Nuffield Health Shrewsbury 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health Shrewsbury Hospital is one of 31 in the Nuffield Health Group. It was opened in 1965 and is situated on the south-west outskirts of Shrewsbury.

We inspected the core services of surgical services and outpatients and diagnostic services as these incorporated the activity undertaken by the provider at this location.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 22 September 2016, along with an unannounced visit to the hospital on 7 October 2016.

We rated both core services, and the hospital as good overall. However, we found that safety in surgical services required improvement because we had concerns that safety checks in theatres were not consistently completed and infection rates for some procedures were higher than the national average.

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? We rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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

We rated this hospital as good overall because:

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- There were systems and processes in place to promote practices that protected patients from the risk of harm. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. When something went wrong, people received an explanation, and a sincere and timely apology. There were sufficient and appropriately qualified and experienced staff working on the ward and in theatres to keep people safe at all times.
- The hospital had systems in place to provide care and treatment in line with national guidance. There was effective multi-disciplinary working with informative handovers, good record keeping and communication Staff were able to respond to signs of a deteriorating patient and medical emergencies.
- There was a stable leadership team who were highly regarded by staff. Staff felt supported and proud to work within the hospital. They were very positive about the matron who had been in post for 12 months and made positive changes to the hospital.
- There were sufficient numbers of trained staff to meet the needs of patients. We saw that equipment in all areas was well maintained and kept clean to minimise the risk of infection. Records were available and well maintained.

We found areas of practice that require improvement in both surgery and in outpatients and diagnostic imaging services.

- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was not consistently completed or adhered to.
- Infection rates for some surgery (primary knee arthroplasty and breast procedures) were higher than the national average.

Summary of findings

- We saw that all nursing staff demonstrated good hand hygiene, however, we also observed a consultant wearing a suit jacket whilst applying eye drops for a patient which does not comply with infection control standards.
- Staff mainly understood and their responsibilities to raise concerns and report incidents and near misses but if an incident had not caused harm or disruption to the service they may not always report it.
- There was a lack of compliance with some policies such as the antimicrobial policy, fasting arrangements and ensuring patients had sufficient information and time to provide informed consent about their operation.
- The hospital did not provide a translation service for patients whose first language was not English.
- The ambulatory care unit did not always ensure patients privacy and dignity when treatment was being administered or care discussed.
- The flooring and hand washing sinks in outpatients did not meet current guidelines but the hospital was in the process of replacing them.
- Not all staff we spoke to in outpatients demonstrated full understanding of the Mental Capacity Act.
- Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected surgical services. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was planned and co-ordinated in a safe way following full consultation and pre-admission assessments. The service had systems in place to provide care and treatment in line with national guidance. There was effective multi-disciplinary working with informative handovers, good record keeping and communication. Staff were able to respond to signs of a deteriorating patient and medical emergencies. Patients were respected as individuals and were empowered as partners in their care and were positive about the care and treatment they received. The staff valued the team-working ethos, stability of the professional team and felt valued. Governance arrangements promoted safe practice. Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. When something went wrong, people received an explanation, and a sincere and timely apology. There were sufficient and appropriately qualified and experienced staff working on the ward and in theatres to keep people safe at all times. However we also saw that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was not consistently completed or adhered to in all theatres we visited. Infection rates for some surgery (primary knee arthroplasty and breast procedures) were higher than the national average. There was a lack of compliance with some policies such as the antimicrobial policy, fasting arrangements and ensuring patients had sufficient information and time to provide informed consent about their operation. The hospital did not provide a translation service for patients whose first language was not English. The ambulatory care unit did not always ensure patients privacy and dignity when treatment was being administered or care discussed.

Summary of findings

Outpatients and diagnostic imaging

Good

Outpatients and diagnostic imaging services at this hospital had systems and processes in place to promote practices that protected patients from the risk of harm.
There were sufficient numbers of trained staff to meet the needs of patients. We saw that equipment in all areas was well maintained and kept clean to minimise the risk of infection. Records were available and well maintained.
There was an open culture where staff were encouraged to report incidents and lessons learned were shared within teams.
The radiology department had recently introduced the use of the World Health Organisation (WHO) Five Steps to Safer Surgery checklist to ensure patient safety.
Treatment and care was provided in line with national guidance. We saw there was good multi-disciplinary working and patient's needs were responded to.
Staff were polite, courteous, friendly and responsive to patients' individual needs.
Staff felt supported and proud to work within the hospital. They were very positive about the Matron who had been in post for 12 months and made positive changes to the hospital.
However, we also saw that flooring and hand washing sinks did not meet current guidelines but the hospital was in the process of replacing them. Not all staff we spoke with demonstrated full understanding of the Mental Capacity Act.

Summary of findings

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Nuffield Shrewsbury Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Nuffield Health Shrewsbury Hospital

Nuffield Health Shrewsbury Hospital was opened in 1965 and is situated on the south-west outskirts of Shrewsbury. The Hospital is one of 31 in the Nuffield Health Group. The hospital primarily serves the communities of Shropshire and Mid Wales. It also accepts patient referrals from outside this area. The nearest NHS acute hospital is Royal Shrewsbury Hospital which 1.5 miles away.

There are 30 individual patient bedrooms each with en-suite facilities. The hospital has three theatres with ultra clean air flow, an endoscopy suite and an ambulatory care unit (ACU) adjacent to theatres, set up 12 years ago. The outpatient department has nine consulting rooms and two treatment rooms for minor procedures. The diagnostic imaging facilities include digital mammography, ultrasound and x-ray. A mobile Magnetic Resonance Imaging (MRI) scanner was available at the hospital two days per week. At the time of our inspection, the hospital was undergoing a programme of refurbishment of all the bedrooms

The Hospital Director is also the registered manager and has been registered with CQC since 1 October 2010. He has been the Hospital Director for over 20 years and is also the controlled drugs accountable officer.

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

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

The hospital provides surgery, and outpatients and diagnostic imaging for adults 18 years and older. The hospital stopped providing care and treatment for children and young people (under 18 years of age) from 1 December 2015. We inspected surgery and outpatients and diagnostic imaging services during this inspection.

We have inspected this hospital three times. Our last inspection was undertaken on 16 January 2014, there were no compliance actions or requirement notices made following this inspection.

Our inspection team

The team that inspected the service comprised a CQC Inspection manager, three CQC inspectors, and a specialist advisor with expertise in theatres.

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

Information about Nuffield Health Shrewsbury Hospital

During the inspection, we visited the ward, ambulatory care unit (ACU) operating theatres, endoscopy suite, recovery area, outpatient clinic and diagnostic services. We observed the care of patients on the ward and ACU, within the recovery area and during surgical procedures in theatre. We also observed care and treatment in the outpatient area.

We spoke with 15 patients and 35 staff including nurses and medical staff, operating department practitioners, therapists, support staff, and senior managers. We held a focus group with staff and reviewed comment cards which patients had completed prior to our inspection. We reviewed a sample of 22 patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital service has

Summary of this inspection

been inspected three times, and the most recent inspection took place in January 2014, which found that the hospital/service was meeting all standards of quality and safety it was inspected against.

Activity (April 2015 to March 2016)

- In the reporting period April 2015 to March 2016,there were 4,739 inpatient and day case episodes of care recorded at the hospital; of these 68% were NHS-funded and 32% other funded. The largest proportion were day case episodes, accounting for 87%.
- Four percent of all NHS-funded patients and 17% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 14,665 outpatient total attendances in the reporting period; of these 86% were other funded and 14% were NHS-funded.
- One hundred and seventy-seven children attended the hospital. Three were as inpatients and eleven were day case episodes. All other attendances were as outpatients. The hospital ceased its treatment, admission, consultation, physiotherapy and diagnostics of all under 18 year olds with effect from 1 December 2015.

Staffing

- There were 150 doctors working at the hospital under practising privileges.
- Two regular resident medical officers (RMO) worked on a fortnightly rota.
- The hospital employed 23.9 (WTE) registered nurses, 8.5 (WTE) care assistants and 3.4 other staff, as well as having its own bank staff.
- The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events were reported in the period April 2015 to March 2016.
- There were 201 clinical incidents reported in the period April 2015 to March 2016. We saw that 107 resulted in no harm, 92 low harm, 2 moderate harm and none resulted in severe harm or death.
- No serious injuries reported in the period April 2015 to March 2016.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), or hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) were reported in the period April 2015 to March 2016.
- No incidences of hospital acquired Clostridium difficile (c.diff) were reported in the period April 2015 to March 2016.
- No incidences of hospital acquired E-Coli reported in the period April 2015 to March 2016.
- The hospital received 29 complaints in the period April 2015 to March 2016. The majority of complaints related to charging and the hospital was looking at improved information to ensure patients were clear about possible charges.

Services provided at the hospital under service level agreement:

- Archiving of Medical Records
- Catering
- Facility Management
- Medical Equipment Management
- Mobile MRI
- Resident Medical Officer
- Security
- Shredding service for confidential waste

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?

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Surgical safety processes were not fully embedded in ophthalmic theatres and in x-ray.
- Improvements were in place to improve and minimise the risk of cross infection to keep patients safe. However, infection rates for some surgery (primary knee arthroplasty and breast procedures) were higher than the national average.
- We saw that all nursing staff demonstrated good hand hygiene, however, we also observed a consultant wearing a suit jacket whilst applying eye drops for a patient which does not comply with infection control standards.
- Staff mainly understood and their responsibilities to raise concerns and report incidents and near misses but if an incident had not caused harm or disruption to the service they may not always report it.
- The consulting room flooring in outpatients was not compatible with infection control standards but we were made aware of plans for it to be replaced after the announced inspection.

However:

- Staffing levels and skill mix were planned and implemented to keep patients safe at all times.
- Incidents were investigated, feedback was given and learning from incidents was implemented.
- Staff were able to respond to signs of a deteriorating patient and medical emergencies.
- Training compliance for safeguarding adults and children was above the hospital target.
- NHS Safety thermometer data was used to measure 'harm free' care
- The hospital environment and all the equipment we looked at was clean and well maintained. Infection control policies were being followed
- All relevant safety legislation and guidance was being adhered to in diagnostic imaging.
- Patient records were well maintained and stored appropriately.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- The hospital had systems in place to provide care and treatment in line with national guidance.
- There was effective multi-disciplinary working with informative handovers, good record keeping and communication.
- An enhanced recovery programme promoted post-operative health and well-being.
- All staff had appraisals and there were effective systems in place to check the competence of medical practitioners with practising privileges.

However:

- That there was a lack of compliance with some policies such as the antimicrobial policy, fasting arrangements and ensuring patients had sufficient information and time to provide informed consent about their operation.
- Staff we spoke with in outpatients showed varying levels of understanding in regards to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Are services caring?

Good

We rated caring as good because:

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- Patients all told us they were treated with care and compassion.
- Survey data confirmed that patients had confidence in being treated at the hospital.
- People's individual physical and emotional needs were considered and met.

Are services responsive?

Good

We rated responsive as good because:

- The hospital provided a responsive and flexible service that met the needs of patients.
- Treatment and care was planned and co-ordinated following full consultation and pre-admission assessment. Discharge arrangements were confirmed prior to leaving the hospital and a discharge pack was issued to support the patient's aftercare.
- The hospital was meeting all targets for accessing services and there were no waiting lists for diagnostic imaging services.

Summary of this inspection

- Patients with complex needs were supported and their carers encouraged to attend with them. This included patients living with dementia and patients with learning difficulties.
- Complaints and concerns were responded to in a compassionate and timely way. There was evidence that lessons had been learnt and actions taken as a result.

However:

- The hospital did not have access to a translation service for those patients whose first language is not English.
- The layout of the Ambulatory Care Unit meant that patient privacy and dignity could not always be maintained when treatment was being delivered or discussed.

Are services well-led?

Good

We rated well-led as good because:

- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood and were able to articulate.
- The senior management team were visible and provided stable, strong leadership to thy hospital. Staff told us and we saw they displayed characteristics of the hospital vision and values on a daily basis.
- The staff valued the positive team-working ethos and felt valued and listened to by managers. There were effective systems for engaging with staff.
- The hospital had a patient forum, who met regularly to provide feedback on a range of patient quality issues.

However:

- Governance arrangements promoted patient and staff safety, although some of the lines of accountability and reporting between the different governance groups was unclear.

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- Staff told us they had received training and felt supported to report incidents such as a patient fall, cancellation of surgery or infection. We found that staff may not report, or sometimes required confirmation from others, to report near misses or no harm incidents; this may delay the investigation, which may delay the report. Staff told us they received feedback about incidents when investigations had been completed. Staff told us and we saw that incidents and any learning was shared with them during team meeting.
- Between April 2015 and March 2016, staff had reported 97 clinical incidents (69 no harm, 27 low harm, one moderate harm) within surgery, which was 48% of the total number of incidents reported for the hospital.
- We saw that there had been an increase in incident reporting across the hospital as staff awareness of incident reporting from 3.3 incidents per 100 patient beds in October to December 2015, to 8.1 incidents per 100 patient bed days between January and March 2016. The matron spoke positively about increased staff confidence to report incidents and agreed that this was ongoing.
- Records we looked at showed that staff discussed incidents during clinical governance meetings and heads of departments meetings.
- We reviewed the Root Cause Analysis investigation report into an incident where a patient was given an injection into the wrong site. We saw that although there was a delay in reporting the incident, a thorough investigation had been carried out and lessons had been learnt and actions taken.
- There had been one unexpected death between October 2015 and December 2015 involving the hospital, although the patient died elsewhere. We saw that the unexpected death had been discussed during governance meetings, the Medical Advisory Committee (MAC), and a need to improve communication with the local trust where the patient had been transferred was identified.

Duty of Candour

- The Duty of Candour (DoC) 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 in relation to the incident and an apology.
- The staff we spoke with were aware of DoC and confirmed they had been given information, both electronically and as a paper report. We saw that as part of the investigation into the incident of a patient given an injection into the wrong site Duty of Candour was applied and the patient was provided with a full apology and explanation, verbally and in writing.
- Matron told us that additional eLearning and classroom based training would also be available for staff.

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

- Safety thermometer data was recorded for NHS patients only in line with the requirements. This applied to more

than half of the patients attending. The hospital sent data to head office on a specified date each month. Harm free days were recorded at 100% since August 2015.

- The service monitored safety via an electronic reporting system. Information gathered through this system was reported at a number of governance meetings and monitored through a quality dashboard. This dashboard was shared both with the hospital management team and staff teams quarterly. The dashboard included patient safety information as well as patient activity data. We saw that information about infection rates was included however; Matron confirmed that the clinical dashboard was not displayed.
- Contracts for NHS funded care had a target of 95% for VTE screening. Throughout 2015, the hospital had achieved more than 95% against this target.

Cleanliness, infection control and hygiene

- Between April 2015 and March 2016, 10 hospital acquired wound infections were reported. These included one hernia repair, one circumcision, three dupuytrens operations and one ankle arthroscopy. During primary knee arthroplasty, there was one out of 83 patients who acquired an infection, this equated to 1.2%, compared to 0.5% in the NHS for the same period. For breast procedures, there were three out of 93 patients who acquired an infection, this equated to 3.2%, compared to less than 1.5% in the NHS for the last six months of 2015/2016.
- The hospital had investigated the causes of these infections and action plans had been implemented. We were told and saw that all infections were reported to the microbiologist, the Infection Prevention Coordinator and infection prevention lead within the hospital. A root cause analysis investigation was undertaken where required. The hospital confirmed there was no theme to the infections as different bacterium were identified in each case.
- Since January 2016, the hospital has submitted information in relation to hip and knee surgery infection to the Public Health England (PHE) surgical site surveillance programme. Information received from the hospital identified that all patients were contacted at or around 30 days post procedure for information about their wound to be included on the database. The PHE reports for April to June 2016 identified that the hospital infection rates for knee surgery were lower than the national average (0% compared to 1.5%).
- We saw that ward equipment was visibly clean, labelled, had been cleaned and was ready for use.
- We saw there were cleaning schedules in place and had been appropriately completed and detailed what had been cleaned and by whom. Staff told us and we saw information that detailed staff had all received additional training in effective cleaning by an external company.
- The 2015 Patient Led Assessment of the Care Environment (PLACE) audit identified a score of 97% for cleanliness across the hospital. The England average for NHS hospitals is 98%.
- The offsite hospital sterile services department ensured that appropriate equipment was available for surgeons. The system promoted the correct flow of dirty to clean equipment and theatre instruments, which reduced the risk of contamination.
- There were clear waste segregation practices in place and we observed these were adhered to in theatre and on the ward. This included safe storage and disposal of sharps.
- Hand wash sinks were available throughout the ward and theatre department. The hospital was in the process of replacing hand wash sinks in ward area to ensure they fully met infection prevention guidelines. This would be met by April 2017.
- We saw that hand sanitising gel were available and we observed staff washing their hands and using sanitising gel. The 'bare below the elbows' policy was observed by all staff during clinical interventions and staff were seen to follow the hospital's infection prevention and control policy by washing their hands between seeing patients and wearing correct personal protective equipment, such as gloves and aprons and appropriate theatre wear within theatres.
- The hospital had a peer review infection prevention audit in October 2015. The audit identified improvements such as: replacement of carpets with washable flooring, replacement of hand wash sinks, effective cleaning processes were required. We saw that that an action plan to address this audit was in place and required improvements were being made. The hospital director confirmed to us that all refurbishment work would be completed by the end of April 2017.

- We saw that infection control audits had been undertaken in all parts of the hospital. Between 1 January and 30 June 2016, compliance with hand hygiene was identified as 91% this included observation of staff hand washing. The Nuffield target for hand hygiene compliance was 100%. Matron told us that there were actions in place to ensure compliance with this target.
- The infection prevention audits over the same period also included insertion of peripheral venous cannulas which identified 85.7% compliance. Staff compliance with the insertion of urinary catheters was identified as 95.3% and management of a urinary catheter 100% with infection prevention procedures. The reasons for the low compliance score were clear and staff had received a briefing to remind them of the policy.
- Staff told us and records we looked at confirmed that patients who attended a pre-assessment appointment for surgery were swabbed for potential infections such as MRSA. We saw that a patient's surgery was only approved when no infection was identified. When infection was present, the surgery was rescheduled following an infection free period.

Environment and equipment

- Patient-led assessments of the environment took place each year. In 2015, the hospital scored 91% for the condition, appearance and maintenance of their premises compared to a national average of 92%.
- Theatre access was secure, with a reception area where staff working in theatre were greeted and shown to changing areas as necessary. The storage of surgical equipment and instruments was well organised with appropriate stock levels.
- Resuscitation equipment was available on the ward and in theatre. Records showed that the equipment had been checked daily and a comprehensive check performed weekly, with the seal on the trolley being broken and replaced to check the contents. Additionally, the trolleys are audited every quarter.
- Patient moving and handling equipment was available on the ward and had been maintained and serviced appropriately.
- Staff told us suitable and sufficient equipment was available to support the surgical procedures undertaken.
- In theatres, we saw that when prosthesis or implants were used, an appropriate record was made which detailed the batch number and identification number for future reference.
- We saw that daily equipment checks and instrument checks were undertaken within theatres. We observed the scrub practitioner and another staff member, as per The Association for Perioperative Practice (AfPP) guidelines for safe practice, checked theatre instrument trays. We saw that swabs, blades and sutures were counted and recorded on the 'count board' as appropriate and safe practice. At the end of the procedures swabs, instruments and other equipment and were confirmed to be correct.
- The theatre air filtration systems for laminar flow had annual checks to ensure compliance with UK Health Technical Memorandum (HTM 2025). Records we looked at confirmed that required checks had been undertaken.

Medicines

- We found that medicines were stored, administered and managed safely. Medicine administration records were clear about medicines that had been prescribed and administered. The hospital had an on-site pharmacy; pharmacists visited the ward five days a week to check and re-stock the medicine supply.
- We saw that information about patients allergies were recorded on medicine records. We saw that one patient with an allergy wore a red patient identification bracelet which highlighted their medicine allergy.
- Because of their potential for misuse, controlled drugs (CDs) require special storage arrangements. We saw that there were suitable arrangements in place both on the ward and within theatres to store and administer CDs. Stock levels were appropriate and seen to be checked at least twice daily. When a patient had their own CDs, they were stored in the CD cupboard and returned to the patient on discharge.
- On the ward, patients' medicines were securely stored. On-site emergency medicines and 'tablets to take home' were available and these were checked regularly to establish the use by date and to ensure appropriate stock control.
- The hospital pharmacist completed a quarterly report of medicines storage and management within the hospital, which was presented at quality and safety

meetings. Trend analysis was completed and included identification of staff involved. Staff members were invited to meetings where incidents were discussed and where necessary retraining was discussed and planned.

- The hospital had an 'antimicrobial' policy that detailed the safe and appropriate use of antibiotics. We were unclear if antibiotics given to a group of patients met the requirements of this policy because the policy advocated that the smaller dose of recommended antibiotics should be given for the shortest time. The matron told us that a meeting with the microbiologist and surgeon was being arranged to ensure that antibiotics were given both safely and effectively.

Records

- The hospital used a paper-based system to record patients' care pathways. We saw that patients' medical and nursing notes were available and securely stored on the wards. Records we looked at were all appropriately completed. They clearly showed the patient's journey including procedures undertaken, with anaesthetists' and physiotherapists' input.
- We looked at six inpatient records. We saw that staff recorded the patient's pre admission assessment, results of tests and investigations and their operative procedure and recovery were clearly recorded. We saw that staff completed risk assessments such as pressure ulcer risk and venous thromboembolism (VTE)risk during the pre-assessment appointment and then reassessed the patient on the ward.
- Record audits between June and September 2016 identified compliance with standards of 92%; this met the Nuffield target of between 90-100%. The audits identified when compliance was not met to ensure staff were aware of required actions and were followed up through re-audit.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults.
- We asked staff what their understanding of safeguarding was but had a mixed response. Staff told us it was about highlighting risk and being the patients' advocate but only one staff told us about the types of abuse. Staff were however clear who they would speak to about any patient concerns. We found during our unannounced inspection that the Matron had reviewed and revised the safeguarding information since the announced inspection to make it more explicit for staff.
- Data provided by the hospital showed that as at September 2016, 100% of ward staff and 86% of theatre staff had completed safeguarding vulnerable adults training level-one training, against a hospital target of 85%.Data also showed that 100% of ward staff and 86% of theatre staff had completed safeguarding children and young adults training level one.
- The hospital ceased its treatment, admission, consultation, physiotherapy and diagnostics of all under 18 year olds with effect from 1 December 2015.
- The matron told us that safeguarding level 2 training was not mandatory for Nuffield Health staff. However, safeguarding vulnerable adults training level 2 had been included in the 2017 training plan. Staff were aware of female genital mutilation (FGM) and domestic abuse. The new training will also include information about this.
- The hospital had two staff trained to children and young person level 3 safeguarding. Staff were able to identify the safeguarding leads for the hospital.

Mandatory training

- All staff who worked at Nuffield Shrewsbury Hospital were required to attend mandatory training to ensure they had suitable training to care for patients safely. Senior managers monitored compliance with mandatory training and compliance was compared across Nuffield Hospitals.
- We reviewed the September 2016 mandatory training records for the ward staff. The hospital had a compliance target of 85%. Data showed that compliance with the target was met for all but three of the 24 required mandatory topics. Compliance was not met for basic life support (74%); infection prevention practical (65%) and intermediate life support (70%) The overall average was 91%.
- We also reviewed the September 2016 mandatory training records for theatre staff. Against the hospital compliance target of 85%, the average level of compliance was 87%. Data showed that the target had been achieved for all but six mandatory topics and included aseptic technique (63%), consent to

examination or treatment (79%), level 1 incident reporting (81%), health record keeping (68%), health safety and welfare (81%) and infection prevention practical (81%).
- Staff we spoke with told us they felt well supported to complete their training which was either classroom based lectures or e learning.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- During pre-admission patients were assessed, considering the planned procedure, for risks to their wellbeing. A patient would not be considered for surgery at the hospital if they had a severe illness or disease
- There had been two unplanned transfers out of the hospital between April 2015 and March 2016. The transfers were reported as incidents and included in the quarterly clinical governance report to the integrated governance committee and the MAC.
- The hospital had a service level agreement with the local acute NHS trust if patients needed to be transferred as an emergency
- We were informed and we saw that surgeons and anaesthetists had 24-hour a day responsibility for their patients until they were discharged from the hospital. Formal patient handover arrangements were arranged when consultants were on annual leave. This commitment was part of their practicing privileges arrangements and was overseen by the MAC.
- We observed that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was not consistently completed or adhered to in all theatres we visited. This process, recommended by the National Patient Safety Agency should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery.
- We observed that staff in general theatres had a 'time out' during which all patient details were checked and this was recorded. We also saw that a 'sign out' was also appropriately completed in the general theatres. We observed patients receiving ophthalmology surgery. We found that the although there was an interactive discussion about the patient, procedure and equipment there was no formal 'sign in' as identified on the safety checklist.
- We also observed that theatre staff did not fully adhere to the time out, the scrub nurse had to ask for the checklist to be brought in to do the check, the anaesthetist was not involved and not all of the elements of the checklist were confirmed verbally. We spoke with one staff member who said that, as the procedures were so quick (approximately 10 minutes) it was difficult to complete the checklist. The staff member also told us "Everyone does the checklist differently and today it was being done differently again".
- Completion of the WHO safety checklist was reviewed as part of the hospital's regular quarterly audit programme and the results were included in the quarterly clinical audit report. Information within the report for March to June 2016 identified that patients' records identified a 95% compliance with the WHO checklist. We saw that staff carried out observational audits of the WHO checklist in theatre and identified when improvements were required.
- Whilst in recovery, patients were monitored by the surgeon and anaesthetist. When the patient's condition was stable, the recovery nurses then made the decision that they were safe to return to the ward. The hospital has one recovery nurse who has advanced life support (ALS), the matron and RMO also have ALS. Nuffield policy is that there are always at least three staff on duty qualified to a minimum of intermediate life support, the hospital was meeting this.
- The ward nurse then received a handover from the recovery nurse and reassessed the patient. We saw that care records covered risk assessments such as pressure ulcers, VTE, patient handling, falls, nutrition and delirium with interventions and outcomes recorded. Nurses told us they used their clinical judgement with all post-operative patients and throughout their whole journey.
- On the ward an early warning scoring system was used to identify any deterioration in patients; this process recorded patient observations enabling early recognition of signs of deterioration, which would require escalation to the medical team. The patient's consultant and the hospital matron were also informed when an escalation had occurred.
- When a patient was required to return to theatre during working hours this was facilitated by the theatre team. When required out of hours, the ward nurses would call the on call theatre team. At weekends, an on call nurse

manager was available from 7pm on Friday night until 7am on Monday morning. A member of the senior management team was also on call 24-hours a day, seven days a week for advice and support.

- We observed discharge information and advice was provided and when needed included specific wound care advice. The ward sister told us that patients were contacted 48-hours after discharge, to check their progress. We saw that patients were provided with contact telephone numbers should they need to ask any advice once at home.
- Matron told us that training for clinical teams in the awareness of sepsis was ongoing. We saw that the hospital used a 'sepsis screening and action tool' that identified the risk of sepsis and actions required to minimise the risk. Matron told us that staff were being trained in the use of a new early warning tool which will be implemented by the end of the year and will also assist staff in the recognition of sepsis.
- Staff on the ward told us they had a handover from the previous shift when they came on duty. We observed patients being transferred from the ward to theatre, from theatre to recovery and from recovery to the ward. We found that comprehensive handovers were given and included details about the patients, their operation, medicines and other postoperative care needs.

Nursing and support staffing

- During our inspection, we saw that the staffing levels were sufficient to meet patient's needs. Matron told us and our observations confirmed that nurse staffing levels were no less than one qualified nurse assigned to five inpatients or eight ambulatory care (patients who generally had a short procedure and did not need to be admitted to a bed). There were no health care assistants employed on the ward.
- Staff told us that they felt staffing was sufficient and the skill mix was correct; Staff told us that staffing levels meant they had time for their patients and were able to give them the high quality care they needed.
- The hospital had recently piloted a staffing tool to assess nurse requirements against the needs of patients. However, we were told the tool was not applicable due to the high volume of day case patients being admitted, discharged and going to theatre throughout the day. There were plans to pilot a different tool in the future.
- Matron told us that most staff worked part time, they were flexible and would work additional shifts to cover when required. Matron told us that agency staff would be used if cover from the hospital's own staff was not available. There had been no agency nurses working on the ward in the last three months of the reporting period (April 2015 to March 2016).
- Staff told us that theatre staffing had been stable, although recently the theatre manager had left and an interim manager was in post. We found that theatres were staffed in line with Association for Perioperative Practice (AfPP). The use of bank and agency nurses, operating department practitioners (ODP) and healthcare assistants in theatres was lower than other acute independent hospitals we hold information about (April 2015 to March 2016).There had been no agency nurses, ODPs or health care assistants in the last three months of the reporting period (April 2015 to March 2016) in theatre.

Medical staffing

- A resident medical officer (RMO) was on the hospital site 24 hours a day, seven days a week. The RMO we spoke with told us that usually they worked one week on duty at the hospital and one week off duty. The RMO was employed by an agency. The RMO offered medical support to the nursing staff; although nursing staff told us, they had no problems contacting individual consultants for information or advice.
- The RMO was informed of all patient theatre lists and we saw that they were included in staff handovers. This ensured they were aware of the nature and acuity of all patients in the hospital.
- Staff told us and we saw that the RMO visited all patients on the ward during the evening after their surgery and if staff had any concerns they would call the RMO for advice who was on call throughout the night. The RMO said that they would speak to the patient's consultant for advice and, when needed, the consultant would come into the hospital.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged cover from another consultant with practising privileges at the hospital, in the event that they were not available. We spoke with staff on the ward who told us there were no issues with cover and when it was arranged it was clearly communicated.

Good

Surgery

- There was a handover from RMO to oncoming RMO on a Monday when inpatients were discussed and any problems that had occurred or may occur.

Emergency awareness and training

- Nuffield Health major incident policy outlined the plan for managing a major incident, which may include a power failure, fire or a fault with the emergency bleeps. Staff, including the RMO, told us about actions they would take in an emergency situation such as not using the lifts, checking patients in the their room for a power or emergency bleep failure.
- We saw that there were regular testing of fire alarms and fire evacuation drills. Information provided by the hospital identified that all staff had attended the theatre fire evacuation of an anaesthetised patient.
- Senior staff told us that they had 'table top' exercises led by the health and safety coordinator which enabled staff to practice actions required if there was a major incident.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We found that policies for care were updated centrally by Nuffield Health and then were sent to the hospital. The policies were written to meet National Institute of Clinical Excellence (NICE) guidance. Meeting minutes we looked at showed that new policies were discussed during manager and staff meetings. We saw that staff confirmed that they have read and understood the policy.
- We found that generally staff followed policies and procedures such as wound care management. However, we found that not all consultants consistently followed all policies and procedures for example the antimicrobial policy, fasting best practice and ensuring that patients have sufficient information and time to provide informed consent about their operation.
- The matron received information on NICE guidelines every month. We saw that new NICE guidelines were discussed at the quality and safety meeting prior to them being discussed at the departmental meetings. The quarterly governance report identified those guidelines relevant to the hospital.
- Recovery Plus, Nuffield Health's recovery programme, was available to private patients, for a number of procedures. This programme was an optional enhanced recovery pathway that started after patients had finished their post-operative physiotherapy. It enabled them to continue their recovery at their local Nuffield Fitness and Wellbeing Gym at no extra cost. Recovery Plus brought together a range of healthcare services across Nuffield Health's Hospitals and their Fitness and Wellbeing Gyms. It provided patients with the support they needed to recover and stay healthy after their procedure.

Pain relief

- We spoke with six inpatients who had operations the day before our inspection. All the patients told us that their pain management had been discussed during the preadmission assessment appointment and prior to theatre. Patients told us that staff asked them regularly if they had any pain and had given them pain relief when needed.
- We saw that theatre staff reviewed prescribed pain relief with the anaesthetists prior to patients being transferred to the ward. Staff told us they contacted the anaesthetist, consultant or RMO when they felt additional pain relief was needed.
- We saw patient's had a pain relief treatment plan and pain-relieving medicines were recorded on the patients' administration charts and given when required. We saw that pain scores were recorded to demonstrate the effectiveness of pain relief and patient comfort level.

Nutrition and hydration

- There was a small kitchen area on the 2nd floor ward where staff could make patients hot drinks and a selection of snacks. Hot trolleys from the main kitchen supplied patient meals. We saw that patients had access to drinks and snacks at all times.
- As part of the patients' pre admission and on admission assessment, patients had their risk of dehydration and poor nutrition assessed. We saw that patients records included completed fluid balance charts which recorded the times and amounts of fluid that the patient had received and their recorded urine output.

Good

Surgery

- The hospital's 2015 PLACE audit scores for the period February to June 2015 identified a score of 92% for hospital food, which was slightly below the NHS England average of 94%.
- Staff recorded patients' dietary preferences and they offered them a suitable choice of meals. Staff offered hot and cold drinks throughout the day and we heard staff asking patients if they were satisfied with their meal or required anything else before removing the serving tray. One patient told us that they felt unable to eat anything at teatime but staff encouraged them to have a suppertime snack.
- Patients told us their pre admission letter gave them information about when they should stop eating and drinking. We found that mostly patients had been told not to eat or drink from midnight prior to the morning of their scheduled operation. We found that this meant patients had nothing to eat or drink for longer periods than the best practice guidelines of six hours for solid food and two hours for clear fluids.
- We asked the matron for the policy, which detailed the time before surgery that a patient could eat and drink. Matron told that the hospital did not have its own policy and they had recognised that patients did not have anything to eat and drink for longer periods than agreed as best practice. The matron told us that they would review the European Society of Anaesthetic (ESA) guidelines on fasting and she would take a proposal to the next Medical Audit Advisory Committee (MAC) meeting. We found during our unannounced inspection that the ward sister was in the process of undertaking an audit of patient fasting times.

Patient outcomes

- The hospital participated in patient reported outcome measures (PROMS) audits. However due to the small number of patient responses (six) for knee and hip replacement, the hospital could not be benchmarked against other services. Information that was available showed 100% of patients identified improvement for both hip and knee replacement.
- PROMS data, self-reported to the Health and Social Care Information Centre (HSCIC) from April 2014 to March 2015 was available for groin hernia. Information provided for 50 groin hernia patients identified that 50% of patients reported an improvement to their health and 20% as worsened. This is similar to the England average.
- All readmissions either to the hospital or an NHS trust were recorded on an electronic data collection system, as were patient returns to theatre. Between January and September 2016 there had been two patients who were readmitted within 28 days of surgery. In the same period, two patients had an unplanned return to theatre and two patients were transferred to an NHS acute hospital.
- There were 52 extended length of stay/delayed discharges recorded in the same time period, due to delayed return from theatre, pain control and nausea. The quality report for June to September 2016 identified that there were nine patients whose discharges were delayed due to nausea and dizziness and three patients due to pain issues. The matron told us that they were looking at the reason for delayed discharges following concerns about increased patient nausea.
- We found that four of the five patients who had surgery on the day of our announced inspection had nausea and vomiting following their operation. Staff told us that they thought it was because all patients now received an identified antibiotic. However, no audit had been undertaken to identify and assess any patterns in treatment or the effectiveness of the treatment.
- The activity at the hospital was predominantly elective surgery. Outcome measures data from 96 completed operations was submitted to the National Joint Registry scheme (NJR). Data showed that 99% compliance had been achieved with patient information submissions from 2015. 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. This aids with improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. This reported data was discussed at monthly governance meetings.
- At the time of our inspection the endoscopy unit did not have Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. Information provided by the senior management team identified there was a plan in place to ensure that all JAG standards were met. The plan was for an application for accreditation to be made late 2016 early 2017.

- The hospital had collected and submitted patient outcome data to Private Healthcare Information Network (PHIN) since the 1 January 2016. This met legal requirements regulated by the Competition Markets Authority (CMA).

Competent staff

- The General Medical Council (GMC) revalidation of consultants was underway where doctors were required to demonstrate their competence in a five-year cycle. NHS consultants received individual appraisal summaries and provided evidence of mandatory training from their NHS employer. As part of this process, the surgeries undertaken in the NHS were the only ones offered to private patients. Consultants who worked solely in the private sector completed the Nuffield Health mandatory training programme including an annual appraisal. The hospital used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process.
- There were 150 doctors working under practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital. We looked at five randomly selected personnel files for medical practitioners and found that all had current appraisal information and up to date revalidation information.
- Staff told us and we saw that new staff received induction training; we heard that this included a 'meet and greet' session in all departments, providing staff with an overview of all hospitals areas. Trained staff were supernumerary to the ward and theatre staffing levels during their planned induction, which was tailored to their previous experience.
- Staff told us they felt well supported when they started to work at the hospital and soon became part of the team.
- We looked at theatre staff training records and found that all surgical first assistants had an appropriate qualification to undertake this role.
- The endoscopy lead did not have any formal endoscopy training. There were no formal in house training competencies for staff although endoscopy staff had received training from companies in the use of equipment such as specialist instrument washers.
- Ward and theatre staff confirmed that appraisals took place regularly and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in the last 12 months. We saw that as part of the appraisal process staff had a six-month review and at the time of our inspection there was a plan in place to achieve this. Staff told us they thought the appraisal system was effective as it formalised individual competencies achieved and identified training needs for the next year. Staff told us examples of how they had been encouraged to train in other areas or areas of interest such as other types of surgery.
- Nursing staff told us they were supported well through the revalidation process and that checks were conducted to make sure all nurses were registered with the Nursing and Midwifery Council (NMC).

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers, good record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and therapies planned. Staff told us they worked together to ensure patients received timely and appropriate care
- We saw that medical and nursing staff, therapists and pharmacist staff worked in partnership on the ward. Ward rounds took place on a daily basis.
- We saw that there was good liaison with other services such as off-site pathology and sterile supplies. We saw that although some tests were undertaken within the hospital, other patients' samples were sent to larger laboratories at other hospitals. There were robust arrangements in place to ensure these samples were transported safely and securely. Staff told us that they received test results in a timely manner or were made aware when tests were sent externally.
- When patients were discharged, the hospital worked well with external services. A letter was sent to the patient's GP on discharge to inform them of the treatment and care that had been provided.

Seven-day services

- Theatres were used flexibly by all consultants six days a week. Theatres were open from 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday.

Good

Surgery

- Theatres were also available for emergency purposes 24 hours a day, seven days a week. To support emergency situations, theatre staff were part of an 'on call rota' including a senior manager each night.
- The hospital pharmacy was open Monday to Friday. Out-of-hours a senior member of staff with the RMO were able to access urgent medicines. In addition a member of the pharmacy staff were on call to provide advice and when needed would come into the hospital.
- Consultants visited their patients daily as part of the pre and post-operative care pathway. The nursing staff told us they had no hesitation in contacting consultants at any time to discuss their patients' condition or care.
- There were arrangements in place to send urgent patients' test samples to larger hospitals, which had a larger laboratory and staff available or on call 24 hours a day. The RMO said that they had used this service and found that it ensured results were available in a timely manner. The RMO also told us that if they required urgent x-rays out of hours this would be arranged.
- The physiotherapist service told us they were available Monday to Friday with a weekend rota in place. This meant that physiotherapy was available for those patients who required it seven days a week.

Access to information

- Policies we looked at were accessible, current, referenced good practice guidelines, referred to professional body guidance, and published research papers.
- Individual nursing records and medical records were stored securely in the nursing office.
- We saw that there was an anonymised board that gave information about patient progress including operation details, recovery and discharge arrangements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Written consent for surgical procedures was given either at pre-admission assessment or on the day of surgery.
- Five patients we spoke with told us the consultant had discussed the procedures during their assessment and they had been given time to consider them before consenting. Another patient told us they had been unable to contact their surgeon and they had given consent on the day. We observed three other patient records that showed the patients had signed the consent form on the day of their surgery. Best practice is that patients complete the consent form at least two weeks before their surgery. Matron told us during the unannounced inspection that consultants discussed the operation in detail during the pre-admission assessment and this information is included in the letter they were sent after their consultation. Matron told us that in future patients would be given their consent form to take away following their consultation to ensure they are not rushed into their decision and provide informed consent.
- We looked at records of patients who had breast augmentation surgery. We found that the consultant had discussed in detail the surgery, breast sizing and risks to ensure patients were providing informed consent. We saw that patients had been given four weeks to consider their decision as cosmetic surgery good practice guidelines require.
- We spoke with staff about informed consent and they were clear about the procedures to follow for those patients who lacked capacity including involvement of those close to the patient. Staff demonstrated an understanding of the mental capacity assessment process including examples whereby relatives had stayed with the patients who lived with dementia. 95% of theatre staff and 100% of the ward staff had received Mental Capacity Act training.
- There were no 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms in place within patients' records at the time of our inspection. Staff were made aware of patients' resuscitation status during handover when necessary.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Patients we spoke with told us that they had received very good care and could not fault the way they had been treated. One patient said, "The staff have been marvellous and have gone beyond my expectations".
- We observed all levels of staff respectfully knocking on bedroom doors and waiting for a response before entering. Patients told us they were referred to by their name of choice. We saw this was recorded in care records.

Good

Surgery

- The hospital participated in the Friends and Family Test for the NHS patients they treated. Data showed that between 98% and 100% of the responses stated they would recommend the hospital to their friends and family should they need similar care and treatment (April 2015 to July 2015.)
- We looked at data from the Nuffield Health Hospitals own inpatient satisfaction survey for the period June to September 2016. Results were consistently high between 96% and 98% and were one of the highest for the Nuffield Health group in that period.

Understanding and involvement of patients and those close to them

- Patients told us they felt they were fully informed to make decisions about their treatment.
- We saw that staff provided information in a way patients understood. Patients told us they had the reason for admission, including the risks involved, explained to them during their pre-assessment appointment and again on admission. They told us their consultant ensured they fully understood the reason for the surgery or procedure. Patients followed the same admission process and received the same information for day care or inpatient care.

Emotional support

- We saw a number of examples where staff provided emotional support to patients. One patient told us that they were afraid of needles. They told us that staff were patient and kind. They told us "they came to take blood but promised they would not do it until I was ready, that really helped and relaxed me straight away".
- Several nurse specialists such as a breast care nurse specialist were available to support inpatients when required.
- If patients required any form of counselling, this was normally arranged as an outpatient service.
- Staff told us that religious or spiritual support could be arranged if requested by an inpatient.
- Visiting times were specified; however, staff told us and we observed this was flexible. One patient gave an example of a relative going on holiday the day of their surgery and staff had confirmed that the relative could visit. Another patient told us they had small children and family were looking after them but staff had allowed them to visit outside 'visiting times'.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital did not provide emergency care and all admissions were planned and arranged in advance.
- Services were planned and delivered to meet patients' needs. Admission dates for each patient were planned during consultations to include patient choice and inpatient or day case bed availability. The booking co-ordinator and the Matron arranged the operating lists for theatre in collaboration with each consultant surgeon's secretary.
- Sufficient time was scheduled between patient admissions to enable smooth admission on to the ward, avoidance of long waits to be admitted and safe preparation for theatres.
- The physiotherapy team planned individual treatment plans from admission to discharge. Physiotherapists attended the ward on a daily basis then, following discharge, the patient could attend the Nuffield Recovery Plus programme. Rehabilitation was based on patients' assessed needs; this included support from physiotherapists, personal trainers and consultants to promoted enhanced recovery.

Access and flow

- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- Between April 2015 and March 2016, the hospital achieved the NHS target of 92% of admitted patients beginning treatment within 18 weeks of referral. During the same period, the hospital met the 95% NHS target of non-admitted patients beginning treatment within 18 weeks of referral.
- We observed a patient being discharged they were given written post-operative advice and guidance including a GP letter, check-up appointment, medication information and wound care advice. The ward telephone number was included if patients needed to ask advice.

- Between March 2015 and April 2016 there had been six procedures cancelled for non-clinical reasons. Information provided by the hospital identified that all six patients were offered another appointment within 28 days that the appointment was cancelled.

Meeting people's individual needs

- Patients told us they had received all the information they required prior to their procedure or surgery. They told us they understood the reason for their admission to hospital and staff had clearly explained the risks and benefits to them.
- We saw that nurses and consultants gave information leaflets to patients to ensure they were fully informed about their procedure or the surgery.
- Patients told us that no sooner had they rang the staff call bell during both the day and night a nurse had been there to help them. Furthermore, they said that staff had encouraged them to ring the bell if they needed anything.
- We were told that staff were allocated their patients for each shift to ensure continuity for the patient. We observed ward nurses escorting patients to theatre and collecting them from recovery.
- Physiotherapy staff also told us that they would assist with patients who had operations that may affect their mobility they would help nursing staff get them out of bed the first time. In addition staff told us and we observed that a physiotherapist would assist patients going home go down and get into their homebound transport.
- We were told at the time of our inspection that no interpreting service was available. Staff told us that they ask that patients whose first language was not English brought either a relative or friend with them who could translate. However, this is not recommended practice. Matron told us that they were exploring the commissioning of an interpreting service for the hospital to address this.
- All patients had individual bedrooms, private en-suite facilities, a television and thermostatic controlled heating. We were told that should a patient require the support of a carer or a family member they were encouraged to stay at the hospital to offer familiar assurances and to assist with the rehabilitation process.
- We found that some patient bedrooms were small and may be restrictive for patients with mobility issues. We discussed this with senior management who confirmed that they had been checked and met the required standard. Matron told us that risk assessments would be used during casualty simulation training for the smaller rooms to ensure safe access in the case of an emergency and to enable access for patients who had mobility difficulties.
- The needs of patients living with dementia or those who had a learning disability were identified at pre-assessment. Patients with complex needs were risk assessed by physiotherapists and their care plans were then based on the risk assessments and professional advice. The dementia lead nurse told us that an multidisciplinary (MDT) meeting would be convened prior to the patients admission to walk through the patient's care pathway and ensure all staff was aware of the patient's needs.
- The hospital had a dementia lead nurse. They told us that they encouraged relatives to complete the 'this is me' booklet that gave staff information about the patient and their likes.
- The dementia lead nurse told us that they used a dementia box, which contained dementia friendly signage, blue pillowcases and blue crockery to make other staff aware that the patient had dementia. They told us as they did not have many patients who were living with dementia but they could use the contents of the box when required.
- Staff told us that if they had a patients living with dementia or a learning disability they encouraged a carer or relative to stay with the patient to provide them with ongoing reassurance.
- We found that at times patients' dignity might be compromised within the ambulatory care unit. Patients were generally sat in a waiting room with reclining chairs. Staff administered eye drops to patients whilst in the waiting room and we noted that due to the close proximity of the chairs, treatment could be observed by other patients and any conversations between staff and the patient could be overheard. We also saw that patients were taken into the corridor to discuss information prior to theatre which demonstrated that staff were aware of the lack of privacy.
- Following the feedback from our announced inspection, there had been a review of arrangements for the ambulatory care unit. During our unannounced visit we saw that a bedroom close to the unit had been allocated to provide additional accommodation where discussion about care or treatment could be delivered

in privacy. Matron and staff also told us they were looking into the use of new medication that only needed staff to administer once into the eye rather than several times as currently.

Learning from complaints and concerns

- We saw 'How to make a complaint' booklets around the hospital, available for patients to read.
- The Hospital Director, assisted by his personal assistant undertook overall responsibility for responding to all written complaints. Formal complaints were investigated by the manager of the relevant department; with matron leading the investigation for concerns with clinical care. The process for responding to complaints included an acknowledgment within 24 working hours either by telephone or letter. All complainants received written feedback following investigations with a target timescale of 20 days.
- Staff we spoke with told us about actions they would undertake if any concerns were raised. One staff member told us about concerns that had recently shared with them. Staff assisted a carer to make a complaint about the concerns raised.
- Any complaints received by the hospital were reviewed at the monthly heads of department meetings, monthly governance meetings and MAC meetings. Outcomes, lessons learnt and improvements on practice were discussed at all these meetings. Action logs were developed to ensure that improvement was monitored and achieved.
- We reviewed four randomly selected complaint files. All the complaints we looked at were investigated and responded to in a timely manner. The tone of the response letters was compassionate and appropriate. Letters of response also included changes that had been made to services in response to the complainant's feedback.

Are surgery services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- There was a clear vision and strategy for the hospital. The vision was for the hospital to be: the private hospital of choice of Shropshire and Mid Wales patients, consultants and staff by ensuring the delivery of high quality personalised care, that is safe, effective, well led and which meets the needs of its users. Staff throughout the service were clear on the vision and their contribution to achieve it.
- The hospital had a set of EPIC values (Enterprising, Passionate, Independent and Caring.)We saw that staff demonstrated these values when providing care to patients.
- Staff we spoke with told us that the hospital's values were regularly discussed during team meetings, interviews and staff appraisals.
- There was a business plan in place for the refurbishment of the hospital to improve the environment. We saw that patient bathrooms had recently been refurbished at the time of our inspection. The hospital director told us they involve staff as much as possible in the development of any plans for the hospital.
- The hospital long-term plan was to extend the hospital to provide a bigger and more spacious ambulatory care unit.
- There were plans to apply for JAG accreditation for the endoscopy unit late 2016 / early 2017.
- The hospital was looking at providing services for more patients and was planning to undertake bariatric surgery. Staff told us they were looking at the provision of new equipment and additional training from the local NHS and anaesthetic support.

Governance, risk management and quality measurement

- We saw quality measurement systems in place, which were managed by the senior management team. The Matron for the hospital took the lead and captured clinical data from the central database to present the clinical governance quarterly and annual reports to the senior management team. These reports identified trends and variances of all patients admitted to the hospital generating an incident report when a variance was noted. The report included complaints, incidents and patient satisfaction survey results. A comparison was made with previous reports and other hospitals in the group including readmission rates and extended lengths of stay. The clinical governance report was also shared at the Medical Advisory Committee (MAC) and Quality & Safety Committee.
- At the time of the inspection the MAC did not have a chairperson in post. The previous chair resigned from

the position at the MAC meeting in April 2016 and a new one was not going to be elected until the Medical Society annual general meeting in October 2016. The deputy chair was acting as chair on an interim basis until the new one was elected.

- Although we saw that governance processes ensured quality and risk was monitored, it was difficult to identify lines of accountability and responsibilities for each of the hospital meetings held which may mean that issues were not escalated or shared with appropriate staff. We reviewed a range of minutes and notes from the various meetings and which reporting lines from one to another were not documented, which made following decision-making processes unclear.
- Following our announced inspection the matron asked a clinical governance specialist to review arrangements. Following this meeting, the matron sent us revised terms of reference, which provided assurance that any concerns would be appropriately shared throughout the hospital.
- The matron told us that they had recognised a need for staff to have greater awareness of clinical governance to identify and respond to risks. They told us that all managers and several other staff had undertaken clinical governance training courses. Staff we spoke with told us they were positive about learning because of this training. There was one risk register for the whole hospital, which logged all the issues identified on site as requiring attention, replacement or review. Staff we spoke with were aware of items on the risk register and actions that were being taken such as replacement of the hospital lift and the hospital bleep system. We saw actions had been planned and implemented to mitigate the risks identified.
- Monthly business review meetings were held with the heads of each department. Workload and staffing were discussed along with staff sickness and any vacancies.
- The Medical Advisory Committee (MAC) held quarterly meetings, which were attended by consultant surgeons and anaesthetists. The role of the committee was to oversee quality and safety issues at the hospital. This included approval of new procedures and equipment that consultants wanted to introduce, approving practising privileges and reviewing quality and safety reports. Minutes we looked at showed the number of incidents and complaints were discussed but it was not evident what the outcome of the discussions was and if any learning or actions had taken place.

Leadership / culture of service related to this core service

- Staff told us that the matron and hospital director were visible and accessible. They said they were able to approach them without question for guidance and support when necessary. A number of staff told us about the support and improvements that had been made since the appointment of the matron 12 months ago.
- Staff described their immediate managers and members of the senior team as having an 'open door' policy and providing 'excellent support'. The ward manager worked clinical shifts on the ward.
- Staff told us they enjoyed working at Nuffield Shrewsbury and were proud to work there. Teamwork and being able to provide excellent patient care was cited by many as being the best thing about working at the hospital.
- There was a culture of mutual respect and recognition. Staff felt valued and respected. They told us that mangers were on first name terms with all of the staff and always greeted them when they saw them. One new staff member said, "The senior management team already know my name I already feel part of the team".
- There was also a culture of openness, honesty and transparency. Staff told us they felt empowered to raise concerns. When mistakes occurred, there followed reflection, learning and support.

Public and staff engagement

- There was a patients' forum held quarterly which the matron facilitated. Representatives who had experience of care and treatment at the hospital attended the meetings. We attended one meeting and reviewed the minutes of other meetings. The patient forum provided feedback to improve the services provided within the hospital. This included the hospital environment, cleanliness, food, and development plans. Members of the forum were also involved in the PLACE audits. The chair of the patient forum attended the MAC.
- The hospital carried out quarterly patient feedback surveys. The average response rate for the surveys was approximately 42%.
- Staff told us about various public information evenings held at the hospital focussing on specific treatments. They spoke proudly of these events telling us that they enjoyed publicising the good work that they do and helping patients with their needs.

Good

Surgery

- Staff told us that they had regular staff meetings. The meeting minutes we looked at showed that the meetings were structured and included discussion around incidents, complaints received and new policies and procedures (including the availability of new or revised NICE guidance).
- The hospital director sent a weekly newsletter by email containing information about any changes and news within the hospital.
- Staff and managers told us about away days and staff awareness evening, about two or three times a year, that were engaging and useful for all staff to attend.
- An annual staff survey was conducted to collate staff feedback. This was in addition to a 'leadership MOT' questionnaire where staff members could confidently give feedback regarding their manager.

Innovation, improvement and sustainability

- The hospital had started specific cleanliness regimes before patients received prosthesis surgery. Staff were also looking at whether it may be more effective to ask patients to shower with the preparation whilst they were in the hospital and before they went to theatre.
- The hospital was looking at providing services for more patients and was planning to undertake bariatric surgery.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- Over the last 12 months there had been no reported never events for the outpatient or diagnostic imaging department. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death.
- The hospital used an electronic reporting system to record incidents of all kinds. All the staff we spoke with demonstrated knowledge and understanding of how to use this system to report incidents and had done so.They were aware of the range of incidents that would require reporting and gave examples of recently reported incidents.
- Staff we spoke with told us that if an incident had not caused harm or disruption to the service they would not always report it on the system. This meant that there may not have been clear identification and management of 'near miss' types of incidents.
- Incidents were discussed at monthly Local Quality & Safety Committee meetings and we saw four sets of minutes from these meetings. We also saw four sets of Clinical Heads of Department meetings where incidents and lessons learned were also discussed.
- There had been no incidents of overexposure to radiation in diagnostic imaging. Staff explained the clear protocol that would be followed if this did occur including taking equipment immediately out of use and reporting on the incident reporting system as well as to the Radiation Protection Advisor.

Duty of Candour

- See the Surgery section for main findings.

Cleanliness, infection control and hygiene

- We saw that waiting areas as well as clinic and diagnostic rooms were visibly clean, tidy and free from clutter. Patients we spoke with said that the outpatient and imaging departments had always been clean when they attended.
- There was a team of housekeeping staff who were responsible for cleaning all areas. We saw that cleaning schedules were signed and dated daily or as required.
- We observed staff cleaning equipment in between patients appropriately. 'I am clean' stickers were used and dated on relevant pieces of equipment when cleaned.
- We observed all nursing staff complying with infection prevention control including demonstrating good hand hygiene and adherence to the 'bare below the elbows' policy. During an observation in ophthalmology, a consultant wore a suit jacket whilst applying eye drops for a patient which does not comply with infection control standards. During our unannounced inspection we were told that the policy had been revisited and consultants reminded that all procedures require them to be 'bare below the elbows'.
- Personal protective equipment (PPE) including gloves and aprons were available in the clinic rooms within outpatients. We saw staff using this equipment.

- Hand gel was available in all treatment and clinic rooms as well as waiting areas. We saw staff using the hand gel and also requesting that patients and visitors use it.
- Over the last twelve months there had been no reported cases of healthcare-associated infection such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or Methicillin Sensitive Staphylococcus Aureus (MSSA) for the outpatients and diagnostic imaging department. These are all infections that could cause harm to patients.
- We saw that infection control audits had been undertaken and that the previous three observations of hand hygiene rated compliance at above 90%.
- The patient toilets in outpatients were found to be clean and fit for purpose with hand hygiene posters displayed inside.
- We observed good use of safe sharps practice in line with the EU Council Directive 2010/32/EU which is a directive implemented to prevent sharps injuries in the healthcare environment. Sharps disposal bins were labelled and closed correctly.

Environment and equipment

- Consulting rooms in the outpatients department had carpeted floors which is contrary to the HBN 00/10 Part A 2.4 which clearly states 'carpets should be avoided in clinical areas'. The environment not being compatible with infection control standards was on the risk register for the Outpatients department. It was due to be refurbished and floors were to be replaced with vinyl flooring after the announced inspection. Some sinks in the department were also non-compliant however we were informed that these were also due to be replaced. after the announced inspection. When we attended the hospital for the unannounced inspection, we saw evidence that the refurbishment had begun.
- We saw single use items used appropriately during our observations.
- Guidance is provided by the Ionising Radiation (medical exposure) Regulations (IR(ME)R) for the safe use of radiological equipment.This includes guidance for operating procedures, incident reporting, training and equipment maintenance and medical physics' role. We observed information about IRMER guidance available for staff on the wall of x-ray rooms.
- The provider had an appointed radiation protection supervisor (RPS) and a radiation protection adviser (RPA) in accordance with the IRMER regulations. This meant the hospital had an independent annual audit of the imaging services; the last one took place in November 2015. We saw the results of this showed the department was fully compliant with no improvements required.
- The radiology department had information displayed with rules to ensure staff and visitor safety when entering the department. IRMER procedures were in place to ensure the safety of staff and patients and minimise the risks of radiation exposure. There was clear signage to restrict access to imaging rooms. A light box was situated outside the door of treatment rooms to indicated when x-ray equipment was in use.
- Safety equipment within the diagnostic and imaging department, including lead coats and eyeglasses to protect staff members from radiation exposure, were available in a range of options for users. We saw records that showed these were checked every six months to ensure they were fit for purpose.
- Staff told us a machine used to process x-ray images to digital format was regularly breaking down. This was on the hospital risk register and the x-ray manager informed us that a new machine had been selected and would be replacing the old one within two months.
- Equipment was maintained by outside contractors and there was a clear log of service dates completed and dates due. We saw service reports and staff were clear on processes for managing any issues with equipment.
- The Electricity at Work Regulations 1989 require that any electrical equipment that has the potential to cause injury is maintained in a safe condition. We saw electrical testing stickers on all items of equipment that were in date.

Medicines

- We saw that medicines were stored in locked cupboards appropriately in outpatients. All of the medicines we checked were in date and labelled. We saw contrast media (used for radiological procedures) was stored appropriately in locked cupboards in the imaging department.
- We saw that staff used a log which was completed every time controlled medications were used during treatments and that the outpatient sister checked the log against the count of the drugs after each use.

Records

- The medical records team worked with the outpatients service to ensure that records were available for

outpatient clinics. Clinicians reported no problems accessing records which were brought to outpatients in the morning before clinics and stored in a locked filing cabinet. The provider told us that their monitoring over the previous three months showed 1% of patients had been seen in outpatients without all relevant medical records being available.

- We saw radiology reports were available on the computerised system which was accessible for all relevant staff.
- We reviewed 15 sets of patient records. The records were all complete, legible and up-to-date including signed consent forms.

Safeguarding

- Safeguarding adults and children policies were in place and in date.
- Staff we spoke with had completed safeguarding level one training. Records showed 100% of staff had completed this training. The hospital had two staff trained to children and young person level 3 safeguarding.
- The hospital ceased its treatment, admission, consultation, physiotherapy and diagnostics of all under 18 year olds with effect from 1 December 2015.
- The matron told us that safeguarding level 2 training was not mandatory for Nuffield Health staff. However, safeguarding vulnerable adults training level 2 had been included in the 2017 training plan. Staff were aware of female genital mutilation (FGM) and domestic abuse. The new training will also include information about this. All staff we spoke with were able to describe the process for managing safeguarding concerns. They knew who the safeguarding lead was (the matron) and where to find further information if they were unsure of the correct process. No staff members we spoke with had felt the need to use the safeguarding referral process.

Mandatory Training

- The hospital had a mandatory training programme in place. Topics on the training programme included basic life support, infection prevention and information governance. At the time of the inspection, the average level of compliance was 96% for staff in outpatients and diagnostic imaging. This exceeded the hospital target of 85%.
- Staff working in the outpatients and diagnostic imaging departments told us they were given time to complete this training and felt up to date with relevant information covered.

Assessing and responding to patient risk

- A pre-admission assessment was carried out on all patients prior to procedures taking place. The assessment identified any risks to the patient and where appropriate, how risks could be minimised. If a risk was identified such as high blood pressure the procedure was postponed until it was safe to continue with. Staff told us and we saw in patient records that during outpatient consultations the patient's risks would be reviewed.
- Following all procedures, patients waited for a period of time set by the consultant where they would be observed by staff and checked prior to leaving the hospital. Staff told us that if a patient became unwell they would be taken to a consulting room for further assessment. At the time of the inspection 93% of staff were trained in Basic Life Support which was provided as part of their mandatory training programme.
- Staff were aware of the transfer arrangements in place for patients to attend the local NHS hospital if necessary.
- Staff told us the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was completed for all interventional radiology procedures and minor surgical procedures. We observed the checklist being used for one procedure and noted that although staff followed the steps required they did not pause to go through the checklist being read and confirmed aloud. An audit had been completed in July 2016 which highlighted that procedure details were not written on any of the forms, all clinical staff were made aware and since the audit this information was included. On three of 10 samples used for the audit there were not complete sign in and out sections. On all 10 of the records we saw during the inspection, procedure information was included as well as sign in and out sections being fully completed.

Nursing and radiology staffing

- The outpatients and radiology departments were up to full establishment for staffing and had 0% turnover in the last twelve months. There were low sickness rates and when staff were absent agency staff were not used as the departments had bank staff available to cover.

Good

Outpatients and diagnostic imaging

- This service did not use a patient acuity tool to determine required staffing levels. Staff told us that the staffing needs were reviewed on a daily basis in advance of each clinic to ensure that patient's needs were met.

Medical Staffing

- There were 150 consultants who had been granted practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital.
- Consultants held regular clinics, having arranged them directly with the outpatients administration team, and were responsible for the care of their patients.

Emergency Awareness and Training

- The hospital had a major incident policy in place that was in date and available for staff as a paper copy and electronically. This outlined the protocols for different types of major incidents with the support of emergency services where necessary.
- There were weekly tests of the fire alarms and fire evacuation drills were conducted twice a year.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the effectiveness of the outpatients and imaging departments.

Evidenced based Care and Treatment

- The National Institute for Health and Care Excellence (NICE) provides guidance on improving health and social care. NICE guidelines were assessed monthly for relevance for the hospital and then cascaded to staff. Staff told us that they were regularly updated with relevant changes in NICE guidance and applied these changes to their work. Policies were written by clinical experts in the relevant field using NICE guidelines and evidence produced by the government or relevant medical societies. We saw minutes from Medical Advisory Committee meetings and the Local Quality and Safety Committee where NICE guidelines were discussed.
- An audit conducted in November 2016 showed the diagnostic and imaging department to be fully compliant with Ionising Radiation (medical exposure) Regulations (IR(ME)R) with no actions required.

Pain Relief

- We saw in patient records that pain relief was discussed prior to and after procedures. We observed appropriate use of local anaesthetic for a patient having ultrasound guided injections. The patient told us that although her procedure had been uncomfortable the pain had been managed very well.

Patient Outcomes

- Diagnostic Reference Levels (DRLs) were obtained for all radiology procedures. They were in line with national recommendations and available in imaging rooms.
- The hospital participated in the Patient Reported Outcome Measures (PROMS) data collection for hip and knee replacement as well as groin hernia repairs. Data from January to March 2016 showed that seven patients reported improvements following knee replacement, for two patients symptoms remained unchanged and three experienced worsening of symptoms. For patients who had hip replacements, all four patients reported improvements. For patients who had groin hernia repairs, seven experienced improvements, two patients had unchanged symptoms and none worsened.

Competent staff

- We spoke with staff in the radiology department who had been through the induction process. They told us the training had been thorough and that they had been well supported.
- Staff within the outpatients and diagnostic imaging departments told us they had annual appraisals and also regular reviews. Data showed that 100% of staff had participated in the appraisal process and staff told us they found this valuable and meaningful towards their development.
- Staff told us they were supported well through the revalidation process and that checks were conducted to make sure all nurses were registered with the Nursing and Midwifery Council (NMC).

Multidisciplinary Working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas that we visited. We saw

Good

Outpatients and diagnostic imaging

good collaborative working and communication between staff in and out of the department. Staff told us that they felt part of the wider team and that this worked well.
- Staff gave an example of how physiotherapists work with the shoulder specialist consultants to give input to patients before surgery, whilst they were an inpatient and then also at follow up appointments in the outpatient department.
- Staff told us that physiotherapy transfers were made directly from the ward. This meant that patients could access post-surgery physiotherapy where appropriate in a timely manner to aid recovery.

Seven-day services

- The outpatients department ran clinics from Monday to Friday between 8am to 8pm and also held clinics on Saturday mornings when necessary.
- The diagnostic and imaging department provided services 8:30am to 6pm Monday to Friday however would open later and on Saturdays to support the outpatient clinics when necessary.
- A radiographer was on call 24-hours a day to provide urgent services if required.
- Physiotherapists were available five days a week.

Access to information

- Consultants, nursing and administrative staff told us that there were no issues with accessing paper based patient notes for clinics.
- An electronic system was in place for diagnostic results which consultants could view easily.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During all of our observations we saw that staff were aware of their duty when obtaining consent and ensured explanations were given in a way patients could understand. Patients we spoke with felt they were given choice and understood the information provided for making decisions about their care and treatment. We saw that consent was clearly documented prior to procedures in all 15 of the patient records we reviewed.
- Staff we spoke with showed varying levels of understanding in regards to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Data provided showed that 100% of staff had completed training in MCA and DoLs at the time of the inspection.
- Staff gave an example of a patient who attended a pre-operative assessment and when staff asked what procedure they were having, the patient was unclear. The staff in the appointment felt that the patient could not fully consent if they did not know the full details of the procedure and so referred the patient back to the consultant for further discussion. The outcome was that the patient had a further appointment and returned with the full knowledge to be able to make an informed decision about treatment.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We spoke with six patients within the outpatients and the diagnostic and imaging departments. All the patients we spoke with said they were pleased with the care they had received and had found the staff to be very helpful. One patient said the staff had been “amazing” and “could not do enough to help”. We did not receive any negative comments from patients regarding the staff.
- The outpatients department conducted a pilot patient satisfaction survey, 38 patients participated between May and August 2016. The survey showed that 100% of the patients asked said that they would recommend the service to friends and family.
- The hospital participated in the Friends and Family Test for the NHS patients they treated. Data showed that between 98% and 100% of the responses stated they would recommend the hospital to their friends and family should they need similar care and treatment (April 2015 to July 2015.)
- We saw a consultant discuss a sensitive matter with a patient and explain technical terms in an easily understandable way. During our observations, all of the consultants had time to discuss patients issues and needs and did not rush appointments.
- We saw nursing staff who were polite and friendly with patients whilst chaperoning them and speaking with patients before and after consultations.

Good

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- All of the patients we spoke with told us they felt fully informed about their care and treatment. They said that they had been given the opportunity to ask questions and discuss any concerns.
- All of the patients who took part in the Patient Satisfaction Survey said that the answers to their questions about upcoming procedures were either very clear or clear.
- Staff introduced themselves with 'my name is' and we observed consultants introduce themselves and shake patients' hand when they were called into their appointment.

Emotional Support

- We saw staff giving reassurance and emotional support to patients in person and over the telephone. We observed a consultant taking the time to listen to a patient's concerns and showed empathy with their response. We saw staff speaking with a patient as requested during a procedure to help distract from the discomfort.

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 Sales and Service Manager held regular events with local GPs to raise awareness of the services on offer at the hospital and had ongoing working relationships with the local NHS acute trust and Clinical Commissioning Group (CCG).
- The outpatients department ran clinics until 8pm in the evenings from Monday to Friday. The main reception was open from 7am. The department also ran Saturday morning clinics as required and was supported by the imaging department at all times with it either being open or having a radiographer on call.
- For patients that required it, a mobile magnetic resonance imaging (MRI) scanner was available two days per week.
- The environment was appropriate and patient centred. Drinks and magazines were available in waiting areas and there was sufficient seating.
- Reception staff escorted all patients to the relevant departments. The outpatients department was clearly signed for patients to find the way out and staff were available to provide any assistance required.

Access and flow

- Patients could refer themselves and either self-fund or pay via their health care insurer or be referred by a GP to access NHS services at the hospital.
- Both self-funding and NHS patients were given a choice of appointments. New patients were allocated a 30-minute appointment (40 minutes if seeing the neurology consultant) and patients attending for follow up appointments were allocated 15-minutes.
- The hospital met the NHS target of 92% of patients beginning treatment within 18 weeks of referral for each month from April 2015 to March 2016.
- There were no waiting lists for patients to attend outpatient or radiology appointments. If consultants needed to see patients urgently there was flexibility to extend clinics. Staff told us that patients were generally seen as it suited them following referral. We spoke with a patient who confirmed that she was seen within two days of self-referring.
- On arrival, patients reported to the reception of the department and a receptionist would book them in on an online system.
- Patients told us that they were usually seen on time or within 10 minutes of their appointments. We saw an audit conducted on 15 July 2016 of the time patients had waited to see a consultant. This showed that 88% patients were seen on time. The audit also looked at patients who did not attend (DNA) and out of 52 patients one did not attend the appointment. Staff told us that generally DNA rates were very low.

Meeting people's individual needs

- Information leaflets were available to patients regarding treatments. Leaflets were provided with appointment letters where possible and also given to patients to take away following appointments.
- The hospital was accessible for people with mobility problems. A lift was available for patients who would be unable to use stairs to access upper floors.

Good

Outpatients and diagnostic imaging

- Car parking was ample and patients told us they had found the hospital easily and had no problems finding a parking space.
- We saw curtains used to promote privacy and dignity for patients having procedures and the staff were very aware and understanding of the needs of patients in regard to this. However, the Patient-Led Assessment of the Care Environment (PLACE) scores for privacy, dignity and wellbeing were 75%, which was worse than the England average of 87%.
- We saw chaperone posters in visible areas around the outpatient department, inside consultation rooms and in the radiology department.
- Staff we spoke with gave us an example of an appointment cancelled for a patient due to a consultant being unable to attend. To apologise for the inconvenience the patient's travel costs were reimbursed and flowers were sent to them.
- Staff told us that when a patient attended the hospital whose first language was not English they would usually ask a friend or relative who could translate to attend with them, which was not good practice. There was no language policy in place however an account for a language interpretation service was in the process of being set up.
- Staff told us they had received training and information for supporting patients living with dementia attending the hospital. Staff asked the patient, with support of relatives or carers to complete a document called "This is me" to enable staff across all areas of the hospital to be aware of the individual needs and preferences of the patient.
- Staff we spoke with were unaware of any protocols in place for patients with a learning disability receiving treatment.The hospital did not have a specific policy in place but the outpatient manager referred to policies relating to vulnerable adults, safeguarding, the mental capacity act and deprivation of liberty safeguards and consent to examination or treatment.
- Staff told us that very few patients with learning disabilities attended the hospital however gave examples of how they have adapted to meet the individual needs of the patient. This included staff members meeting a patient who found new situations and surroundings stressful prior to the appointment in order that they could familiarise themselves and settle into the environment more easily for the consultation. This patient was also chaperoned by a nurse they had met before throughout her appointment and the hospital received very good feedback about the patient's experience.

Learning from complaints and concerns

- See the Surgery section for main findings.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Vision and strategy for this core service

- See the Surgery section for main findings.
- The outpatient sister was able to describe the clear vision for the service in line with the hospital vision. She described the plan for refurbishment and infection control by replacement of sinks and flooring. This was in addition to improving quality through focussing on audit and review of services. The x-ray manager also discussed the vision and strategy for diagnostic imaging which included refurbishment and updates of equipment.

Governance, risk management and quality measurement

- See the Surgery section for main findings.
- The hospital risk register included risks relevant to the outpatients and diagnostic imaging departments. For example, a machine used to process x-ray images to digital format was regularly breaking down and caused disruption, this was included on the risk register. Each department also had their own risk register, which were reviewed monthly at Heads of Department meetings. Both department managers were clear about what was on each risk register.
- The outpatient sister and imaging department manager attended monthly clinical department meetings where risks, incidents, action plans and updates from other areas were discussed. Information from this meeting then fed into the monthly Quality, Safety and Clinical Heads of Department meeting and that into the quarterly Medical Advisory Committee, Integrated

Good

Outpatients and diagnostic imaging

Governance Committee and monthly Senior Management Team Board. We had concerns that as these meetings were not clearly connected it may be possible for issues to not be escalated appropriately.

Leadership and culture of service

- See the Surgery section for main findings.
- All the staff we spoke with felt supported and valued by their managers.
- Staff discussed a strong team spirit and told us that they felt included as part of their own smaller teams but that the entire hospital team was friendly and inclusive.

Public and staff engagement

- See the Surgery section for main findings.

Innovation, improvement and sustainability

- The physiotherapy department included the clinical lead for women's health and continence. Work completed by the team included promoting the treatments through articles available in popular women's magazines. A recent focus had been on all patients who had undergone major gynaecological surgery receiving follow up physiotherapy sessions with the specialist. They had found this to be very successful and were working on how to continue this practice.

Outstanding practice and areas for improvement

Outstanding practice

- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The physiotherapy department had completed work to provide follow up physiotherapy sessions for all patients who had undergone major gynaecological surgery. This had proved successful outcomes and there were plans to progress this work further.
- The patient forum provided feedback to improve the services provided within the hospital. Representatives who had experience of care and treatment at the hospital attended the meetings. The chair of the patient forum attended the MAC.

Areas for improvement

Action the provider MUST take to improve

- The registered manager must ensure that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist is consistently completed and adhered to at the hospital.
- The registered manager must ensure steps are taken to improve the infection rates for surgical procedures.
- The registered manager must ensure all policies are complied with, specifically the antimicrobial policy, fasting arrangements and ensuring patients had sufficient information and time to provide informed consent about their operation.

Action the provider SHOULD take to improve

- The registered manager should ensure that the flooring and hand washing sinks in outpatients meets current guidelines.
- The registered manager should ensure that all staff are able to demonstrate a full understanding of the Mental Capacity Act.
- The registered manager should ensure that a translation service is available for patients whose first language was not English.
- The registered manager should ensure facilities are put in place to ensure patients privacy and dignity is maintained when treatment is being administered or care discussed in the Ambulatory Care Unit.
- The registered manager should ensure that lines of accountability and reporting structures between the different governance groups are clear and the responsibilities of each group are understood.
- The registered manager should ensure that all staff and clinicians follow good hand hygiene practices at all times to ensure the risk of infection is minimised.
- The registered manager should ensure that all staff understand their responsibilities to raise all concerns and report near misses even if the incident had not caused harm or disruption to the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** People who use services and others were not protected against potential risk as the provider was not doing all that was reasonably practical to mitigate risks. Surgical safety procedures were not being consistently carried and observational audits were not being carried out to provide assurance.