Nuffield Health

Nuffield Health Wessex Hospital

Inspection report

Winchester Road
Chandlers Ford
Eastleigh
SO53 2DW
Tel: 02380266377
www.nuffieldhealth.com/hospitals/wessex

Date of inspection visit: 8 December 2022
Date of publication: 27/01/2023

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

Ratings

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

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

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

However:

- However, there was one record which contained the wrong person's name. This was brought to the attention of senior managers during the inspection.
- Oxygen was not always prescribed in line with guidance.
- There was inconsistent recording of NEWS.
- The clean utility room was unlocked with keys left on the cupboard.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	

Summary of findings

Contents

Summary of this inspection

Background to Nuffield Health Wessex Hospital

Nuffield Health Wessex Hospital is operated by Nuffield Health. The hospital opened in 1977. It is a private hospital in Chandlers Ford, Hampshire. The hospital primarily serves the communities of Hampshire. It also accepts patient referrals from outside this area. The hospital provides surgery, medical care and outpatients and diagnostic imaging.

The hospital is an Elective surgical hospital site with 52 registered beds, 4 theatres- 3 of which are laminar floor, orthopaedic and spinal theatres, one is digital laparoscopy gynae theatre.

There are 12 outpatient consulting rooms currently, in the final commissioning stage for another 5. The hospital has 283 staff working across FWO through bank, majority being contracted.

222 consultants with practicing privileges, 160 of them work on a regular basis at the hospital. All patients are pre-assessed, all general anaesthetic patients are pre- assessed face to face and anybody requiring sedation or local has telephone pre assessment.

The hospital provides elective surgery to patients who pay for themselves, are insured, or are NHS patients. Surgical specialities offered include orthopaedics, ophthalmology, general surgery, gynaecology, cosmetic surgery, urology, maxilla-facial and endoscopy.

How we carried out this inspection

We carried out an unannounced inspection on 8th of December 2022 using our comprehensive inspection methodology.

During the inspection, we assessed the surgical services. We reviewed the safe and well-led domain. We visited the hospital and spoke with 12 members of staff. This included consultants, senior managers, pharmacists and assistants, a resident medical officer, nurses, healthcare assistants and domestic staff. We also spoke with three patients. . We reviewed six sets of care and treatment records, and looked at hospital policies, procedures and other documents relating to the running of the services.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that oxygen is prescribed and records of this is maintained as administered.

Action the service SHOULD take to improve:

Summary of this inspection

- The service should ensure that NEWS scores are recorded consistently.
- The service should ensure that details of patients are accurate in their records.
- The service should review access to the clean utility room and kept secure in line with internal procedures.
- The service should ensure that weekly and daily emergency equipment checks are consistently carried out and records are maintained.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good

Surgery

Safe	Good
Well-led	Good

Are Surgery safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The hospital had an essential training and mandatory training policy which explained the training responsibilities of all staff. Mandatory training was split into job roles.

We assessed the mandatory training requirements, and it was comprehensive and met the needs of patients and staff. Staff completed training through face to face and e-learning modules. Staff told us there were no barriers to accessing mandatory training.

Data provided from the hospital showed a compliance rate of 95% for modules for all Nuffield Health Colleagues. The compliance rate for modules specific to job roles was 89%.

Staff were responsible for when they needed to update their training, however managers also alerted them when they needed to do so.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had received training on how to recognise and report abuse, and they knew how to apply it. They knew how to identify adults and children at risk of, or suffering, significant harm.

The service had developed systems and processes which supported staff in dealing with any safeguarding concerns.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw a good example of a recent safeguarding incident where a member of the public had sought a place of safety at the service. All necessary actions were followed to safeguard them from harm including referrals to external agencies Staff were confident on how to seek help and support, if they had any concerns.

The service had a safeguarding lead who had completed safeguarding adults and children level 3 training. All other staff had training at level 2, data showed 100% of staff had completed this.

The service had raised one safeguarding concern in the 12 months prior to this inspection; it was not patient related.

Good

Surgery

There was a safeguarding policy and procedures which staff told us they could access and were aware of other senior staff to contact for support.

The safeguarding policy reflected recruitment practice to protect patients from the risks of abuse. There were clear arrangements to support staff and ensuring they had an up to date enhanced Disclosure and Barring Service (DBS) checks prior to them starting work.

Cleanliness, infection control and hygiene

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

We found the areas of the hospital we visited were visibly clean and tidy and in very good state of repair.

Antibacterial hand gels were available at entrance to the wards and in the main reception area and in other clinical areas. Patients were reminded to use this to minimise the risks of cross infection.

Equipment were cleaned in between patients to ensure effective infection control and reducing the risks of cross infection.

All patients were accommodated in single rooms with en-suite facilities. Staff said this was a big advantage in managing patients who had tested positive to COVID19 or those suspected of having an infectious condition.

The hospital reported one case of healthcare acquired infection (MSSA) in the last 12 months prior to our inspection. Patients were tested for MRSA during the pre- operative assessment and results of these tests were available in patients records prior to them undergoing their surgical procedures.

Staff adhered to guidelines such as bare below the elbow procedures in clinical areas. Staff adhered to the five moments of hand washing in line with the World Health Organisation protocols to prevent the spread of infection. There were adequate Personal Protective Equipment which staff used and disposed of in line with infection control guidance.

Patients were complimentary about standard of cleanliness and staff followed their daily cleaning routine of the rooms and en-suite facilities.

The service carried out regular hand washing and environment audits to monitor compliance with infection control.

We observed theatres to be clean with chemical spill kits and a decontamination hood for endoscopes.

The hospital employed evening cleaners and had recently employed daytime cleaners for theatres. Staff commented that this had made a huge difference.

The hospital sent their theatre instruments to their own HSSU facility based off site.

The most recent infection prevention and control audit results carried out for theatres and wards at the hospital. In quarter 4 the theatre department achieved an overall compliance of 82.6% for Infection prevention and control. Data for the same quarter for the wards wasn't available to us.

Good

Surgery

Following the inspection during the factually accuracy process the service told us this was due on December 2022.

Staff worked effectively to prevent, identify and treat surgical site infections (SSIs). The service monitored SSIs for both inpatients and acquired post-discharge. The service reported eleven inpatient SSIs and eleven SSIs post discharge from January to November 2022. All SSIs were investigated, and learning identified.

Environment and equipment

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

The design of the environment followed national guidance, and the waiting area met the current guidelines for social distancing measures. The setting enabled staff to observe and monitor patients who were in the waiting room. Corridors and rooms were spacious, allowing staff to carry out tasks efficiently.

The reception area was appropriately furnished and doors were wide enough to accommodate people with limited mobility and wheelchair users. People had access to hot and cold refreshment in the waiting room.

The service managed the environment and their equipment safely. All fire exits were clearly signposted and easily accessible in the event of a fire requiring evacuation.

All areas we visited were clean and well maintained. There was a programme for servicing of equipment which showed this was completed within the schedule to ensure they remained safe and ready for use.

The resuscitation trolley was maintained securely with a tamper evident tag. All single use items were sealed and within their expiry dates.

Although staff mostly followed their internal process for emergency equipment checks, there were some gaps in the weekly and daily records.

All patients were accommodated in single rooms with en-suite facilities. The flooring in patients' rooms were well maintained and washable flooring to reduce risks of cross infection. Portable equipment such as suction machines were readily available, the operating theatre was situated on the same floor as the inpatient wards.

The service managed substances that were hazardous to health safely and in line with Control of Substances Hazardous to Health (COSHH) Regulation 2002, these were locked securely to prevent access by unauthorised persons.

The hospital was part of an equipment loan board as equipment was often loaned from other hospitals in the area. The hospital had a service level agreement with certain companies for larger equipment.

During the inspection, we found the clean utility room to be unlocked. When we raised this with the ward staff, they noted this door to be faulty which did not auto close when staff exited the room. A request was made to the Estates team to rectify the fault.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Good

Surgery

The service used National Early Warning System (NEWS2) to record patients' observations following their surgery and recovery stage NEWS2 is a recognised tool used as a guide which looks at a patient's vital signs such as respiration rate, blood pressure, oxygen saturation level, pulse and pain levels. Any changes in these parameters could indicate early deterioration and prompt actions would be indicated.

The NEWS scores were mostly completed, although in two records there were incomplete recording of patients NEWS which could impact on patient's care.

Following the factual accuracy process the service told us they completed audits for NEWS and had scored 90.8% for July, 93.3% for September and 90% for November. This showed that 10% of the results did not show compliance.

The hospital used the World Health Organisation (WHO) guidelines, 5 steps to safer surgery checklist. The surgical safety checklist is guidance to promote safety of patients undergoing surgery and sets out what should be done during every surgical procedure to reduce the risk of errors.

We reviewed six sets of patient's records which showed staff adhered to the guidelines and all steps of the checklist were fully completed.

Pre-operative assessments were completed prior to surgery as part of risks management. We reviewed the pre-assessment questionnaire and found it to be thorough.

The hospital ran a Spine School Enhanced Recovery programme for patients at no extra cost. The program focused on patient outcomes and optimising patient recovery and rehabilitation and gave patients the opportunity to find out how to prepare themselves and their home for surgery and discharge and to have their questions answered in a relaxed small group setting.

The service used recognised tools in assessing patients risks such as falls, malnutrition, pressure ulcer, and venous thrombosis (blood clots). Care plans were developed to manage this as needed. Patients were prescribed anti thrombosis prophylaxis which included anti embolic stockings and other non- invasive equipment was used.

The service followed the Royal Society of Anaesthetist guidelines in patient's selection for surgical procedures. The senior management team confirmed that they accommodated ASA 2 patients as the service did not have a high dependency unit. This is a system to assess patients' fitness for surgery which allowed for safe patients' selection and low risks patients.

The spinal lead nurse supported staff in clinically reviewing all pre and post-operative spinal patients during their hospital stay.

The Sepsis six pathway had been developed and staff received training in the management of sepsis. The Sepsis Six consisted of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis. This included timely bloods, and antibiotic therapy.

We saw a recent example of the pathway being followed for a patient who presented to the outpatient clinic with a spinal abscess. The patient was transferred out to a local NHS. Access to microbiology in house and out of hours (OOH) on call system meant the staff received results in a timely way and within 48 hrs.

Good

Surgery

The hospital had a service level agreement for acutely ill patients to be transferred to a local NHS trust. The service defined an acute transfer as a transfer to a higher acuity unit for specialist care. The admitting consultant was responsible for arrangement of emergency transfers.

Staff at the hospital completed adult basic life support or immediate life support training depending on their role. Data provided to us post inspection showed an overall compliance of 90% for basic life support for ward staff. This was 91% for immediate life support.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The hospital ensured the ward and theatres had enough skilled staff to provide appropriate care and treatment on site.

The hospital reviewed their staffing daily and held forward planning meetings with the theatre team on Tuesdays to look at the list to ensure they had adequate numbers and right skills to deliver safe care.

Theatre staff completed a safety checklist and theatre daily allocation to ensure staffing for department was appropriate. These included looking at the theatre list, any issues and concerns.

Staffing consisted of long term staff and bank staff. The hospital used bank staff who regularly worked at the hospital and were familiar with the facilities and the teams they worked in. These staff received a full induction and understood the services offered. The hospital reported a low usage of agency staff.

The hospital had an on call system with senior managers, operational manager and clinical manager who were available out of hours and during the weekends for support.

Medical staffing

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

Each patient was admitted to the hospital under the care of a named consultant with the relevant experience in that area of medicine. Consultants led and delivered the surgical service at the hospital under practising privileges. A practising privilege is, “Permission to act as a medical practitioner in that hospital” (Health and Social Care Act, 2008).

All consultant surgeons had to complete an application for admitting rights. This information was used by the Nuffield Hospitals management team to determine whether the person had the required skills and experience to carry out treatments at the hospital. Consultants had to demonstrate they were competent to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice. Medical staff who could not demonstrate they had the relevant skills were not granted practising privileges.

There was a resident medical offer (RMO) at this hospital who was available for support and worked a week rotation. Two of them who worked on a weekly rotation of seven days and provided 24/7 cover.

Good

Surgery

All care and treatment at the service was consultant led. Out of hours cover was provided through an on call system. Consultants were responsive and attended the service as needed. They reviewed their patients daily and worked well as part of the multi- disciplinary team.

Reviews of staff files showed the hospital carried out the appropriate checks and reviews of the consultants working at the hospital under practising privileges.

The hospital had a medical advisory committee (MAC). One of the remits of the committee was to ensure doctors working in the service continued to meet the required standards to practice at the hospital. The MAC made sure any new consultant was only granted practising privileges if deemed competent and safe to practice.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

At the time of the inspection, the service was using a paper based record system with plans to introduce electronic patients records by September 2023.

We reviewed six patients' records and found these were comprehensive and contained good details about assessments, care plans and care delivered.

Records were multi- disciplinary, up-to-date, stored securely and easily available to all staff providing care.

When patients were transferred, there were no delays in staff accessing their records. All patients had copies of their records sent with them on transfer which included medicines records with up to date information to maintain continuity in patient's care.

The administration team had developed an effective system for storage of patient's records which staff could access out of hours. Access to the records office was restricted to authorised staff in line with data protection guidelines. NHS patient's records were managed by a team based at the service. Staff said there were no delays in accessing patient's records when referred from the NHS for treatment.

However, there was one record which partly contained the wrong person's name. this was brought to the attention of senior managers during the inspection.

All patients' records were coded by latest admissions and stored in that order. These were loaded onto the system which assisted with tracking. NHS choose and book patient records were coded yellow for tracking and staff on site prepared the documents required during pre-assessment.

The hospital was in the process of rolling out private patient's records- single patients records (SPR). There were 10 consultants currently on SPR.

Staff recorded records which had been removed out of hours and updated the system the next morning. At the time of the inspection, there were nine months records available on site, staff were working to reduce this, as the service had a secured a facility to store their records off site .

Good

Surgery

Medicines

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

There were clear processes for the management of medicines which were followed. Medicines were stored securely and access to medicines was restricted.

There was an in-house pharmacy service which was an integral part of the service. Staff worked cohesively and pharmacy support and advice was sought regularly.

The service was staffed Monday to Friday and pharmacy support was available out of hours via an on call system.

Staff followed their internal procedure which required two people to access any medicines out of hours and a record of medicines removed was maintained. This worked effectively to reduce the risk of medicines misappropriation.

The pharmacist and the resident medical officer (RMO) carried out medicines' reconciliation for inpatients. This ensured that patients' medicines were reviewed on admission, and they continued to receive their medicines as needed.

Emergency medicines were available in the resuscitation trolleys which was secure to reduce the risks of unauthorised access. Medicines were checked regularly and a sample of medicines seen were all in date.

The service managed controlled drugs (CDs) in line with regulations. All controlled drugs were checked daily and all entries had a double signature in line with their internal process and guidance.

Keys for this were held locked in a key safe in the managers office.

The pharmacy manager held quarterly anti-microbial stewardship meetings which was a multi- disciplinary team looking at antibiotic management. The last meeting took place on March 2022 and there hadn't been one since. The hospital had a plan in place to recommence these meetings in 2023.

The service completed Antimicrobial audits and scored 98% for quarter 1 and 96% for quarter 3. Results for quarter 2 and 4 wasn't available to us. Following the factual accuracy process the hospital told us these audits were submitted to the National Infection Prevention Committee. Any concerns or escalations were reported within the Infection Prevention Team forum.

Minutes from the IPC and anti-microbial stewardship meetings showed surgical site infections, cleanliness and IPC audit results were discussed.

The hospital completed medicine audits which included Controlled drugs. Audit results were collated and used to improve patient safety and quality of services offered.

The hospital carried out quarterly controlled drugs audits for wards and theatres.

In addition to this, the hospital carried out medicines' management audits. We reviewed this for quarter 1 which had identified actions and improvements. Some of which included reminding ward staff to check all opened bottles of medicines on the drug trolley, and write when they are opened, as this was only still partially being done and Pharmacy to stick yellow stickers on oral medicines issued to the ward.

Good

Surgery

At the time of the inspection we found a patient was administered oxygen for two days which had not been prescribed. They had received higher level of oxygen due to a deterioration in their condition. Records showed they had received five to six litres of oxygen. Staff confirmed that oxygen should be prescribed in line with policy and there was no record of a prescription for this.

Incidents

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

Staff followed their internal process to report, record incidents and sought advice as needed.

The service had an incident policy. This described roles and responsibilities and outlined how to report incidents using their online system. Staff raised concerns and reported incidents and near misses in line with provider policy

We reviewed ten incident records which were comprehensive, fully investigated, and action plans developed to mitigate risks. Actions taken included reviewing procedures and staff training and lessons learnt were shared.

The incidents were reviewed at the clinical governance meeting. We reviewed three sets of minutes and saw evidence incidents, adverse events and near misses were discussed, investigations into incidents reviewed, identified emerging trends and actions taken to reduce risk and reduce the likelihood of reoccurrence put in place. The hospital saw incident reporting as a tool to drive improvement. Incident information from the clinical governance meeting was fed back by senior staff. This happened in several ways, via team meetings, emails and during handovers.

Minutes from the medical advisory committee (MAC) meetings showed incidents were discussed at these meetings. This showed that consultants had awareness of incidents being reported at the hospital.

The hospital had no never events in the last 12 months. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The hospital had a being open (duty of candour) including saying sorry policy which explained staff's responsibility to be open and honest with patients and their relatives when something had gone wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

We reviewed three incidents which showed that staff informed patients when things went wrong, offered them support and ensured that the duty of candour process was instigated in a timely way and followed up in writing.

Are Surgery well-led?

Good

Our rating of well-led improved. We rated it as good.

Good

Surgery

Leadership

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

The hospital had a management structure with clear lines of responsibility and accountability.

The hospital was led by a hospital director who had overall responsibility for the hospital. They were supported clinically by the matron and senior nurse leads. Leaders were visible and approachable. Staff including consultants said the matron, hospital director were both visible and approachable. The hospital director operated an open door policy and was accessible for advice and staff could raise any concerns.

All staff knew who the hospital director was and felt confident to approach them.

Leaders had a genuine interest in developing staff abilities and skills to benefit the service. Staff we spoke with told us they could access development through leadership programmes.

The pharmacy manager worked with the consultants and microbiology team in ensuring the service worked together in meeting medicines optimisation priority, as led by NHS England and supported by public health England (PHE).

Anti- microbial stewardship was pharmacy led and was an agenda item in IPC quarterly meetings. Lessons learnt were shared at team meetings, handovers and via newsletter.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

The hospitals purpose was to build a healthier nation by supporting individuals and communities by

- Designing and providing connected health and wellbeing services with superior health outcomes.
- Expanding the reach of their flagship programmes and
- Influencing wider practice by sharing their expertise.

The hospital vision was to provide high quality services working in collaboration with their key partners and stakeholders to support the needs of the local community, regional and UK populations.

Staff understood the vision and strategy and what their role was in achieving them. They could describe the core values which was Connected, Aspirational, Responsive and Ethical, CARE.

The heads of departments attended quarterly governance days to engage in the hospital strategy and operational running of the hospital. Minutes of these meetings were shared with staff and other Nuffield hospitals.

The governance days were unique to the hospital and scheduled every 4-6 weeks. Leaders told us all services were paused on the day so that staff could attend departmental meetings, education and undertake necessary team events.

Good

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were welcoming, helpful and professional in their communication with each other, patients and visitors. Staff described good teamwork and respect amongst their colleagues, and we could see this in practice when we inspected the theatre and ward areas.

All staff focused on the needs of patients. They showed kindness and consideration at all stages of the patients' contact with the service.

All staff we spoke with said they felt that their concerns were addressed, and they were easily able to talk with their managers. The organisation had a freedom to speak up guardian to ensure staff could raise concerns in a safe and supportive way.

The service promoted equality and diversity and had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement. Ninety five percent of staff had completed equality, diversity and inclusion training.

The hospital provided learning resources including articles and videos to help managers educate themselves and their teams on diversity and inclusion. The resources were specially compiled for each driver to help managers focus on the areas that needed the most improvement.

The hospital produced a diversion and inclusion report following their survey. We reviewed the last survey which showed a participation rate of 62% and a diversion and inclusion score of 8.4. The diversity and inclusion score is important because it's an indication of how your employees perceive the organisation's efforts to maintain a diverse workforce and create an inclusive environment.

The score of 8.4 was at benchmark, which meant employees perceived the segment "Wessex Hospital" to be as diverse and inclusive as the average.

Governance

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

The hospital had a governance framework through which the hospital was accountable for continuously improving their clinical, corporate, staff and financial performance.

Governance was discussed at the medical advisory committee (MAC) with information from the clinical governance committee reported to the MAC. The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practicing standards and granting practicing privileges. The MAC would also discussed new procedures to be undertaken to ensure they were safe; equipment was available and staff had relevant training.

Good

Surgery

We reviewed the last three minutes from the MAC , they were planned, structured and followed a set agenda and were thorough in their content. Topics including operational updates, incidents and practising privileges were discussed.

In addition to the clinical governance meetings, information from the infection prevention and antimicrobial stewardship committee fed into MAC. The Infection prevention Control (IPC) committee met quarterly and was a multidisciplinary team with input from orthopaedic consultant surgeon, microbiologists, decontamination lead, chief pharmacist and IPC lead.

The hospital held several monthly meetings with the leaders and the heads of departments. Information from these were shared with the staff.

Staff we spoke with told us they reported to either the theatre manager or ward manager.

The service held daily safety huddles to discuss issues or concerns and share information. The hospital also held a daily hospital-wide safety huddle with representation from all departments in the hospital.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were effective processes for identifying, recording, managing and mitigating risks. Risks were identified and added to the risk register and given a risk score depending on severity.

The hospital director held weekly Senior Management meetings where risks were discussed. The local risk register at service level was reviewed monthly by the hospital director and the matron. At the time of the inspection, IPC risks were on the hospital risk register.

The hospital managed surgical site infections for hips and knees patients who were out of area by following up at 30 days and reported surveillance.

The hospital also took part in surgical site infection audits. Positive results were investigated individually. The service had developed a system to identify patients who were admitted and those which were identified at Outpatient and day patient clinics.

The audits looked at trends and themes. There was effective MDT working with the microbiology consortium from Nuffield and other IH services. The hospital used the Situation Background Assessment Recommendation, SBAR tool and sought advice accordingly. There was a systematic programme of clinical and internal auditing to monitor quality and operational processes.

The hospital did not hold local Morbidity and Mortality meetings. All patient deaths were reviewed by the Learning from Deaths Committee held quarterly at a national level. This committee was chaired by the Medical Director and any learnings shared nationally.

Good

Surgery

Information Management

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

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as local commissioners and the Care Quality Commission (CQC). There was transparency and openness with all stakeholders about performance.

Staff had access to a range of policies, procedures and guidance which was available on the hospital's electronic system. This included patient data and the hospital's policies, procedures and general guidance which were updated when required to ensure the information was the most up to date guidance available.

Staff ensured they maintained patient's confidentiality through the management of information. They stored patient's paper records securely in lockable files or in locked rooms. Staff were able to access the information they needed to deliver care and treatment.

Managers used routine data collections to monitor and improve performance issues and to provide assurance to senior leaders and the board. Senior staff used audit data and performance dashboards to have a collective understanding and oversight of the services they managed. They used this data to develop quality and safety reports for providing assurance to the board.

The patient, on discharge, received a letter that included details of their surgical procedure, findings, medication and any changes and details of any follow up. A copy of this letter was sent to the GP and saved in the patient's medical records at the hospital. The medical staff were able to access patient's information, including scan results and blood tests.

Staff also told us they used IT systems to access the e-learning modules required for mandatory training.

Information governance was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations.

Engagement

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

The hospital and surgery service actively encouraged patients and their relatives to give feedback to help improve services. For example, through patient satisfaction surveys. Feedback was used to inform improvement and learning and to celebrate success.

The hospital held regular quarterly patient focus group which had been paused during COVID19. This was usually well attended by on average 5-8 patients. During the time of the inspection the hospital was starting to recruit new members to the group and had four patients who had signed up.

Good

Surgery

The hospital held a Menopause Awareness Event during October to bring Menopause to the forefront of their conversations and also advertise the gynaecological services they offered. As part of this event, the hospital held the 'Demystifying the Menopause' patient event followed by a Q&A session with one of their consultant. This was well attended and feedback showed 100% of the patients would recommend the event to friends and family.

In addition to this, the hospital also held a menopause information talk with their staff which was well attended. Staff said they found this informative and helpful.

The staff area consisted of information boards on fire safety, Infection Prevention Control, Information Governance, Safeguarding, Duty of Candour and List of First Aiders.

Learning, continuous improvement and innovation

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

Spinal Nurse Lead had been focussing on setting up the Centre of Excellence for Spinal Services for Wessex Hospital and the Nuffield Hospital group. This included the development of the Spinal Practice Framework Policy for the Nuffield Health group, Spinal Pathway for Nuffield Health group and Spinal MDT meetings which were due to start on the 4/1/23.

Spinal surgeons employed by the hospital were a member of the British Association of Spine Surgeons (BASS). This allowed sharing of alerts and best practice information.

The recovery lead at the hospital had developed an arterial line pathway and performed audits in order to identify areas for improvement and development.

The pharmacist had developed a medication reminder chart for patients and the hospital provided information on pain relief at home.