held in a file on the ward which gave an overview of the incidents across the hospital. All staff had to sign to say they had read the

minutes which we were able to review. All staff we spoke with on the ward and in theatre told us they were encouraged to report incidents using the electronic reporting system. This was confirmed by the Matron who told us that they encouraged an open reporting culture and preferred to over report than under report.

- The Infection control specialist nurse told us that in 2016 ,four contaminated blood cultures were found at the hospital. We reviewed the investigations undertaken by the hospital. The recommendations were clearly documented and a action plan was developed. Further training was organised for all staff undertaking blood cultures.
- We reviewed the minutes from a variety of meetings including the Medical Advisory Committee (MAC), Clinical Audit and Effectiveness meeting , medical devices forum, information governance meeting and saw incident reporting was a regular agenda item where incidents were discussed with learning outcomes. The RMO told us all relevant clinical incidents were discussed with them as they were unable to attend any meetings due to the clinical pressures.
- No morbidity and mortality meetings took place. These meetings are peer reviews of complex patients or where there may have been concerns over the clinical care and lead to improved services. The matron told us all deaths, incidents, and complaints were discussed at the Clinical Governance and MAC Meetings. However we saw no evidence of this as no deaths had been reported in the period October 2015 to September 2016.

Duty of Candour

- Staff we spoke with had a good understanding of the Duty of Candour requirement and were able to explain how it applied to their specific roles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Following the recent never event we saw that the duty of candour process was initiated. We were able to review the actions taken by the consultant , informing both the patient and the hospital director. The patient was verbally spoken to regarding the incident. This was followed up by a written explanation documenting the risks and follow up clinic appointments.

Clinical Quality Dashboard

- There were systems and processes to measure the quality of care delivered at the Nuffield Health Tunbridge Wells. Quality indicators data was being collected and was placed on the notice board outside the ward. This information included evidence of harm free care including the number of falls, Venous Thromboembolism (VTE) compliance and hospital associated infections (HAI). In January 2017, no falls or HAI were reported and VTE compliance was 100% .
- Data for the NHS Safety thermometer was collected monthly when NHS patients were treated at the Nuffield Health Hospital. This included data on patient falls, urinary tract infections, pressure ulcers and Venous Thromboembolism (VTE). All Key Performance Indicators (KPIs) were monitored and discussed at the quality meetings with the Clinical Commissioning Group and Nuffield Health clinical governance meetings.
- We reviewed the Safety thermometer data for September and October 2016. We saw harm free care was delivered .There were no reported falls, pressure ulcers or urinary tract infections during the two months data we reviewed. All data was benchmarked across the Nuffield Health Group of hospitals.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, reviewed at regular intervals. We saw evidence of completed risk assessments in the patient records we reviewed. However VTE screening rates were 95% or above in the reporting period (Oct 15 to Sep 16), except for in Jan 16 to Mar 16 when it was 85%.
- Two incidents of hospital acquired VTE or PE were reported in the reporting period (Oct 15 to Sep 16). However since then, no acquired VTE have been reported due to a new VTE assessment process and follow up training.

Cleanliness, infection control and hygiene

- The matron was the director of infection prevention and control lead for the hospital, supported by an infection prevention control nurse, who had specialist training in infection prevention and control (IPC).There were link nurses for IPC across all departments
- A microbiologist provided services to the Nuffield Hospital. The microbiologist would link with the infection prevention control (IPC) nurse and attend the infection prevention control meeting. The infection prevention control meeting met quarterly and had to adhere to the work plan set out in the Nuffield organisational framework for the management of IPC (version 5). The group discussed incidents, surgical site infections, water safety, any outbreaks of infection, infection control training, and feedback from audits and reports. We saw the minutes of the infection prevention control meeting held in November 2016 and saw the above clinical practices were discussed.
- The IPC specialist nurse told us the duties of the role included assisting the director of infection prevention control, the inputting of audit data, patient-led assessments of the care environment (PLACE) events, organising IPC events, hand hygiene audits, engaged staff and raised awareness. All staff attended training sessions annually, plus completed e-learning enhanced competency training. All clinical staff must complete a formal clinical assessment. We saw records confirming, in February 2017, IPC training was 100% compliant and IPC practical training was 89% compliant across the hospital.
- The IPC audit tools used had been developed from the Infection Prevention Society. The IPC nurse told us they were piloting a new system of electronic records across all the Nuffield hospitals. This would allow benchmarking to take place. Individualised cleaning schedules had been developed for each department and were due to be signed off in the coming weeks.
- We reviewed the minutes of the November 2016 water safety group. This group oversaw legionella and other water safety matters. The legionella samples from September 2016 had no reported issues. Air sampling in theatres took place regularly and was discussed at the IPC committee. House keeping staff had processes in place to run taps in the patient rooms weekly and between cases to prevent any water issues developing.
- The in house maintenance engineer carried out daily checks of the air flow of the theatre ventilation system. We saw records which indicated these checks were occurring.
- The heads of department undertook cleaning audits of their area. The next cleaning audits were due to be returned during February 2017. We reviewed the theatre IPC audit undertaken in September 2016. We saw theatres achieved 97% compliance for cleanliness, 99% for hand hygiene observations, 100% for surgical scrub and 98% for peri operative care.
- During the reporting period (October 15 to September 16), no incidents of methicillin-resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C. Diff) and Escherichia coli (E.coli) were reported. The IPC nurse explained that patients are given chlorohexidine sponges at pre assessment to use prior to admission. These help to focus patients on the importance of good cleansing procedures prior to surgery.
- The operating theatres were found to be visibly clean and tidy, we reviewed the cleaning schedules. We saw instructions for the cleaning and decontamination of equipment and daily cleaning check lists .We reviewed the cleaning checklists in use since January 2017 and saw there were completed correctly. Historical checklists were available from the provider however they were not reviewed during the inspection.
- The segregation and storage of clinical waste was in line with current guidelines set by the Department of Health, Management and disposal of healthcare waste (07-01) 2013. However, bags were not labelled , which was not in line with the guidelines. This was raised with the theatre manager at the time of the inspection who ensured the appropriate labels were put on the bags.
- We observed sharps containers, were properly maintained and were in accordance with the current guidelines.
- There were seven surgical site infections (SSI) in total between Oct 15 and Sep 16. The rate of infections during primary knee arthroplasty, breast, upper gastrointestinal, colorectal and cranial procedures was above the rate of other independent acute hospitals we hold this type of data for. The IPC nurse told us plans were in place to reduce SSI's. This included Aseptic Non-Touch Technique (ANTT),training around enhanced

pre operative and intra operative cleaning. A patient information leaflet was introduced and given to patients on admission to raise awareness and reduce the risk of infection.

- There were no surgical site infections resulting from primary hip arthroplasty, revision hip arthroplasty, revision knee arthroplasty, other orthopaedic and trauma, spinal, gynae, urological or vascular procedures.
- In theatre we observed the opening of sterile trays and the visible and verbal confirmation between the scrub and theatre circulating practitioner against the checklist which followed best practice guidelines of the Association for Perioperative Practice (AfPP), 2016. We saw staff wore the appropriate personal protective equipment (PPE) including face masks to perform the procedure.
- We observed processes in theatre for the checking of swabs and sundries. Both verbal and visual checks took place between the scrub and the theatre circulating practitioners. The information was recorded on the count board by the circulator and checked by the scrub practitioner.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions to minimise the infection risk. When a procedure had commenced, movement in and out of theatres was restricted. However, in theatre two, we observed a scrub practitioner undertaking poor surgical scrub technique. This was raised with the theatre manager during the inspection and further training has been arranged for staff. We observed a surgeon donning gown and gloves using an aseptic technique.
- Staff in theatres were observed to be wearing appropriate theatre clothing. When theatre staff left the department, they applied disposable coats and changed their footwear to prevent contaminating their theatre gowns. We saw staff following good practice guidelines for infection prevention and control, for example bare below the elbows. We observed staff washing their hands between patients to minimise the risk of infection to patients.
- We saw records confirming deep cleans took place twice a year in theatres. These were organised by the house keeping manager. All records were up to date and completed. Disposable curtains were used in the recovery area. These were changed every 12 months or when contaminated. The last curtain change was in October 2016.
- Hand washing sinks were available in the theatre sluice and recovery area. However we saw evidence of a leak below one of the sinks. There was visible mould damage which could give rise to an infection control risk.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; patients' representatives go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness, patients living with dementia or disability and general building maintenance
- The PLACE assessment for cleanliness for the period February to June 2016 was 99%, which was better than the England national average of 98%. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixtures and fittings.
- All areas of the hospital we visited were visibly clean. Some areas of the ward (28 patient rooms) had carpet which could not be as easily cleaned as laminated flooring when spills occurred. Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states; 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, we saw carpets were visibly clean and free from stains, we also saw regular deep cleans of carpets had taken place. We reviewed the carpet planning schedule. This gave assurance the carpets were being cleaned following the timetable.
- All nursing and housekeeping staff were trained and competencies completed, to clean up spillages on the carpets and then deep cleaning using the appropriate equipment and disinfectant. The ward sister told us that following a terminal room clean the room was not used for 48 hours to allow the carpet to dry.
- The ward sister told us that high risk patients were moved to one of the 10 rooms with laminated flooring.

Carpets had been risk assessed and placed on a risk register. As the carpets got old or damaged there was a rolling replacement programme . We were told this was a two year programme.

- On the ward we observed equipment cleaning assurance labels , which indicated that re-useable patient equipment was clean and ready for use. Commodes we inspected were clean, labelled and ready for use. All cleaning products were stored appropriately, in line with the Control of Substances Hazardous to Health guidelines 2003.
- Housekeeping staff had received appropriate training and were supplied with nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination.
- The housekeeping staff were able to demonstrate their daily cleaning log with the duties they perform. This included cleaning the patient rooms and re-placing towels. A full clean was performed after a patient was discharged.
- Personal protective equipment (PPE) such as disposable aprons and gloves were easily accessible for staff. We saw gloves and aprons were available in all the patient rooms. We observed staff wearing them when delivering personal care and we saw the housekeeping staff were wearing the appropriate PPE when undertaking full cleans in the bedrooms. However, in theatre we observed two members of staff not wearing the appropriate PPE to clean the C-arm x-ray machine, lead coats and to remove dirty linen.
- We observed alcohol hand gels were available in the patient rooms. However, we saw no posters around the gel to highlight to staff, patients, and the public to use the gel when entering and exiting an area.
- At pre assessment patients were given antiseptic body washes for patients to use prior to admission.
- On the ward one patient room was allocated for infection control patients. The room had a hand washing area on entry with a separate door to the patient to prevent the spread of infection.

Equipment and environment

- The operating suite comprised of three operating theatres, theatre one was a High Definition (HD) Digital Integrated theatre, with theatre two and three being laminar flow theatres (a system that circulates filtered air to reduce the risk of airborne contamination). The theatre manager told us laminar flow checks were performed yearly in theatres two and three. We saw the records to confirm this. Test results were discussed at the IPC committee.
- All theatres had the capability for emergency surgery, however theatre one was the theatre of choice due to the proximity of the emergency equipment. Theatre two was the main location for children's and young person's surgery due to the proximity to additional acute support resources including emergency equipment.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements. There were systems and process in place to provide traceability of all surgical equipment used. We saw evidence of this within the patient care record.
- Registers of implants, for example hips and knees, were kept by theatres; these ensured details could be quickly provided to the health care product regulator if required.
- There was one recovery area with three beds which could be extended to four when necessary. There was a dedicated paediatric recovery bed in an appropriate child friendly environment. Recovery staff would wear child friendly scrubs for paediatric lists.
- In theatre we saw a centralised area was in place for the storage of sutures and prostheses. This was tidy and organised. On the ward we saw there was adequate storage for medical and non-medical equipment. No equipment was left in corridors causing a trip hazard or infection control issue. However, we saw a defect on the floor of the dirty corridor behind theatre two. This was identified with hazard tape and posed an infection control risk. We raised this with the theatre manager at the time of the inspection.
- In theatres a Control of Substances Hazardous to Health (COSHH) metal cupboard was in use. The cupboard had a warning sign indicating it contained hazardous substances/highly inflammable liquid on the door as a warning to all. The cupboard was appropriately locked.

- In theatres we saw fire extinguishers and blankets attached to the walls outside theatre two. Fire equipment had recently been serviced (November 2016). Fire risk assessments were undertaken by an independent company. Across the hospital two members of staff had been identified as fire wardens.
- We spoke to the maintenance engineer who was able to show us equipment checks were undertaken to the theatre ventilation system including air flow checks. We saw records which showed the checks were undertaken daily. We were told that temperature control issues in theatre were being addressed at the time of the inspection.
- In theatre we were told by the deputy theatre manager that all equipment was now on a data base with all equipment and service dates in place. This had been put together in the last 12 months. Records of service contracts were also available electronically. We reviewed the records and saw they completed correctly.
- Policies and procedures were in place and equipment was available to prevent and treat hypothermia in patients undergoing surgery. This complies with NICE guidance CG65 for hypothermia: prevention and management in adults having surgery.
- In the anaesthetic room we saw the anaesthetic machine had daily checks completed and the Association of the Anaesthetists of Great Britain and Ireland (AAGBI) checks for anaesthetic equipment (2012) were attached to the machine. This was in line with the guidance for daily pre use checks from the AAGBI which provides assurance that anaesthetic machines work safely. We saw the log book and records were complete from August 2016.
- Equipment in the anaesthetic room was seen to be visibly clean and all had a record of being serviced and electrically tested. The theatre manager explained suppliers looked after all new equipment.
- On the wards and in theatre equipment faults were logged with the in house engineer. Areas covered by the engineer included water, heating, generators and all plant work. An outside contractor would organise the repair of medical equipment and any estate issues such as broken windows. We were told by the matron that the outside company were responsive and would come immediately if it involved patient equipment or area, however repairs took longer if it involved a non patient area. A previous backlog of repairs had been reduced.
- We checked the ward sluice and found the room to be clean with all equipment stored in cupboards appropriately. A weekly cleaning schedule was in place and all records were up to date and signed.
- All the bathrooms and bedrooms on the ward had call bells. We saw these were regularly checked. Resuscitation trolleys were available in the wards and the theatre area. On the ward resuscitation trolley, we found no tag had been in place to seal the trolley for five days and no checks had taken place during the last five days which meant it was unclear whether all the emergency equipment was available. During the inspection a tag was obtained and the seal was attached. On opening the trolley in the recovery area, all equipment was seen to be correctly listed on the checklist and checks were undertaken daily. The paediatric resuscitation trolley was tagged and checked daily.
- In theatres the resuscitation trolley was checked daily. Records were only available from February 2017. We saw daily user tests of the lifepak (defibrillator) were attached to the list and completed daily with a service date for August 2017. Resuscitation Council guidelines were attached to the trolley.
- There was appropriate paediatric resuscitation equipment available in case of an emergency. The resuscitation trolley was well-organised and had a tamper evident seal in place. We saw records indicating the trolleys and their contents were checked daily and monthly from the beginning of February 2017. Old records were reviewed and completed on the majority of days. We saw the paediatric anaphylactic kit was in date.
- A dedicated difficult airways trolley was seen in theatre. The AAGBI guidelines “checking anaesthetic equipment” (2012) states “equipment for the management of the anticipated and or unexpected difficult airway must be available and checked regularly.” We saw the difficult airway society guidelines were attached to the trolley for

easy access and laminated pictures detailing the contents of each drawer were available. We saw the contents of the trolley were checked monthly. Records were up to date.

- In theatre, we saw medical gases cylinders were stored as per national guidance. We checked two cylinders of oxygen and found they were not due to expire until 2019.
- There was a system to review any alerts sent out by the Medicines and Healthcare products Regulatory Agency (MHRA) and ensured that the heads of departments were informed of any national safety alert. We reviewed the theatre meeting minutes and saw that safety alerts were raised and staff were asked to read the alerts and put any safety checks in place.

Medicines

- Access to pharmacy out of hours was only permissible to the Resident Medical Officer (RMO) and senior nurse on duty, who both held keys and should attend together for security reasons.
- All stock on the ward was safely stored in line with legal requirements, including controlled drugs in a designated double locked cabinet.
- Prior to admission the pharmacist would review the admissions information around the patient's medication and contact the General Practitioner (GP) if further information was required. On admission the patient's medication would be counted, expiry dates checked and a review carried out. The RMO wrote up the patient's medication administration chart to support their stay in hospital. Patient's own medication was kept in a drawer in the drugs trolley as there were no secure cupboards in the patients' room.
- The pharmacist attended the ward daily and reviewed the patient prescription charts. Prescription charts were also reviewed during the monthly medicines audit which included checking that patient allergies were noted, reconciliation medications were reviewed and whether charts were signed and dated. We saw the January 2017 audit was 100% compliant. Information from the audit was sent to the Nuffield Group.
- The pharmacist proactively identified patients due for discharge and ensured all take home medications(TTO's) were available. The pharmacists had developed a leaflet for staff to use when giving patients their TTO's on discharge, to ensure staff were able to give patients the correct information regarding their medications.
- We reviewed nine medication administration charts and saw they were fully completed, including details of any missed doses and the reason for this. Allergies were clearly documented on each chart and all charts were signed and dated.
- The pharmacist told us they checked all post operative drugs were correctly prescribed and annotated any relevant information regarding the drugs, for example if an oramorph (opioid pain medication) was prescribed , take care with tramadol (another opioid pain medication). Any medication omissions would be highlighted to the RMO.
- The pharmacist attended the monthly ward meetings to help in the updating of medication information. Patient information leaflets were being reviewed to look at additional information that could be provided at pre assessment.
- The medicine management meetings took place monthly, where audit results would be discussed. We reviewed the data for the April and November 2016 controlled drugs quarterly audits and found the audits found no areas of concern.
- The medicine room on the ward was entered through a door with a controlled key pad. Controlled drugs (CDs) are medicines liable for misuse that require special management. We saw CDs were stored in accordance with guidance. A CD register was in place, we saw CDs were tracked and signed out by two members of staff at all times. The records seen showed us staff were checking the stock levels in line with the hospital policy.
- In theatres we observed two registered nurses (RN) checking the controlled drugs. All CD's were correct as per the CD register. We saw all checks were completed twice daily by two practitioners since October 2016. We did observe that the recovery area CDs were checked only once daily highlighting two different processes in theatre.
- We observed in theatre the appropriate checking of medication prior to it being administered to the patient.

Before the administration of adrenaline, the scrub nurse checked the preparation, strength and expiry date both verbally and visually with the circulating practitioner. This followed best practice guidance.

- In theatres, medication was available to treat malignant hyperthermia. The malignant hyperthermia kit was in a clearly identified cupboard along with the AAGBI emergency guidelines . All drugs were clearly identified with location and expiry dates.
- In the ward medicine room, IV antibiotics and 'to take out' medicines (TTO's - medicines given to patient on discharge from hospital) were all safely stored in locked cupboards. However, in theatres we saw that intravenous (IV) fluids were not stored in an area with key pad access as required by national guidance.
- All medications given on discharge were communicated to the General Practitioner on the discharge letter. A copy of the TTO's and discharge letter formed part of the patient's discharge pack.
- Blue sharps boxes were available in the medicine room for the disposal of medicines along with the register the staff completed when disposing of medications.
- Fridge temperatures were recorded daily, on the ward and theatre in line with best practice. The temperature of the fridge in the recovery area was seen to be checked daily and the staff members knew what to do if the temperature fell outside of the expected range. On the ward there was a fridge cleaning schedule. The fridge was cleaned weekly, all records were up to date.
- Antibiotic usage was being monitored across the hospital. An antibiotic policy was in place.

Records

- Staff followed their corporate 'Health records standards policy (including guidance for all business documentation and healthcare records)', which included the creation, storage, tracking and the destruction of health records and the management of electronic records.
- The hospital used a paper based record system to record all aspects of patients care. We found the records to be comprehensive, however there were loose documents which was a risk, as loose papers could easily be lost. Patient records contained information of the patient's journey through the service including pre assessment, investigations, test results, treatment and care provided. All ward medical records were kept in the patient's room.
- On admission, patients were placed on a short stay or long stay care pathway. The Registered Nurses (RN) would complete a range of risk assessments. These included the Malnutrition Universal Scoring Tool (MUST), venous thromboembolism (VTE), falls, pain and skin risk assessments. In the nine records we reviewed we saw the risk assessments were completed for each patient on admission.
- We reviewed nine sets of medical records on the ward. We found all patients had consent forms which were signed by the consultants and patients. We were told that anaesthetists completed a safety checklist with the patients but not a consent form. We saw evidence in all the records of daily ward rounds including reviews by senior clinicians, diagnosis and management plans and all patients were seen on a ward round within 12 hours of admission.
- In theatres we observed traceability labels were placed in the appropriate sections of the patients care records. These included sterility checks from instrument trays and disposable bi polar diathermy labels. This ensured the clear identification and traceability should any issues develop in the future.
- We observed in theatres the confirmation and recording on the count board of the time of application of the tourniquet and time of the removal.
- We saw the theatre register was completed and contained a clear record of patient details, procedure, consultant and key theatre staff. Records were available since November 2016. However, we found two dates in December when the register was not completed.
- We saw in the four medical records we reviewed the WHO surgical check list was completed, anaesthetic charts were completed, theatre clinical notes were written up and stickers were in the medical records allowing the traceability of implants.
- The theatre prosthesis book, contained information regarding the orthopaedic implants. Information

included the label, record of procedure, team and all appropriate sterile implant labels. This allowed the traceability of implants if required in the future, along with an audit trail of the procedure.

Safeguarding

- Nuffield Hospital had systems in place to safeguard children and adult patients who may be identified as at risk of abuse. No safeguarding concerns were reported to CQC in the period October 2015 to September 2016.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children and could locate and describe the hospital's safeguarding policy. Data indicated 100% of staff in theatres had completed adult and children's safeguarding level one training and 92% of required staff in theatre had completed level two children and young adults training. On the ward 100% of staff had completed level one adults and children's safeguarding training.
- One of the theatre practitioners was able to explain a potential safeguarding issue related to a child. The staff member was able to describe the process followed and involvement with the safeguarding children lead. The actions taken were documented in the patient records.
- The matron was the hospital lead for adult safeguarding and there were link people in each of the main departments; on the ward and in theatre. The matron and nurse consultant for children's services for Nuffield Health Hospitals were the children and young adults safeguarding leads. The matron was trained to level three and had completed all the necessary safeguarding training . Concerns from all staff would be escalated to the matron and the appropriate safe guarding organisation.

Mandatory training

- The hospital had a mandatory training policy which specified the type of training each staff group was expected to undertake on an annual basis. Reminders for training were sent out to all staff.
- Mandatory training included fire, basic and intermediate life support, moving and handling, infection control, and consent to examination and treatment. We reviewed the ward and theatre staff training records and saw the ward had 100% compliance for incident reporting, consent to treatment, fire safety and health records. We found poor compliance levels in adult and paediatric immediate life support (62% and 74%) and manual handling 74%.These compliance levels were below the hospital target of 85% for mandatory training.
- Staff completed their mandatory training though the online system and attending face-to-face training. Staff told us time was made available during the working week to complete the mandatory training.
- All nursing staff had to complete life support training. Registered nurses completed immediate life support (ILS) training. Across the hospital in December 2016, ILS training sat at 77% compliance with clinical support staff completing basic life support (BLS) training (89% compliance). Paediatric basic life support was 62% compliance. Compliance rates need to be improved to protect patients from harm.
- The RMO completed mandatory training prior to attending sites through the agency who employed them. The training included MEWS, medicines management, protecting children and young people, ionising radiation regulations, intra venous fluids for adults and paediatrics, the 10 principles of ANTT, duty of candour, General Medical Council guidance, incident reports, sepsis and assessing and responding to patient risk.

Assessing and responding to risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Risks were managed positively.
- The majority of patients attended a nurse-led pre-operative assessment prior to their surgery. However, the pre assessment nurse told us some patients would have telephone consultations. This included patients less than 60 years of age, patients with no long term medical conditions and colonoscopy patients less than 60 years of age. If any issues were raised during the telephone consultation, this would lead to a full assessment. Any patients who were identified as not medically fit would be referred back to their General Practitioner(GP).
- We observed a pre-operative assessment clinic and found the clinic was organised by experienced

registered nurses (RN) who conducted thorough pre operative assessments. Due to their experience, we were given a variety of examples where undiagnosed medical conditions were highlighted which required further investigations prior to being admitted for their booked procedure.

- The pre assessment RN recorded the patient's observations, reviewed their medical and drug history, completed an infection control screening tool, discussed the procedure they were being admitted for and the discharge arrangements. They also completed a risk assessment including VTE, falls and pressure ulcers. The lead RN told us a holistic needs assessment was completed as everything about the patient's well being was important.
- On a daily basis the pre assessment RN's would check the patient's results to ensure they were fit for surgery. Any medical tests undertaken elsewhere would be requested to ensure all the appropriate information was available on admission.
- Any concerns identified during pre-assessment were highlighted to the anaesthetist and consultant to ensure the hospital provided a safe place of care. The pre assessment RN would place a notice in theatre for the anaesthetist to review any patient's notes where issues arose during the pre assessment clinic appointment prior to admission. If any memory issues were identified at pre assessment a mini mental state examination was performed .
- The World Health Organisation (WHO) 'five steps to safer surgery' procedure is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. The WHO safety checklist had been under review following the never event in October 2016. A new corporate checklist was being launched by the Nuffield health Chief Nurse in February 2017. The new checklist clearly set out the necessary actions required by the theatre staff before, during and after surgery. All surgeons had been written to regarding the introduction of the checklist. Adapted checklists would be introduced for cataracts and pain lists. The deputy theatre manager had been identified as the WHO champion.
- We observed one theatre team following the WHO safety checks. The initial safety checks took place between the patient ,ward nurse, anaesthetic practitioner and the anaesthetist. Checks included consent , surgical site marked , fasting and allergies as per the checklist. On the patient entering the theatre we observed all elements of the checklist ticked as being completed.
- In the afternoon we observed safety checks being undertaken on the patient in the anaesthetic room. These included the checking of the patient's wrist band and consent form by the surgeon and scrub nurse and 'stop before you block ' process with the surgeon verbally confirming the site of the block prior to the administration of drugs. We also observed the counting of instruments by the scrub nurse against the checklist. Verbal and visual checks were made. This demonstrated staff were following procedures set out in the WHO surgical check list.
- We observed a safety huddle which started with the introduction of team members by name with the surgeon reviewing the patients on the operating list including the procedure and equipment requirements. The anaesthetist discussed the anaesthetic requirements including the type of block and drugs. The safety huddle was fully interactive and allowed any staff to raise any issues. However it was noted the radiographer was not at the briefing. At the end of the operating list we observed the 'time out' which was led by the theatre circulating practitioner. We observed this was not verbalised as per the checklist. We also observed on two occasions in theatre one the 'time out' process. We saw the nurse failed to engage members of the medical team during these processes. Further work is therefore required to embed this process into clinical practice to ensure patients are cared for in a safe environment.
- Theatre, the wards, and catering staff were informed of any special needs patient's may have following the pre assessment visit. This included personalised information including allergies, chronic medical conditions and infection control status. This ensured all staff were adequately informed prior to the patients admission.
- The practising privileges agreement required the designated consultant to be contactable at all times when they had inpatients in the hospital. Consultants

and anaesthetists were required to be available within a thirty minute radius of the hospital for the duration of their patient's stay or to ensure suitable cover was provided by a colleague within the same speciality.

- The anaesthetists in charge of the list were responsible for patient's airway management in the post- surgery period and were available if there were any requirements to return to surgery. Anaesthetists were also required to be available for the duration of their patient's stay. The anaesthetist needed to be available to attend within an appropriate timescale according to the level of risk of a medical or surgical emergency.
- The hospital did not have the facilities to manage patients who required level three critical care support. We were told if a patient's condition deteriorated, they would be transferred as an emergency to the local NHS hospital. This meant the hospital carefully screened patients during the pre-admission consultation to exclude operating on patients assessed as a surgical risk.
- We saw the hospital policy for the management of changes to the operating list were followed. The decision to change the list order was discussed and agreed as a team. The theatre list was re printed.
- In theatre, staff told us what would happen if an emergency were to happen. There was an internal alarm bell system to summon help in the case of patient collapse and cardiac arrest. Any patients requiring further interventions would be transferred to the neighbouring NHS Trust.
- The ward was using the Modified Early Warning Score (MEWS) scoring system to identify and escalate care of any deteriorating patients. When a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to the RMO. The RMO was available on site 24 hours a day and reviewed any deteriorating patients immediately. If the RMO was concerned about a patient's condition, they contacted the consultant to make them aware of the situation. In one set of records we reviewed we saw no documentation to support the escalation procedure however we did see that the patient was appropriately cared for and safe care was delivered.
- VTE assessments were undertaken on admission. Data provided by the hospital in December 2016 showed 100% VTE screening rates. However previous rates were lower due to 24 hour reviews did not always taking place. To address this, a reminder had been placed on the nursing handover sheet. A monthly VTE audit monitored compliance.
- On the ward we saw the use of flowtron boots post operatively for the prevention of VTE's. Flowtron boots are boots which use intermittent pneumatic compression (IPC) to maintain circulation in limbs that are not mobile.
- The theatre manager told us any risks were discussed at the Heads of department meeting monthly and the clinical governance meeting. Any new procedures the consultants wanted to introduce into theatre must be agreed with the Medical Advisory Committee. (MAC)
- We saw appropriate evidence that pregnancy testing took place for all patients of childbearing years undergoing a procedure which needed sedation or general anaesthetic.
- The RMO told us an evening handover took place each evening at 7.30 pm on the ward. All patients were discussed with the most up to date clinical information placed on the patient's summary. The RMO conducted the last patient review of the day at 10pm.

Nursing staffing

- The Nuffield Health Tunbridge Wells Hospital followed both the guidelines set by NICE and by the RCN- safe staffing in adults, children and young persons services/ inpatient wards in acute hospitals, in order to provide effective and safe staffing levels. To address staffing recruitment issues the Nuffield Health Tunbridge Wells Hospital were pro active in the forward planning of staff. This included a preceptorship programme (two cohorts straight from university), return to practice (two staff in theatre) and a apprenticeship nursing scheme.
- The matron told us that two senior nursing roles were vacant and included the ward manager and lead chemotherapy nurse. Interviews were organised for the ward manager however the appointment of a chemotherapy lead was proving difficult to appoint to so other options were being discussed. A visiting Nuffield Health Tunbridge Wells Hospital matron assisted two days per week on the ward and chemotherapy unit to support the staff.

- The ward had an establishment of 16.8 whole time equivalent (WTE) registered nurses (RN's) and 3.0 WTE Health Care Assistants (HCA's). Since the large majority of patients were elective admissions, staffing levels were planned in advance.
- The ward sister completed duty rotas in advance. Staff worked flexible hours to cover the rota and all shifts. Staffing levels were re-assessed and adjusted as a result of any occupancy changes or altered length of stay to maintain patient safety
- Association for Peri-operative Practice (AfPP) guidelines were used to ensure that staffing levels and skill mix was appropriate within the operating theatre. We observed the staffing levels for theatres, on the staff board. All theatre lists were staffed as per AfPP recommendations for safe staffing, 2014.
- In theatre, the establishment was 5.5 WTE operating department practitioners (ODP) and HCA's with 12.9 WTE registered nurses (RN's). The theatre manager told us bank or agency staff would fill any gaps in the rota. The hospital was in the process of recruiting theatre staff which meant theatres were reliant on agency staff until the recruitment programme was completed.
- The theatre recovery area had one WTE and two part time RN's. Two long term bank nurses also supported the area.
- The vacancy rate for theatre nurses was similar to the average of other independent acute hospitals that we hold this type of data for. One WTE post was vacant giving a vacancy rate of 7%.There were no vacancies for theatre ODPs or health care assistants as at 1 Oct 16.
- We reviewed the data over the reporting period (October 2015-September 2016). The use of bank and agency nurses in theatre departments was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period, except for in Oct 15, Aug 16 and Sep 16.
- The use of bank and agency ODPs and health care assistants in theatres was higher than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in Oct 15, Aug 16 and Sep 16.
- The hospital had a lead registered sick children's nurse (RSCN) and two RSCN's who worked Monday to Friday. The RSCN's worked long days and informed out patients in advance of the days that can not be covered. One RSCN was allocated per three patients. Any gaps in the rota were filled by bank staff and agency as a last resort.
- The use of bank and agency nurses in inpatient departments was higher than the average of other independent acute hospitals we hold this type of data for in the reporting period (Oct 15 to Sep 16), except for in Aug 16 and Sep 16.
- The use of bank and agency health care assistants in inpatient departments was variable in the same reporting period. Rates were higher than the average of other independent acute hospitals we hold this type of data for in Nov 15 and Jan 16 to May 16.
- The pre assessment clinics had one WTE lead RN supported by three part time RN's and one part time health care assistant (HCA).The pre assessment clinics operated five days a week with the staff covering four clinical rooms.
- The hospital had a five day booking rule which meant that no patients could be booked in with less than five days before the admissions date unless strict criteria were met and it was agreed and signed off. However, staff told us the five day booking rule was not always adhered to and extra patients could be added to the ward or theatre lists up until the last moment which meant staff felt pressured however care was not compromised. Patients were often booked for surgery on a Monday following a Saturday consultation, this meant patients did not have pre assessment appointments which introduced a level of risk to the patients care.
- All rotas were reviewed by the senior members of staff and any concerns would be escalated to the senior management team.
- All agency staff completed an induction programme and if possible the same agency staff were re-employed.
- Administrative assistants were employed in the operating theatre and on the ward to support nursing staff and enable them to concentrate on patient care.

Medical staffing

- Patient care was consultant led and the hospital practising privilege agreement required the consultant

review inpatients admitted under their care at least daily or more frequently according to clinical needs. Consultants were required to be available within a thirty minute radius of the hospital for the duration of their patient's stay or to ensure suitable cover was provided by a colleague within the same specialty should they be further away. Consultants had direct access to the Ward through a dedicated mobile telephone. Up to date contact numbers for consultants were available to nursing staff in the ward and operating theatres.

- If a patient was required to return to theatre out of hours because of complications, an on-call system was in place to notify staff quickly.
- Nuffield Health Tunbridge Wells Hospital had two Registered Medical Officers (RMO's). There was a RMO on site 24 hours a day. The Resident Medical Officers (RMO) alternate a week on/week off rota. Should the RMO need to be absent for any reason, the provider agency was able to provide cover within a short timeframe.
- Due to the nature of the workload, it was unusual to need to call upon the RMO out of hours. The ward team ensured all routine jobs had been identified and actioned prior to the RMOs last round of the day at 10pm. In this way the RMO was only called due to an emergency or unexpected situation that cannot be postponed.
- The RMO's were contracted through an outside agency. The agency provided training and undertakes assessments on the RMO's.
- The RMO took clinical responsibility for the patients 24 hours a day. The RMO's were supported by individual consultants who were contactable 24 hours a day by telephone. The RMO's told us consultants were approachable and provided appropriate support.

Emergency awareness and training

- All staff received fire safety training as part of their mandatory training programme; staff told us they had the opportunity to rehearse scenarios and we saw evacuation equipment was available on the ward and in theatre. A recent fire scenario took place in theatres which included attendance by the medical staff. Fire alarms were tested weekly. Fire safety training was 100% compliance across the hospital.
- The Nuffield Health Tunbridge Wells Hospital was part of the West Kent emergency planning group for independent hospitals that meet quarterly. The group were developing an agreement to help other providers in the case of an emergency developing. This included the transfer of patients to surrounding independent hospitals.
- A hospital business continuity policy and plan was in place covering various scenarios that may affect the day-to-day running of the ward and theatres such as severe weather conditions, utilities failure, IT infrastructure failure, armed robbery and a hostage situation. We saw procedures in and out of hours were in place along with the contact details of all relevant persons and emergency response numbers. The senior management team were 100% compliant in incident management training.
- The matron told us that each head of department was developing their own business continuity plan which were due to be completed by the end of April 2017. All departments had completed their plans except for theatre who were still developing their plan.

Are surgery services effective?

Good

We rated effective as Good.

Evidence-based care and treatment

- Policies and procedures used within the surgical department and the hospital, followed evidence based practice. Matron told us that the Nuffield Group developed corporate policies and if required, local standard operating procedures were developed to fill in any local gaps in policy. We reviewed four policies and saw they were up to date and referenced to current best practice from a combination of national and professional guidance. Reviewing the clinical governance meetings minutes we saw new legislation, National Institute of Health and Care Excellence (NICE) and Royal College guidelines were regular agenda items. NICE guidance updates were received from head office each month.

Good

Surgery

- A comprehensive care record was in place for all patients who were either day case surgeries or overnight with a length of stay of 24 hours or longer. This included the nutritional assessment tool (MUST), pressure sore assessment and falls risk assessment. Pathways also included anaesthetic room care, surgical safety checklist, theatre notes including traceability recordings, theatre notes and post-operative care
- Theatre provision followed guidance from the Royal College of Anaesthesia for the provision of anaesthetic services which included an appropriately trained and experienced anaesthetist must be present throughout all general and regional anaesthetics.
- Care and treatment was delivered to patients in line with the National Institute of Health and Care Excellence (NICE) and Royal Colleges guidelines, for example the Royal College of Surgeons. For example staff assessed patients for the risk venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines [CG92]. The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines[CG74].
- All staff knew how to access policies online, although printed copies were available as new members of staff could not access policies on line. One new member of staff we spoke to had been in post four weeks but was still waiting for access to the system. Challenges existed with printed copies, as version control could be difficult. A register was kept to record which members of staff had read which document. All staff were encouraged to read policies relevant to their scope of practice.
- The Nuffield Health Tunbridge Wells Hospital had a comprehensive audit programme in place which supported the care provided against its own policies, work instructions, and standard operating procedures. This audit programme reflected local and national audit requirements for example Patient Recorded Outcome Measures (PROMS) and the National Joint Registry (NJR). Results were used to influence change. Local audit outcomes were reported to the clinical governance committee and submitted to the head office to benchmark the service across the Nuffield health group.
- The inpatient department and theatres completed quality assurance audits on a quarterly basis. These included venous thromboembolism assessment, falls, World Health Organisation safety checklist, healthcare records, infection prevention and control, catheter management and discharge. However, medication audits were behind schedule due to staffing issues. The senior management team had appointed a short-term contract pharmacist to support the service.
- Best practice guidance advises the use of enhanced recovery programmes (ERP) for certain types of surgery. Staff in theatres and inpatients used enhanced care and recovery pathways that were in line with national guidance. These included for example, integrated care pathways specific for hip or knee replacements and a day case pathway under general anaesthetic Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. These were completed in the records we reviewed.
- There was a sepsis screening and management policy in place, which was up to date and reflected national guidance on quality standards for sepsis. To raise awareness, a sepsis point was placed in the staff rest room.
- The hospital recorded all implants on the theatre implant register. Orthopaedic implants were also recorded on the relevant National Joint Registry (NJR) record. The NJR collects information on all hip, knee, ankle, elbow, and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery. The Nuffield Health Tunbridge Wells Hospital submitted data to the NJR.
- The service followed guidance regarding the recording and management of breast implants.
- Venous Thromboembolism (VTE) assessments and prophylaxis were embedded in pre and post operative care planning. This was routinely audited to measure quality and risk. The audit data and the medical records we viewed demonstrated compliance during the inspection.

- Blood supplies were available in theatres. We saw protocols for the blood fridge and major haemorrhage. Both protocols were in date and were based on national and professional guidance.

Pain relief

- The matron told us a pain group had been set up to improve the pain management protocol. This consisted of a consortium of anaesthetists who would develop and ratify the new pain management protocol with the aim being all patients have the right pain control at the right time. A new protocol was expected to be issued in the following months.
- The pharmacist told us training had been given to nursing staff on the pain ladder. Staff training was an on-going process and was being ratified by the lead anaesthetist. The pharmacist pro-actively supported pain management at ward level providing advice and support to the patients and the clinical teams. Two patients told us that their pain was managed very well and staff regularly reviewed their pain score.
- A medical questionnaire completed by patients was reviewed at the pre-assessment clinic where individual concerns regarding pain were reviewed and documented. Any concerns identified would be placed on the pre assessment information sheet, which was reviewed by the anaesthetist. We saw evidence that patients had their pain needs assessed at their pre-operative assessments.
- During the admissions process the control of pain post operatively was explained to patients. We saw patients had regular analgesia prescribed on their Medical Administration Record (MAR), as well as "as required" (PRN) medication for breakthrough pain by the anaesthetist. The RMO on the ward would review the painkillers if the patients' pain was not controlled. However, a RN told us that the MEWS was not consistently used to manage pain.
- Anaesthetic staff managed the pain relief of patients who had immediately returned from theatre. Consultant staff also reviewed this if required following return to the ward. There was no pain management team at this hospital.
- The service provided a range of analgesia options to patients including oral, intravenous and Patient Controlled Analgesia (PCA). Guidance on the use of PCA was available for staff. If a patient required a PCA pump these were attached in recovery. Patients undergoing joint surgery were offered spinal anaesthetics. Pain control and anti-coagulants would be written up before the patient leaves theatre.
- The patient satisfaction questionnaires routinely asked patients how well their pain/discomfort was controlled. We saw on the January 2017, questionnaire that pain management achieved 82% compliance, which was below the Nuffield Hospital average of 93%. We reviewed two pain audits which took place in April and November 2016. We saw several areas where practice required improving. These were placed on an action plan for implementation.

Nutrition and hydration

- Nursing staff assessed nutrition on admission using the Malnutrition Universal Screening Tool (MUST) and we saw the MUST was completed in the nine records we reviewed.
- Any patients identified as being at risk of getting dehydrated would have all fluid intake and output recorded on a fluid balance chart. A 24 hour balance would be reviewed and appropriate action taken to address any concerns.
- Any dietary requests would be discussed at the pre assessment clinic and the catering manager would be informed to ensure dietary requests were in place for the patient on admission.
- Patients were given a 'pre-operative fasting instructions and advice' information sheet at pre assessment. This gave written instructions to the patient regarding their admissions date, fasting instructions, instructions regarding medications and the use of any skin preparations. Information regarding fasting followed national guidance.
- Pre-assessment and ward nurses advised patients of fasting times before surgery. In the care pathway we saw it was six hours fasting prior to surgery for fluids and 12 hours fasting for solids. This was in line with the Royal College of Anaesthetists (RCOA) guidelines.
- Water jugs were available to all patients in their rooms. We saw and patients told us these were changed regularly.

Good

Surgery

Patient outcomes

- Between October 2015 and September 2016, there were nine cases of unplanned transfer of an inpatient to another hospital in the reporting period. The assessed rate of unplanned transfers (per 100 inpatient attendances) was not high when compared to a group of independent acute hospitals, which submitted performance data to CQC. There were no trends, with regards to types of surgery, or concerns with individual surgeons, identified.
- When a patient was transferred to a neighbouring NHS Trust, the RMO would regularly phone the trust for updates of the patient's condition. On discharge, patients received follow up care at the Nuffield hospital.
- There had been 13 cases of unplanned readmission within 28 days of discharge in the reporting period (Oct15 to Sept16). The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) was not high when compared to a group of independent acute hospitals which submitted performance data to CQC. We reviewed the data provided by the hospital and no trends were identified. There were nine cases of unplanned return to the operating theatre in the reporting period (Jul 15 to Jun 16).
- VTE screening rates were 95% or above in the reporting period (Oct 15 to Sep 16), except for in Jan 16 to Mar 16 when it was 85%. Data showed that two incidents of hospital acquired VTE or PE in the reporting period (Oct 15 to Sep 16).The matron told us investigations were carried out regarding the two incidents. It was found hospital policy was not followed. This had been addressed and no further incidents had occurred.
- The hospital submitted data to Patient Reported Outcome Measures (PROMS).The adjusted average health gain for PROMs - Primary Hip Replacement (Apr 15 to Mar 16) could not be calculated for the following measures as there were fewer than 30 modelled records (NHS patients only).
- EQ-VAS or EQ-5D indexes are additional measures of patient health outcomes and showed health gains for primary hip replacements for NHS patients. EQ-5D Index1 is a Generic health status measure. Out of five modelled records 100% were reported as improved and EQ-VAS1 (Visual Analogue Scale component of the EQ-5D) - Out of five modelled records 100% were reported as improved.
- The adjusted average health gain for PROMs - Groin Hernia (Apr 15 to Mar 16) could not be calculated for the following measures as there were fewer than 30 modelled records. The EQ-5D1(Generic health status measure) Index - Out of 16 modelled records 62.5% were reported as improved and 12.5% as worsened. EQ-VAS1(Visual Analogue Scale component of the EQ-5D) - Out of 16 modelled records 25% were reported as improved and 25% as worsened.
- The Oxford Hip Score (OHS) is a PROM specifically designed and developed to assess function and pain with patients undergoing hip replacement surgery. The hospital recorded Oxford Hip Score1and out of five modelled records 100% were reported as improved.
- The Nuffield hospital reported no deaths at the hospital in the period October 2015 to September 2016.
- The theatre manager told us that in January 2017 a pain audit was undertaken in theatre. Theatres were found to be 94% compliant. We saw evidence an action plan was put in place to improve compliance. The audit findings were presented at the clinical effectiveness group, clinical governance and theatre meeting. A senior consultant who attended the MAC and Clinical Governance meeting fed back to the consultants, the actions and findings of audits to ensure all staff were actively supporting the process.
- Data was provided regarding surgical site infection rates. There were seven infections in total between Oct 15 and Sep 16. The rate of infections during primary knee arthroplasty, breast, upper gastro intestinal, colorectal and cranial procedures was above the rate of other independent acute hospitals we hold this type of data for.
- There were no surgical site infections resulting from primary hip arthroplasty, revision hip arthroplasty, revision knee arthroplasty, other orthopaedic and trauma, spinal, gynaecological , urological or vascular procedures.
- The theatre manager told us consultants would submit data to the National Breast Implant Register. The

registry was designed to record the details of any individual, who had breast implant surgery for any reason, so that they could be traced in the event of a product recall or other safety concern relating to a specific type of implant.

Competent staff

- The Matron told us the hospital had signed up to the apprenticeships programme for the development of the health care assistants (HCA) roles. At the time of inspection HCAs were trained to level three. The introduction of the care certificate would allow further development to foundation degree level. Another area of development was the theatre first assistants. One member of staff had completed the course with a second member of staff due to start.
- We saw data that confirmed all inpatient health care assistants had their appraisals completed in the previous appraisal year (Dec 15 to Dec16) with 75% of inpatient nurses and other staff had their appraisals completed in the previous appraisal year. Less than 75% of theatre nurses, ODPs and health care assistants had their appraisals completed in the same appraisal year.
- Patients were cared for by staff with the right knowledge, experience, and qualifications to support their needs within the surgical team. One RN told us competencies were being introduced for recovery staff which had been developed in house with Canterbury Christchurch University as part of a theatre recovery course which was awaiting ratification.
- The RMO was part of the emergency crash team and was trained in advanced life support for both adults and paediatrics. Scenario training took place every six months. Every two years the RMO attended refresher courses and competency training. We saw records that confirmed the RMO's training was up to date.
- The theatre manager told us there was no advanced life support (ALS) trained staff available on a Monday in recovery. This shortfall was being covered from minor procedure department. In the recovery area, one member of staff had Advanced life support (ALS) with another member of staff due to be trained in April. All other recovery staff were Paediatric life support (PLS) and ILS trained. Staff told us there had been recent scenario training which included a paediatric haemorrhage, cardiac arrest and the collapse of a patient on the ward. Six scenarios had taken place in the last 12 months which helped to maintain the knowledge and skills of the staff.
- The hospital followed robust procedures to ensure that surgeons who worked under practising privileges had the necessary skills and competencies. Checks completed ensured that surgeons performed only the procedures they carried out in the NHS. This ensured they were competent and confident in undertaking the procedures.
- Consultants with NHS contracts had their appraisals and revalidation done at their employing trust and a copy had been provided to the hospital.
- Recovery from anaesthesia can be a life threatening process and requires prompt intervention by adequately trained staff in the post-anaesthetic period to ensure a safe outcome for patients. The theatre manager told us competency frameworks were in place around the scrub role, anaesthetics, and the recovery area.
- Nursing staff undertook further competency-based training to ensure they had the relevant skills to care for patients (for example administration of oral medications, patient controlled analgesia syringe drivers, bladder scanning and patient equipment). A competency around working with children and young people would be introduced when the new paediatric lead nurse came into post. The staff competencies were started in December 2016 by the ward manager. Senior staff had the opportunity to access a leadership and management module. This course was available centrally with local workshops in place.
- Some nurses had completed further training as 'link' nurses (for example, infection control and dementia care). The nurses attended regular meetings and updated ward and theatre staff about any changes or up-dates to practice that were required.
- Staff were positive about access to further training and development courses. Courses were available externally or online through the Nuffield Academy. The matron told us the training budget had been doubled in 2016/17 to support the training of their staff.

- All new staff including agency staff were inducted into their area of work. We were shown completed induction checklists, which outlined department orientation and familiarisation with specific policies. Competencies were also required and these were recorded once completed in a competency booklet. We saw evidence of these completed competencies in staff members' induction files.
- Surgical staff competence was scrutinised by the medical advisory committee before practising privileges were granted. Practising privileges were routinely reviewed at the MAC meetings and this was evidenced in the meeting minutes we viewed.
- There was a process for checking General Medical Council and Nursing and Midwifery Council registration, as well as other professional registrations. This ensured all staff were fit to practice. A weekly report was generated. The matron told us the Nuffield Group had their own system in place to support nurses in the re validation process.100% of inpatient nurses had completed re validation and met the practising requirements set by the Nursing and Midwifery Council.
- Staff spoke positively about the resident medical officers (RMOs) and their support in delivering care and treatment to patients. The consultants provide professional and peer support.

Multidisciplinary working

- It was evident there was a functional multidisciplinary approach to the care delivered in the surgical department. The documents we reviewed and the staff we spoke with confirmed this. We saw input from pharmacists and physiotherapists in the medical records we reviewed.
- The matron told us that regular meetings took place between the matron at the local NHS Trust and processes had been developed for the new paediatric lead to be provided with support and supervision by the paediatric lead at the local NHS trust.
- There were no formal multidisciplinary meetings held for surgical patients.
- We observed the nursing handover and found it to be a structured and effective communication tool, which promoted continuity of good care. The handover took place in the ward office to protect patient confidentiality and privacy. Relevant information including NEWS, which indicates any risk of deterioration was discussed.
- During the inspection, we observed good team working between nurses, theatre staff, pharmacist, and RMO. We also observed positive interactions and collaborative working between the ward and theatre staff and in theatres between the surgeons and theatre staff.
- We found throughout the hospital, staff worked collaboratively to promote the health and well-being of the patients. It was a medium sized hospital and all staff groups were fully involved with improving patients' health and recovery both before and after surgery.

Seven-day services

- Consultants provided on-call cover for the duration of their patient's hospital stay. RMOs were available on site 24 hours per day, seven days per week. They were expected to review patients whenever needed and complete day-to-day tasks on the wards.
- A senior nurse was on duty at all times on the ward. There was a clinical on-call rota consisting of the Clinical Heads of Department and deputies and a Senior Management Team on call rota which supported the ward team out of core hours. The clinical and management on call person offered telephone advice and, where required, would attend the hospital for more practical support, including direct nursing care if appropriate.
- The hospital had an on call rota for pharmacy and radiology.
- An on-call theatre team were available for emergency returns to surgery out of hours. The team comprised of a theatre scrub practitioner, a health care assistant and recovery staff.
- Patients were advised to contact the ward staff if they had any concerns out of hours.

Access to information

- There were systems in place to ensure that staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included test results, risk assessments and medical and nursing records.

Good

Surgery

- There were paper-based records for each patient; one for medical notes and one for nursing notes; both sets of patient records including observation charts were accessible in the patient's room. This enabled consistency and continuity of record keeping whilst the patient was on the ward, supporting staff to deliver effective care.
- Staff showed us how to access key policies and standard operating procedures on the hospital's intranet. The clinical governance coordinator told us corporate policies were received by the matron and cascaded down to the Heads of departments (HODs). Standard operating procedures (SOPs) would be written if gaps in policy were found locally. Staff were encouraged to print off SOPs when following them during work practices.
- Communication from senior management was cascaded to staff via team meeting, emails or through the hospital newsletters. Staff confirmed this during the inspection.
- We found the hospital provided information, which supported patients and their relatives to make decisions about their care and treatment. At the pre assessment clinic, all the necessary patient information leaflets were given to the patient prior to the procedure. The pre assessment nurse was able to show the wide variety of well presented patient information leaflets covering all the surgical procedures undertaken at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Nuffield hospital had a consent policy in place. In the nine patient records we reviewed, all patients had been consented for their surgical procedure. Consent forms fully described the procedure, as well as risks and benefits associated with the procedure. We saw full signatures from the consenting clinicians and patients.
- Staff we spoke with, both in theatres and on the wards were aware of the consent policy and the correct procedures to ensure patients gave valid consent prior to any treatment or surgical intervention. We observed a patient transfer from the ward to the theatres. Both the ward and theatre practitioner checked the patients identification and wrist band. The patient had to visualise and verbalise confirmation of their consent form which had been completed earlier.
- One patient we spoke to told us they had received lots of written and verbal information and time to make a decision regarding the surgical procedure. Consent was then undertaken after the period of reflection on the morning of the procedure.
- All staff received training in the requirements of the Mental Capacity Act (MCA), 2005 as part of their mandatory training. We saw the Mental Capacity policy and had documentation to undertake mental capacity assessments were in place. In theatres, pre assessment and the ward MCA training was 100% compliant.
- Staff we spoke with had received training and were aware of Deprivation of Liberty Safeguards (DoLS) principles. In theatre training was 93% compliant ,with 86% on the ward and 75% in pre assessment. Staff explained they did not have experience of completing a DoLS application. A DoLS policy was in place.
- The matron told us prior to admission any patient with a learning difficulty or living with dementia would have a mental capacity or best interests meeting to establish whether or not a DoLS was needed and this could be applied for.

Are surgery services caring?

Good

We rated caring as good

Compassionate care

- We observed the staff on Abergavenny ward being very kind, caring, and compassionate towards their patients. All patients and relatives we spoke with told us staff always introduced themselves, were polite, and treated them well.
- One patient told us the care was very good and felt the staff went 'above and beyond'. They explained to staff that they only drank fresh ground coffee, the catering team ensured that fresh ground coffee was made available. Another patient told us they were 'extremely happy with everything, the staff and the room were lovely'. The patient commented 'is it wrong to say I enjoyed my stay'.

- Following their surgery three patients told us they had received excellent care. One patient told us the staff were 'very attentive, food was great and they had no complaints'. Another patient said they were 'very lucky being able to have their surgery at the Nuffield'.
- All patients were encouraged to complete Patient Satisfaction Questionnaires on discharge. The questions in the questionnaire varied from ' how likely are you to recommend the hospital', to the 'confidence and trust in the healthcare staff to the accommodation and catering'. We reviewed the results of the January 2017 patient satisfaction survey and saw 82% of patients were likely to recommend the hospital. Benchmarked against other Nuffield Health Hospitals, Tunbridge Wells were ranked 26th out of 31.
- The Patient Led Assessment of the Care Environment (PLACE) for the period of February to June 2016 showed the hospital scored 88% for privacy, dignity, and well-being, which was above the England average of 83%. The PLACE assessment for privacy, dignity and well-being, focuses on key issues such as the provision of outdoor and recreational areas, changing and waiting facilities, access to television, radio and telephones. It also includes the practicality of male and female services such as bathroom and toilet facilities, and ensuring patients are appropriately dressed to protect their dignity.
- The hospital's Friends and Family Test (FFT) scores were lower than the England average of NHS patients across the period April 2016 to September 2016. Between April and September 2016, the hospital achieved between 95% to 98%. Response rates were lower than the England average of NHS patients across the same period. There was no differentiation of service between NHS and privately funded patients. The FFT is a simple test that asked patients whether they would recommend the hospital to their friends and family.
- Patient's privacy was maintained by ensuring the doors were closed during personal care or whenever patient's needed some privacy with their relatives. We observed that staff always knocked before entering the room.
- Patients felt pleased and respected as they were involved, supported, and encouraged to be partners in their care and decision making. This commenced at the consultation meeting with the consultant and continued through pre-assessment and discharge planning. Support was available across the whole of the surgical pathway.
- We observed one patient in the theatre area. The nurse looking after the patient was seen to be kind and caring and gave a full explanation and support to the patient throughout the procedure. Privacy and dignity was maintained throughout the procedure.

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful to patients and their loved ones. They explained treatments in a way patients and relatives could understand and kept them informed about their care. In theatres we observed the anaesthetic practitioner explain to patients they were being transferred from a bed to a trolley and why along with explanations prior to an injection of local anaesthetic that this would sting . All observations we observed showed staff were keeping patients involved in even the smallest aspects of their care.
- The patients we spoke with on the ward knew the names of the staff and who to ask for if needed. They all told us they felt able to ask questions and ask for help if required.
- Patients told us they had received information from the hospital on the type of surgery they were admitted for and they fully understood the care, treatment and choices available to them.
- All the patients we spoke with were aware of what to do if they felt unwell during admission and when discharge home.
- Patients were informed of the cost of the initial consultation with the consultant by the consultants secretary . Following this a letter with a quote for the procedure would be sent having been agreed with the consultant. This information was sent to the patient with all the relevant information including what was included in the price and not in the price and methods of payment.

Emotional support

Good

Surgery

- The nursing staff on the ward mainly provided emotional support. Support included reassurance from nursing and medical staff, and referrals to the appropriate professional.
- Patients were given appropriate and timely support and information to cope emotionally with their care, treatment, or condition. Patients we spoke with informed us staff were supportive and reassuring and gave them and their family the reassurance to ease their anxiety before and after their procedure.
- The hospital did not provide counselling services. However, the ward sister told us that if support was required they would consult with the matron for guidance.
- No chaplaincy service was available. Staff told us they would usually contact the nearest place of worship for the patient's religion and arrange for a visit if this was required.

Are surgery services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- All surgery carried out at the hospital was elective. Operating theatre lists for elective surgery were available in advance and patients could select times and dates to suit their family and work commitments. The theatres were open from Monday to Friday from 8am to 7pm, with occasional Saturday lists.
- The hospital offered a range of private and NHS elective surgical procedures for a range of specialities, including, orthopaedics (hip and knee arthoplasty), general surgery, urological and gynaecological surgery, ear, nose and throat and cosmetic and plastic surgery.
- Eighteen percent of patients attending The Nuffield Health Tunbridge Wells Hospital were NHS patients who were referred from the local clinical commissioning group(CCG). Work performed included joint replacement surgery. We found there was active collaboration between the hospital and the local CCG to ensure the hospital were delivering care to NHS Standards and fulfilling the contract in place. NHS patients were booked via e-referral.
- Private patients were generally referred to a consultant by the GP or via another consultant although a small number of patients were self-referrals. We found that not all rooms had wheelchair access and access to the showers was limited in some rooms due to step over shower bases.
- The hospital was a 36 bedded unit comprising of 33 individual adult beds and three individual paediatric beds (could extend to six beds if necessary).
- A registered nurse (RN) told us that patient rooms with walk- in showers were available and would be allocated to patients who were being admitted for joint surgery. Raised toilet seats were available to support patients with mobility issues.
- A bariatric patient room was available with appropriate bed, chair and bathroom access.
- Day case patients who required admission had immediate access to overnight facilities, should they require them. For patients whose stay had to be extended for clinical reasons, the facilities were extended and no extra costs were incurred.
- The ward and theatre staff told us they had good teams in place who could work flexibly if circumstances needed. Extra staff could be brought in if the workload was extra busy although this rarely happened. All patients needed to be admitted and full risk assessments were undertaken prior to surgery.
- All surgical patients discharged from the hospital, including those who had day case procedures, had a telephone follow-up call two or three days post discharge, to ensure no issues had developed.
- A variety of menus and foods were available to support the needs of patients. Several patients told us the food was enjoyable and a good variety of food was offered. In the January 2017 patient satisfaction survey, the overall quality of the food at the Nuffield hospital was rated at 95%, this was slightly above the Nuffield group average of 94%. However on reviewing complaints, food was an area of concern. The matron told us this was addressed by the recent appointment of a new chief.

Good

Surgery

Access and flow

- Patient access and flow was found to be good at this hospital. The ward sister told us that Tuesday and Thursdays were their busiest days for theatre. So to manage that, a dependency tool was used to look at the planned admissions(medical and surgical). The ward sister was able to explain the tool used and how it aided in the staff planning of this small unit.
- There were 7,150 inpatient and day case episodes of care recorded at the hospital in the reporting period (Oct 15 to Sep 16); of these 18% were NHS funded and 82% were other funded. During the same period, 18% of all NHS funded patients and 15% of all other funded patients stayed overnight at the hospital.
- During the reporting period, 14 children between the age of 3 to 17 years, were admitted to the hospital with 237 day case patients.
- The Nuffield Health Tunbridge Wells Hospital could demonstrate compliance with the 18 week pathway for NHS funded referrals. The hospital monitored patient wait times and helped facilitate admissions to ensure no breaches occurred. One hundred percent of patients were admitted for treatment within 18 weeks of referral in the reporting period (Oct 15 to Sep16).
- All other (non-NHS funded referrals) access services were subject only to consultant availability. Once a decision to operate was made in clinic, the bookings team worked closely with the consultant, the consultant's secretary, ward staff, and the patient to agree a suitable date for surgery.
- Patients were offered a choice of appointments and staff strived to meet individual surgeon's and patients' requirements. Patients had timely access to initial assessment and treatment.
- The hospital's admission policy ensured that patient received a pre-operative assessment. All patients were assessed which meant patients could be identified as being safe for surgery, which helped to avoid any unnecessary cancellations. Patients with co-existing conditions were identified during this process and then given further tests, for example blood tests or diagnostic imaging.
- Patients with multiple comorbidities were assessed by a consultant anaesthetist and if they were deemed unsuitable for surgery, their admission was deferred. Exclusion criteria were used which followed National Institute for Health and Care Excellence guidelines
- A discharge pathway for patients was in use on the ward. The patient was provided with appropriate medication required on discharge. A full discharge pack was given to the patient which included information on DVTs, surgical wound healing, pain relief information mobilising post operatively and a patient survey.
- Staff discharged the patient using a discharge checklist . This included, whether the patient had stitches, any dressings given, TTOs, follow up appointments, contact numbers and if consent was given a copy of the discharge letter to the GP. Following this checklist ensured patients were discharged in a planned and organised manner.
- The Nuffield Hospital reported they had cancelled 19 procedures (primarily due to a flood) for a non-clinical reason in the last 12 months; of these 100% (19 patients) were offered another appointment within 28 days of the cancelled appointment.

Meeting people's individual needs.

- Services were planned and delivered to take into account the individual needs of its patients, for example, age, disability, gender, religion or belief. We were told that any patients in a wheelchair would be allocated a bedroom with the appropriate access to the room and shower area. Children were allocated child friendly bedrooms.
- Discharge planning started at the pre-operative assessment stage. Length of the patient's stay was discussed and this helped patients plan for any additional support required at home.
- The pre assessment lead nurse told us clinics were flexible and extra bookings could be added in at short notice, this included one stop clinics where elderly people would be offered a pre assessment appointment following their consultation to prevent multiple visits to the hospital.
- The service had a range of leaflets and bespoke information regarding certain procedures. For example,

certain consultants had specific guidelines on the patient's post-operative care, so there were specific patient leaflets individually tailored depending on the guidance.

- Patients were sent initial information regarding their procedure and hospital stay by the consultant's secretaries. Information included expected length of stay, procedure, date of admission and costing. During the pre assessment clinic, clinical information was given by the nursing staff who would verbally explain the procedure to the patients and follow this up with comprehensive patient information leaflets.
- The pre assessment clinic used 'makaton signs' to communicate with patients . Makaton is a language programme designed to provide a means of communication to individuals who cannot communicate efficiently by speaking. The folder included signs ,symbols, pictures and photographs and covered both care and clinical symbols to support the patients in describing their needs and preferences and any clinical symptoms they may have.
- All patients had individual rooms with en-suite facilities that promoted privacy and dignity. Staff completed care round throughout the patients stay. One patient told us staff made regular checks and made sure all requests were met. During pre-operative care rounds patients would be kept up to date about the time they were due in theatre and post operatively they would ensure the patient was not in pain and water was close by.
- Patient needs were identified at the initial pre assessment stage of care. If specific needs were identified, they were communicated to the ward, catering, and theatre staff to ensure appropriate planning before admission.
- All patients had a comprehensive risk assessments carried out at their pre-assessment appointments and on the day of admission. We reviewed nine sets of patient records and saw all risk assessments were carried out at pre assessment and on the day of admission.
- Patient Led Assessment of the Care Environment (PLACE) for February to June 2016 showed the hospital scored 85% for dementia, which was better than the England average of 80%. The PLACE assessment for dementia was included for the first time in 2015 and focuses on key issues such as, flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- The matron told us patients with a diagnosis of dementia were admitted to the hospital for treatment. All patients were risk assessed prior to admission to ensure the hospital provided a safe environment. The hospital had signed up to the light blue pillow case scheme. With consent from the patient and carers a light blue pillow case would be used. Other dementia tools included red rim crockery and the use of a red shower curtain. Signs would be placed on the door to the shower room saying 'toilet' and 'way out ' to support the patient around their room.
- For patients with learning difficulties the hospital used 'my hospital passport' this included individualised information, such as, their likes and dislikes, their interests and their favourite type of drink. This would be kept by the patient's bed side and in their patient records. The passport was started at the pre-assessment stage.
- Extra time was allocated to patients with learning difficulties at the pre assessment clinics so that they could have a tour of the hospital and meet the team of staff who would be involved in their care. This was to help reduce stress and anxiety.
- Carers and relatives were encouraged to stay with patients living with dementia or a learning disability. Carers were offered to share a room or have a separate room allocated during the patients stay. If a carer was unable to stay with the patient, then the ward staff would ask for additional staffing whilst the patient was an inpatient, to provide one to one care. The hospital offered pre admission visits to familiarise the patient with the environment.
- In theatre, we saw specialist equipment including a special table, blood pressure (BP) meters and larger gowns were in place to support bariatric patients.
- We observed call bells were answered immediately and staff were attentive to patient needs. We observed one patient was sitting on a chair with the buzzer placed close at hand ensuring support could be called for in a timely manner.

- Patients were offered a choice of food and drinks from a menu. The catering manager could access a variety of menus, including special dietary requirement such as pureed food. In the January 2017, patient satisfaction questionnaire the quality of the food achieved 94% and the menu choice achieved 93%. The hospital was 14th out of the 31 Nuffield hospitals. Staff told us they provided refreshments for relatives and loved ones. One patient told us 'the food was lovely'.
- Staff had access to the 'Big word' to assist communication with non-English speaking patients. This was either over the phone or face to face. We also saw staff had a list of staff who could speak various foreign languages and who could help in an emergency.
- Information on special cultural, religious, or dietary needs was gathered at the pre-assessment stage and this information was passed onto the ward, catering department and theatre teams. The patient's individualised admissions letter also asked patients if they had any dietary requirements so these needs can be meet on admission.
- A hearing loop was available if patients were hard of hearing.
- The PLACE assessment for the period of February to June 2016 showed the hospital scored 85% for disability, which was better than the England average of 81%. The PLACE assessment for disability was included for the first time in 2016 and focuses on key issues of access including wheelchair, mobility (e.g. handrails), signage and provision of such things as visual/ audible appointment alert systems, hearing loops, which can prove helpful to people living with disability.
- The hospital had Wi-Fi, this enabled patients to keep in contact with friends and relatives.

Learning from complaints and concerns

- There were systems to ensure patient's comments and complaints were listened to and acted upon effectively. Patients could raise a concern and have it investigated and responded to within a realistic timeframe. The hospital director would ensure the complaint or concern was investigated by the appropriate member(s) of staff and that a full record of this investigation was maintained in the complaint file which was stored in the management offices. For all the complaints we reviewed, the provider met the target response times of 20 days.
- The hospital manager had overall responsibility for ensuring that all concerns and complaints that were received for local resolution were managed in line with the process and timescales set out in the Nuffield Health Standard Operating Procedure (SOP) 1 (Process for Managing Concerns and Complaints) and for their recording in the Risk Management System Complaint Module.
- All complaints / concerns were recorded in the monthly Clinical Governance Report for the hospital which was completed by the matron and authorised by the hospital director. The report was then reviewed by the hospital's Clinical Audit and Effectiveness Committee of which all Heads of Department were full members. This committee would review the data in order to identify any trends and would seek further information as a result of that review. This report would then be reviewed by the MAC Chairman (and Clinical Governance Lead) in advance of each (quarterly) MAC meeting. Learning and actions identified from complaints were discussed with staff members involved. Any learning for a particular member of staff was handled by the head of department.
- The complaints co-ordinator told us a meeting took place weekly with the hospital director and matron to review all complaints and stages in the three stage complaints process. Any outliers would be highlighted and actions taken. At the time of the inspection 12 open complaints were at stages two or three of the complaints process. The complaint themes identified include inadequate pain relief and catering.
- One consultant told us the hospital was responsive when dealing with complaints. We were told that both the staff and the patient were treated fairly and openly during the complaints process. An example was given where a patient was not happy with their diagnosis and treatment plan. The patient was referred by the Nuffield hospital for a second opinion.
- The matron was responsible for investigating clinical complaints and introducing actions to help prevent a similar complaint happening again in the future. Copies

of complaints were sent to the relevant head of the department or consultant. Any learning from complaints were cascaded to the appropriate department and shared with all staff at clinical governance meetings, department meetings and via email.

- The hospital received 36 complaints between October 2015 and September 2016. No complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the rate of other independent acute hospitals we hold this type of data for. The Care Quality Committee received one complaint regarding the hospital in the above reporting period.
- 'How to complain or raise a concern' leaflets were displayed around the hospital and were accessible to all patients and visitors. The ward sister told us that if a patient was unhappy with any aspect of their care, they would try to resolve the issue verbally for example if there was a delay in the time of surgery staff would give regular updates. The complaints coordinator told us not all complaints go through the formal complaints procedure. Staff or the matron may resolve the complaint at a local level but they are still logged on the electronic incident reporting system so themes and trends can be identified.
- Patients were able to speak with the matron and ward sister during their visit/admission to hospital to discuss any issues they may have. All patient rooms had a 'Patient Information Guide', which included a section outlining the formal complaints procedure. Patients and their relatives were supported to make comments and raise concerns if they were not happy with the care they received and staff were unable to answer their concerns. The complaints coordinator told us that people were happy to come in and talk about their complaints or they would meet the person in a neutral environment such as a hotel or go to the persons home.

Are surgery services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- The Nuffield Hospital vision was a continuous improvement plan for the development of hospital services and focused on key areas included improved quality flow/loop closure, robust training plan, clearer meetings structure and information flow and improved communications (internal and external).
- The hospital underpinned its service delivery with six core principles, which were: we believe that commercial gain can never come before clinical need, we believe in no nonsense, we believe in being straight with people, we believe in taking care of the small stuff, we believe that caring starts with listening and we believe in you.
- The 'Vision' was developed by the Senior Management Team (SMT) following the appointment of the new Hospital Director in October 2016. In order to deliver this vision, the senior management team had to secure the support of all its staff and the consultants in those (sub) specialties with whom the hospital worked collaboratively with. A recently developed Internal Communications Strategy set out the process for staff engagement .
- The hospital director told us information around the vision was cascaded from the SMT at weekly informal heads of department meetings, staff and consultant news letter and the staff forum . A monthly SMT report via matron included a critical review of patient satisfaction survey trends. Any key concerns and positive comments were cascaded via the clinical governance process to all staff groups.
- Consultants would learn about the vision through the Medical Advisory Committee (MAC) which met quarterly.

Governance, risk management, and quality measurement for this core service

- There was a clear governance structure in place with committees for medicines management, infection control and prevention and health and safety, which fed into the clinical governance committee. There was also the MAC which had separate meetings to discuss the consultants 'professional registrations and appraisals.
- The hospital matron told us that the Nuffield Group work in clusters (four across the UK). The South East cluster had a matron's group that met every two months to share good practice and receive central information

from the quality care partners (QCP). The matron had an action plan in place and covered areas such as embedding the WHO checklist with all staff and consultants, removal of consumables which were out of date, improving poor IPC practices and appropriate storage of medications.

- The matron attended the National Matrons conference which took place three times a year. These conferences discussed current practices with the aim of keeping practice current.
- The recent introduction of a communications strategy allowed information to be effectively cascaded. Reports were provided by the relevant heads of departments and presented for review at the integrated governance meeting. All incidents and adverse events were recorded on the electronic incident recording system and included in the Clinical Governance Report, which was reviewed and discussed at the Clinical Governance Committee each quarter and by the Medical Advisory Committee (MAC), Chairman and the full MAC each quarter.
- A summary of the Clinical Governance Report was also made at each individual (monthly or bi-monthly) Integrated Governance Meeting to support learning. Other committees in place included the audit & clinical effectiveness committee, resuscitation committee, infection prevention & control, medicines management forum, local safeguarding meetings and the children & young peoples service committee.
- The Clinical Governance committee (CGC) meetings were held quarterly. We reviewed the minutes of the January 2017 meeting. Discussions at these meetings focussed on quality and risks and we saw areas such as incidents, complaints, clinical risk, patient feedback, practising privileges, and the review of policies and procedures were discussed. The deputy chair of the MAC was a member of the CGC and told us that the format had greatly improved since the new hospital director had come into post. The deputy's role was to provide clinical input at committees and provide feedback and cascade information to consultant colleagues.
- The hospital director told us there were robust systems in place around quality benchmarking. This included health and safety audits supported by the regional health and safety manager and business continuity plans which included table-top scenarios using corporate expertise. Clinical quality was monitored through Key performance indicators (KPI's) and regular meetings with the Clinical Commissioning Groups (CCG's) for NHS patients. Each month an audit and clinical effectiveness meeting took place which was not attended by the consultants.
- The matron was able to show us a number of quality reports which ensured compliance across a number of quality areas. The reports were submitted to the MAC and Nuffield head office. The reports included incident trends, NICE audits, staffing updates, safety alerts and patient satisfaction.
- There was a hospital wide corporate risk register. The register identified mainly operational, legal and quality and safety risks and were discussed at the clinical governance committee by the SMT. Risk registers were in place for all areas. Department leaders we spoke with knew and were seen to be managing risk pertinent to their clinical areas.
- The senior management team had systems in place to assure themselves the hospital were delivering on its values, CARE. These being connected, aspirational, responsive and ethical. Various sense checks were in place including reviewing patient satisfaction surveys, complaints and incidents, which were all discussed at the clinical effectiveness meeting and the clinical governance committees.
- Senior staff from the surgical services was engaged with governance activities at the hospital and represented theatres and the wards at various meetings, including infection control, resuscitation, heads of departments and governance committee meetings.
- The hospital had a schedule of audits performed throughout the year, which were the mechanism to ensure there was a cycle of continuous service improvements and good care was being delivered. A wide variety of audits were undertaken including infection control, WHO checklists, medicine management and paediatric audits. Audit results were reviewed at the link meetings. Following that, results were shared with clinical departments. Action plans were put in place to ensure audit findings were actioned.

- The MAC meetings took place quarterly and discussions took place regarding areas of practise including practising privileges, incidents, complaints and patient surveys along with key points from the clinical governance committee. The hospital had an effective system in place to ensure that practising privileges were updated with the relevant information. Data received from the hospital showed that a total number of four staff had been suspended with 39 having their practising privileges removed in the reporting period (Oct 15 to Sep 16).
- Hospital policies, standard operating procedures and work instructions were reviewed regularly by the senior management team who would identify policies which needed updating and sent those to the relevant heads of departments. All policies were allocated a named owner with a review date. We reviewed a variety of policies including the consent policy, health and safety policy uniform policy and the resuscitation policy.
- We saw health and safety and resuscitation meetings took place every three months. Agenda items included policy updates, audit schedule, accidents/incidents, training and medicine updates. All incidents discussed had outcomes documented and actions taken.
- Feedback from hospital wide meetings was disseminated to staff at local team meetings. Information feedback included learning and development, building updates, any theatre issues and health and safety. Team meeting minutes were shared with staff unable to attend. We reviewed the theatre team meetings which took place in November 2016 following the never event. We saw the matron attended and discussed the never event and how practice was changing following the incident.

Leadership / culture of service

- The hospital was led by a senior leadership team that included the hospital director, the finance director and the matron. The hospital's director and matron were new in post. The team had regular contact with each other due to the relatively small nature of the hospital. The senior leadership team was supported by heads of departments. We found there was a team of suitably qualified heads of department with managerial responsibilities. Staff spoke positively about the recent appointments to the senior management team and felt they were listened to with actions being followed through.
- The hospital matron responsibilities included the Director of infection control and prevention, Caldicott guardian, adult and safeguarding lead and a member of the west Kent safeguarding group. Training was being undertaken to fulfil these roles.
- In theatre, staff told us that the hospital processes had improved since the appointment of the hospital director and matron. One RN told us there had been a lot of issues with staffing in the recovery area however since the appointment of the theatre manager and the senior management team this had now improved.
- On the ward staff told us that they felt supported by the ward sister however they felt a figure head was needed in the form of a ward manager. Many new staff had come to the ward recently which had been difficult but they told us 'it now feels we are working better as a team'.
- Staff we spoke with across the hospital were motivated and positive about their work, and described all members of the senior management team as approachable and visible. Staff told us there was a friendly and open culture since the appointment of the new SMT.
- The RMO told us they felt supported in their role. However, they were unable to attend any hospital meetings due to the pressures of clinical work. This included the MAC and clinical governance meetings. Following meetings the RMO told us they would be briefed about any points they needed to know about.
- Between October 2015 and September 2016 The Nuffield Hospital had 38 Consultants who had their practising privileges removed as the surgeons had not worked at this hospital for a period greater than six months and one due to the death of a surgeon.
- The medical director was the chair of the MAC. All new policies were disseminated to the consultants at the MAC meeting along with the clinical governance committee minutes.

- Regular walkabouts by the senior management team encouraged discussion and comment. Staff on the ward felt able to feedback any issues straightaway. Staff confirmed that members of the senior management visited the ward daily.
- Staff on the ward and in theatre told us their managers were approachable and supportive and there was a 'no blame culture'.
- There was a culture of candour, openness and honesty. Staff told us they felt able to raise concerns and were encouraged to report incidents. There was also an up to date whistle-blowing policy in place. Staff attended training on whistle blowing as part of their mandatory training.
- The Human Resources coordinator told us that as part of the induction process new staff attended a workshop where they would meet new staff along with the hospital director and matron. All new staff would have a 10 minute meeting with the hospital director.
- Staff told us they received training and were empowered to acquire new skills. Managers accessed courses run by the Nuffield Health Academy, including coaching, leadership skills and difficult conversations.
- Staff were confident that managers had the skills, knowledge, experience and integrity that they needed to lead the departments.
- The vacancy rate for theatre nurses was similar to the average of other independent acute hospitals that we hold this type of data for. One WTE post was vacant giving a vacancy rate of 7%.
- There were no vacancies for theatre ODPs or health care assistants as at 1 Oct 16.
- The rate of inpatient nurse turnover was below the average of other independent acute hospitals but the rate of theatre nurse turnover was above the average of other independent acute hospitals we hold this type of data for in the reporting period (Oct 15 to Sep 16).
- There was no staff turnover for inpatient health care assistants in the current or previous reporting period. The rate of theatre ODP and health care assistant turnover was below the average of other independent acute hospitals we hold this type of data.
- The rate of other staff turnover was above the average of other independent acute hospitals that we hold this type of data for in the same reporting period.
- Sickness rates for theatre nurses were variable throughout the reporting period (Oct 15 to Sep 16). Sickness rates were higher than the average of other independent acute hospitals we hold this type of data for in Oct 15, Jan 16 to Apr 16 and Jun 16.
- Sickness rates for theatre ODPs and health care assistants were 0% or lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in Oct 15 and Feb 16.

Public and staff engagement

- A communications plan and framework had been introduced. From this the Hospital Director had introduced staff forums which were designed to be informal and to encourage a high level of staff engagement, with an opportunity to share the vision, results, and future strategy for the hospital. Staff were able to bring anything to the forum they wished to discuss. The forums were due to be run monthly but had been more frequent in order to engage with staff.
- An open door policy was in practice within the hospital for members of staff to discuss ideas and concerns. A staff suggestions box had been introduced and suggestions were discussed at the staff forum.
- The matron told us that at a recent staff forum staff raised the issue of food out of hours and beverage points. This had been addressed by the management team and food was now available out of hours and checks were regularly made on the beverages machine. Staff suggested there should be a social committee. This was set up with a staff party being the first event organised by the committee.
- A staff newsletter and suggestion box were recently introduced. The staff newsletter focused on a department with the head of department writing an article on the department.
- Patient satisfaction surveys were undertaken by the hospital. However they were fairly generic and not discipline specific. The patient satisfaction survey captures feedback on competency of grades of staff, pain management and nutrition. They were also able to

gain feedback from patients on nutrition and hydration, pain and staff competency by direct personal contact and discussions; the ward manager and the matron undertook regular contact rounds with inpatients to discuss their experience and cover all elements of their care journey, particularly their opinion of how the care had been delivered and whether it met the expectations as regards staff, approach and competency.

- All public areas within the hospital displayed information providing guidance on how people could raise concerns or complaints. The matron told us any concerns that arose whilst a patient was admitted would be addressed as soon as possible. A patient forum meeting was held in January 2017. Patient volunteers agreed to support the hospital in improving the patient experience. The matron told us they were looking at involving the parents of paediatric patients in the patient forums.
- In the patient satisfaction survey January 2017 'overall satisfaction with experience' received 95% compliance with urology,ophthalmology and oncology achieving 100% satisfaction.
- The Nuffield Hospital participated in the annual PLACE audit to ensure they could respond to patient feedback, the results were published and areas for improvement identified with an action plan put in place to improve the quality of care delivered.

Innovation, improvement, and sustainability

- The hospital's orthopaedic service offered a service for all private patients to include Nuffield Health recovery plus programme. This included an extended membership at fitness and wellbeing centres, supported by a personalised programme post-operatively to improve outcomes and patient experience and provided patients with the support they needed to get well and stay healthy after their procedure.
- There had been an improvement in communication and transparency throughout the hospital with the recent implementation of a robust open communications plan to ensure effective information dissemination throughout the hospital. This included, weekly informal heads of department meetings, staff and consultant news letter, staff suggestion box and forum to facilitate a review of any concerns or ideas, reviewed by the senior management team, solutions agreed and disseminated. Monthly SMT reported via matron a critical review of patient satisfaction survey trends, noting any key concerns and positive comments, cascaded via clinical governance process to all staff groups.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

We rated safe as good.

- The service planned, applied and reviewed staffing levels and skill mix to keep children and young people safe at all times.
- The service had a good track record on safety. Openness about incidents was encouraged and learning was shared. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The service gave priority to safeguarding CYP and most staff had completed their safeguard training.
- Risk to CYP was identified and managed to ensure safety at all times.

However,

- There were no devoted waiting areas for children.
- It was not always clear from the Datix whether duty of candour and learning had been considered or performed.

Incidents

- The hospital did not report any patient deaths, never events or serious incidents related to children and young people (CYP) between July 2015 and June 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. The occurrence of never events could indicate unsafe practice.
- The hospital used an online software system for reporting incidents and monitoring trends. Staff described the process for reporting incidents, and gave examples of times they had done this.
- Staff told us that there were five incidents involving young people between September 2016 and February 2017. There were no trends in these incidents.
- Staff told us when there was learning from incidents, it was shared with staff individually and at department staff meetings. We saw that there had been an incident where a child had to be called back for blood draws two times due to staff errors. We saw the electronic incident reporting system, which indicated areas for learning and staff were reminded to check to make sure all bloods had been progressed at the end of each day. We saw 26 January 2017 staff meeting notes, which reflected the learning was discussed with staff. Staff meeting notes were kept in the office and staff had signed to indicate they had read the notes. This meant learning was identified and circulated to improve safety.
- In the above incidents, learning with regard to errors made by individuals was identified and shared but there was no review of whether a process should be put in place to avoid future errors. This meant that while incidents were reviewed, systemic issues may not have been identified.

Good

Services for children and young people

- Whilst incidents were recorded, duty of candour and learning were not always recorded. So, it was not always clear from the electronic recording system whether duty of candour and learning had been considered or performed.
- The Nuffield Incident Policy required that staff implemented the duty of candour when an incident occurred, in compliance with Regulation 20 of the Health and Social Care Act 2008. The duty of candour requires health care providers to tell patients (or other relevant persons) when something goes wrong and provide reasonable support to that person.
- Staff we spoke to reflected understanding of their responsibilities under the duty of candour. Staff were able to provide examples of when they provided information and apologies under the duty of candour. One staff member described how they met the duty of candour by providing an explanation and apology after the incidents regarding blood tests discussed above.
- Another staff member told us that where appropriate they spoke to the child first and then to the parent when discussing incidents. This was in line with the Children and Young People in Hospital Policy (CYP policy) requiring staff respect CYP and their involvement in their own care.
- Themes of incidents were identified and acted upon. For instance, the 17 October 2016 Medical Advisory Committee (MAC) notes reflected that there was a theme of CYP day patients converting to unexpected overnight stays. As a result of review, staff were required to fill out a CYP assessment form for each patient. Staff verified that they now perform the risk review for each patient. There was one day case who converted to an overnight stay between September 2016 and February 2017.

Cleanliness, infection control and hygiene

- There were no infections of Methicillin-Resistant Staphylococcus Aureus (MRSA) relating to CYP from October 2015 to September 2016. MRSA is a type of bacterial infection; it is resistant to many antibiotics and has the capability of causing harm to patients.
- There were no infections of Methicillin-sensitive Staphylococcus aurous (MSSA) relating to CYP from October 2015 to September 2016. MSSA is a type of bacteria in the same family as MRSA, but is more easily treated.
- There were no infections of Clostridium difficile (C.diff) relating to CYP from October 2015 to September 2016. C.difficile is a type of bacteria that can infect the bowel and cause diarrhoea.
- There were no infections of Escherichia coli (E.coli) relating to CYP from October 2015 to September 2016. E. coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness and other illnesses.
- PLACE (patient led assessments of the care environment) assessments see local people go into hospital environments to assess elements of the environment that matter to patients. The hospitals PLACE score was 99% for cleanliness, which was above the England average of 98%.
- We saw a training plan, which showed that all staff had been trained in asepsis technique or would be in the next seven weeks. This was part of a hospital wide asepsis training program.
- All staff we saw in the departments were bare below the elbows to prevent the spread of infections in accordance with national guidance in compliance with NICE guidance.
- We saw a cleaning schedule was in place for cleaning the toys, which was signed and up to date. All toys were cleaned after use to prevent the spread of infection.
- Please see the Surgery and outpatient sections of the report for general discussion of cleanliness, infection control and hygiene relating to CYP.

Environment and equipment

- The hospital had child friendly treatment spaces. The outpatient phlebotomy (blood taking) room was decorated with butterflies on the wall and had a mobile hanging from the ceiling. Pet pictures were posted beside the chair for distraction. This meant some children were treated in an engaging space with appropriate distractions.

- However, children in outpatients were sometimes seen in adult consulting rooms. This meant that children did not always benefit from treatment in a child friendly space.
- We saw that there was a paediatric resuscitation trolley in the outpatient department. We saw evidence that the monthly checklist for checking trolley contents was completed. We reviewed a sample the trolley's contents and all items were in date and sealed. This ensured that emergency equipment was effective and clean.
- We saw that the defibrillator had a label showing evidence of recent electrical safety testing. This provided the hospital with assurances around the electrical safety of these items.
- The paediatric defibrillator was kept on the adult trolley. When we asked staff why it was kept there, we were informed that it was a historic decision and they planned to move it to the paediatric trolley.
- We saw that medicines were kept in locked cabinets where children could not access them. Sharps and sharps bins were also kept out of reach of children in the treatment rooms.
- However, there was no designated CYP waiting area in the hospital's main waiting room or the outpatient departments waiting rooms. This was not in accordance with the hospital's Standard Operating Procedure (SOP) 9 which said that , 'Facilities should include a designated area… or, where possible, a separate waiting area for children.' This meant that children waiting for care were not separated from adult patients.
- We saw that children on the wards stayed in designated rooms. Staff told us that at night the ward was secured with a swipe card entry system. Staff told us that children were not left alone in their room as parents or staff were always with them.

Medicines

- We reviewed four sets of notes for children who had surgery at the hospital. In all four sets of notes, we saw staff had recorded weight and allergy information. This enabled safe and appropriate prescribing.
- Staff had access to appropriate resources related to medicines such as the British National Formulary for Children 2016 to 2017 and online access to an intravenous medicines guide.
- Staff described working closely with the pharmacy department with regard to CYP medications. For instance, CYP and pharmacy staff had developed a take home medicines chart, which included a suggested last dose given. This helped CYP and parents to understand when to administer medicines.
- For our detailed findings on medicines, please see the Safe section in the surgery report.

Records

- We reviewed four sets of notes for children who had surgery at the hospital. All of the records reviewed were thorough, clear and legible. This was in line with General Medical Council (GMC) guidance.
- We reviewed several theatre lists where we saw children were placed first on the theatre lists. On the ward, the children's booking log was completed. This included the date of the operation, pre assessment process and the follow up telephone call two days following discharge with the patient and parents. A telephone follow up book was available where calls from parents were logged so that any queries or concerns could be passed onto the relevant clinician for action.

Assessing and responding to patient risk

- We saw the hospital's Children and Young People in Hospital Policy (CYP Policy), which was in date. This set out clear admissions criteria for surgery, as well as inclusion criteria for all outpatient and diagnostic imaging services. The hospital did not accept children under the age of three for surgery. The hospital only accepted children age three and over for elective surgery and did not accept any emergency surgery admissions.
- The hospital did not admit CYP with additional pre-existing conditions, (with the exception of certain mild conditions). This enabled the hospital to provide a safe level of service for children's surgery as it did not have level two or three critical care facilities should a child need this level of support after surgery.

Good

Services for children and young people

- All CYP had a pre-operative assessment before surgery. Most assessments were face-to-face although some were by telephone. Patients were brought to the ward to look at rooms if possible, shown medical equipment, and a 'Nuffy the Bear Visits Hospital' book to introduce them to the hospital.
- The hospital had a service level agreement to transfer critically ill children and young people to the local NHS hospital. Staff told us that there was a paediatric retrieval service that included 24/7 clinical advice and support.
- The CYP Policy and Standard Operating Procedure (SOP) 9 detailed the delivery of care to CYP. These outlined the staff required to provide service to CYP at two care levels. Any competent and confident nurse could provide Level 1 services (outpatient consultation only including invasive diagnostic procedures) with remote support from a children's nurse available. A children's nurse was required to lead and oversee Level 2 services, outpatient treatment (surgical outpatients-invasive treatment procedures). Staff verified that this policy was applied in practice. This ensured the correct level of care and support was provided when staff provided care to CYP.
- The policy and SOP allow only proficient staff to draw blood from CYP. This included phlebotomists and nurses with experience in CYP blood drawing or medical staff who were competent and confident to draw blood from CYP. Staff told us that in the outpatient department only the RMO or children's nurse drew blood from CYP.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable children, in an online module, as part of their induction.
- Safeguarding of children training was undertaken every year for level one, every two years for level two and every three years for level three.
- The hospital's training tracker reflected that 97% of required staff had completed their Safeguarding Children and Young Adults: Level 1 training. It showed that 95% of required staff had completed their Safeguarding Children and Young Adults: Level 2 training. It showed that 100% of required staff had completed their Safeguarding Children and Young Adults: Level 3 training. This exceeded the hospital's training target of 85% and reflected that staff had received appropriate training to recognise and report safeguarding concerns.
- The matron was the safeguarding lead for children and young people.
- Admitted and day case children were looked after by children's nurses who all held level 3 safeguarding. The matron who, staff explained, was normally on site Monday to Friday also had level 3 training.
- There was a strict criteria for admission of CYP into the hospital requiring children were only admitted when an appropriately trained nurse was on duty. Thus, someone with the appropriate level of safeguarding training should always have been present when a child was admitted.

Mandatory training

- We reviewed the training tracker reflecting mandatory training data for staff involved in the care and treatment of CYP. This showed 93% of relevant staff were up to date with their Paediatric Basic Life Support (PBLS) training and 100% of relevant staff were up to date with their Paediatric Immediate Life Support (PILS). This was better than the Nuffield Health mandatory training target of 85%.
- Please see the Surgery section of this report for the main findings relating to mandatory training topics.

Nursing staffing

- Children's care was planned, delivered and supervised by the registered children's nurses. The registered children's nurses cared for CYP and supported other nurses in providing care.
- The hospital employed two children's nurses, the CYP interim lead and one other children's nurse for 20 hours per week. A third children's nurse was due to begin their contract as the permanent children's lead imminently. When this nurse started, the hospital would have three children's nurses (two full time equivalent) including a clinical lead.
- The service used a staffing ratio of one registered children's nurse to three surgical patients. Staff told us that if they had four children they could get an extra nurse. They said this did not happen often but there was

a system in place to address the scenario. This ratio was better than the Royal College of Nursing (RCN) recommendation of one registered children's nurse to four patients over the age of two. This was the standard for bedside, deliverable hands-on care set out in the RCN's 2013 guidance "Defining staffing levels for children and young people's services".

- Inpatients up to the age of 15 were treated by the children's nurse. Inpatients aged 16-17 were risk assessed and treated by adult nurses when appropriate. This ensured that a nurse with appropriate skills and experience was present during children's inpatient care.
- The hospital ensured the service maintained its nursing staffing ratio by only booking surgery for CYP once the CYP lead nurse confirmed availability of a registered children's nurse to care for the child.
- Staff told us that, in the event that another children's nurse was needed, they could hire agency staff. Staff reported that they tend to use the same agency staff repeatedly and had hired agency staff 15 times over the past year when patients stayed overnight. The use of the same agency staff ensured staff was familiar with the hospital's policies, staff and environment.
- In the outpatient department, children were only seen when a children's nurse was on site. We saw the children's nurses rota was on the outpatient department notice board along with contact information to ensure accurate scheduling and cover.
- In the outpatient department, a children's nurse was present for any invasive treatment procedure for children under age 13. Children over age 13 were risk assessed and treated by a children's or adult nurse depending on the assessment. This ensured that a nurse with appropriate skills and experience was present during children's outpatient care.
- Staff told us that the children's nurses used a diary to record when CYP patients were receiving care. This allowed the children's nurse to follow patients in different parts of the hospital, even when they were not providing direct care.

Medical staffing

- All paediatric patients were under the care of a named consultant.
- Two resident medical officers (RMOs) worked at the hospital on seven day on, seven day off shifts. There was always a RMO on duty at the hospital. Staff could call on the RMO when they needed any medical assistance or advice regarding CYP. This ensured there was medical staff with appropriate training available in the hospital at all times.

Emergency awareness and training

- The hospital reported that the lead nurse for children's services was European Paediatric Advance Life Support (EPALS) trained and was on shift three to four days per week. An RMO, who was also EPALS trained, was resident and onsite at all times. The Matron, deputy matron, ward manager and a theatre recovery nurse also possessed EPLS training.
- The hospital reported that anaesthetists caring for children were paediatric anaesthetists or anaesthetists with regular clinical experience in anaesthetising children and were able to manage airway complications where required.
- Staff told us that they practiced emergency paediatric scenarios.
- For details of the main findings, see information under this sub-heading in the surgery section of this report.

Are services for children and young people effective?

Good

We rated effective as good.

- The service planned and delivered CYP care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- CYP had comprehensive assessments of their needs including wellbeing, nutrition, hydration, pain assessment and other clinical needs.
- Staff were qualified with the skills and experience they needed to carry out their roles effectively and in line with current legislation and best practice. The service had an induction process for new staff that included an assessment of CYP competencies.

- Staff from different disciplines worked together to meet the needs of children and young people who used the service.

Evidence based care and treatment

- The service planned and delivered children and young people's care and treatment in line with current evidence-based guidance, standards, best practice and legislation. The service monitored this to ensure consistency of practice.
- Children and young people had comprehensive assessments of their needs. These included consideration of clinical needs, wellbeing, nutrition and hydration needs. Paediatric patients were risk assessed before any overnight stay. This meant that CYP risk was managed. Patients who were at risk for needing care that the hospital could not provide were transferred to local hospitals with appropriate levels of care.
- Staff were suitably qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The service had a robust induction process for new staff that included an assessment of paediatric competencies.
- Staff from different disciplines worked together to meet the needs of children and young people who used the service across the wards, surgery and outpatient departments.

Pain relief

- Staff had access to hospital and corporate policies and procedures through the hospital's intranet. Staff we spoke to knew how to access the policies and procedures they needed to do their jobs.
- We reviewed the hospital's policies relating to children and young people (CYP). All policies we saw were within their review date. We saw that the hospital based its CYP policies on relevant and current evidence-based guidance and standards. These included National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) guidance.
- For example, the hospital's CYP policy referred to the most recent 2016 Royal College of Anaesthetists guidance on the provision of Paediatric Anaesthesia services and guidance from the Royal College of Surgeons and Royal College of Paediatrics and Child Health. Standard operating procedure (SOP) 9 referred to the NICE Guidelines.
- All dosing for post-operative analgesia were correct in accordance with the British National Formulary for Children. This meant that the hospital was using national guidance to safely administer medication to children.
- A CYP patient we spoke to verified that their pain was controlled throughout their inpatient stay and nurses regularly inquired about his pain levels.

Nutrition and hydration

- The hospital scheduled children's operations at the start of the theatre list to avoid prolonged fasting in young children. This followed the hospital's policy that children's surgery should be scheduled to minimise fasting times and allow at least four hours recovery time.
- The hospital had menus for children that were included in the CYP admission pack. Children were asked for their food order before staying overnight.
- One CYP patient told us that the hospital provided a selection of menu options during their inpatient stay and that the food was good.

Patient outcomes

- The hospital performed a paediatric intra-operative and post-operative pain relief audit. The 4 July 2016 audit reviewed 10 patient records. The audit showed that all children received intra-operative analgesia and 60% received post operative analgesia. All children's pain scores were 0 or 1 prior to discharge. This meant that children's pain was managed during and after procedures.

Competent staff

- Staff reported that children's nurses were provided with specialised training and paediatric competencies. This meant that children's nurses were familiar with every aspect of the paediatric pathway.

- Part of the role of the lead children's nurse was to coordinate all CYP care. This provided assurance that all nurses providing care to CYP had the skills and expertise to provide that care.
- Staff told us that the CYP nurses provided paediatric competencies for adult trained nurses so that adult trained nurses had the skills and experience to help the children's nurses as necessary.
- The matron assigned nurses to support the children's nurses. This ensured that staff with the correct competencies were treating CYP.
- Children's nurses were always on site when CYP were in the hospital for care. Part of the role of the CYP nurses was to support other staff members in providing care to CYP. The presence of children's nurses meant that if any staff member had a question or concern regarding CYP care, the children's nurse could provide support by telephone or in person.

Multidisciplinary working

- The hospital reported that the CYP team was involved in committees including; Audit & Clinical effectiveness committee, Resuscitation committee; Infection Prevention & control; Medicines Management Forum; Local Safeguarding meetings (Early help and quarterly health reference group); Medical Advisory Committee; Children & Young Peoples Service Committee.
- Staff throughout other departments reported that they worked closely with the children's nurses when they treated CYP. They reported that children's nurses were responsive to enquiries and came to other departments to see children as necessary. One staff member told us if they had any CYP questions, they just bleeped the children's nurse and the nurses were 'very responsive'.
- Staff from other departments reported that they correlated CYP appointments with the children's nurses' schedule. This meant that if children were in a department, a children's nurse would be aware that they were there and in the hospital in case they were needed.
- Additionally, there was a CYP link nurse in each department and the physiotherapy department had a paediatric physiotherapist.
- Staff told us that there was a Nuffield corporate children's nurse who provided legislation updates to local CYP lead nurses. The lead nurse disseminated this information to other CYP nurses and staff. This ensured that the CYP team was practicing with understanding of the most recent legislation.

Seven-day services

- Children's nurses were scheduled on the rota from Monday to Friday. There was not a routine provision for CYP care on weekends.
- The hospital carried out most CYP surgery as day case procedures. Any children who needed to stay overnight received care from a registered children's nurse throughout their hospital visit. The hospital delivered care during these periods by hiring agency staff. Staff reported that agency nurses had been used approximately 15 times in the past year.
- There was one day patient who converted to an overnight stay between September 2016 and February 2017. This was due to post surgical pain. This meant agency staff would have been used to cover this night.
- For CYP who needed an overnight stay, see information under this sub-heading in the surgery section of this report for the main findings relating to access to imaging and other seven-day services.

Access to information

- Staff described the discharge process. Consultants saw the patient along with their parent or guardian and gave verbal advice. A registered children's nurse gave additional information. The nurse gave all patients a contact number in case of 'any concerns'. This allowed CYP, their parents or their guardians to contact a nurse for advice if they developed any concerns after they went home.
- Staff explained that a nurse would call the CYP, parent, or guardian within 48 hours after discharge to check on the patient and answer any questions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff explained that in some cases where a CYP under 16 refused treatment, they could use the Gillick

competence test. This was the statutory process for assessing whether children under the age of 16 were competent to make decisions about their own care and treatment.

- We saw that the CYP admissions information contained consent guidance and forms for CYP and their parents or guardians
- A young person and their parents explained that in practice both a parent and the young person had given informed consent in writing before the young person had surgery.
- We reviewed four sets of notes and saw that all had a fully completed consent form for surgery.

Are services for children and young people caring?

Good

We rated caring as good.

- Staff provided compassionate care to patients and their families. The service provided a supportive setting for CYP and their families.
- Children's nurses were able to build relationships with patients and their families. This allowed the nurses to provide reassurance, information and support to patients and families.
- Staff empowered patients to be involved in their own care. They interacted with patients as individuals and considered their age and abilities to provide meaningful and age appropriate information.
- Staff provided emotional support to patients and their families.

Compassionate care

- We saw staff respected CYP's privacy and dignity at the hospital. For instance, we saw staff take CYP patients to a consulting room to discuss their treatment and we did not see any sensitive or private discussions held in public areas. Additionally there was no confidential or sensitive information left on view in public areas.
- We saw staff treat a patient and their family with understanding and respect when the family arrived late for an appointment. Staff were calm and understanding and were able to resolve the family's concerns about being late.
- Staff made patients as comfortable as possible. For instance, they used numbing cream on children's skin to minimise the discomfort of drawing blood.
- Staff interacted with patients in an encouraging, sensitive and supportive manner. Nurses we spoke with cited the hospital's ethos of providing compassionate care. A nurse explained that they, and their colleagues, built rapport with patients and families and could provide comfort and support to patients and families.
- The hospital provided CYP Feedback forms to all inpatients. We reviewed the last ten forms, which reflected that nine patients were extremely happy and one was very happy. Comments included, 'nurses were very attentive', 'nurses were very nice' and 'all staff from the moment we arrived were friendly, helpful and approachable.'

Understanding and involvement of patients and those close to them

- Staff interacted with both patients and their families so they would understand the care, treatment and condition. This was in line with the Royal College of Surgeons "Standards for Children's surgery- Patients and Families" (2013).
- Children's nurses wore brightly coloured tabards when working with young children to identify themselves and engage the children.
- We spoke with two patients aged 16 or under. CYP patients said that the consultants and staff had spoken to them in terms that they understood. They said that consultants, nurses and other staff provided complete information. When CYP asked for further information, staff gave a full answer.
- Another patient noted on their feedback form, 'nurse explained what would happen'. This was in line with the corporate CYP policy, which required staff respect CYP and involve them in their own care.
- Staff recognised when people who used services and those close to them needed additional support to help

them understand and be involved in their care and treatment. Each patient had a children's nurse who usually supported the patient and their family from pre-assessment through the care pathway. Patients met with the nurse at a pre-assessment appointment to discuss concerns. This was generally at a face-to-face appointment although sometimes the appointment was by telephone.

- On admission, the nurse used a CYP admission pack to admit CYP. This included a menu, medical record checklist, Nuffy Bear checklist, consent guide for parents and children, and allergy alert. This meant that patients and family were involved in their care and were fully informed about their procedure(s).
- On discharge, the nurse provided patients and their parents or guardians with contact information so that they could contact the nurses with any concerns. We saw the discharge pack which included emergency information, letters for the GP and school nurse, a medicines chart, feedback form, discharge leaflet and discharge letter. This ensured patients and their families had the information and resources they needed after leaving the hospital.
- The nurses also followed up with patients after surgery by phone within 48 hours. We saw follow up call notes for five patients, the nurse spoke to four and attempted to call one patient three times but had no answer. These calls ensured patients felt involved and could easily ask for help or information.

Emotional support

- Staff understood the impact of their care on the CYP who they cared for as well as their families. Staff reported that they were able to spend the necessary time developing a rapport with the patients and their families. Nurses provided emotional support in their interactions with children and their families. They also supported the patients with distraction techniques whilst they were inpatients or outpatients.
- CYP attended for pre-assessment on the ward with a children's nurse. They could look at the Nuffy Bear Visits Hospital book and see a cannula, mask, electrodes and other equipment that might be used during their procedure. This allowed CYP to get to know the staff that would look after them and to see equipment and the environment they would recover in after surgery.
- When CYP patients went into theatre, both their parent and the children's nurse could go with them.
- Staff members told us about one young child who had built a rapport with a member of the diagnostic imaging staff during the child's time in that department. The child and their mother asked if the member of staff could go with the child to theatre. The request was risk reviewed and it was determined that the staff member could walk the child to theatre so the staff member did so. We saw the child's thank you card saying that they had had a 'wonderful hospital visit'.

Are services for children and young people responsive?

Good

We rated responsive as good.

- The service was flexible in meeting the needs specific to CYP. For instance, the service offered outpatient appointments for CYP during the afternoon, and holidays so that families could attend during non-school hours.
- Patients were able to access appointments quickly and easily.
- The setting was responsive to children's needs. Outpatient and inpatient rooms were decorated in child friendly motifs.
- Children were usually given the first slot on the theatre list to minimise fasting times and maximise recovery time for day patients.

However,

- There were no dedicated CYP clinics or surgery lists.
- There were no dedicated CYP waiting areas.
- Children were not always treated in children's treatment areas.

Service planning and delivery to meet the needs of local people

Good

Services for children and young people

- The service was flexible in meeting the needs specific to CYP. For instance, the service offered outpatient appointments for CYP during the afternoon, and holidays so that families could attend during non-school hours.
- We observed children's rooms that were responsive to children's needs in accordance with the environmental criteria outlined in Department of Health guidance, "You're welcome: Quality criteria for young people friendly health services" (2011).
- Some rooms in the outpatient department and the wards were decorated with child themed wall decals to engage children.
- We observed a box of children's toys and books, for a variety of ages, available under a chair in the diagnostic imaging waiting area. We observed the up to date cleaning rota reflecting that the toys were cleaned regularly. This reflected that clean toys were available for patients and other children visiting the hospital.
- The diagnostic imaging department had reward stickers to give to children at the end of their visit.
- We observed the diagnostic imaging department's projector. This projector was used to project rainbows, disco lights and stars on the ceiling during scans. Staff said that the projector was regularly used in the diagnostic imaging department and that other departments borrowed it for CYP as well.

Access and flow

- Staff explained that the CYP team was involved throughout the CYP pathway. The bookings team received information from the consultant and passed it to the CYP team. The booking team booked an appropriate theatre time and anaesthetist. This ensured that the right staff were present during CYP pre-op, surgery and post-op.
- Staff explained that pre-assessment appointments were tailored around the inpatient list and CYP needs (for instance after school appointments).
- One parent told us that they had been offered appointments and surgery dates to accommodate their child's school schedule, the parents' need to fly in from overseas during a short window and the need for expediency.
- Parents we spoke to reported that scheduling appointments was easy, they could set up appointments by phone at convenient times and that staff supported them in the process.
- We saw one parent with a child arrive late to their appointment. We saw that staff were able to fit in the patient even though they were late. The parent explained later that the appointment had been scheduled to match the child's holiday. They told us the staff had been able to change their schedule so that the family would not need to return later.
- The service scheduled paediatric operations at the start of theatre lists. The Medical Advisory Committee agreed at their 18 July 2016 meeting that children would be prioritised first on the theatre list unless an adult required the slot due to co-morbidities. This helped minimise fasting times and anxiety for children waiting for surgery and provide adequate recovery time in line with the hospitals CYP policy.
- However, there were not dedicated CYP clinics or surgery lists, which is preferable for both the adults and children attending the hospital. This did not meet the Royal College of Surgeons recommendations as outlined in Standards for Children's Surgery, Children's Surgical Forum, 2013.

Meeting people's individual needs

- CYP services were directed towards the needs of children and families. Local policy required a children's nurse to be responsible for admission, pre-operative and post-operative care of CYP.
- There were publications directed to children available at pre-assessment. "Nuffy bear visits the hospital" was a Nuffield specific booklet explaining what a child can expect when visiting the hospital. It featured "Nuffy" the bear, talking about a child's visit to the hospital in child friendly language and cartoon pictures.
- The hospital had access to interpreters of different languages for patients who spoke limited English. We saw posters with contact details for telephone translators, face-to-face translators on the wall in the staff rooms in the outpatient department and on the ward.

Good

Services for children and young people

- Staff showed us the communication cards used to communicate with patients who had communication difficulties. These cards showed pictures of actions and things that were relevant to people in the hospital setting.
- Staff explained that they did not have many patients with disabilities. When they cared for patients with disabilities, they followed the hospitals Standard Operating Procedure. They told us they discussed the disability at the pre-assessment appointment and followed the parent's lead in caring for the child as, 'parents have their own methods.'
- The hospital's CYP policy specifically excluded CYP patients with pre-existing conditions and emergency acute admission (except for readmissions). As a result, the department did not treat CYP with complex needs and was not set up to manage complex CYP.
- Children received an information pack when a pre assessment appointment had been scheduled. This contained information to be completed called 'it's all about me' which included the child's likes and dislikes. The RN told us that one child loved superheroes so a superhero was placed on their bed prior to admission.
- Staff explained that inpatients arrived to find a Nuffy bear on their bed that they could take home. We saw the Nuffy Bear 'Bravery Award' that CYP patients were presented after surgery. These provided reassurance and credit to the hospital's young patients.
- The RN told us that children with learning difficulties would be encouraged to bring a toy from home to support them during their stay.

Learning from complaints and concerns

- People were able to complain to the hospital verbally or in writing. There was information about how to complain on the Nuffield website. On the website, there was a form for patients to use or a pamphlet called "How to Make a Comment or Formal Complaint". The pamphlet explained the complaints process. It directed patients to the hospital director or general manager to make a complaint.
- However, we did not see complaints forms in the patient rooms or outpatient waiting rooms. We did see patient feedback forms. This meant patients could provide feedback but would have to request the form or find it online if they wanted information about how to make a complaint.
- There were no complaints specific to CYP in the past six months. Please see the surgery report for a general discussion of complaints and concerns at the hospital.

Are services for children and young people well-led?

Good

We rated well-led as good.

- The CYP team was going through changes when we visited the site. The CYP lead was in an interim role. Staff expected a permanent CYP lead to take over later in February 2017.
- The future aim for CYP was to grow the department. However, changes to grow the department had not yet begun.
- The CYP team was represented at hospital wide meetings and CYP risk was reviewed and managed.
- In recent months, the department had strengthened controls, increased visibility and improved support to staff.

However,

- Due to the imminent change in CYP management, the leadership and culture in the department could change when a permanent CYP lead takes over.

Vision and strategy for this this core service

- The CYP team was going through changes when we visited the site. The CYP lead was an interim lead. Staff expected a permanent CYP lead to take over later in February 2017.
- Staff explained that the interim lead was an experienced CYP nurse. We saw that the lead worked closely with the matron to manage the CYP department.
- The future aim for paediatrics was to grow the department. However, staff reflected that change would

start after a permanent lead began. Additionally, 17 October 2016 Medical Advisory Committee (MAC) meeting notes showed that further training was necessary before growth began.

- See information under this sub-heading in the surgery section of this report for the main findings.

Governance, risk management and quality measurement

- Corporate Quality Partners worked with CYP staff to ensure that quality systems were in place at the hospital. The quality partners provided guidelines to the hospital. The hospital then responded to tell quality partners whether they following the guidelines.
- Staff told us that any incident involving CYP was reported to the CYP nurse. Either the staff involved or the CYP nurse filled in the incident forms. The incidents were reviewed for trends and trends were discussed at the MAC meetings as reflected by MAC meeting notes.
- The hospital reported that there was CYP representation on the committees including; Audit & Clinical effectiveness committee, Resuscitation committee; Infection Prevention & control; Medicines Management Forum; Local Safeguarding meetings (Early help and quarterly health reference group); Medical Advisory Committee; Children & Young Peoples Service Committee.
- The hospital had a medical advisory committee (MAC), which met quarterly. We saw copies of the minutes and saw that a consultant paediatrician and the Children's Safeguarding Lead attended. The Children's Service Report was a regular item on the agenda as noted in the 18 July 2016 MAC meeting notes. The MAC provided the formal structure for consultants to communicate and reviewed practicing privileges. The MAC provided quality and safety assurances to the hospital board.
- There was no local risk register for CYP. The hospital recorded risks relating to CYP services on the hospital risk register. We saw the hospital recorded services for CYP as an area of moderate risk in August 2016. This was related to delivering CYP service safely, changing standards set by CQC and inadequate numbers of contracted children's nurses.
- The hospital changed CYP services to a low risk in December 2016 after putting controls into place including; action logs and plans, regular review and gap analysis, having a children's nurse approve bookings and book appropriate staff, using a controlled schedule for managing children's surgery and interventional procedures and active recruitment and booking of approved children's nurses.
- The matron attended the local safeguarding meetings as part of their role as the hospital's safeguarding lead. However, there was no evidence from notes of HODS meetings or MAC meetings that information from the local safeguarding meetings was shared.
- See information under this sub-heading in the surgery section of this report for the main findings.

Leadership and culture of service

- The MAC meeting notes, the risk register and staff comment reflected that in the past six months the department had strengthened controls, increased visibility and improved support to staff.
- Staff working with children's nurses spoke positively of the culture. They said that the children's nurses were responsive and supportive.
- The CYP lead in position at the time of our visit was in an interim role. This meant that leadership and culture in the department could change when a permanent lead takes over.
- See information under this sub-heading in the surgery section of this report for the main findings.

Public and staff engagement

- The hospital used a CYP experience feedback form to collect CYP specific feedback from children and/or their parents. We reviewed the 10 most recent forms all of which were positive.
- The hospital's public and staff engagement processes have been reported on under the surgery service within this report.

Innovation, improvement and sustainability

- The hospital planned to expand its range of services for CYP, as it was the only independent CYP provider in the area. October 2016, HODs meeting notes reflected that

allocated CYP rooms were to be assigned the following week. Additionally, 17 October 2016 Medical Advisory Committee (MAC) meeting notes showed that further training was necessary before growth began.

- We saw that the hospital used technology to improve the CYP experience of care. For instance, the diagnostic imaging department used technology to project child friendly images including a rainbow, and night sky during CYP procedures. The surgery department used a tablet to provide distraction to children before and after procedures.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good .

Incidents

- The Nuffield Health Corporate Policy for reporting and management of adverse events and incidents governed the hospital. The policy was due for review in April 2019.
- There was a Standard Operating Procedure (SOP), which explained the processes staff must follow for the recording, management, and investigation of incidents under the Policy. The SOP was due for review in April 2019.
- There were no patient deaths, 'never events' or serious incidents in the outpatient departments from October 2015 to September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. The occurrence of never events could indicate unsafe practice.
- There were 50 clinical incidents in the outpatients and diagnostic service in the reporting period from October 2015 to September 2016. This was above the average of independent providers for which we hold this information.
- There was one non-clinical incident in the outpatients and diagnostic service in the reporting period from October 2015 to September 2016. This was similar to the average rate of independent providers for which we hold this information.
- Staff reflected that the hospital had an open reporting culture and that they knew how and when to report incidents or concerns. Staff gave examples of when they had reported incidents.
- Incidents we reviewed showed that incidents at varying levels of risk (from near misses where there was no harm to incidents where patients were harmed) were reported. This meant that risks were identified and escalated quickly.
- The reports did not always show that learning was taken from incidents, however, when we discussed one incident with staff where no learning was recorded, they were able to describe lessons learned. This showed that learning was not always recorded.
- Staff told us that when there was learning from incidents, it was shared directly with staff and at department staff meetings. We saw that there had been an incident where a patient had to be called back for to have their blood taken two times due to staff errors. Learning was taken and we saw 26 January 2017 staff meeting notes showed that learning was discussed with staff. The notes were kept in the office and staff had signed to reflect that they had read the notes. This meant learning was circulated to improve safety.
- The Nuffield Incident Policy required that staff tell patients when something went wrong in compliance with Regulation 20 of the Health and Social Care Act 2008. This is called the duty of candour. It requires

providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person.

- Staff we spoke to showed understanding of their responsibilities under the duty of candour. Staff were able to provide examples of when they provided information and apologies under the duty of candour. One staff member described how they met the duty of candour by providing an explanation and apology after the incidents regarding blood tests discussed above. Another staff member described contacting a patient about a failed implant, many years after the failure, when further research had provided new, relevant information.
- There was one incident involving ionising radiation. Due to the low level of exposure, the incident did not need to be reported to the Health and Safety Executive or the CQC. We looked at the incident report and e-mail trail relating to evidence of the incident. This reflected that the incident was analysed and actions were put into place.
- We saw several examples of the department's response to incidents where the department reviewed the risks, learned from the event and changed practices.
- For example, a consultant was carrying out a procedure that required suction. The filter stopped working and needed replacement. There was only one spare filter; this meant after replacing the old filter there were no spare filters in the department. There were no other procedures requiring suction scheduled that day. If another procedure requiring suction had been scheduled, the consultant would have had to cancel it. As a result of this incident, the department had changed the way it ordered and now stocks multiple filters.
- In another incident, a nasendoscope became stuck in a patient's nose during a procedure. Following investigation the department could not find why this happened. The department removed the nasendoscope from use and returned it to the manufacturer for assessment. There was no further impact on patients as the department had six other working nasendoscopes.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from healthcare-associated infections. The outpatient department used the Nuffield Health corporate policy for infection prevention and control. The policy outlined arrangements for the prevention, detection and control of Healthcare Associated Infections (HCAIs), including the procedures required in the event of outbreaks of infection. The policy was due for review in May 2018.
- There were no infections of Methicillin-Resistant Staphylococcus Aureus (MRSA) in the outpatient departments from October 2015 to September 2016. MRSA is a type of bacterial infection, it is resistant to many antibiotics and has the capability of causing harm to patients.
- There were no infections of Methicillin-sensitive Staphylococcus Aureus (MSSA) relating to the outpatient department from October 2015 to September 2016. MSSA is a type of bacteria in the same family as MRSA, but is more easily treated.
- There were no infections of Clostridium difficile (C.diff) relating to the outpatient departments from October 2015 to September 2016. C. diff is a type of bacteria that can infect the bowel and cause diarrhoea.
- There were no infections of Escherichia coli (E.coli) relating to the outpatient departments from October 2015 to September 2016. E. coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness, and other illnesses.
- PLACE (patient led assessments of the care environment) assessments see local people go into hospital environments to assess elements of the environment that matter to patients. The hospital's PLACE score was 99% for cleanliness, which was above the England average of 98%.
- The outpatient departments used Standard Operating Procedure (SOP) 01-04 to manage hygiene including the SOP 1 Procedure for Hand Hygiene Technique.
- We saw that the department was performing hand hygiene audits. Staff explained that the infection control lead had trained and supported a Health Care Assistant (HCA) to perform hand hygiene audits. The department

received 100% in the May 2016 audit and 98.6% in the December 2016 audit. Staff told us that the 98.6% was based on one staff member's incomplete removal of false nails and that the matter had been resolved.

- We saw an infection prevention bulletin board in the outpatient department including an up to date action plan, training information and infection prevention committee meeting notes from December 2016. The board was available for staff and patients to see. This reflected a culture that prioritised infection prevention.
- We saw a training list that showed all department members had been trained in aseptic non-touch technique (ANTT) or would be in the next seven weeks. This was part of a hospital wide asepsis training program aimed at reducing the risk of healthcare acquired infection during any invasive procedure.
- All staff we saw in the departments were bare below the elbows, in line with national guidance and in compliance with National Institute of Health and Care Excellence (NICE) guidance. If staff are bare below the elbow they are able to clean their hands more effectively to prevent the spread of infections.
- There were 10 consulting rooms, which were similar in their layout. We looked at four rooms, all of which were clean and tidy. There was carpet in some consulting rooms but the flooring under couches was a hard, wipe clean, surface. Rooms contained sinks with elbow controls taps that did not pour directly into the drain. This complied with Health Building Note (HBN) 00-09: Infection control in the built environment.
- Each room had a dedicated clinical hand wash basin. This meant there were sufficient numbers of hand washing sinks available, in line with HBN 00-09. Soap and disposable hand towels were available next to sinks. We observed hand hygiene posters displayed near sinks.
- Rooms contained fully stocked trollies. We looked at a random sampling of medical supplies on the trollies, these were all in date.
- The rooms had apron and glove dispensers affixed to the wall so that personal protection equipment was available to staff at all times.
- We reviewed a sample of sterile surgical instrument trays. All seals were intact, trays were in date, and there were lot numbers on each pack or tray. This meant the equipment was sterile and could be traced if it needed to be.
- There were separate, clearly identified, waste bins for clinical and domestic waste. This complied with the Department of Health (DH) Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw secure sharps bins were affixed to walls in the treatment and clinical areas where sharps may be used. We saw that these containers were labelled and none was filled above the fill line. This demonstrated compliance with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, 5(1) d.
- We saw evidence of cleaning schedules and a checklist for the department. These showed that equipment that was in contact with patients was cleaned after every use and daily. Telephones were cleaned daily and other equipment was cleaned weekly. We saw the monthly cleaning audit for the past four months reflecting scores of 90% to 93.67% with the exception of one room, which scored 87.7% in October. The target for compliance was 90% to 100%. This meant that the department met cleaning targets most of the time and that the environment was regularly cleaned.
- We reviewed cleaning charts for the most recent six weeks. These showed that all rooms and equipment had been marked as cleaned across that time period. This meant that staff were using clean equipment in a clean environment.
- We saw that the ultrasound probe was cleaned using a medical equipment three-in-one wipe system. We saw the audit trail book, which showed that the probe was decontaminated after each patient and this was recorded. This meant that the probe was clean for every patient.
- Staff told us that the same three-in-one wipe system was used on nasendoscopes in the department. This was in line with the hospital's SOP for the Decontamination of Flexible Endoscopes and Heat Labile Equipment.

Good

Outpatients and diagnostic imaging

Environment and equipment

- The outpatient departments used the Nuffield Health Corporate health and safety policy. The policy aimed to achieve a healthy and safe working environment, provision of safe equipment, the use of safe systems, adequate information, training and supervision. It was due for review May 2019.
- The hospital scored 97% in the PLACE assessment for condition, appearance and maintenance, which was higher than the England average of 93%.
- In January 2017, the outpatient department began monitoring patient feedback using a department specific feedback form. There were six respondents whose rating on average was 90% for both facility comfort and cleanliness.
- We saw that the hospital had contracted with third party provider to manage the facilities. We saw that the facilities management company had a staff member on site who kept maintenance up-to –date using the company's app, which alerted them when routine maintenance was due. We saw that there was some maintenance outstanding. Staff explained that this had built up when a third party staff member had been ill. Staff told us that the company was assigning this work to prioritise its completion.
- Outpatient department staff told us that they found the facilities staff to be timely and responsive when they reported a fault or requested assistance.
- We saw waste was removed from the hospital and kept appropriately in locked bulk storage bins on the hospital premises until collected. This was in line with HTM 07-01, which says bulk storage areas should be, totally enclosed and secure, and kept locked when not in use.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria. Staff explained to us that the cleaners flushed the taps daily. We saw that temperatures were tested weekly and water testing was performed quarterly. These steps are important because they reduce the risk of legionella, a water borne bacteria that causes Legionnaires Disease. We saw the 13 December 2016 certificate reflecting that the hospital passed its most recent legionella test. This was in line with requirement of Health and Safety Executive (HSE) L8; and Health Technical memorandum HTM04-01 A and B: guidance on the control of legionella.
- Facilities staff explained that the hospital was responsive to requests to update equipment for safety health and safety purposes. For instance, when a contractor requested to replace all of the showerheads in the facility due to possible legionella risk, the hospital purchased new showerheads that the contractor installed.
- Flammable liquid was stored in a holding room in the outpatients department. This room was appropriately labelled with hazard signs affixed to the orange cupboard door. This meant that patients and staff were protected from the risks of storing flammable liquid.
- Emergency equipment was located in a treatment room in the outpatients department. Both the children's and adult resuscitation trollies were in secure positions and sealed with emergency tags.
- The trolley checklists showed that staff checked the top of the trolley daily and the defibrillator's PAT test was in date. We saw evidence that the monthly checklist, checking trolley contents, were completed. We reviewed a sample of the trolly's contents and all items were in date and sealed. The paediatric defibrillator was kept on the adult trolley. When we asked staff why it was kept there, we were informed that it was a historic decision and they planned to move it to the paediatric trolley.
- We saw that the department checked temperatures of rooms and fridges daily. We saw, in one incident, a room temperature had risen above the recommended range ('2- 25'C) and was escalated to pharmacy for review of drugs held in the room. Staff knew how to escalate the issue if a room or fridge was outside of recommended range.
- We saw that the department had installed an electronic temperature monitoring system to monitor and log temperature information, but it was not yet in use. This would ensure constant temperature monitoring when it was in use.

Good

Outpatients and diagnostic imaging

- We saw the outpatient end of day checklist that outlined steps to prepare rooms for the next day and secure the department. We saw the most recent week's checklist, which showed checks were carried out. This was verified by a signature and date.
- The hospital's clinical equipment review/ escalation for replacement plan 2017, showed several pieces of equipment in the diagnostic imaging department required replacement. There were five substantial pieces of equipment in the radiology department in need of replacement due to age. Staff explained to us that, while the equipment was old, it was still reliable, passed safety tests and rarely broke down.
- The 16 year old x-ray was on the risk register due to its age. The register showed that the main x-ray machine breaking down was a very low risk due to controls including use of other machines, ability to borrow a machine and ability to outsource urgent requests. Notes from the Heads of Department meeting on 18 October 2016 showed that they planned to complete a local capital expenditure bid to replace the machine.
- The Dexa machine was not working during our inspection. Staff explained that this machine was used for bone density scanning. They told us the machine was not used often, it was due for repair and two patients had been rescheduled. The 2017 clinical equipment review reflected that the machine would not be replaced due to low usage.
- As part of the previous clinical equipment review/ escalation for replacement, the department had replaced its static magnetic resonance imaging (MRI) suite in 2016.
- The previous clinical equipment review/escalation for replacement showed that some of the equipment was old but that the hospital was managing the risk and planning the replacement of old equipment.
- The diagnostic imaging department was equipped with working light up radiation signs to alert people when x-ray was in progress. There was keypad entry to the MRI suite and signs and barriers to the scanner.
- We saw pregnancy warning signs in the diagnostic imaging department to warn people that there was a risk of radiation.
- Staff explained that there were two Radiation Protection Supervisors (RPS) on site. We saw training certificates showing that their training was in date. We were advised that one RPS would be due for updated training in May, and that the training had been scheduled.
- The RPS' role was to ensure compliance with the Ionising Radiation Regulations 1999 (IRR '99) and Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000. The RPS was the first point of reference in the investigation of all radiation related incidents.
- In the event that RPS needed further, expert support and advice, they referred to the Radiation Protection Advisor (RPA). The RPA was contracted from another hospital and was available to provide telephone advice as necessary. The RPA visited the hospital on a yearly basis to audit the service.
- We observed that (IR (ME) R) checklists were kept in every diagnostic imaging room. Staff used these checklists to verify that they were scanning the right patient and the right body part.
- We saw reports reflecting that the department performed regular quality audits, staff reported that the audits were sent to the RPA's hospital for monitoring.
- The audit outcomes were kept in a file in the main office. We saw audits showing areas for improvement. For instance, one audit looked at the scan rejection rate and another found a cracked specialised protective apron. In response to the audits, the department had offered further training and reassessed the rejection rate and the specialist protective apron was taken out of use. This meant that when the audits highlighted areas for improvement, the department used the information to make changes.

Medicines

- The outpatient department used the Nuffield Health Corporate Medicines policy, which was due for review October 2016.
- Staff told us that they do not administer controlled drugs (CDs) in the outpatient department. Our review of the drugs cupboard confirmed that there were no CDs present.

Good

Outpatients and diagnostic imaging

- We looked at the drugs cupboards in the outpatient department. We found the cupboards were locked and drugs were neatly stored and accessible. We checked a sample of drugs, which were all in date. This meant that medicines were secure, accessible and safe for use.
- We saw that temperatures were monitored in the drugs cupboard. A review of the log showed that no temperatures were out of the recommended range (2'-25' C) from November 2016 through the date of inspection.
- Prescription pads were held securely in a wall fixed safe which was opened using a key pad. The keypad code was changed every six months. Prescription pads were allocated to consultants each day and collected by nurses. We saw the log recorded the daily allocation and return of prescription pads dating from September 2016 to present.
- Prescription sheets were not individually logged when they were used. However, staff told us that the pharmacy audited individual script use.
- For our detailed findings on medicines, please see the Safe section in the Surgery report.

Records

- Outpatient data supplied by the hospital confirmed that, no patients were seen without all relevant patient records being available in the past three months.
- We spoke with staff who told us that they could not remember a patient being seen without patient records. One staff member told us that in one example they had to put together a new file when they had not been able to access the patient record. The new file contained the required information and the two files were later put together.
- The outpatient records were kept separate from other hospital records. Consultant notes were kept on site or by the consultant's own secretaries. Patient files were kept on site and delivered to the department by secretaries for clinics. In the department, the records were kept in a locked cupboard in the department office and delivered directly to the consultant for the clinic by the nurse. The consultant returned the notes to the nurse or office on conclusion of the clinic and they were returned to the cupboard. We saw that the cupboard was kept locked throughout the day.
- The hospital was piloting a method of keeping combined records including consultant and hospital records. Six consultants in the outpatient department were involved in the pilot but it had not yet been decided whether the pilot would be adopted throughout the hospital.
- The outpatient department performed a monthly care record audit looking at 17 pieces of information documented in the care record. The audit showed that from September to November 2016 (the most recent information), the department generally scored 90%-100%. There were two areas that were consistently low: 'use of ANTT [aseptic non-touch technique] documents', which scored 50% to 90% and 'dates and times', which 40% to 50%.
- Staff explained that the hospital had rolled out a hospital wide ANTT training program. We saw training information showing all staff had completed this training or were scheduled to do so by March 2017. One staff member told us that they expected the audit results to improve with the training.
- Staff told us that the 'dates and times' score showed that recorders had used a 12 hour clock rather than 24 hour clock. To improve this number the manager reminded all staff to use the 24 hour clock at a team meeting. We also observed a poster reminding staff to use the 24 hour clock on the outpatient's staff bulleting board.
- We looked at six adult outpatient care records. All the records reviewed were legible and all sections were completed, dated and signed. Consent forms were completed and the care pathways were clearly documented.

Safeguarding

- The hospital reported no safeguarding concerns from October 2015 to September 2016.
- The hospital had a Female Genital Mutilation (FGM) standard operating procedure (SOP), which outlined FGM and its effects. However, staff told us they had not received FGM training. This meant the hospital could not be confident that staff would know how to raise FGM as a safeguarding concern.

Good

Outpatients and diagnostic imaging

- Staff we spoke to told us that they had received safeguarding training, understood it and thought it was useful. Staff said they had not made a safeguarding report at this hospital but could refer to the flowcharts or senior staff if they had questions or concerns.
- We saw safeguarding flowcharts in offices throughout the outpatient departments. These flow charts contained actions to be taken and who to contact in the event of adult or child safeguarding issues arising. Staff told us the actions they would take if they suspected a safeguarding incident; this was in line with the hospital's safeguarding policy.
- All staff members were required to complete level 1 Safeguarding children and young people and level 1 Safeguarding vulnerable adults as part of their induction and to update the training annually. This training was provided as e-learning modules which staff could complete at their own pace. Heads of Department and nursing staff were required to complete safeguarding level 2 training as an e-module and update it every two years. The hospital's mandatory training policy required staff to complete these modules within one month of joining.
- The training tracker showed that 100% of staff in the outpatient and diagnostic imaging departments had completed their required Safeguarding Children and Young People training.
- The training tracker showed that 100% of required diagnostic imaging staff had completed Safeguarding Vulnerable Adults training, but only 88% of outpatient staff had completed Safeguarding Vulnerable Adults training. This showed that one of eight required staff members had not completed the training.
- Staff told us that one member of staff had not completed safeguarding training because they were new and still in their training period. They told us that they believed new staff had three months to complete this mandatory training, although the policy stated they had one month. This meant that not all staff understood the policy regarding when training should be completed and, until the training was completed, the hospital did not have assurance all staff had the necessary up-to-date safeguarding training to keep patients safe.
- In the diagnostic imaging department we observed staff 'paused and checked' patients' identifications before proceeding. This ensured the right person received the right radiological scan of the right body part.

Mandatory training

- The outpatient department followed the Nuffield Health Corporate Mandatory Training policy, due for review in July 2018. The policy defined processes, roles and responsibilities involved in the management of mandatory training throughout Nuffield Health.
- The mandatory training requirements varied by division and role but included courses covering clinical updates, consent, record keeping, governance, ethics, safeguarding and patient protection, health and safety, and whistleblowing.
- The hospital's mandatory training rate target was 85%.
- The tracker showed that some modules had 67% compliance because one of three required staff members had not completed the training. Staff explained that again, this was because new staff had three months to complete training. The staff member who had not completed training was expected to complete the training within the allotted time period. This means that while the department had not met its target, there was a reason and the department was expected to meet its targets in line with its own policy.
- We were advised that the tracker reflected erroneous training rates for Basic Life support and Paediatric Basic Life Support. We have requested further information which reflected that the rates, at the time of the second request, were 100% for both Basic Life Support and Paediatric Basic Life support.
- The training tracker showed that training rates for manual handling were 38% for outpatient staff and 43% for diagnostic imaging staff. The hospital told us that this was due to a change in training. The hospital used to provide generic manual handling training but is now providing department specific manual handling training on site. The tracker showed training levels with regard to the new training. We saw the training plan which showed that all staff due for training would be trained

by the end of quarter two. However, this indicated that staff is not fully compliant with mandatory training at the time of the inspection which could put patients or staff at risk.

Nursing staffing

- The hospital reported that the vacancy rate for full time nursing posts as of 1 October 2016 was 100%. This meant that there were no nurses employed for the outpatients department on that date. This was above the average of independent hospitals for which we hold this type of data.
- However, at the conclusion of our inspection three nurses were in post in the outpatient department. This included the outpatient department manager, who also performed clinical duties and came into post in October 2016. A senior nurse began in November 2016 and another nurse began in February 2017.
- Staff informed us that they had received funding to hire one more nurse for 20 hour per week. When that nurse began employment, the department would be fully clinically staffed.
- Sickness rates for outpatient nurses were variable from October 2015 to September 2016. Sickness rates were higher than the average of independent hospitals we hold this type of data for in October and November 2015 and January and March 2016.
- The use of bank and agency nurses during the reporting period from October 2015 to September 2016 was higher in the outpatient and diagnostic imaging departments than the average of independent providers for which we hold this information.
- Staff explained that due to the high turnover of registered nurses, experienced bank nurses had been used to fill shifts.
- Staff reported that they were able to fully staff every shift using permanent and bank staff. The current rota showed that shifts were staffed at planned levels.
- Staff said that there had previously been communication problems in the department resulting in high turn over, but that they believed that these had been resolved since changes at the management and senior management levels. This meant that while there was previously high nursing turn over, staff told us that the underlying issues causing this turn over had been resolved. At the time of inspection it was too early to see if the staff turnover rates would remain low.
- The use of bank and agency health care assistants (HCAs) during the same period was 0% in the outpatient and diagnostic imaging departments. This was lower than the average of independent providers for which we hold this information.
- Sickness rates for outpatient HCAs were variable during the same period. Sickness rates were higher than the average of independent hospitals we hold this type of data for in November 2015 and February, April and September 2016.
- On 1 October 2016 there were no vacancies for outpatient HCAs. Due to the small values, no comparative rate was available.

Medical staffing

- The hospital granted practicing privileges under the Nuffield Practicing Privileges Policy, which is due for review in June 2018. The policy provided details of the criteria and conditions under which licensed registered medical practitioners may be granted authorisation by the Hospital Director to undertake the care and treatment of patients in a Nuffield Health Hospital.
- Staff explained that consultants scheduled their outpatient consultations according to their patients and their own needs. The consultants arranged clinic times with the department manager to assure that there was adequate staffing to support the consultant's needs.
- There was an RMO on site at all times. They could provide support to the outpatient departments in the event of an emergency or if patients required additional medical support.
- For our detailed findings on medical staffing please see the Safe section in the surgery report.

Emergency awareness and training

- The hospital used the Nuffield Health Clinical Risk Management Strategy to promote the reduction of clinical and non-clinical risks associated with healthcare. The strategy was due for review in October 2017.

Good

Outpatients and diagnostic imaging

- Comprehensive risk assessments were carried out for people who used the service and risk management plans were developed. We saw the department's risk assessments and associated plans and saw that they detailed concerns, risks and an action plan.
- For example, we saw that staff performed a risk assessment with regard to staffing. In the risk assessment, risks were identified and an action plan was created that provided short and long term actions. This meant that the risk was managed, information was shared with staff and management and the likelihood of impact on patients was lessened.
- We saw that management reviewed risk assessments and risks were put on the hospital's risk register, which meant that the risks were evaluated and managed.
- We saw fire exits were clearly marked, fire seals were intact on fire doors and fire extinguishers were clearly marked for their purpose and were in date. Staff told us a weekly fire alarm test took place. We were present for the test; we were able to hear the alarm, and witnessed a staff member respond by calling to verify they had heard the alarm and it was a test.
- Staff explained that they had regular emergency practice scenarios. The most recent scenario involved an emergency in the radiology department. Staff members in different roles described their involvement in the scenario. They said they had learned from the scenario and felt the hospital was prepared for emergencies. They also noted that staff's fast response times had been reassuring.
- One staff member described actions they would take if they were alone in a consulting room with a patient and there were an emergency. They described ringing the alarm bell for assistance and starting the 'ABCs' (emergency treatment). They knew there was a phone number to call for treatment in an emergency and where this was posted. This reflected that the staff member could react in an emergency and had an understanding of emergency procedures.

Are outpatients and diagnostic imaging services effective?

We do not rate effective as we do not currently collect enough evidence to rate.

Evidence-based care and treatment

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) and the Royal Colleges guidelines.
- Staff in the outpatient department told us they followed national and local guidelines and standards to ensure effective and safe care. They cited National Institute for Health and Care Excellence (NICE) and other guidance.
- Staff members told us they read professional publications and attended courses to keep up-to-date of changes to guidance and disseminating this information to other staff members.
- We saw NICE guidelines NCG45 for preoperative tests were on display in the phlebotomy room. This meant the hospital could be confident that staff were ordering the right tests and unnecessary testing was avoided.
- We saw the department used an outpatient surgery safety checklist adapted from the World Health Organisation (WHO) surgery checklist. We saw that the checklist was completed, signed and attached to patient records on the two outpatient surgery patient records we looked at. This meant that the department used a procedure to reduce risks to patients having outpatient surgery.
- In the diagnostic imaging department, staff told us that two team members were members of the Society of Radiographers. They received regular e-mails and the Society journal, which they share with other staff.
- We saw a 5-point identification IR (ME) R checklist in every diagnostic imaging treatment room. This required staff to ask patients five identification questions and ask about pregnancy status. We observed staff using the checklist with patients. This ensured patient safety by verifying that staff scanned the right patient and right body part.
- We saw 'dignity' folders in the outpatient department office which were staff member's folders that provided information about meeting standards to provide dignified treatment to individual patients. We reviewed one of the dignity folders, which included NICE Guidelines, RCN guidelines and their own departmental 15 steps Challenge – quality from a patient's prospective guidance.

- Staff told us that they had received equality training and had not witnessed any discrimination at the hospital.
- We saw that technology was used to enhance the provision of care in the diagnostic imaging department. For instance, last year the hospital purchased a new MRI suite that allowed patients to listen to the music of their choice while watching moving pictures to promote relaxation.
- The outpatient department undertook a variety of local audits. They were to check equipment, medicines management, hand hygiene, and compliance with policies. We saw copies of these audits. Some audits, such as the chaperoning audit, were introduced recently and no actions had been taken. Some audits, such as the records audit, had resulted in changes to procedure, which we saw.

Pain relief

- During our inspection, we did not find any patients who were in pain, or required pain relief. However, staff described how they would offer support to patients who reported being in pain. Staff said that they would assess the level of pain and speak with the consultant for pain relief to be prescribed.
- Staff in outpatients told us that they did not use a specific pain-scoring tool. However, they described asking patients about pain levels after procedures and at follow up visits.
- One staff member described pain being 'what the patient says it is', and managing pain based on the patient's experience. For example, a staff member told us about a patient who had not been taking their pain medication because it was a suppository, which they did not like. The staff member was able to contact the consultant who prescribed medication the patient was willing to take.
- Staff told us that if they could not contact a consultant about a patient's pain levels, they called the RMO on duty for assistance.

Nutrition and hydration

- The hospital scored 87% for organisational food, which was below the England average of 91%.
- Staff told us that patients were not generally offered food in outpatients but they were offered coffee, tea or hot chocolate after procedures when they stayed for observation. Hot drinks were available to patients, free of charge, from machines in the outpatient and general waiting areas.

Patient outcomes

- The outpatient department did not audit outpatient outcomes specifically, although a staff member described measuring outcomes as reflected in the Surgery part of the report.
- The diagnostic imaging department performed a variety of audits including, for example; dose reference levels, reject rate audits, mammography, image quality, patient journey, reporting of theatre images.
- We saw the diagnostic imaging department used audit information to improve care. For instance, the audits reflected a high rejection rate for one type of x-ray. A staff member explained that all pertinent staff had received training in the specialised technique. Audit results we reviewed reflected reject rates then fell from 3% to 5% to as low as 2.3%.
- The diagnostic imaging department surveyed consultants about their experience with the department. We reviewed the survey results, which showed that consultants were generally happy with the service provided by the diagnostic imaging department. The main concerns found in the audit were that consultants would like new, specialised, equipment and to improve reporting times.
- Generally, consultants were happy with reporting times. Reports following diagnostic procedures could be made available on the same day, when necessary staff were present, or were otherwise made within two days. Concerns were raised in the survey about delivery times and double reporting times. Staff said that to address this they now delivered reports directly to some consultants, although reports were also immediately available on the internal electronic system.
- Staff told us that there was not a delay. They explained that when a test required double reporting, (where two radiologists review the result) it took longer because two staff members were involved.
- Staff told us that double reporting was important when reading mammograms because it ensured the patient was given correct results. A staff member told us they

believed ensuring test results were correct outweighed the risk of relaying an erroneous, but quick, result based on a single review. Staff we spoke to did not believe that the department had misreported a mammography in recent years, if ever.

- For our detailed findings on Patient outcomes, please see the Effective section in the surgery report.

Competent staff

- The hospital reported that 100% of outpatient and diagnostic imaging staff had received their 2016 appraisals. The staff member told us that the appraisals were currently in process and would be complete by the deadline.
- One staff member told us the process was valuable. They were encouraged to recommend changes to improve the department and their learning needs had been discussed.
- Staff told us that the department manager was reviewing all staff competencies as part of the appraisal process.
- A new member of staff told us they had four weekly probation reviews with their manager. They said these were useful and supportive.
- Staff across the outpatient departments described Nuffield's support for continued learning. Staff were able to identify their own developmental areas independently or with support. They told us they received funding for continuing professional development (CPD), further education, training and funding to attend conferences. They told us they viewed webinars on a variety of topics and went to informal training, for example speakers at meetings and lunchtime.
- Staff told us that they were also involved in creating educational tools. For example, one staff member had recently created a webinar about her specialty.
- Staff told us about training they had taken to increase their skills. For example, some staff told us they received training in clinical areas for example, training to use a specific x-ray machine effectively, to perform urodynamic testing and to remove clips.
- One staff member told us they received training and support to perform auditing.
- One staff member told us that they had requested wound care training for this year and believed it would be available based on discussions with their manager. Continued training meant that there were more staff available to perform certain procedures and staff were adding to their skill set.
- However, staff told us that it had been difficult to access training during the past year due to low staff numbers. Staff said they believed, based on discussions with senior staff members, that they would have more opportunities for training in the upcoming year.

Multidisciplinary working

- Staff reported there had previously been a lack of communication between departments and from management. However, staff in the outpatients departments told us, there was now open communication and a multidisciplinary approach to care. Diagnostic imaging staff described working closely with individual consultants to identify consultant needs and consultants confirmed this. We saw the department sent out surveys to consultants to identify satisfaction and learning points. This provided valuable information and staff told us that other departments were also adopting this practice.
- An outpatient staff member told us they worked with other departments to learn about their practices and build relationships. They said this practice had been stopped last year when permanent staff numbers were low. They told us they had recently been encouraged to start the cross departmental training again. This meant staff would have the opportunity to share best practices and build relationships with other departments.
- Staff described close working relationships with specialist oncology, breast care and paediatric nurses. The specialist nurses were available to answer questions and attend patients as necessary. Staff told us that the specialist nurses were very responsive to requests for assistance.
- We saw that departments linked schedules so that the radiology and pathology departments were open when the consultants who used them had clinics. This scheduling allowed patients to go for their tests immediately. This meant results were not delayed, patients did not have to return for tests and relevant staff were available to discuss care.

Good

Outpatients and diagnostic imaging

- Staff from outpatient, diagnostic imaging and physiotherapy departments told us about 'lunch and learn' sessions with GPs. At these sessions, staff and GPs shared information about the services they provided. This meant they could have an understanding of services offered in the community and exchange information.
- Diagnostic imaging staff told us they had good links with diagnostic imaging departments at other hospitals who they liaised with to make use of previous images of the same person requiring the test.
- Physiotherapy staff told us that they did a handover with staff on the wards every morning to share information about patients.
- Staff in all of the outpatient departments told us they had good relationships with consultants. This ensured that staff could share necessary information about patients and provide holistic care.

Access to information

- The hospital kept its patient records in paper format. We saw the consultants managed their own notes and could choose to keep them electronically or on paper.
- Outpatient data supplied by the hospital confirmed that no patients were seen without all relevant patient records being available in the past three months.
- Staff members told us of one incident where a patient record had been returned to the filing department and could not be found. Staff were able to put together a new file before the patient's appointment and the file was later found.
- As a result of this incident, the department changed the way they managed files so that the return files were kept on a shelf separate from the active files.
- The imaging department told us there was a 48 hour reporting time for most scans. It was only when a scan needed a second opinion (double reporting) that results would take longer. All images were saved to the picture archiving and communication system, which linked directly to the computerised radiology information system. This meant that the images were immediately stored on the patient's record and available for the consultant's review.
- Staff told us that they delivered reports directly to some consultants when the consultant requested this service.
- In the physiotherapy department, physiotherapists recorded all notes electronically. This meant notes were centralised, safe and accessible.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The outpatient departments followed the Nuffield Health corporate consent and Mental Capacity Act (MCA), 2005 and Deprivation of Liberty Safeguards (DoLS) policies. Both policies were due for review in 2018. The policies included the law that applied to anyone who lacked the mental capacity needed to make their own decisions about their medical treatment.
- The training tracker showed that 88%, or seven of eight required outpatient department staff and 100% of required diagnostic imaging staff, had completed their consent training.
- It showed that 67%, or two of three required outpatient department staff, and 100% of required diagnostic imaging staff, had completed MCA and DoLS training.
- Outpatient department staff told us that the person who had not completed training was a new member of staff who was still in their three month training period. This meant the staff member's training was not overdue.
- Staff regularly consented patients prior to outpatient procedures. We saw that the consent form was part of the admissions pack for each patient. We reviewed six adult outpatient records. The records showed that verbal or written consent was taken and documented in each case. Where there was written consent, the documentation was complete and had been signed and dated by the patient and consultant.
- The training tracker showed that 100% of required staff in the diagnostic imaging department had completed their MCA and DoLS training.
- A staff member told us MCA had been discussed at the last team meeting and that they were familiar with the MCA forms. They said outpatient care was not urgent so they had time to review concerns and take advice as necessary in the outpatients departments.

Good

Outpatients and diagnostic imaging

- We observed MCA and DoLS informational documents displayed on the staff bulletin board.
- Nursing staff were aware of DoLS and MCA, but could not remember an incident in the outpatient department when they had needed to be used.
- The hospitals 2017 Quality and Improvement Plan highlighted MCA and DoLS as areas where the hospital would provide training to ensure learning and understanding.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- The outpatient department followed the Nuffield Health Privacy & Dignity Policy, due for review January 2017. The policy included the Policy and Standard Operating Procedures (SOPs) for promoting the privacy and dignity of patients.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction about care they have received. The hospital's Friends and Family Test scores from April 2016 to September 2016 were 96% to 98%, which was lower than the England average. The response rate was 16% to 32%, which was also lower than the England average. The hospital reported that the rates were rising and they were working to continue this trend. This showed that most patients were positive about recommending the hospital to their friends and family. However, on average, patients were not as likely to recommend this provider as other independent hospitals.
- We observed that staff treated patients and their families with care, dignity and respect. Staff welcomed the patients into the department and directed them to free refreshments and the waiting area.
- We witnessed staff treating older patients with great dignity.
- Chaperones were available for patients. Information about chaperones was provided in hospital literature and we saw posters on display in the department. The January 2017, chaperone audit reviewed five patient visits. The audit showed that 100% of patients were told that chaperones were available. This information was provided in their appointment letter or on arrival at the hospital and that they all used the chaperone. However, the audit reflected that one patient who used a chaperone was 'not specifically' offered one.
- Staff took the time to interact with patients and family in a respectful fashion. Patients we spoke to were all happy with the way staff interacted with them. One patient told us that the staff were, 'lovely'. Another said that staff, had listened, were straightforward and helpful and had provided detailed information.
- Staff showed an encouraging and supportive attitude toward patients. One staff member told us about coming into the hospital on Christmas day, when the department was closed, to change a dressing on a patient, following surgery, that needed to be changed daily.
- Staff stated that they had not seen any disrespectful, discriminatory or abusive behaviour, but that they would know how to report it if they did.
- Staff reflected that they recognised the importance of maintaining patient's confidentiality, privacy and dignity. However, the department's reception desks were on a hallway next to small waiting rooms and there was no private space in the area. This meant patient conversations with staff outside of consulting rooms could be overheard in the reception area.
- We saw thank you letters and notes in diagnostic imaging reflecting that patients' experiences were made much better by the radiographer's kindness.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. Patients reported that they liked the detailed information that they were provided by staff. They also told us that when they called the department with a question, staff were always quick to answer with detailed information.

Good

Outpatients and diagnostic imaging

- Patients reported that their conditions and treatment were explained to them in ways that they could understand.
- One patient highlighted appreciating the written instructions they received after a test, which detailed when and how to access results and how to get further information.
- Staff provided holistic care. One staff member described seeing a patient who had recently had surgery, for an unrelated procedure. The staff member could see that the patient was in post surgical pain, which the patient thought was normal. The staff member was able to arrange for the patient to see the consultant the next day.
- Staff also had access to communication cards to help communicate directly with any patient who might have difficulty in speaking, such as patients who did not speak English, had learning difficulties or were living with dementia. Staff members from the outpatient and diagnostic imaging departments described the cards and one staff member demonstrated how they used them to communicate. This meant staff could interact directly with patients to communicate simple ideas.
- Staff told us that, in accordance with the company's values, patients always came before profits. This was reflected in the care. One staff member explained that they discussed certain costs of treatment with patients such as the cost of dressings. They told us that if dressings were too expensive for a patient, they would refer them to their GP to get the dressings.
- One staff member explained that the secretaries generally sent costs of treatment to the patients before their appointment. Insured patients were reminded to discuss costs with their insurer. If a consultant ordered further tests at the consultation, she said the nurses used a charge sheet to discuss costs with patients. Another staff member said that they discussed costs when the patient raised them. This meant that patients may not have got costs information if they did not ask for it.
- One patient we spoke with said they had received an unexpected invoice. The patient was responsible to pay a certain amount before his insurance began to pay for care. The patient said that they had not received any information about costs prior to the appointment, until receiving an invoice. The patient told us that the invoice was higher than expected but they did not make a complaint. The patient said that, despite the unexpected invoice, they rated the service received as ten out of ten.

Emotional support

- Staff understood the impact that a patient's care, treatment and condition had on their wellbeing. Staff we spoke to stressed the importance of treating patients as individuals.
- One staff member described an experience with a patient who had had life altering surgery. The staff member spoke with the patient about post surgical care and gave the patient options about dressings. The patient said that having control over their own care, after life altering surgery, was empowering.
- Another staff member described talking to patients during procedures to put them at ease. They talked about managing an anxious patient who felt faint after blood tests by offering them a glass of water, sitting with them and talking with them until they were ready to leave.
- A member of diagnostic imaging staff explained how they had supported a young patient during their diagnostic imaging test by explaining the tests and being at hand. Later, the patient requested that the staff member be present to support them when they went in for surgery. This was arranged and the staff member was able to provide emotional support throughout the patient's pathway.

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 needs of the local population were used to inform how services were planned and delivered. The outpatients department provided care for patients from NHS lists to respond to local demand and minimise NHS waiting times.

Good

Outpatients and diagnostic imaging

- One staff member explained that when weighing if they could meet new demands, they considered the departmental impact as well as whether there would be enough demand for staff to maintain competencies. This ensured staff had the time, skills and experience to provide the care offered by the hospital.
- The hospital had begun holding monthly staff and patient forums to better understand patients' views. Only one forum had occurred and the hospital was reviewing how to maximise its value and patient turnout.
- The outpatient department added Saturday and evening services to meet demand. It was open Monday to Friday from 8am to 9pm and Saturday from 8am to 4pm.
- The diagnostic imaging department added service access when there was patient demand. It was open Monday to Friday from 8am to 8pm Saturday from 8am to 4pm.
- The physiotherapy department added service access to meet demand. It was open Monday through Friday 8am to 5pm or 7pm and alternating Saturdays.
- Extended opening hours for outpatient, and diagnostic imaging meant patients could be seen after work and on Saturday mornings.
- Between 2011 and 2016, the diagnostic imaging department increased MRI availability from two days a week to four and half days and added Saturday service to meet patient demand. As a result of the increased demand, the hospital invested in a new MRI suite in 2016 that allowed patients to listen to music of their choice while watching moving pictures during the scan.
- In 2016, the hospital started to offer computerised tomography (CT) colonoscopy. Staff told us patients preferred this to the traditional colonoscopy as the preparation was easier and did not require patients to have an enema.
- Some consultation rooms were used for specific specialties, with dedicated equipment, for example; gynaecology and urology. This meant the consultant would be able to work in an appropriate room according to their specialty and staff could be arranged to support and deliver the service.
- The hospital offered ample free parking and was accessible by public transportation.

Access and flow

- The hospital exceeded the target requiring that at least 92% of patients on incomplete pathways wait 18 weeks or less for treatment. Patients received their first incident of treatment 100% of the time during the period from October 2015 to September 2016.
- Patients started non-admitted treatment with 18 weeks or less 100% of the time during the period from October 2015 to September 2016.
- Patients said it was easy to access appointments and they were offered convenient and rapid appointment times. One patient explained that they had waited about a week for their first appointment, and that it was arranged for a time that suited them. The patient said they had been able to rearrange appointments and had made follow up appointments by e-mail.
- Outpatients initially booked in at the outpatient's reception desk, they were then directed to one of two waiting rooms. There were hot drinks and reading material available to patients while they waited.
- Staff told us they would alert patients if clinics were running late but that this rarely happened. We observed patients waiting for short periods or walking directly into their appointments during our inspection.
- Staff reported that clinics ran on time save for, at times, the oncology consultants. They stated that patients accepted that due to the nature of oncology appointments they might run over but that they would have as long as they needed to speak to the consultant themselves. We did not speak to any patients who verified or denied this.
- In some cases, oncology appointments were scheduled for one hour rather than 15 to 30 minutes to avoid over running and delays.
- From September 2016 to February 2017, 13 clinics were cancelled by the hospital affecting 25 patients. The hospital gave patients nine to 31 days notice of the cancellations. Clinics were cancelled because; consultants were not available or on call, a patient required hospital admission and bereavement. Patients

were rebooked for dates seven days before their original appointment to 14 days after. This meant that clinics were cancelled but patients were given notice and provided timely alternative appointments.

- The outpatient and diagnostic imaging departments worked together to coordinate schedules. This meant when a consultant ordered a scan, the patient could go directly to the imaging department rather than having to schedule it and return another day. A staff member in diagnostic imaging said that if a consultant stayed late, they would stay until the clinic was finished. This provided faster results and minimised disruption for patients.

Meeting people's individual needs

- Staff reported that the service took account of people with different needs including dementia, learning disabilities and physical limitations. Staff gave examples of support provided to patients and their family members.
- An interpreting service for patients who did not speak English was available. Hospital staff members were able to provide translation services in several languages. These staff members' details were kept on a list which was accessible to staff. Staff could alternatively access the NHS language line.
- One staff member told us how they helped to manage patient's pain. Staff told use that the level of pain with most outpatient procedures was low. One staff member stated that they asked patients about pain levels and if the patient was unhappy with their pain levels staff would turn to the RMO for further pain management.
- Another member of staff member explained how they helped minimise the use of enemas, which are required before certain diagnostic imaging procedures. They explained that taking enemas could be physically and emotional difficult for patients who found the process uncomfortable and humiliating. As a result, the staff member worked to offer an alternative, CT colonoscopies. The hospital offered CT colonoscopies, which provided the same information without requiring the enema.
- Hearing loops were available at the reception desk, which helped those who used hearing aids to access services on an equal basis to others.
- We observed information leaflets about a range of concerns including dementia in the patient waiting areas.
- Staff told us that consultants knew their patients and advised nurses if patients were coming into the department who required extra support. This could be communication requirements, need for a wheelchair, or any other extra support.
- There was a communication folder in the outpatient department office with information about communicating with people with different needs. It included picture cards with a variety of images showing things that were relevant in a medical setting such as body parts and equipment. Staff demonstrated how they could use the cards to communicate with patients.
- The service had ordered a dementia scrapbook, dominoes, and memory cards to increase engagement with patients and family members living with dementia.
- Staff told us that they apply the dementia policy when caring for patients living with dementia. Staff discussed giving extra time to patients who needed it, listening, making sure they understood and being there to help. One staff member described sitting with a patient's family member who was living with dementia so that the patient could see the consultant without distraction.
- Staff told us about one staff member who requested and received training to become a 'dementia friend'. They used the training when caring for patients living with dementia.
- Staff told us that they did not see many adult patients with learning disabilities and were not able to think of any examples of when they had. Staff said they would speak to the department manager with questions about treating patients with learning disabilities as necessary. See the Children and Young People section of the report for information about children with learning disabilities.
- The departments provided physical access to services including wheelchair service for patients who needed it.
- In the physiotherapy department, physiotherapists wrote individual programs for each patient. The physiotherapist e-mailed the program to patients and/or provided a paper copy.

Good

Outpatients and diagnostic imaging

- The hospital was focusing on making services more accessible for patients with different needs as reflected in the hospital's Quality improvement plan 2017. The plan included reviewing evening and weekend services and weekly patient capacity meetings to review and plan for patients with special needs.

Learning from complaints and concerns

- The outpatient department followed the Nuffield Health Group Policy for the Management of Concerns and Complaints, due for review in 2018. The policy included the Standard Operating Procedure (SOP) 1: on the Process for Managing Concerns and Complaints in Hospitals, which set out the process by which concerns and complaints were handled and managed across Nuffield Health.
- Complaints information and a complaints form were available on the hospital's internet site and we saw patient feedback cards placed in the outpatient department's waiting rooms.
- There was a Nuffield Complaints leaflet, which outlined the three stages of the Nuffield complaints procedure. Stage one was a written complaint sent to the hospital director or general manager, stage two was a written complaint to the Chief Operating Officer and stage three was a review by an independent, external adjudicator.
- The standard operating procedure (SOP) stated there should be acknowledgement of a complaint, in writing, within two working days and response within 20 days (which could state the investigation required further time if necessary).
- From June to December 2016 there was one complaint about the outpatient department. The complaint was made by telephone to the Matron on 20 October 2016, an acknowledgment was sent 2 November 2016. This meant the hospital did not meet the target of responding, in writing, within two working days.
- The complaints tracker showed that a response to the complaint was sent on 21 November 2016. This did not meet the target of 20 working days.
- The response letter was dated 24 October 2016, this date was clearly a mistake based on the above information. This error did not show the patient that care was taken in responding to their complaint.
- However, excepting the date, the letter showed that the complaint was taken seriously. It outlined an understanding of the complaint and the steps that the hospital had taken to resolve the patient's concerns about care. Finally, the writer thanked the complainant for writing and invited them to make further contact if necessary. This showed that the hospital did not meet all of its internal targets, but it did provide a meaningful response to the complainant.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- Nuffield Health had clear corporate Beliefs and Values, which had recently been 'refreshed' at corporate level. Staff were able to tell us that the values were changing, if not to discuss the new values in detail. The hospital values were well embedded with staff, who were able to explain the hospital's vision and values across the outpatient and digital imaging department. For example, staff members described how quality patient care was their primary focus and that they were encouraged to recommend innovations to care and processes.
- The hospital director, Matron and outpatient department manager were all new to post. The outpatient department manager had been in post for four months.
- We saw the Matron's Vision and One Year Plan prominently displayed on the outpatient department notice board.
- Staff told us that the new outpatient manager focused on patients and safety. The manager focused on staffing, as there were no permanent nurses in the department when they took over the role. We saw the manager's risk assessment of staffing, short-term actions to address patient care and longer-term actions taken to fully staff the department.
- We saw evidence that showed the department had progressed against delivering the plan. At the time of

inspection, the department had three clinical staff members in post (including the manager), and one remaining 20 hours per week post to fill. The department had been granted funding for the remaining post and were advertising for the role.

- The diagnostic imaging department was well established with experienced staff and management. Staff and the manager showed understanding of the Nuffield values and behaviours. For instance, staff described patient centred care and innovations that had improved and developed the including the new MRI suite and CT colonoscopy.
- The hospital had implemented a 'quality improvement journey' or continuous improvement plan. For more information about the hospital's improvement, plan and overarching vision please see the Surgery section of the report.

Governance, risk management and quality measurement

- The hospital had a risk management strategy setting out a system for continuous risk management. Risks could be identified and reported by any staff member. The risks were reported by Heads of Department (HoD) to the Senior Management Team (SMT) and placed on the local risk register. Risks were then escalated to specific boards or committees as appropriate. A Board Risk Assurance Report outlining the top strategic risks was presented to the board quarterly to ensure that the board were aware of current and new risks.
- Staff reported that they knew how and when to report concerns on the electronic reporting system, that they had done so, and that there was an open culture encouraging reporting.
- 'A robust clinical governance structure' was one of the actions on the hospital's continuous improvement plan. It required introduction of a clear quality structure, standard agenda and process to ensure robust information flow. The HoDs and SMT were responsible for this on-going action.
- We saw that there was a standard meeting agenda in the departments that followed the CQC's Safe, Effective, Caring, Responsive and Well Led structure.
- In recent months, the outpatient department had introduced new audits to monitor performance. Staff explained that this information would be used to identify areas where there were learning needs.
- We saw evidence, discussed in the Safe and Effective sections above, that both the outpatient and diagnostic imaging departments had used audit information to make improvements to care and policy. This was integrated into the diagnostic imaging department practice and the outpatient department had used audit information to identify learning areas in recent months.
- There was alignment between the recorded risks and concerns discussed by staff, particularly with regard to staffing.

Leadership and culture of service

- Staff in the outpatient and diagnostic imaging departments told us they trusted the departmental leaders and relied on managers' knowledge and experience. In both departments staff stated that they could and did turn to department managers for advice and assistance.
- Outpatient staff reported to the outpatients' manager, who reported to the director of clinical services (DCS). Diagnostic imaging staff reported to the radiology manager, who reported directly to the DCS. Physiotherapy staff reported the lead physiotherapist, who reported to the DCS.
- The risk register, electronic incident reporting system and audit results, and reports showed that the managers understood the risks to the department and acted on them.
- The outpatient department faced specific risks as a department with new management and clinical staff. We saw evidence that showed large organisational risks and smaller individual risks were addressed in the department. For instance, risk assessments relating to staffing were completed which identified risks and outlined responsive actions. We also saw evidence that when there was incident or concern in outpatients it was risk assessed, evaluated and action was taken.
- Staff throughout the outpatient department said that it had been a difficult year but that there was change

under the new managers. They discussed a new culture with open communication, where there was continuity of staff. Staff members felt that they were valued and performing the role for which they were employed.

- The diagnostic imaging department had a different culture as it was well established with long-term staff members. The department was focused on improving the services offered to patients and consultants. Over the past five years, the department had increased hours and services offered to its patients.
- In both departments, staff described collaborative work within the team and positive relationships with managers. Staff told us that their direct line managers were approachable, available and involved in day-to-day care in the department.
- Staff said the senior management team were visible and approachable. They said that senior management were in the department and engaging with staff, multiple times a week. We saw senior managers visiting the departments during our inspection.
- Staff told us that they were confident in the ability of the senior management team. The said if their line manager were not available they were comfortable turning to the matron for assistance or direction.

Public and staff engagement

- Comment cards were prominently placed in each waiting room for positive or negative patient feedback. We saw there were boxes throughout the hospital to place completed form. Patients could also provide feedback through the hospital website if they wanted to do so.
- The outpatient department had recently started providing patients with a department specific patient feedback form. Patients were asked to assess facilities, information provided, timeliness, staff, dignity, respect and comfort. Staff explained that they planned to use this information to improve the service, although they had not yet had the opportunity to do so as the program was new. We saw that some patients had returned the forms providing scores and additional comments most of which were positive.
- The hospital had just begun running a staff and patient forum where patients could provide their views. Only one meeting had occurred at the time of the inspection. The hospital was considering how it could encourage patient interest in attending the forum.
- Senior staff described a culture where staff members were all encouraged to recognise opportunities for improvement and recommend changes. Staff confirmed that they were encouraged to bring forward ideas for change, large or small, and that they believed their ideas would be implemented.

Innovation, improvement and sustainability

- The diagnostic imaging department provided comprehensive, responsive services. This included using a new MRI suite, which focused on providing a relaxed environment by letting patients listen to their choice of music while watching moving pictures. The department also offered specialised scans including CT colonoscopies and leg length scans. Additionally the department used special techniques such as the Schuss view, which provides better visibility of knee joint space.
- We saw that the outpatient department was working to improve record keeping by piloting electronic and integrated records schemes.
- The physiotherapists used an internet based program to send reminders to patients to increase patient compliance.

Outstanding practice and areas for improvement

Outstanding practice

- The chemotherapy nurses constantly sought funding from outside organisations and charities that enabled service improvements for oncology patients. For example, sourcing items from various organisations to include in a welcome "goody bag" given to all new oncology patients on arrival.
- A chemotherapy nurse initiated and led a monthly support group for oncology patients, relatives, friends and carers called the "Nuffield Cancer Support Group". The group met monthly and welcomed all NHS and private patients.
- The hospitals orthopaedic service offered a service all private patients to include Nuffield Health recovery plus programme. This includes an extended membership at a fitness and wellbeing centre supported by a personalised programme post-operatively to improve outcomes and provided patients with the support they need to get well and stay healthy after their procedure.
- We saw that the hospital used technology to improve the CYP experience of care. For instance, the Diagnostic Imaging Department used technology to project child friendly images including a rainbow, and night sky during CYP procedures. The surgery department used a tablet to provide distraction to children before and after procedures.
- The diagnostic imaging department's consultant survey and proactive response to the rejection rate audit reflected outstanding practice.
- The outpatient department's risk assessment and action in response to low permanent staff levels reflected outstanding practice.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should take action to replace carpets. Flooring in the majority of the patient bedrooms on Abergavenny Ward was carpets. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages contrary to the Department of Health's Health Building Note 00-09.
- The provider should take action to upgrade clinical hand washing provision as there were no dedicated clinical hand wash basins in patient bedrooms. This meant staff had to wash their hands in the basins in patient's en-suite bathrooms contrary to the Department of Health's Health Building Note 00-09.
- The provider should ensure that staff in theatre are effectively trained in surgical scrub techniques. We observed a scrub practitioner undertaking poor surgical scrub technique. This was raised with the theatre manager during the inspection and further training has been arranged for staff.
- The provider should improve the appraisal rates for theatre and in patient nurses.
- The provider should improve training rates for adult and paediatric intermediate life support.
- The provider should fully embed the WHO surgical checklist.
- The provider should ensure processes around CD checking are consistent in theatres.
- The provider should ensure learning from incidents is recorded in the outpatient department.
- The provider should ensure outpatient staff have completed their competencies and training tracker is accurate.
- The provider should review areas of outpatient records audits that were consistently low to confirm additional training has been successful.
- The provider should consider implementing standardised methods to measure pain levels in outpatients.
- The provider should ensure that there is a private area at reception where patients can speak to staff.
- The provider should ensure patients receive cost information, about their care and treatment.

Outstanding practice and areas for improvement

- The provider should review clinics cancelled by the hospital to assess whether cancelations can be minimised.
- The provider should ensure the hospital meets its internal timeliness targets with regard to complaints.
- The provider should consider providing dedicated waiting areas for children.
- The provider should consider providing dedicated CYP clinics and surgery lists in line with Royal College of Surgeons recommendations as outlined in Standards for Children's Surgery, Children's Surgical Forum, 2013.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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