Nuffield Health Guildford Hospital

Quality Report

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

Ratings

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

Overall summary

Guildford Hospital is operated by Nuffield Health. The hospital has 49 beds and is an independent hospital. Facilities include four operating theatres, oncology unit, outpatient and diagnostic facilities.

The hospital is located in Guildford and is sited close to the local NHS trust Hospital. The hospital provides surgery, medical care including oncology, services for children and young people, outpatients and diagnostic imaging.

Summary of findings

We inspected the service using our comprehensive inspection methodology. We carried out an unannounced visit to the hospital on the 10 and 11th April 2019. We inspected surgery, medical care, services for children and young people and outpatients.

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

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

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

Services we rate

Our rating of this hospital stayed the same. We rated it as **Good** overall.

We found good practice in relation to:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- The service controlled infection risk well and had suitable premises and equipment and looked after the general environment well.
- Staff completed and updated risk assessments for each patient and kept detailed records of patients' care.
- In all areas caring for adults the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service provided best practice when prescribing, dispensing, recording and storing medicines.
- The service managed patient safety incidents well by completing investigations and learning from outcomes. The service used safety monitoring results well and used them to initiate change of practice.
- Staff gave patients enough food and drink to meet their needs and improve their health, the service made adjustments for patient's religious, cultural and other preferences.
- The staff assessed and monitored the patients regularly to see if they were in pain and audited outcomes to improve care.
- The service provided care and treatment based on national guidance and a local audit plan was established to check effectiveness.
- All staff had an appraisal and the service made sure staff were competent for their role and supported their professional development.
- Staff of different kinds worked together as a team to benefit patients.
- Staff understood how and when to assess whether a patient had the capacity to make their decisions about their care and followed procedure when a patient could not give consent.
- Staff cared for the patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness and provided emotional support.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of patients. The service took account of patient's individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with staff.
- Managers at all levels had the skills and ability to run a service and shared a corporate strategy, vision and values with the staff of what it wanted to achieve.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish.
- The service engaged well with patients, staff and local organisations and collaborated with partner organisations effectively.

Summary of findings

We found areas of outstanding practice in the oncology service, surgery and children's and young people's service.

- Oncology patients could be referred to a personal trainer as part of the hospital's 'Recovery Plus' initiative. This was a personalised training programme which was part of the patient's care planning.
- The implementation of monthly scenario training for all staff developed learning and auditing of clinical practice. Staff had put their scenario training into practice in a critical situation and the learning was shared nationally across the Nuffield hospitals.
- Information for children and young persons was clearly displayed on the ward in books, information leaflets, on boards and addressed general wellbeing as well as specific hospital admission information. The information was current and in line with best practice.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached.

Nigel Acheson

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and responsive and well led.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, responsive and well-led. Caring was found to be outstanding.
Services for children & young people	Good	Children and young people's services was a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and responsive and well led.
Outpatients	Good	Outpatients services were a significant proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, caring and responsive and well led. We do not rate effective in outpatients.

Summary of findings

Contents

Good

Nuffield Health Guildford Hospital

Services we looked at

Medical care (including older people's care); Surgery; Services for children & young people; Outpatients;

Summary of this inspection

Background to Nuffield Health Guildford Hospital

Guildford Hospital is operated by Nuffield Health. The hospital opened in 1999 with a significant refurbishment and extension in 2012. It is a private hospital in Guildford, Surrey. The hospital primarily serves the communities of Surrey. It also accepts patient referrals from outside this area.

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

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

The hospital has a registered manager in post. At the time of the inspection, a new hospital director had recently been appointed and was registered as the registered manager with the CQC in January 2019.

The service had four previous inspections, the most recent in November 2016 when the service was rated as good overall. There was one requirement notice requiring the service to ensure that patient records contain a complete record of care delivered and decisions taken in relation to care and treatment provided to service users.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector,an inspection manager, three other CQC inspectors, and specialist advisors with expertise in surgery, children and young person's services and oncology. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Nuffield Health Guildford Hospital

The main service is surgery with outpatients also providing a significant part of the activity. There is one ward area of 49 single rooms. On this ward there are 33 inpatient beds, four of these are dementia friendly rooms and the rest are generic rooms designated for inpatient surgery. There is a surgical day care area on the ward of 14 beds and two rooms allocated for children and young people. There is a designated oncology unit staffed separately to the ward areas and the unit has its own reception and waiting area.

The outpatient department is located on the ground floor with 14 consulting rooms including one for children and young people. There are four treatment rooms, one minor procedure room and an ophthalmic diagnostic room.

During the inspection, we visited the ward, theatres, oncology and the outpatient department. We spoke with 44 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 16 patients, four parents of children and one relative. During our inspection, we reviewed 29 sets of 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.

Activity (August 2017 to July 2018)

- In the reporting period August 2017 to July 2018 There were 7,552 inpatient and day case episodes of care recorded at The Nuffield Health Guildford Hospital; of these, none were NHS-funded and 100% other funded.
- 28% of patients stayed overnight at the hospital during the same reporting period.
- There were 28,864 outpatient total attendances in the reporting period; of these 99.8% were other funded and 0.2% were NHS-funded.

One hundred and ninety consultants (doctors and dentists) worked at the hospital under practising

Summary of this inspection

privileges. Four regular resident medical officers (RMO) worked on a 24-hour rota with two on duty at any one time. The hospital employed 78.5 FTE registered nurses, 36.8 FTE care assistants and operating department practitioners and 105.8 FTE other hospital staff such as allied healthcare professions, support and administration staff. The service has its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events
- Clinical incidents: 349 no harm, 164 low harm, 26 moderate harm, 1 severe harm, no deaths
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile (C. diff)
- Two incidences of hospital acquired Eschericia-Coli (E.coli)
- Eight complaints

Services accredited by a national body:

- Macmillan Quality Environment Mark
- Pathology Laboratory is CPA-UKAS accredited, MHRA (BSQR) 2005) compliant and approved by the Institute of Biomedical Sciences (IBMS) for health and care Professions Council (HCPC) registration training.

Services provided at the hospital under service level agreement:

- RMO provision
- Catering
- Transfer arrangement to critical care services at co located trust.
- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Facilities Management
- Laser protection advisor
- Laundry
- Maintenance of medical equipment
- Palliative care
- Clinical nurse/allied health professional specialist services from the local trust

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe stayed the same. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure all staff completed it. There was a good level compliance with mandatory training across the hospital, which used internal online system.
- 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 knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. The environment of all areas of the hospital appeared well maintained.
- Staff completed and updated risk assessments for each patient to minimise the risk of harm. They kept clear records and asked for support when necessary.
- In all areas of the hospital managing patients the service had enough nursing staff with the right qualifications and skills to keep the patient safe and provide the right care and treatment.
- There were safe arrangements for medicines. Safe systems were in place to safely prescribe, administer, record and store medicines
- All areas except outpatients managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

However:

- In outpatients substances subject to Control of Substances Hazardous to Health Regulations (2002) were not always stored securely. Following the inspection, the provider informed us that key pad locks were added to the sluice room doors.
- Nasoendoscopes that were re-used on site were not leak tested in line with best practice. Following the inspection, the provider sent us adapted record sheets to enable leak testing to be documented as part of the decontamination process.

Summary of this inspection

- Data provided to us prior to and during the inspection indicated that no incidents had been reported for the outpatient department. However, following the inspection, the provider informed us that 26 incidents had been reported for the outpatients department between January 2018 and December 2018. This meant it was not clear if the outpatients department was aware of all the incidents that had been reported in the service.
- Not all staff were consistent in their assessment and escalation of National Early Warning scores.
- Not all patient's rooms had intact flooring being seamless between walls and floors making cleaning easier.

Are services effective?

Good

Our rating of effective stayed the same.We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. New guidance was widely circulated and acted on.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' religious, cultural and other preferences.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them using appropriate national and a comprehensive local audit plan.
- Staff worked well as a team and with other health professionals in and out of the hospital to provide services for patients.
- Competent staff provided the service and staff were engaged in developing their skills further. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The service provided up to date health promotion information in the hospital and on their website.
- Staff had an understanding of the Mental Capacity Act 2005 and how this applied in practice. They followed the hospital's policy and procedures when a patient could not give consent.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw staff being friendly, approachable and professional with patients.

Summary of this inspection

- Staff provided emotional support to patients to minimise their distress. We saw staff interacting with patients in a supportive manner by offering sympathy and reassurance.
- Staff involved patients and those close to them in decisions about their care and treatment. All patients received information in writing on the costs of their care or treatment prior to commencing treatment. Patients received full explanations about the procedures they were to have.

However:

- The response rates for the outpatient survey were low. The service had recently included pre-paid envelopes to encourage feedback.

Are services responsive?

Good

Our rating of responsive stayed the same.We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of their patients. Services were suitable for the needs of all communities and could be accessed promptly.
- The service took account of patients' individual needs. Holistic needs assessments were carried for all patients at regular intervals throughout their treatment pathway and care planning. Services were adapted for some people, including patients with decreased mobility and hearing impairment.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. We found that there were systems to listen to patients concerns and take appropriate action if required.

However:

- The escalation of the complaints procedure was not made explicit in three out of the five response letters to complainants that we reviewed.

Are services well-led?

Good

Our rating of well-led stayed the same.We rated it as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Staff told us the hospital director and matron were routinely visible and approachable.

Summary of this inspection

- The service had a vision for what it wanted to achieve and workable plans to turn it into action. Nuffield Health values were aligned to staff working practices by the staff appraisal and professional development system.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. All the staff we spoke with were proud to work for the hospital. Staff felt fully engaged with the success of the hospital and their role in making it happen.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish. The hospital had a governance framework which included policies, procedures and oversight by the senior management team and corporate provider.
- The service had clear systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. Services in the hospital had risk registers and risk management processes to monitor and manage risks.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The hospital engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.
- The hospital was committed to improving services by learning from when things went well or wrong, and by promoting training and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	☆ Outstanding	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Are medical care (including older people's care) 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.**
- There was a good level of compliance with mandatory training across the hospital. The hospital had an electronic learning management system. This enabled staff and managers to monitor individual staff training records and compliance with the hospital's mandatory training requirements.
- Mandatory training for oncology included: health, safety and welfare (100%), consent training (100%), fire safety (100%), infection prevention and control (100%), manual handling (100%) and information governance (100%). (Compliance rates are bracketed).
- The hospital had an online 'Academy'. The matron received a daily report on staff that had not completed mandatory training. The matron sent reminders to ward managers if staff had not updated their training. Mandatory training compliance was also monitored by ward managers as part of this staff six monthly and 12 monthly professional development reviews (PDR). This had led to high rates of staff compliance with mandatory training, with oncology having 100% compliance for all mandatory training modules.

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.
- There had been no safeguarding concerns raised from the ward or oncology unit in the previous 12 months.
- The hospital had an up to date safeguarding vulnerable adults and children policy and procedures which contained key information and contact details for the local authority to raise any concerns. The policy had links to other safeguarding related policies to enable staff in accessing the Nuffield Health policy on specific areas of safeguarding concern, such as the policy on preventing violent extremism, PREVENT. Staff were trained to recognise adults and children at risk and were supported by a range of safeguarding adults' and children policies to do this.
- There were good rates of compliance with mandatory safeguarding training. All staff, (100%), had up to date safeguarding training. For example, 100% of the 17 staff that were eligible had up to date safeguarding adults and safeguarding children level 1 training: 100% of the 10 staff eligible for level 2 safeguarding children's training had completed the training.
- The lead for safeguarding on the ward was the ward manager who was trained to level 3. The matron was the hospital's safeguarding lead and was trained to level 3. Nuffield Health had a national safeguarding lead that was trained to level 4. This met intercollegiate guidance: 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff', January 2019.
- The ward manager was aware of the Department of Health (DoH) female genital mutilation (FGM) and

safeguarding guidance for professionals, March 2016. Staff told us FGM, modern slavery, and child sexual exploitation (CSE) was included in the safeguarding training module.

- Staff were aware of the hospital's safeguarding leads and knew who to report safeguarding concerns to. Staff demonstrated understanding of the term safeguarding and were able to give examples of the type of abuse covered in safeguarding training.
- An annual safeguarding report was produced, and this monitored compliance with safeguarding policies and raising concerns processes. We viewed the 2018 report, which was based on safeguarding data from 2017. The report identified themes from safeguarding incidents and set improvement goals.
- The hospital matron sat on the Surrey safeguarding strategy board, this enabled the hospital to learn from the local safeguarding network and share learning across the hospital.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.**
- We found equipment and the premises were clean. They used control measures to prevent the spread of infection.
- The hospital's infection control manual was available to staff in hard copy form on the ward and oncology unit.
- All areas of the oncology unit and ward were visibly clean. Equipment had high visibility stickers applied to indicate the equipment was clean and ready for use.
- The oncology unit and ward had clinical cleaning schedules that detailed the cleaning tasks for clinical areas. We viewed records that confirmed cleaning schedules had been completed from January to March 2019.
- General housekeeping staff had cleaning schedules for non-clinical areas. We viewed records that confirmed these were complete and up to date in April 2019.
- Infection prevention and control training was updated annually. All (100%) eligible oncology staff were up to date with both their infection control and aseptic not touch technique (ANTT) training. The ANTT training was both theory based and practical training in the use of infection prevention and control methods and precautions during invasive clinical procedures. The technique aims to prevent microorganisms being transferred to sterile body sites from healthcare professionals, equipment or the immediate environment to a patient.
- There was an infection prevention and control board in the treatment room on the ward. This gave staff guidance on the colour coding of cleaning equipment and waste disposal.
- Staff knew the name of the infection prevention and control lead nurse.
- All inpatients were cared for in individual private rooms with en-suite bathroom facilities. Staff had access to personal protective equipment as this was kept in patients' rooms.
- Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively. Staff were 'bare below the elbow' to facilitate effective hand washing. Staff demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene, from the World Health Organisation (WHO) guidelines on hand hygiene in health care. Patients we asked reported that staff washed their hands before providing care or treatment.
- We saw hand gel dispensers located in all clinical areas and in patients' rooms. Sinks (compliant with the NHS standard HB09) were available for use on the ward and oncology unit. Soap and hand towels were available next to the sinks.
- Hand hygiene audits were conducted quarterly to monitor compliance with the Nuffield Health hand hygiene policy. These included a minimum of 10 observations of staff hand hygiene practice in a quarter. In quarter four, October to December 2018, the ward and oncology unit had both achieved the hospital's 90% or above compliance rate with hand hygiene.
- Patients requiring isolation were isolated in their rooms. There was a symbol staff would place on the patient's door to alert staff that the patient was in isolation and isolation procedures would need to be observed. There were no patients requiring isolation at the time of our visit. Staff told us patient's rooms would be deep cleaned when an infectious patient vacated the room.
- All patients were screened for MRSA prior to admission to the hospital. There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) or Meticillin-susceptible Staphylococcus Aureus (MSSA) reported between April 2018 and April 2019.

- Waste was segregated in accordance with Health Technical Memorandum (HTM 07-01), control of substance hazardous to health (COSHH) and Health and Safety at work regulations by using a waste segregation colour codingscheme. For example, purple bags were used for the disposal of hazardous waste which required incineration such as waste contaminated with cytotoxic waste. Staff also had access to cytotoxic spillage kits, these are specialist kits for dealing with spillages of cytotoxic chemotherapy.
- The hospital followed guidance from the National Patient Safety Agency (NPSA) colour coding of cleaning materials and equipment to ensure that cleaning equipment was not used in multiple areas, therefore reducing the risk of cross infection.
- The hospital participated in patient ledassessments of the care environment (PLACE). Results from the 2018 PLACE found the hospital achieved 100% compliance with PLACE for cleanliness. This was better than both the Nuffield Health average score (98%) and better than the National average score (98%).

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The environment of the oncology unit and the ward appeared well maintained. The oncology unit met recommendations of Health Building Note (HBN 02-01): Cancer treatment facilities.
- The ward housed the acute dependency unit (ADU). The ADU was a four bedded inpatient area that provided higher-dependency care for level one patients who were very unwell. There were no patients in the ADU at the time of our visit. The ADU had a partitioned escalation area, bed space 53, which was being used at the time of inspection to store equipment. This bed space was listed on the ward's risk register due to the area not having dedicated bathroom facilities. The risk register recorded that bed space 53 on the ADU should not be used except in exceptional circumstances and only as a result of pressures on capacity in the hospital.
- We reviewed the resuscitation trolley on the oncology unit and found that daily and weekly checks had been marked as complete on all days the unit was open during February, March and April 2019. The contents of the trolley were within the date limits specified on their packaging.
- We saw sharps bins were available in treatment areas where sharps may be used. This demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had been fully completed, this ensured traceability of each container.
- Staff reported no problems with repairs to equipment. Staff told us they had enough equipment to run services.
- Individual pieces of equipment had stickers on to indicate equipment was serviced regularly and ready for use. We saw electrical testing stickers on electrical equipment, which indicated electrical equipment was safe to use.
- An external provider was contracted to service equipment, this included hoists. We checked hoists on the ward and saw these had been serviced in February 2019. Other equipment we checked such as patient monitoring equipment, computers, and infusion pumps were up to date with servicing and electrical appliance testing.
- The hospital patient ledassessments of the care environment (PLACE) 2018 found the hospital achieved 97% compliance with the PLACE for condition, appearance and maintenance. This was better than the Nuffield Health average (94%) and better than the national average (94%).

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**
- Staff told us that the hospital would only take patients if services had the capacity to carry out their care and treatment safely.
- The hospital's administration pathway included pre-treatment checks and risk assessments in order to assess a patient's risks and to ensure patients were provided with appropriate interventions during treatment. These included the patient's medical history, venous thromboembolism (VTE) assessments and observations such as temperature, pain or discomfort, and side effects during treatment.

- Staff told us the hospital routinely enquired about whether patients were diabetic and whether this was controlled by diet or medicine. Diabetic patients' blood sugar levels were measured prior to patients being fed and medicine timings were closely monitored.
- The oncology unit used the UK Oncology Nursing Service (UKONS) 24 hour triage rapid assessment and access toolkit. This toolkit was designed to ensure that patient's received robust and reliable assessment every time they contacted the services helpline. This system was monitored on a monthly basis and outcomes were submitted to the clinical governance committee.
- The service used the National Early Warning System (NEWS 2) whilst people were undergoing treatment. This is a scoring system based on a set of observations such as blood pressure, heart and respiratory rate. The observations when combined produce a score, which indicates if a patient is becoming seriously unwell.
- Both nursing and health care assistants had received training to complete patients NEWS 2 observations. Health care assistants told us where patients had an elevated NEWS 2 score they would escalate this to nursing staff.
- We reviewed four patients NEWS 2 scores on the ward and found that although these had been scored correctly, staff were using different methods of recording. For example, staff told us the hospital policy was to record NEWS 2 as dots, to provide a clear graph of the patients observations over time. We found two of the scoring tools had dots, whilst two had ticks. We also found that some NEWS 2 documents recorded patients' blood pressure rates, whilst others did not have the actual blood pressure rate recorded.
- The hospital used a falls risk assessment booklet for patients at risk of falls. Staff told us where a patient' initial assessment indicated that a patient was at risk of falls, a falls booklet would be introduced into the patient's notes.
- The sisters' meeting minutes dated 5 October 2018 confirmed that training on the deteriorating patient would be rolled out to staff in January 2019. Staff we spoke with confirmed that they had received this training.
- The service had an agreed transfer policy and pathway in the event of a patient medical emergency. Staff on the ward were able to clearly demonstrate the process should they need to commence an emergency transfer. Patients would be transferred to a local NHS hospital. We viewed minutes from a sisters meeting, dated 5 October 2018, which confirmed the patient transfer policy had been reviewed. The minutes noted that ambulance crews could use a tunnel that ran between the hospital and the NHS trust hospital. However, ambulance crews were responsible for the patient as soon as handover of care was completed.
- Patients with suspected neutropenic sepsis, (this is a life threatening complication of anticancer treatment), were be transferred to the acute NHS hospital for assessment. Staff on the ward told us if a patient became septic they transferred the patient to an NHS hospital without delay.
- Resident medical officers (RMO) were required to have submitted evidence of up to date emergency response training certification prior to being offered work at the hospital. An RMO told us they had recently received training in immediate life support (ILS) and paediatric life support. This was in accordance with the Nuffield Health Group resuscitation policy.
- Both the ward and oncology unit had a copy of the hospital's emergency on-call booklet. This provided contact details for emergency services, utility companies and senior managers in the event of a disruption to services.

Nurse staffing

- **The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- Staff on the ward told us there was more likelihood of shifts being over staffed than under staffed. At the time of our inspection inpatient services employed the equivalent of 43.2 qualified registered nurses.
- Staffing on the ward was planned in advance depending on capacity and patient acuity. There were five registered nurses and three health care assistants (HCA) on duty during the day on the ward on 10 April 2019. The ward had 15 surgical and three medical inpatients. This was better than the assessed staffing level ratio of one registered nurse to five patients.
- The oncology unit was staffed by a dedicated experienced oncology nursing team 24 hours a day, seven days a week. The oncology nursing team were on hand at all times to provide advice on care and treatment to patients and their relatives throughout the patients' course of treatment at the hospital. The oncology unit staff included: an oncology manager and

a team of clinical nurse specialists (CNS), including a Macmillan clinical nurse specialist in palliative and oncology care, three senior staff nurses, a ward sister, five chemotherapy trained staff nurses, one fully qualified nurse, and four health care assistants.

- At the time of inspection, the oncology unit had 0.6 full time equivalent CNS vacancy, 0.6 senior nurse vacancies. This was 1.2 full-time staff below the established staffing requirement of 15.5 full-time staff.
- The oncology unit had a rolling programme of recruitment. This included: advertising vacancies on the UK oncology nurse society (UKONs) to attract staff with a recognised skill set. The hospital had recruitment open days at weekends where prospective staff could meet the senior team and be interviewed on the day. Staff were employed on a range of contract options including full time, fixed term, term time contracts.
- A handover took place on the ward daily at 7:30am. This was done from a handover sheet, which had been completed by the nursing team that had worked during the previous shift. Staff told us they received updates on every patient at the handover.
- Both the hospital's oncology unit and ward did not use agency staff. The hospital's own staff worked bank shifts to cover staff shortages or absence. Managers told us unfilled shifts were rare, but, staff were willing to cover any unfilled shifts.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- At the time of our inspection, there were 190 consultants working at the hospital under practising privileges. Practising privileges are a 'licence' agreed between a medical professional and a private healthcare provider. They set out the clinician's offer, such as the range of services they are competent to perform.
- Consultants practising privileges stipulated that a consultant must be available to visit their patient daily. Staff told us consultants would also visit patients upon request. Although, nursing staff told us they would have to consult the nurse in charge prior to requesting a patient's consultant.
- The number of episodes of care carried out by consultants with practising privileges across the hospital from October 2017 to September 2018 were: 28 consultants with over 100 episodes of care; 51 consultants with between 10 and 99 episodes of care; and 39 consultants with between one and nine episodes of care.
- From April 2018 to April 2019, 21 consultants had practising privileges removed by the hospital due to not having regular clinics. Two consultants requested removal of practising privileges as they were not continuing to practice in the independent sector. Two consultants had practising privileges removed as a result of retirement.
- At the time of inspection there were four resident medical officers (RMO) working at the hospital. RMOs were provided by an external agency and were not directly employed by Nuffield Health.
- RMOs worked 24 hours a day, seven days a week. The RMO's worked seven 24 hour shifts in a row, with facilities on site for them to sleep over night. The RMOs on duty worked closely together to ensure they had sufficient rest time in each 24 hour period. The hospital informed us if an RMO worked significant number of overnight awake hours, the hospital could get an extra agency RMO to provide additional cover during the subsequent 24 hours to ensure the RMO had adequate rest.
- Individual consultants responsible for patients were contactable whilst the patient was receiving treatment. The RMO was aware of how to contact consultants. Consultant's names were displayed on the door to patient's rooms to enable staff in the easy identification of a patient's consultant.
- The hospital had a bleep system. Staff told us medical staff were responsive if they were called by the bleep.
- Consultants were responsible for arranging their own cover arrangements in the event of them being on leave. Staff told us consultants had to arrange cover from the body of consultants with practising privileges at the hospital. Staff told us consultants were supportive of covering each other's absences and they had not experienced issues with consultants' absences not being covered.
- There were no occasions when consultants had their practising privileges suspended, removed, or receiving supervised practice in the previous 12 months.

Records

Good

Medical care (including older people's care)

- **Staff kept detailed records of patients' care and treatment**. Records were clear, up-to-date and easily available to all staff providing care.
- Records were easily accessible within lockable cupboards either behind reception or in the nursing office. We reviewed five sets of patient records on the oncology unit and four sets of patient notes on the ward during the inspection.
- Records were audited as part of the hospital's quarterly clinical audit. We reviewed audit results for quarter four, October to December 2018. The audit found 100% compliance with the most appropriate care record being used for each patient. However, the audit also identified areas of non-compliance. For example, only 33% of patient records stated the designation of the staff member, and only 57% of entries in the patient record by unqualified staff were countersigned by a qualified member of staff as per the hospital's policy.
- We reviewed an oncology audit report dated April 2019. The report commented on a series of rolling oncology records audits that had taken place in July and October 2018 and April 2019. The audit report found that during the audit period there had been improvements in staff recording practice. This included an increase in the period from 45% to 70% of all care records being dated and timed; improvements in patients' details being documented in the signing sheet from 10% to 70%; improvements on staff designation being documented. The audit also reported that the move to a standard set of care records for all patients had resulted in 85% compliance with the records audit. There was a further audit planned in July 2019 to follow up on improvement actions the April 2019 audit had identified.
- Staff we spoke with on the ward and oncology unit told us that when patient information was needed it was readily available. Records for the hospital patients were stored on site in a secure records storage room, which made them accessible to the staff at all times.
- Specific oncology care bundles were in place (sets of interventions that, when used together, improve patient outcomes). We saw these were complete in each patient record we reviewed.
- Nursing records, including risk assessments were completed in full as needed, and plans of care were clearly documented.
- Consultant notes were present and legible within the patient record.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.
- The oncology unit used an electronic chemotherapyprescribing system. This ensured patients basic data was consistent, tailored for each patient, and could be adjusted when needed.
- Medicines on the oncology unit were stored securely. We saw that medicines were kept in a locked cupboard which only authorised staff had access to. The hospital used the NHS Protect medication security self-assessment to assure itself that all medicines were kept safely and securely.
- There were separate storage arrangements for both intravenous antibiotics and cytotoxic medicines. These were kept in a locked cupboard which only authorised staff had access to.
- Room and fridge temperatures on the oncology unit were monitored and recorded daily. We reviewed checks for March and April 2019 and saw these remained within acceptable levels.
- All medicine trolleys had up to date copies of the British National Formulary, this is guidance on prescribing, dispensing and administering medicines. Staff said they also had access to the online formulary to ensure they had access to the most up to date guidance. Staff told us the pharmacy would also advise on medicines.
- Controlled drugs were not kept on the oncology unit. Should controlled drugs be needed then these were accessed on the ward.
- We attended the ward to check the procedures for controlled drugs. We saw that storage arrangements were appropriate. These medicines were kept within a locked medicines cupboard within a locked room.
- We undertook checks for three controlled drugs and saw that the stock available matched that which was detailed in the controlled drugs book.
- The hospital policy stated that controlled drugs should be checked twice daily by two members of staff. During the two months prior to our inspection we found regular twice daily checking of controlled drugs had taken place.
- The service had access to the hospital's pharmacy team who undertook audits on controlled drugs. We reviewed

a controlled drug audit for the ward dated 23 October 2018 and saw that for the period August to October 2018 there were no incidents where controlled drugs had not been checked.

- We reviewed the hospital's clinical audit for medicine administration for quarter four, October to December 2018. The audit found 100% of prescription charts were legible and complete with patient's allergies recorded and known conditions requiring medicines at the time of pre-assessment were recorded. The audit also found that in the period 100% of medicines had been administered as prescribed.
- Medicines incidents were reported on the electronic incident reporting system. The hospital had introduced a reflective, 'Medication error action and learning tool'. This was a reflective exercise whereby staff involved in a medicine's administration incident were required to reflect on the incident. Staff were also required to meet with their line manager to discuss the incident, and any harm or potential harm to the patient, with the aim of reducing the risk of any repeat errors.

For our detailed findings on medicines please see the Safe section in the [main service] report

Incidents

- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. 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.
- We spoke with eleven members of staff who were aware of their responsibilities to report incidents through the hospital's electronic reporting system. Each member of staff gave appropriate examples of the types of incident that required reporting.
- Staff told us incidents were discussed and reviewed at team meetings and incident reports were regularly sent to the governance committee and the medical advisory committee (MAC). We reviewed the medical advisory committee (MAC) meeting minutes dated December 2018 and January 2019 these recorded that information had been submitted in relation to incidents. This meant that sufficient overview and scrutiny of incidents was in place.
- From 13 June 2018 to 1 April 2019 oncology had reported 15 incidents on the hospital's electronic incident reporting system. The incidents were assessed for severity and impact or potential impact upon patients. In the reporting period 13 incidents were assessed as 'no harm' and two were assessed as 'low harm.' The low harm incidents involved a patient with attending the oncology unit for chemotherapy and the unit identifying a community acquired infection and an unexpected clinical event when a patient attending the oncology unit for chemotherapy was identified with a venous thromboembolism (VTE) at consultant review. Actions the oncology unit had taken in response were recorded on the incident reporting system. For example, the patient with the VTE was admitted to the hospital and had a full set of observations completed and medicines prescribed including antibiotics. The patient with the infection was discharged home with antibacterial drugs in accordance with the chemotherapy protocol and samples sent to pathology, when the samples identified an infection the Nuffield Health national infection prevention and control lead was informed.
- The electronic incident reporting system enabled staff in identifying themes from incidents. For example, the most common theme for incident reports from 13 June 2019 to 1 April 2019 were medicines incidents, of which there had been six in the period. The next most common incidents were two delays with pathology results and two incidents with blood transfusions. All these incidents were recorded as 'no harm' to the patients involved.
- We reviewed an incident that had involved an unplanned transfer to the acute dependency unit (ADU) of a patient with respiratory compromise, and the same patient then being transferred to an NHS intensive care unit (ICU). We saw that, following a root cause analysis (RCA) lessons had been identified and steps were taking place to ensure patients were escalated; and to ensure patient transfers to an NHS provider of intensive care were timely.
- Actions taken in response to the RCA at the hospital included: the introduction of NEWS 2, all staff receiving training in Sepsis awareness in October 2018, targeted support for the resident medical officer (RMO) from the medical director, training for all staff in the management of patients with respiratory compromise, circulation of the standard operating procedure (SOP) for respiratory

compromise to all RMOs, introduction of situation, background, assessment, recommendation (SBAR) techniques with deteriorating patients, and on 19 October 2018 a discussion with staff on the requirements for early escalation of patient concerns to the nurse in charge. However, clinical audit results for quarter four, October to December 2018, indicated that 50% of patients with a NEWS score of four or more were not escalated in accordance with the hospital's procedure of referring the patient to the RMO or consultant without delay. Following our inspection the hospital informed us there was a discrepancy in the data in the clinical audits. However, we were not provided with evidence of actions the hospital had taken to address this.

- There had been no never events (wholly preventable serious incidents) or serious incidents within the oncology service between April 2018 and March 2019.
- The hospital had regard to the duty of candour. This is the duty on healthcare providers to act in an open and transparent way with patients when a notifiable safety incident occurs in relation to their care or treatment. Staff on the oncology unit told us they had not had any incidents in the previous 12 months requiring the hospital to use the duty of candour. However, when we discussed duty of candour with one RMO on the oncology unit they told us they were not sure of what duty of candour was.
- The hospital did not have mortality and morbidity meetings. Staff told us mortality and morbidity was covered in the monthly head of department (HOD) meetings. Medical and oncology care at the hospital had not had any unexpected deaths in the previous 12 months. Staff said any learning identified at the HOD meetings would be disseminated to staff at ward meetings.

Safety Thermometer (or equivalent)

- **The service used safety monitoring results well.** Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). We reviewed the hospital's clinical audit for quarter four, which covered the period from 1 October to 31 December 2018. The audit recorded that the hospital had achieved 100% compliance with safety thermometer measures in the period, with the exception of falls. The overall compliance with falls standards was 91% this was within the accepted range of the safety thermometer. However, the compliance rate for fully completed initial falls screening assessments that triggered an alert for a full risk assessment for patients identified at risk of falls was 67%. This was worse than the 90% required standard. However, we noted that there were a number of months where data for initial falls risk screening assessments were not recorded on the audit.

Are medical care (including older people's care) effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness**. However, we found some policies had not been reviewed in accordance with the published review date.
- Hospital policies and procedures were developed nationally by Nuffield and took account of relevant best practice guidance including that issued by the National Institute for Clinical Excellence (NICE), the Department of Health and relevant royal colleges such as The Royal College of Nursing (RCN). However, we found some policies the hospital provided us with had not been reviewed on their published review date, this meant the hospital could not be assured that these policies were the most up to date. For example, the 'Medicines management policy, v2, roles and responsibilities' policy had a review date of August 2017. Following our inspection the hospital informed us that these policies had been updated.
- NICE Guidance was taken into account in the oncology unit. This included 'NG36: Cancer of the upper digestive tract' and 'NG35 Myeloma diagnosis and management'. The oncology unit ward manager told us they reviewed all new cancer guidance to determine if any changes to practice were required.

- Oncology meeting minutes dated 20 June 2018 recorded that new policies and NICE guidance were discussed at the meeting. This included the hospital's isolation policy and management of diarrhoea and vomiting in the workplace policy. Staff had signed a form to confirm they had read the policies.
- Staff on the ward told us they received email updates when new guidance was issued by the hospital. New guidance was printed by the ward manager and placed in the staff room. Staff signed a list to confirm they had read the new policies.
- During our inspection we saw a board in the treatment room on the ward which gave staff guidance on using a skin care bundle. This is a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers. There was also guidance in the treatment room on heel dressings for the prevention and treatment of heel wounds.
- Staff had been provided with laminated prompt cards that could be affixed to their belts to enable staff to look at guidance prompts whilst working. The prompts included procedures for: sepsis, procedures for the use of the situation, background, assessment, recommendation (SBAR) tool, and procedures in the event of concerns about female genital mutilation (FGM).
- The endoscopy facility and processes were not Joint Advisory Group (JAG) compliant. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards. Although the hospital planned to apply for accreditation within 12 months and had an action plan to work towards this.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service made adjustments for patients' religious, cultural and other preferences.
- The waiting areas of the oncology unit had cold and hot drinks making facilities.
- Patients were offered a choice of meals if their treatment was being administered during a mealtime. A blackboard displayed the choices on offer during the day. Fruit pots were provided for patients arriving early as a breakfast option and also for patients where chemotherapy treatment side effects gave them a dry mouth.
- All patients receiving chemotherapy had regular screening for malnutrition and weight loss, the service recorded this using the Malnutrition Universal Screening Tool (MUST).
- Nutritional supplements, if required, were prescribed by the consultants and should further intervention be required then nutritional advice was available to patients through referral to a dietitian. Specialist nutritional advice was also provided as part of the hospital's integrated cancer rehabilitation programme.
- The nurse in charge during the night shift was responsible for checking totals and accumulative balances on patients' fluid balance charts. Staff we spoke with confirmed they had received training in the use of fluid balance charts. Staff told us fluid balance charts were introduced if patients had a national early warning score (NEWS 2) of three or above. If a decision was made not to introduce a chart staff were required to document the reasons for this.
- We viewed 46 patient catering experience feedback forms dated January 2019 and found all were positive about food experiences.
- The hospital patient ledassessments of the care environment (PLACE) 2018 found the hospital achieved 98% compliance with the PLACE for food. This was better than the Nuffield Health average (94%) and better than the national average (90%).
- Staff told us the hospital's catering staff could provide food for any type of diet. For example, diets for religious reasons or diets for medical reasons. Staff told us catering staff would also cater to patients preferences if a patient did not wish to eat the food offered on the hospital's menu.
- The ward had purchased a dedicated refrigerator for patients who wished to keep and eat their own food whilst in hospital.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.** They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- All patients had their level of pain assessed prior to commencement of each cancer treatment. This was

done using a five stage grading system. Should a patient's pain be graded high, then nurses would take action to provide advice to the patient or refer them back to the consultant for a pain review. Cancer patients told us that nurses dealt with pain quickly and effectively.

- Patients told us that cancer nurses were observant about symptoms when introducing chemotherapy drugs. Nursing staff made the necessary adjustments to ensure patients were as comfortable as possible during chemotherapy.
- Staff told us the specialist palliative care nurse advised staff on pain management upon request.
- We reviewed a pain audit for the ward dated January 2019. The audit looked at how quickly patients were seen and had their pain assessed on arrival at the oncology unit. The audit found 20% of patients were seen within five minutes of their booked appointment time, 75% patients seen between five and fifteen minutes of their booked appointment time, 5% of patients were seen in excess of their fifteen minutes booked appointment time.
- We reviewed a pain audit dated November 2018 this recorded that 47% of patient reporting moderate or severe pain, were given appropriate analgesia within 30 minutes of their pain score being recorded. The audit recorded that analgesia was not applicable to 53% of patients. The audit found an alternative pain relief method was used or identified in 11% of patients; but, 63% of patients did not receive or were offered an alternative pain relief. Following our inspection the hospital informed us 100% of patients with moderate or severe pain were given appropriate analgesia within 30 minutes and therefore did not require an alternative method of pain relief. This meant all patients requiring pain relief received it.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- We reviewed a copy of the hospital's January 2018 to December 2018 audit plan. The plan identified which audits would be completed every month for oncology and the ward. This meant there were regular opportunities for the service to assess their effectiveness and make improvements to benefit patients.
- We reviewed the outcomes of an oncology baseline outcomes audit dated July 2018 to October 2018. The aims of the audit were to establish whether a full set of baseline observations were completed for every oncology patient attending for pre-assessment. The audit found improvements in patients' vital signs being recorded across the period, with 95% of patients having a baseline set of observations in October 2018, this had improved from 80% in July 2018. The audit found 75% of patients had a national early warning score (NEWS) record in October 2018, this was an improvement from 0% in July 2018. However, the audit also identified that the hospital's escalation protocol had not always been followed in a timely way in the period.
- There were quarterly clinical audits completed by the matron. We viewed results for the quarter four audit, which covered 1 October to 31 December 2018. The audit was a comprehensive review of patient outcomes. For example, in the reporting period 100% of patients had venous thromboembolism(VTE) risks assessed and managed. In the same period 100% of patients had a completed moving and handling risk assessment; 100% of patients had consented to treatment in accordance with the hospital's consent policy. The audit also found 100% compliance with NEWS 2 early warning score completion.
- The hospital had undertaken a qualitative audit of patient night time experience in November 2018. The findings of this audit were: 100% of patients felt that they were well cared for; 100% of the patients that used the call bell felt it was answered in a timely manner; 92% of patients felt that the ward was quiet enough to sleep, 100% of patients felt their night medication was given in a timely manner.
- Cancer services tracked patient outcomes through regular follow up appointments with the oncologist and scans.
- The hospital did not participate in the National Cancer Audit.

Competent staff

- **The service made sure staff were competent for their roles**. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- The matron monitored nursing revalidation to ensure that staff renewed their professional registration every three years and could demonstrate effective and safe practice.
- The oncology unit had clinical nurse specialists (CNS) in upper and lower gastrointestinal (GI), breast and gynaecology. The service was advertising for a CNS in immunotherapy.
- All staff received an induction prior to commencing work at the hospital. Resident medical officers (RMO) received both an agency and hospital induction programme. All new RMOs shadowed the established RMO for seven days as part of their hospital induction. During this time, they would complete mandatory training and competency assessments. RMOs would also receive access to and training on the hospital's IT systems.
- New nursing and health care assistants (HCA) received a two week induction. The first week was desk based when staff would complete e-learning and mandatory training. New HCA were supported by a 'buddy' until the staff member felt confident with their role and tasks.
- All new nursing and HCA staff were supernumerary until they had completed their two week induction. Staff were formally reviewed after four, eight, and 12 weeks following commencement of employment.
- Nurses working with patients with cancer had appropriate skills for their role. They followed accredited chemotherapy courses with relevant providers.
- Staff had access to learning and development courses such as advance communication and clinical study days to support them in their roles. Nurses were also encouraged and supported to undertake academic qualifications. For example, a member of the nursing staff told us they were undertaking a master's degree (MSc) in cancer. An HCA told us they had training in venepuncture booked, (this is the puncture of a vein as part of a medical procedure, typically to withdraw a blood sample or for an intravenous injection).
- Staff told us clinical supervision was available to staff at departmental meetings. Staff could also receive clinical supervision upon request.
- The hospital identified learning needs through the appraisal process. For example, 100% of nurses working on the oncology unit had been appraised within the last year. We reviewed the appraisal documents for two nurses and found them fully completed. The appraisals contained both personal and standard corporate objectives aligned with the Nuffield Health values.
- The practice educator delivered regular practice based training scenarios to staff. For example, six nursing staff attended an action learning set on patient haemorrhaging on inpatient ward. Another scenario involving an overview of a patient's condition and actions to take in a scenario where a patient experienced chest pain, including patient observations, had been attended by five health care assistants (HCA).
- Staff we spoke with confirmed that they were regularly competency assessed in areas such as chemotherapy administration, equipment use and the insertion of cannulas. Health care assistants we spoke with told us they had regular competency assessments. Staff said when the hospital introduced any new clinical procedures staff had to be competency assessed and have these 'signed off.'
- Oncology meeting minutes dated 20 June 2018 recorded that all staff had completed training in NEWS 2 training. We also saw a document that had been reviewed at the meeting which all staff had signed as evidence of completion of this training.
- We viewed a blood competency audit and action plan from 2018. The audit had an action plan to address areas of non-compliance: As part of the audit all staff giving blood had their competency assessed in regards to the National Patient Safety Agency (NPSA) blood transfusion competencies. All staff giving blood were signed off as competent in May 2018.
- We asked a visiting consultant about nursing staff. They told us, "The nurses here are superb. They have always known what to do and how to do it."
- There was a robust procedure for the granting and monitoring of practising privileges for consultants. This was overseen by the medical advisory committee (MAC). All consultants practising at this hospital were required to submit a copy of their annual appraisal and evidence of General Medical Council (GMC) revalidation as part of ensuring they maintained practising privileges at the hospital.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.**

Good

Medical care (including older people's care)

- Hospital staff engaged externally with the local NHS trust. The ward staff told us they attended multidisciplinary meetings where patients care and treatment were discussed by the multidisciplinary team (MDT).
- Staff at the oncology unit told us they did not regularly attend other local providers' MDT meetings. Staff told us the oncology unit received MDT meeting minutes and scanned these onto patients' records. However, staff said there was a plan that a member of the nursing team would regularly attend local MDT meetings. The purpose of these meetings (attended by a group of health professionals with expert knowledge in specific types of cancer) were to regularly review patient's clinical conditions, assess the adequacy of treatment and discuss any further interventions which may benefit the patient.
- The oncology nursing team provided support and guidance to staff on the inpatient ward so that they could care appropriately for oncology inpatients. Staff told us the hospital's physiotherapists were accessible. However, staff said accessing occupational therapy (OT) services was more difficult, as OT services had been outsourced to an external provider and the procedure for OT services had changed as a result.
- Staff on the ward told us physiotherapists and the hospital pharmacists regularly attended the ward handover.
- Physiotherapy staff told us they worked across site with a Nuffield gym in Guildford. Staff said patients could be referred to a personal trainer at the gym as part of the hospital's 'Recovery Plus' initiative. This was a personalised training programme which was part of the patients care planning.
- The oncology unit had a service level agreement (SLA) with a local NHS trust which provided access to oncology dietitians who gave advice on patients' nutrition requirements. The oncology unit's staff also worked closely with Macmillan community nurses.
- All patients had access to clinical nurse specialists (CNS) in palliative care with a SLA with a local NHS trust. The specialist palliative care team visited the oncology unit for two hours daily to meet patients with palliative care needs. The specialist palliative care team were also available out of hours.
- The service reported good links with the palliative care team at the NHS trust and with the hospice. Staff at the hospital tried to engage with external support services at the earliest opportunity to support patients.
- All staff we spoke with described effective multidisciplinary working with staff at the local acute hospital and local ambulance service. Staff told us there were new transition procedures for transferring a patient from the service. Staff said this had been an aid to multidisciplinary working as it had clarified the hospital's and other service providers' roles.
- Staff on the oncology unit described good working relationships and strong links with the local university.

Seven-day services

- The oncology unit did not operate as a seven-day service. Treatment was usually provided Monday to Friday 8am to 6pm. However, we were told that the service was flexible and opened outside of these hours depending on demand and individual treatment regimes.
- High dose chemotherapy was administered on the inpatient ward by chemotherapy nurses seven days a week.
- The inpatient ward was supported by two resident medical officers (RMO) 24 hours a day, seven days a week.
- There was a 24-hour telephone service available to all patients for advice and support.
- Pharmacy services were available Monday to Friday from 8am to 6pm and Saturday from 8am to 12 noon. The hospital informed us that there was a twenty four hour seven day a week on call pharmacy service.
- Diagnostic imaging services were available Monday to Friday from 8am to 8pm and from 8 am to 4pm on Saturday. There was a twenty four hour seven day a week on call diagnostic imaging service.
- Pathology services were available 24 hours a day, seven days a week, with on-call arrangements out of hours.

Health promotion

- The hospital's website had an 'advice hub'; this carried information on a range of conditions, symptoms, causes and treatments. These included explanations of types of cancer, exposure to radiation, as well as explaining different types of tests and scans.

Good

Medical care (including older people's care)

- Patients we spoke with told us they were provided with a range of information prior to their appointment. Patients said staff promoted healthy lifestyles during their appointments by explaining the impact of lifestyle choices on their health and general wellbeing.
- There was a range of printed information available to patients in both the oncology unit and on the ward. For example, we saw patient information which explained the use of peripheral cannulas; (these are small tubes which are inserted directly into the small veins in the patients arm or hand for the administering of prescribed medication or fluids/blood products directly into the patient's bloodstream). We also saw leaflets which gave advice to patients on preventing urinary tract infections (UTI). This included a guide for patients for checking the colour of their urine.
- Staff at the oncology unit worked closely with McMillan cancer support services that could provide patients with a range of information and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** They followed the service policy and procedures when a patient could not give consent.
- The Nuffield Health policy for consent to examination or treatment policy we received prior to the inspection was due for review in August 2018, this meant it was not current. The policy was readily available for staff to access and included guidelines for treating adults who were unable to consent to investigations or treatment. A separate consent form was used in these instances which included the involvement of the patient's family, a capacity assessment and a declaration of best interest.
- Nursing staff we spoke with had a good understanding of consent and when consent was required. For example, verbal consent was sought at the start of each treatment episode.
- We reviewed nine patient records and saw, in each case, that consent forms were complete and legible. Risks and benefits of treatment were discussed with patients and clearly documented on the consent forms.
- Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training was provided to staff. At the time of our inspection training compliance was at 100%.
- Staff we asked demonstrated a good understanding of the requirements of the MCA and Deprivation of Liberty Safeguards. They were aware of the assessment criteria needed to assess if someone had capacity and understood the decision making processes for people lacking capacity to be in their best interests.
- The hospital had provided staff with a laminated pack of guidance that could be attached to their belts and used as prompt cards whilst working. Staff showed us prompt cards that outlined the principles of the MCA and Deprivation of Liberty Safeguards.
- The hospital had Nuffield Health corporate policies available for the resuscitation of patients including 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions. The policy made clear that all patients who had a cardiac arrest would be resuscitated unless a current DNACPR order was in place. No medical inpatients had a DNACPR form in place at the time of our inspection.

Are medical care (including older people's care) caring?

Good

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

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness.
- Throughout our inspection, we saw examples of staff being friendly, approachable and professional. We witnessed people being spoken to with respect at all times.
- We spoke with four patients during our inspection. All the verbal feedback we received from patients was positive. One patient told us that the staff were, "Fabulous" and that they could not fault any aspect of their care. Another patient said, "I do feel I have been treated with compassion, dignity and respect". A third patient commented, "The staff have been brilliant, they have all been very caring."
- We viewed the results of a patient experience audit for oncology dated November 2018. We found that most patients reported positively on the service, with 93% responding that their privacy and dignity were protected. A patient response to the audit was, "Professional approach, good communication,

wonderful people. The 24 hour 'emergency' line works well." Another patient commented, "Excellent nursing and treatments. Warm and friendly ambience in the oncology unit."

- The oncology unit used a Friends and Family Test (FFT) as part of the department's audits. The FFT results demonstrated 93% of respondents would recommend the oncology unit to their friends or family.
- We reviewed a six monthly Macmillan patient satisfaction survey dated February 2019. There were 10 respondents to the survey and 100% of patients had responded that they would recommend the oncology unit to their friends and family.
- The hospital patient ledassessments of the care environment (PLACE) 2018 found the hospital achieved 92% compliance with the PLACE for privacy, dignity and wellbeing. This was better than the Nuffield Health average (88%) and better than the national average (84%).
- The risk register also recorded that patients of the opposite sex should not be cared for in the ADU at the same time, except in exceptional circumstance. This was in accordance with the Nuffield Health CL 10 privacy and dignity policy (including chaperoning) policy, 1.6 which recorded "mixed sex accommodation may be unavoidable at some points of patient. care/treatment e.g. recovery area, intensive care, high dependency; but those patients should be moved to single sex accommodation as soon as it is clinically appropriate to do so."

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Patients we spoke with told us staff were kind and considerate to them and their families during their visit to the hospital. For example, one patient stated, "They all ask how you are and how you are feeling." Another patient said, "I have been provided with information on where I can access emotional support." Another patient told us, "Last week they mentioned that I could get support from the Macmillan nurses and gave me the details.
- We saw staff interacting with patients in a supportive manner by offering sympathy and reassurance. Staff we spoke with were aware of the emotional impact having cancer could have on people. Staff gave us examples of how they would support patients, which included making time to sit and talk with them and following up on their welfare the day after treatment.
- The lead oncology nurse chaperoned patients through various stages of their treatment. She made herself available to accompany patients if they were likely to hear bad news following a diagnostic procedure or operation.
- Counselling and mindfulness sessions were offered to patients, at additional cost, as part of patients' treatment options.
- Staff told us they would not admit a patient in a mental health crisis due to being unable to meet their mental health needs. However, patients that were not a risk to themselves or others would be admitted and could access support from Nuffield cognitive behavioural therapists (CBT). The hospital could also access emotional support and complimentary therapies from a charity that was located next door to the hospital, which provided support and counselling to people living with cancer.
- Staff told us the chaplaincy at the local acute hospital were supportive. Staff said the chaplaincy would provide pastoral support to patients at Nuffield Hospital Guildford. The chaplaincy could also contact leaders from a number of different faith groups to provide spiritual support to patients.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- All reception staff and HCA's had received 'Sage and Thyme' communication training. This trains staff in how to listen and respond to patients or carers, who are distressed or concerned. There were plans for all nursing staff to receive either 'Sage and Thyme' training or advanced communication skills training. All clinical nurse specialists (CNS) had been trained in advanced communication skills.
- All patients received information in writing on the cost of care and treatment prior to their care or treatment commencing.
- Staff discussed side effects of treatment with patients in a kind and considerate matter.

Good

Medical care (including older people's care)

- Oncology patients received full explanations of what to do if they felt unwell. Patients carried a record book with details about what to do if they experienced feeling unwell. This was in accordance with the Manual for Cancer Services: Department of Health; 2011.
- Patients received full explanations and details about the procedures they were to have. We saw information leaflets on procedures were available on the wards. For example, the ward had information for patients on preventing deep vein thrombosis and pulmonary embolism. This explained in accessible language how to recognise the signs and symptoms of blood clots.
- Patients undergoing an endoscopic procedure attended the pre-assessment clinic to receive a full explanation about the procedure. Staff gave patients information and medicines necessary for them to have their procedure at this appointment.

Are medical care (including older people's care) responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of their patients.**
- The Nuffield Hospital in Guildford is a private hospital, which provides oncology to self-funding or medically insured patients. Due to the private business set up, the hospital could provide flexibility and choice to patients choosing to undergo their treatment at the hospital.
- The proportion of patients that stayed overnight at the hospital from August 2017 to July 2018 were 6% NHS funded and 22% non-NHS funded.
- The most common medical procedures from August 2017 to July 2018 were: oncology treatment (3934); diagnostic colonoscopy (496); diagnostic gastroscopy (374); diagnostic endoscopy of the bladder (325); injection into joint without x-ray (221).
- There had been 3,856 episodes of chemotherapy from April 2018 to April 2019, of these 96.9% were funded by insurers, 3% were self-pay patients, 0.01% were funded by the NHS.
- The oncology unit had been expanded and refurbished in 2018 in accordance with the health building note, (HBN 02-10), for 'Cancer Treatment Facilities.' The unit had its own reception and waiting area and provided chemotherapy treatment in rooms where patients could sit with other patients and relatives whilst treatment took place. There were also private rooms (including a bedroom), to accommodate patients needing time for privacy or to be alone.
- The oncology unit had 18 treatment chairs in total, one bedroom, and two consulting rooms within the unit where patients were seen by their oncologist and supported by nurses. There was a small quiet room, and the necessary staff spaces to allow care to be delivered safely. The unit had a staff office that provided enough space for staff to work alongside a resident pharmacist who was on hand to discuss treatment options and medication side effects with staff and patients.
- The hospital's inpatient ward had 33 rooms and was configured to provide care for surgical and medical inpatients. There was a whiteboard in the ward office that clearly defined which patients on the ward were medical patients and which patients were surgical. Rooms 22 to 28 were configured for medical patients as these were in a corridor that was separate from the corridor used for surgical inpatients.
- The oncology unit had its own reception and waiting area and provided chemotherapy treatment in rooms where patients could sit with other patients and relatives whilst treatment took place. The unit had 18 treatment chairs. There were three privacy rooms, including a bedroom, to accommodate patients needing time for privacy or to spend time with relatives. There were three consulting rooms within the oncology unit where patients were seen by their oncologist and supported by nurses. All patients were reviewed by their oncologist and had blood tests prior to receiving chemotherapy. In the event of a consultant being on leave the nurse in charge would oversee the patient's chemotherapy following the criteria for the patients' treatment.
- Service leaders told us the service was aiming to increase their work in conjunction with other local and community services. Staff told us the service aimed to maintain its private hospital atmosphere while also contributing to NHS patient lists.

Meeting people's individual needs

Good

Medical care (including older people's care)

- **The service took account of patients' individual needs.**
- Holistic needs assessments were carried for all patients at regular intervals throughout their treatment pathway and care planning. This meant that their needs were continually reassessed so that signposting or referral for specialist input could be made.
- The provider had developed a 'Recovery Plus Programme' and patients could benefit from an integrated cancer rehabilitation programme as part of this initiative. Patients were offered a 12-week programme at a local Nuffield Gym, which was supported by fitness instructors who had received specialist oncology training. The purpose of the programme was to improve quality of life by improving physical function, psychological and social wellbeing. The aim was to alleviate side-effects from cancer and its treatments (chemotherapy, radiotherapy), such as fatigue, insomnia, breathlessness, depression, lymphoedema and to help prevent risk of disease reoccurrence or development of another cancer. This programme met the recommendations from the National Cancer Survivorship Initiative, which stated that people living with and beyond cancer should have access to physical activity interventions.
- The oncology unit and ward were accessible. The oncology unit was on the ground floor of the hospital and ramps were available where appropriate to enable people with mobility needs or wheelchair users. The inpatient ward was on the first floor and this was accessible using the hospital's lifts.
- The hospital patient ledassessments of the care environment (PLACE) 2018 found the hospital achieved 95% compliance with the PLACE for disability. This was better than the Nuffield Health average (85%) and better than the national average (84%).
- Nursing staff we spoke with were aware of people's social needs. Staff told us that every effort was made to find services that could support patients in the community if that need was identified whilst the patient was using the service. However, we were told that the coordinating of these services could be problematic because the hospital did not have a discharge co-ordinator, which meant nursing staff were responsible for co-ordinating patient discharges and often spent time looking up information on community care provision.
- An interpretation service was available for patients that did not speak English. Information about this service was included in the patient information folder kept in inpatient rooms. Patients using the oncology clinic were provided with information on interpreters as part of their pre-assessment to the service.
- The hospital was equipped with a hearing loop; this is a special type of sound system for use by people with hearing aids.
- The medical sister was the dementia lead and had completed 'Dementia Friends' training. There was a range of information available on the ward regarding the 'Dementia Friends' scheme. The ward had four inpatient rooms which were dementia friendly, this included the use of contrasting bed linen to help patients define their sleeping area. The hospital had adopted a coloured pillow case scheme, this enabled staff in identifying patients that had a communication need or a degree of cognitive impairment.
- The oncology unit had a dementia friendly waiting area. This was a quiet room close to the oncology unit reception area. Staff told us the room could also be used for patients with a learning disability to give them a quiet space or as a multi-faith room to accommodate patient's faith needs.
- The hospital patient ledassessments of the care environment (PLACE) 2018 found the hospital achieved 95% compliance with the PLACE for dementia. This was better than the Nuffield Health average (81%) and better than the national average (79%).
- Staff on the ward showed us flash cards, these were to aid staff in communicating with patients who were non-verbal in their communication. Staff told us all the hospital's information was available in large print or other languages upon request from the Nuffield Health accessible communications team. However, there was limited information available on the ward and oncology unit in other languages.
- Staff told us beds at the hospital could hold patients weighing up to 250 kilograms in the event that a patient weighed more than this the hospital could order a bariatric bed. The hospital had bariatric wheelchairs and commodes. Staff told us that where there was an identifiable need for a specific piece of equipment the hospital were responsive in either hiring these or purchasing them.
- Staff told us they did not have any specific arrangements for people with a learning disability.

However, staff said they had provided care for people with learning disabilities in the past and had been able to meet their needs. Staff told us all patients were pre-assessed before being admitted to the hospital. Staff said if the hospital was unable to meet a specific patients needs they would not admit the patient.

- The hospital provided a dedicated end of life service, including an end of life care pathway. The hospital had three consultants in palliative medicine holding practising privileges at Nuffield Hospital, Guildford. Patients were referred to palliative care consultants by their usual consultant. There was an on-call rota available for out of hour's advice.
- Clinical nurse specialists (CNS) in palliative care from the local acute hospital provided five sessions a week through a service level agreement (SLA) to support the nursing staff in managing patients' physical and emotional symptoms relating to their treatment or disease. Should a patient who had received their care and treatment at the Nuffield Hospital Guildford express their preferred place of care to be the hospital, then this was catered for with the support of trained nursing staff.
- Patients could participate in advanced care planning with discussion and recording of their future wishes and preferences surrounding end of life care. The oncology unit routinely spoke with patients about their expressed wishes following a terminal diagnosis, this included preferred place of care. We were provided examples of when a patient had preferred to die at the hospital and the service worked to ensure that this could be provided for the patient where possible.
- The oncology unit had links with the local hospice and the Macmillan At Home Team to support patients at the end of their lives. Staff told us members of the nursing team had been to the local hospice in order to learn and improve the way in which the hospital worked.
- Families or carers could stay overnight with end of life care patients, children, or patients with additional needs. Staff said families would be offered an empty room on the inpatient ward if possible, or if no rooms were available family members or carers could be accommodated in the patient's room on a portable bed.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Patients could access the service in a variety of ways, which included self-referral or GP referral following suspected or diagnosed cancer. Staff told us the hospital had eligibility criteria for patients the hospital could provide care and treatment for.
- Patients were seen in outpatient clinics by their consultant to discuss and agree on diagnostic and treatment options.
- Oncology staff told us the admission criteria had changed in the previous 12 months. This meant patients that were acutely unwell had to be assessed by the local NHS trust before the hospital could provide care or treatment.
- The ward manager was responsible for managing bed occupancy. The manager was supported by an administrator with this. A white board in the ward office gave the manager an at a glance view of bed spaces on the ward and patients that were due for discharge. This meant the manager could assess the capacity of the ward at a glance and could plan patients' admissions accordingly.
- There were no inpatient beds reserved for oncology patients on the ward. Staff told us it was very rare that an oncology patient would not get a bed on the ward. Staff said there had been no incidences of oncology patients not being allocated an inpatient bed in the previous 12 months.
- Patients who had been diagnosed with cancer and wanted to be treated at the Nuffield Hospital Guildford waited no longer than two weeks for their first appointment.
- We viewed an oncology waiting time audit dated April 2019. The audit was to ensure all oncology patients were seen at their scheduled appointment time. The audit looked at three separate clinics and involved 19 patients. The findings of the audit were that 16 patients were either seen at their appointment time or prior to this, and three patients were seen between five to 15 minutes after their appointment time. The results indicated that patients were being seen within the hospital's key waiting times indicators that all patients were seen within 15 minutes of their appointment time.
- All (100%) GP referrals were responded to and actioned within 28 days of receipt of the referral.
- There was a rapid access system for people requiring chemotherapy. A patient could be seen at Nuffield Guildford Hospital for chemotherapy within 48 to 72 hours after referral.

- There was no delay in patients accessing chemotherapy and the service worked flexibly to ensure people's treatment regimens happened as planned.
- Where surgery was decided as part of a patient's treatment plan surgeons and oncologists worked together to provide consistency in care. This meant that following surgery oncologists could act quickly to provide any further treatment.
- Where appropriate, there was access to diagnostic and imaging services and patients were offered these services in a timely manner in order for their treatment plan to be started. There were clear pre-admission systems for surgery and a nurse-led pre-treatment service.
- We viewed an audit of waiting times for oncology patients referred for a computerized tomography (CT) scan at the hospital dated November 2018. (A CT scan combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside the body).The audit found 70% of patients were seen on the same day, 10% were seen within one day, 10% were seen within two days, and 10% were seen within four days.
- Nurses from the community and the hospice would routinely be invited in to meet patients and be involved in their care in the lead up and prior to a patient being transferred into NHS care. There was a formal transition pathway in place for this.
- Staff told us patients discharge arrangements commenced during the patients care planning. A patient would only be discharged if the hospital were assured that there were appropriate arrangements in place if the patient was discharged home.
- Discharge arrangements included referral to NHS services or the patient's GP. From August 2017 to July 2018 5% of hospital discharges had been inpatients. These discharges were in the following patient groups: no children aged between 0 to two years old were discharged from the hospital's inpatient service in the period; there had been 22 inpatients discharged aged between three and 15 years old; 10 inpatients discharged aged 16 to 17 years old; 1278 inpatients discharged aged between 18 and 74 years; 362 discharged inpatients were aged over 75 years.
- The hospital did not have any delayed discharges and patients were not moved during their stay, unless this was to transfer a deteriorating patient to an NHS trust. Staff told us the latest a patient would be discharged home was 9pm.
- All patients received a discharge letter. Copies of discharge letters were sent to the patients GP and a copy was kept in the patient's notes. Staff showed us referral forms which would be used to refer a patient to NHS community nursing teams or Macmillan community nurses.
- The hospital's clinical audit for patient discharges in quarter four, October to December 2018, found 100% compliance with the hospital's discharge procedures in the period. This included clinical information being sent to the receiving health care providers and general discharge information being provided to the patient and a copy of this information kept in the patients' notes.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- There were systems to listen to patients concerns and take appropriate action if required. The hospital had a complaints policy and procedure available for staff to access if needed.
- The hospital director had overall responsibility for the management of complaints in line with Nuffield Health complaints policy. The hospital matron was responsible for investigating clinical complaints. Any complaint involving a consultant with practising privileges was being addressed with the consultant.
- Information on complaints was displayed in the oncology unit. Inpatients were provided with information on complaints in the patient information pack in their rooms.
- There was a complaints procedure at the hospital, accessible to both staff and patients. The procedure had defined timescales whereby complaints were acknowledged in writing within two working days and complaints would be investigated and a response sent within 20 working days. Complainants were responded to by members of the senior management team. Complainants were offered face to face to meetings to discuss the outcome of complaint investigations. The hospital informed us that where complaints were complex and the investigation was likely to run over the

20 working days investigation timescale, complainants were informed in writing and given and explanation of the reasons for the delay and a new date for the hospital's response to their complaint.
- In the period December 2017 to November 2018 there had been eight complaints to the hospital.
- In order to identify learning opportunities complaints were reviewed and discussed on a monthly basis at the hospital board meeting and heads of department (HoDS) meetings and on a quarterly basis at the Medical Advisory committee (MAC) and clinical governance meetings. Staff told us consultant specific complaints were discussed at the MAC.

Are medical care (including older people's care) well-led?

Good

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

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- We saw a flowchart that clearly defined the hospital's organisational structure. The matron reported to the hospital director. Ward managers, the clinical governance and education lead, pharmacy manager, infection prevention and control lead and clinical outcomes nurse, pathology lead, and senior sister for cancer care, reported to the matron.
- Staff told us the hospital director; general manager and matron were routinely visible and approachable. Ward managers met at 9.30am daily with the heads of departments (HOD), matron and general manager at the 'heads up' meeting. This was a meeting to review the current status of all wards and departments at the hospital. The meeting minutes were emailed to ward managers and senior sisters on the same day as the meeting. This ensured discussions from the meetings were shared with senior leaders on the wards.
- Staff told us the oncology unit leadership team were accessible and approachable. We found the oncology unit managers were knowledgeable about the service, where their risks were and how they planned to improve their service.
- Staff on the ward told us the service was supported by a dedicated and proactive manager who worked to continually improve the service.
- All senior nurses were required to complete online training on leadership and management. Senior nurses we spoke with confirmed they had completed this training.
- We reviewed results from a 'Leadership MOT' survey the hospital had conducted in 2018. There were 89 respondents to the survey, with most responses being positive. For example, 56% of responders reporting that they felt "committed" to working for Nuffield Health. However, 17% of responders had responded that they felt "frustrated." Although, 92% of responders responded that they did expect to be working for Nuffield Health in 12 months' time. The hospital had produced an action plan in response to the survey; this included daily senior management team walk arounds and monthly staff engagement events.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- The national Nuffield strategic intent was to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner'.
- Staff told us that as a not for profit organisation in addition to the vision the hospital worked to fulfil its charitable purpose which was "to advance, promote and maintain health and healthcare of all descriptions and to prevent, relieve and cure sickness and ill health of any kind, all for the public benefit." Staff had laminated wipe clean copies of the Nuffield Health strategy on key rings, with the Nuffield Health values statement, which staff could attach to their belts.
- The Nuffield Health values were aligned to staff appraisals; this was how the hospital aligned staff practices with the organisation's values. When we asked staff about the hospital's values, staff were able to show us the values statement and demonstrated an understanding of the goals and values of the hospital and how it had set out to achieve them.
- The oncology unit had a plan in response to the National Cancer Strategy. This included: immediate

access to a full range of diagnostic tools, patients completing the Macmillan patient satisfaction survey regularly, staff training and supervision, and fast access to consultants.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- All the staff we spoke with were proud to work for the hospital and felt fully engaged with the success of the hospital and their role in making it happen.
- Many staff had worked for many years at the hospital and told us how proud they were to work at the hospital. Staff told us the hospital was a friendly place to work.
- Staff said they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- Staff told us there was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong. Staff told us they received feedback on incidents in their team from their line managers. Staff told us if there was a root cause analysis (RCA) investigation it would be shared with all staff on the ward at the team meeting. Staff also said incidents were discussed at the monthly clinical governance meeting. The meeting minutes were shared with staff across the hospital by email. Staff told us the culture in the hospital was to learn from incidents to reduce the risk of reoccurrence.
- The hospital had an established system of departmental meetings where staff felt able to contribute and raise issues and concerns. Team meetings were held on a regular basis and staff told us they felt able to contribute where necessary. The ward team meetings were joint medical and surgical team meetings. We saw minutes from team meetings from both the ward and oncology unit which included team member discussions about relevant issues such as team behaviour and concerns.
- The service had a whistleblowing policy. Staff had been provided with laminated copies of the procedure for raising concerns which was part of an easily accessible keyring pack of information which staff could attach to their belts. The pack included information on the procedure for reporting concerns anonymously to an external whistleblowing monitor.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for clinical care to flourish.**
- The hospital had a governance framework which included policies, procedures and oversight by the senior management team, the clinical governance committee, quality and risk committees and the Medical Advisory Committee (MAC). The committees monitored incident reports, complaints and issues that impacted on the hospital's activities.
- We reviewed minutes from the clinical governance committee meetings dating from September to December 2018. The meetings covered all services within the hospital. Topics discussed included reviews of clinical governance reports and risk registers. For example, the December 2018 meeting discussed incidents and the number of planned and unplanned admissions to the acute dependency unit (ADU). The meetings also reviewed human resource management at the hospital and actions the hospital were taking to manage staffing.
- The service had a structured process in place for the MAC. We reviewed the MAC meeting minutes of meetings held in December 2018 and January 2019. The meeting minutes in December were more detailed and provided evidence that a range of topics were discussed, including consultant practising privileges. The January meeting minutes were less detailed and only covered consultant practising privileges. Following our inspection the hospital submitted meetings from the February 2019 MAC meeting. We found these discussed a range of topics and were detailed. The meeting minutes were circulated to the hospital director and all members of the MAC.
- Practising privileges were routinely discussed as part of the MAC. Privileges were renewed and reviewed every three years as a minimum. There were 190 consultants on practicing privileges at the hospital and all privilege renewals would be discussed at the MAC, as well as new consultant appointments. Examples of where consultants had not adhered to requirements or fallen below the expected standards of behaviour were discussed at the MAC as well as reasons for the suspension or removal of practising privileges.

- The oncology unit and ward reported into the governance framework by completing monthly reports, which were submitted to the governance committee. We reviewed a report from October 2018 and saw that relevant service information such as incidents, audit outcomes and health and safety information were reported for scrutiny by the committee. The MAC received a quarterly update on the performance of the oncology service
- The hospital was subject to Nuffield Health peer reviews. We viewed the results of a peer review that was conducted on 3 December 2018. This benchmarked the hospital against other Nuffield Health services. We saw copies of the most recent peer review this identified areas of good practice and areas for development in order for the hospital to make changes or improve services further.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- Services had risk registers and risk management processes. We reviewed the risk registers for the ward dated January 2019 and oncology unit dated 2019. The risk registers used a red, amber, green (RAG) traffic light system to highlight a risks status as either, low, moderate or high.
- On the oncology unit risk register there were four identified risks. All these risks were rated as amber, moderate, risks. There was clear detail of the recorded risk and plans the service had in place to mitigate risks. For example, there was a risk that chemotherapy chairs could tilt over if patients tried to get out of the chairs without putting the foot rest down. In mitigation the service had trained staff on safe use of the chairs. The register also recorded that all patients were advised by staff on the safe use of chairs and use of foot rests, upon arrival for their first chemotherapy treatment.
- We also reviewed the ward's risk register. There were seven risks recorded on the ward's risk register. All risks on the ward's risk register were amber, moderate, rated risks. We could see clear progression and monitoring of risks, with detailed updates and actions taken to mitigate risks where possible. This included clear reasons to downgrade and close risks on the register.
- The risk register was a standard agenda item on the senior team meeting agenda, and risks were discussed at the clinical governance meeting and head of department (HOD) meetings.
- Managers were aware of major incident and business continuity plans and the risks associated with anticipated events and emergencies. We saw emergency contact numbers were available in both the inpatient ward and oncology unit offices.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Staff told us the hospital was a relatively small place. As a result, staff said it was easy to find other members of staff to discuss patient care or to get updates on patients.
- The provider collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.
- Staff told us there were enough numbers of computers across wards and departments. This enabled staff in accessing the hospital's electronic or computerised systems.
- All staff we spoke with demonstrated they could locate and access relevant information and records easily, this enabled them to carry out their day to day roles. Patient records could be accessed easily but were kept secure to prevent unauthorised access to patient information.
- Staff at the hospital had been provided with access to NHS email systems. Staff were positive about this, as staff said it had simplified the process of contacting and sharing information with patients' consultants and the NHS.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.**
- The hospital engaged patients in patient ledassessments of the care environment (PLACE), these are patient led assessments aimed at driving improvements in the care environment.The Nuffield Guildford Hospital scored better than the Nuffield Health average and the National average in all categories of the PLACE assessment.

Good

Medical care (including older people's care)

- Staff informed us about the variety of ways that they had worked to engage the public to attend patient feedback forums and to provide patient representation; but staff said the hospital were struggling to get patients' engagement with this.
- There were no items of rated feedback on the NHS Choices website relating to medical care at Nuffield Hospital in Guildford for the reporting period April 2018 to March 2019.
- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings, but they were also able to attend other meetings within the hospital if they chose, for example governance meetings.
- Staff received regular newsletters from the hospital leadership team. These included quarterly clinical governance newsletters that updated staff on patient risks and audits. For example, a newsletter dated September 2018 provided staff with information on: the number of unplanned readmissions in the previous quarter, transfers to other providers and patient feedback.
- Health care assistants (HCA) told us they were invited to ward meetings. Health care assistants said if they could not attend the ward meetings they would receive a copy of the meeting notes. Health care assistants said they were fully involved in meetings, and new ideas from the health care assistants were welcomed by nursing, medical and managerial staff at the hospital.
- The provider had a number of award schemes to reward long-serving members of staff. For example, staff received awards and recognition for five, 10, 15, 20, 25, and 30 years of service to Nuffield Health. There was also an award staff could receive for practice that embodied the Nuffield Health values.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.**
- The hospital had been awarded the Macmillan Quality Environment Mark at Nuffield Heath Guildford Hospital. The award was reviewed and successfully retained in December 2018. The Macmillan award was developed in collaboration with more than 400 people living with cancer, who helped to shape its criteria.
- Patients could be referred to a personal trainer at the Nuffield Health gym in Guildford as part of the hospital's 'Recovery Plus' initiative. This was a personalised training programme which was part of the patients care planning.

Good

Surgery

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

Are surgery services safe?

Good

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 section.

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

- All staff had access to an online system for mandatory training. Only resuscitation and moving and handling was delivered by face to face training. On-line training consisted of but was not limited to health and safety, infection control, information governance and equality, diversity and inclusion.
- Staff described the electronic system as easy to use and said they had time during their working day to complete the training.
- The system was able to give the ward and theatre managers an overview of performance and gave prompts when staff were due to re-take or refresh their training. The matron and lead nurse for training monitored mandatory training compliance and reminded managers if any staff were approaching their due dates.
- An overview of mandatory training for all staff showed compliance to be 99%. Theatre staff were 100% compliant.
- There was a current policy for sepsis management and for sepsis training staff were directed to the sepsis trust website to complete online training. In-house sepsis training for staff had been completed in November 2018.

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 access to the current Nuffield Health safeguarding policy for adults, children and young persons. This policy covered local hospital responsibilities and identified the corporate lead for safeguarding. A matrix set out the required safeguard training for all hospital staff and consultants. This training was provided online by the Nuffield Academy.
- Safeguarding training was delivered at an appropriate level in line with national guidance. All staff had safeguarding adults training and two members of staff had level three training including the matron who fulfilled the role of hospital lead for adult safeguarding. All clinical staff had completed safeguarding children and young adults: level 2.
- Staff identified potential abuse and used established referral pathways to report safeguarding concerns. The hospital submitted an annual report for safeguarding completed in 2018. It showed two referrals to the local authority.
- This report showed full compliance with PREVENT training, one part of the government counter terrorism strategy.

- The hospital liaised with partner organisations. The matron was part of the surrey safeguarding board in line with best practice.
- Information on escalation of safeguarding concerns was displayed in the clinical areas. There was safeguarding (protecting people from harm or damage) information for people living in Surrey, for visitors to the ward.
- The theatre department had a flow chart displayed of what to do if any patient showed signs of having undergone female genital mutilation in the past and how this should be reported.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff took steps to prevent the spread of infection by washing their hands and keeping the equipment and the environment clean.
- All staff we saw in the clinical area were bare below the elbows to prevent the spread of infections in accordance with national guidance. This had improved since the last inspection when not all staff on the ward were complying with this requirement.
- Alcohol-based hand gel was located at the entrance to ward areas and throughout the department. Notices reminded staff and visitors about the importance of hand hygiene. We saw that staff washed their hands and used gel before and after treating patients in accordance with the World Health Organisation 'Five moments for hand hygiene'. The ward and theatre staff completed observational hand hygiene audits which showed more than 90% of staff were complaint with good practice.
- On the surgical ward and in theatres there was access to personal protective equipment such as gloves and aprons and these were available in sufficient quantities.
- The patient rooms had easy to keep clean flooring although in two rooms there was no coving which means the flooring was not compliant with the Department of Health's Health Building Note (HBN) 00-09: Infection control in the built environment. In clinical areas there should be a continuous return between the floor and wall, for example cover skirting to allow for easy cleaning. There was a plan in place to address this when funding was agreed.
- On the ward area the main corridor had carpet tiles following a patient's request for a quieter environment. A risk assessment and specialised cleaning policy had been put in place.
- Cupboards and storage areas on the ward were visibly clean and tidy with safe storage of equipment. After equipment was used it was cleaned and a sticker saying, 'I am clean' and dated showed the equipment was clean and ready for use.
- Ward housekeeping staff had a cleaning schedule and demonstrated the cleaning system with colour coding of cloths and containers used in line with policy. Staff had received training and were positive about the new process.
- Theatre staff wore appropriate uniforms, such as theatre scrubs, hats and masks and staff were bare below the elbow. We observed good scrub technique and aseptic non-touch technique (ANTT) in theatres.
- Theatre staff followed National Institute for Health and Care Excellence (NICE) guideline (CG)74, Surgical Site Infection' this included skin preparation and management of post-operative wound. Staff described their awareness and the importance of following procedures for the reduction of surgical site infection.
- Theatre was fully complaint with HBN 00-09 Infection control in the built environment with no high or low dust. Cleaning took place between each theatre case and at the end of the list. Cleaning schedules and validation records were signed and dated.
- Theatres displayed certificates showing that both theatres and endoscopy had undergone a deep clean with the last month and this was repeated every six months.
- There was good differentiation of clean and dirty areas in theatres. Maintenance for the airflow and filters in theatres was completed by a third party.
- Decontamination of reusable surgical instruments was completed off site by a corporate provider and staff reported that this worked well with no delays of equipment.
- At pre-assessment patients were screened for Meticillin-resistant Staphylococcus aureus (MRSA), either prior to admission as an elective patient, or on admission. If positive, the patient received treatment prior to admission.
- The most recent PLACE (Patient Led Assessment of the Care Environment) audit scored cleanliness at the

hospital at 98% and was in line with the national average. The assessment of cleanliness covers areas such as patient equipment, baths, showers, toilets, floors and other fixture and fittings.
- All staff had access to a current infection control policy and structure which showed the matron working with a lead nurse and link persons for each department who acted as a resource for staff. Infection control meetings took place monthly.
- An annual infection control report completed in 2018 showed actions taken against previous years objectives and recommendations for the current year. This included the role of the on-call microbiologist whose services were provided under a service level agreement.
- The lead nurse for infection prevention and control attended regional meetings to benchmark practice and this was seen to feed through to the hospital meetings.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The main ward had 49 beds of those 29 were allocated to surgical inpatients, 16 beds were allocated to day surgery patients, this included 2 beds allocated for children and young people. The service could be flexible in the allocation of beds across the whole ward area depending on the demand of each service.
- The theatre department had four theatres, one digital and two laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). There was a six-bed recovery area. The department was connected to the local NHS trust hospital by an underground corridor which meant patients could be transferred between the two sites. The theatre manager was also responsible for the endoscopy unit located on the first floor of the hospital.
- Systems were in place to make sure access to theatres and other areas were limited to specific staff. The theatre department and recovery were seen to be tidy and organised, equipment clean and in a good state of repair. Corridors were kept free of clutter.
- On the ward and in theatres we found control of substances hazardous to health (COSHH) managed safely. In the ward area these were stored in the housekeeper's cupboard which was secured with a key pad and within a closed cupboard. A folder of relevant safety data sheets was located by the stored chemicals and a spillage kit was available to staff.
- On the ward, we checked nine pieces of equipment and electrical testing was completed. The ward was able to provide a current service record for all ward equipment. Equipment maintenance was provided by a third party, some equipment had a separate service record with the manufacturer. In theatres we checked ten pieces of equipment and all had been electrically tested and serviced.
- The fabric of the estate was in good repair. General maintenance of the environment was provided by a second third party supplier.
- The hospital undertook bariatric surgery. Bariatric chairs and wheelchairs were available on the ward area. Theatre tables could tolerate a weight of up to 300kg making them suitable for bariatric surgery and there was a range of theatre table extensions and equipment to facilitate all surgery. Ward beds took weights appropriate for bariatric surgery.
- Emergency equipment was available and checked to make sure it was ready for immediate use. Two resuscitation trolleys were checked in wards and theatres. Both were tamper evident and daily external checks were complete and weekly content checks were completed. On the ward the trolley was opened to do a full content check, and this was correct with all equipment in date. Weekly battery checks were completed for automated external defibrillator.
- There was a difficult airway trolley in theatre this was checked and noted to be correct with all equipment in date.
- We checked four anaesthetic machine log books and in three of the log books all signatures were complete with no gaps. The log book for theatre four showed a number of gaps in signing. This was discussed with the theatre manager at the time of inspection and on reviewing the theatre register it was evident the theatre was closed at these times. When theatres are closed this should be documented in the log book to demonstrate a complete record.
- The theatre had three lasers for some surgical procedures which were used in theatres and outpatients. A member of staff was the laser protection supervisor and had completed the correct training to do this role. The laser protection advisor is supplied by a third party and a recent safety audit showed the department to be fully compliant.

- The department had a record of training and certificate of competence for all laser users and those working with the lasers. There were signs to be displayed when a laser was in use.
- Theatre staff recorded the use of implants in the theatre record, this allowed staff to identify where implants are used and support any requirement to provide information to the health care products regulator.
- Staff had access to sharps disposal facilities by using designated bins. All bins were dated, signed and not over filled. This was in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Staff had access to a current policy for safe handling and management of sharps.
- Wards and theatres had effective processes for the separation and disposal of waste. There was separate colour coding for general and clinical waste. Staff had access to a current waste handling and disposal policy. There was information displayed about waste streams and on checking we saw that waste was correctly segregated.
- All waste was kept appropriately in bulk storage bins on the hospital premises until collected. External to the building it was seen that all clinical waste was in locked yellow bins chained to the wall, tagged ready for collection. There was a corporate contract for waste to be collected by an external company and we saw dockets for completed collections.
- There was an annual follow through of the waste disposal stream and a quarterly internal waste audit. The most recent was in December 2018 and covered labelling, segregation, transfer notes and cleanliness and hygiene. This was fully complaint with HTM 07-01 The safe disposal and management of healthcare waste.
- On the ward and in theatre all fire doors were closed, and fire exits kept clear. Fire extinguishers were in date and signage in place indicating exits.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- There was a protocol for pre-assessment and patients for surgery under general anaesthetic attended the hospital for a nursing pre-assessment. Patients having a local anaesthetic were assessed by phone using a structured questionnaire.
- Pre-assessment staff had access to a current corporate operating procedure setting out the criteria for pre-operative assessment in line with NHS Modernisation agency (2003) National Good Practice Guidance on Pre-operative assessment for inpatient surgery.
- If staff had any concerns about a patient's fitness for surgery or the patient had any anxieties, they contacted the patient's consultant and arranged a further appointment or phone conversation.
- Risk assessments of the patient's condition was completed at pre-assessment to give the ward staff a baseline to assess any post-operative deterioration on admission or following surgery. Risk assessments included but was not limited to assessments for pressure ulcers, venous thromboembolism, patient handling, malnutrition scoring and bedrails assessment.
- Before the start of each operating list there was a team briefing of all staff involved in each theatre list to discuss any patient concerns, allergies or equipment requirements to minimise any potential risk to the patient.
- Before the start of each procedure, we observed theatre staff carrying out the World Health organisation (WHO) 'Five Steps to Safer Surgery'. We saw that all steps of the process were fully completed. During the inspection we observed on two separate occasion the sign in, time out and sign out of the process at the end of the theatre list we observed the debriefing process and saw all staff fully engaged and participating.
- The WHO checklist completion was audited quarterly results for 2018 showed 97% and 90% compliance. The clinical dashboard showed the most recent results in December 2018 to be 100%.
- The department developed Local Safety Standards for Invasive Procedures (LocSIPPs) using the National Safety Standards for Invasive Procedures (NatSSIPs), for example, the requirement to 'stop before you block' (injection of local anaesthetic to an area to provide pain relief).
- Staff had developed a local safety standard to ensure patient safety when the theatre list was changed. The department used four different colours of paper to print the list. Each colour alerting staff that a change had been made and to check the list and patient.
- In each theatre a white board was in use to record swab and instrument counts and a separate board used to record implants, so all staff were clear what was being

used and include in the patient record. This made sure no items were left in patient's bodies following surgery and was in accordance with the Association for Perioperative Practice (AfPP) guidelines.

- In line with National Institute for Health and Care Excellence (NICE), guideline (NG), 51, sepsis: recognition, diagnosis and management, staff on the surgical ward managed patients who were at risk of deteriorating safely. The National Early Warning Scores (NEWS) tool was used across the service to monitor the patient and to identify patients at risk of unexpected deterioration, in line with National Institute for Health and Care Excellence (NICE) Guidance
- We checked five NEWS scores, and these were fully complete, and scored correctly. In theatres staff audited completeness of NEWS scoring by displaying large posters reminding staff to complete this assessment correctly compliance had improved from 60% to 90%. Staff had access to a current NEWS policy.
- The service used a recognised communication tool called Situation Background Assessment Recommendations (SBAR) for both the resident medical staff and nursing staff to use when escalating concerns about a patient's condition to ensure all relevant information was communicated.
- Staff had access to an inpatient sepsis scoring and action tool and the sepsis six pathway which set out the actions to take in the case of a patient showing signs of sepsis.
- The ward had a three-bed acute dependency unit taking level one post-operative patients located in the ward. Level one is ward based care where thepatientdoes not require organ support, they may need a fluid infusion, or oxygen by face mask that required closer monitoring. This area allowed one nurse to manage up to three patients.
- There was a process for the emergency transfer of deteriorating patients to an acute hospital for assessment and treatment. The hospital had a service level agreement to transfer patients to critical care unit at the co-located NHS trust if this was required.
- Following discharge patients were given the contact number for the hospital and could speak to a trained member of staff at any time of the day. Referral could made either to the resident medical officer or directly to the consultant to deal with any patient concerns.
- We saw in patient records, that patients had a falls risk assessment carried out in line with NICE guidelines (CG)161 Falls in Older People, Assuring, Risk and Prevention.

Nursing and support staffing

- **The service had enough nursing staff with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.**
- Ward staff were able to describe how required staffing levels were assessed using a risk-based approach depending on acuity and patient numbers. To assist with the allocation of staff, each side of the inpatient ward was allocated to a team of nurses. On the inpatient ward each nurse was allocated five patients. In addition, there were healthcare assistants who worked as part of the team.
- Inpatient wards were staffed safely with nurse: patient ratios in line with national guidance. In England, the 2014 National Institute for Health and Care Excellent (NICE) guidelines for staffing on adult wards state that when the nurse: patient ratio reaches eight patients to one nurse, this should act as a red flag that care is potentially at risk of becoming unsafe.
- Inpatient departments had 43.2 full time equivalent (FTE) trained staff in post supported by 17.1 FTE healthcare assistants. Information from the hospital showed bank staff were occasionally used, and agency staff are not used. There were no unfilled shifts for the reporting period September 2018 to November 2018.
- Patients on the surgical ward commented that nurses did not seem as rushed as they did in the NHS. They said calls bells were answered immediately and nurses had time to talk.
- The day surgery ward was in the process of recruiting another member of staff and their staff to patient ratio was more variable depending on number of admissions and dependency.
- The theatre department had 12.7 FTE nurses and 7.5 operating department and healthcare assistants. There was use of bank staff but no agency staff in the last three months period December 2017 to November 2018. The data reported a vacancy factor of 2.5 FTE staff but anecdotally the department reported seven vacancies and were actively recruiting. There were no unfilled shifts for the reporting period September 2018 to November 2018.

Good

Surgery

Medical staffing

- **The service had enough medical cover, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- No medical staff were directly employed by the hospital. There were 190 consultants with practising privileges, a term which means consultants have been granted the right to practise in an independent hospital.
- Consultants were available twenty-four hours a day seven days a week, with the hospital holding all contact details. The consultants provided details of cover arrangements when on leave. Staff told us they had no difficulty in contacting consultants at any time.
- The service had a service level agreement with a third party to supply two resident medical officers twenty-four hours a day and seven days a week. The team changed each week and had one week off before returning.
- The resident medical officer provided continuous medical cover and reviewed patients reporting any change in condition to the consultant.
- Staff told us they felt well supported by the resident doctors and were able to contact the consultants when it was necessary to do so. Most consultants saw their patients daily.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- We observed consultants had written notes when a patient had been reviewed and this was an improvement on the previous inspection. To enable this to happen, a red clipboard was in each patient room and medical staff when visiting their patient were asked to write progress notes which were then added to the patient record.
- We looked at six sets of patient records across the surgical wards and they were comprehensive and well documented. The patient journey was easy to follow and included a diagnosis and patient pathway document.
- Patient risk assessments were completed, and nursing entries were signed. Legibility was helped when staff used a pre-printed stamp with their name; if this was not done, the signature and designation of the nurse was sometimes unclear.
- We saw examples of multi-disciplinary input and documentation in line with National Institute of Clinical Excellence (NICE) quality standard 15 statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health professionals.
- One set of patient records showed the complete patient journey from operating theatre to critical care at the local NHS trust hospital, returning to Nuffield Guildford hospital. There was a complete record of the patient's journey including all multi-disciplinary notes.
- Patient records were kept in the patient room. No patient sensitive data was seen at the nurse station. Following discharge notes were secured in a locked room so there was no unauthorised access.
- Information governance was part of the mandatory training programme and 98% of staff had completed this training. No patient sensitive data was seen at the nurse station.
- On discharge patients received a letter for the general practitioner which included details of their current medication. In addition, pharmacy sent a copy of the discharge prescription to the general practitioner to make sure had all the information required to continue current medication.
- Staff in theatre recorded all information of timings and procedures in the theatre register located in each theatre. We checked the register from theatre two was seen to be complete with no gaps or abbreviations. All operating notes were kept within the patient records.
- Staff had access to a current corporate health records standard policy setting out roles, responsibilities, compliance and audit.
- Results of the health records audit was accessible on the clinical governance and audit dashboard. Actions were documented against areas of non-compliance. A separate more detailed current action plan showed the person responsible for actions including the where the medical advisory committee needed to be aware of actions to improve documentation by consultants with a plan to re audit in three months.

Medicines

- **The service followed local policy when prescribing, giving, recording and storing medicines.** Patients received the right medication at the right dose at the right time.
- The pharmacy department was available six days a week and provided a seven-day week on call facility. The pharmacy manager was supported by one fulltime pharmacist, two part-time pharmacists and two technicians.
- The pharmacy department was secure and fit for purpose. The pharmacy door was secured with a key pad lock and the department appeared to be visibly clean and tidy with adequate storage for medicines.
- A pharmacist visited the wards daily, looked at prescription charts and liaised with the nursing team. We saw records of clinical interventions made by the ward pharmacist on the prescription chart. Once a week all medication charts were reviewed.
- Nursing staff had access to pre-labelled drugs for patients being discharged and there was a protocol for nursing and medical staff dispensing out of hours. This included how to label medicines for patients to take home.
- On the surgical ward, the treatment room was visibly clean and tidy. The door of the treatment room was secured by a keypad lock, so only authorised staff could access medicines.
- All medicine cupboards were locked. All medicines that were checked were in date. Controlled drugs (medicines liable to be misused and requiring special management) were stored securely and access was restricted in line with hospital policy.
- We looked at controlled drugs in wards and theatres. We checked registers and found entries to be correct and fully completed and this was an improvement on the last inspection when registers in theatre were not consistently legible or complete.
- Staff checked the controlled drug balance daily and we found these to be fully completed. We randomly checked a sample of stock in each department; all were in date and the stock balance correct.
- Pharmacy carried out a quarterly controlled drug audit with the accountable officer present and concerns were addressed in action plan. The most recent audit results from January 2019 showed all requirements met in pharmacy and wards with one identified action in theatres.
- Medication drug fridges on the ward and in theatre were monitored centrally in pharmacy. Pharmacy staff were able to explain what actions they would take if temperatures were out of range.
- Medication charts showed documentation of patient details and allergies. The documentation of allergies was regularly audited by pharmacy. The four charts we checked showed doctors signed and dated all prescriptions.
- Copies of the most recent British National Formulary were available on the ward to facilitate safe prescribing.
- Patients on long term, regular medication could self-administer medicines. They were assessed as to whether this was appropriate and that they were competent to do so. Completed consent and assessment forms were kept in pharmacy.
- Staff had access to a medicine management policy however this was due for review in March 2017. Following the inspection, the hospital informed us that these policies had been updated.
- There were processes for the stewardship of antimicrobials with a corporate and current local policy which established local guidelines for the prescribing of antibiotics. Policy and practice were discussed at the quarterly infection prevention and control meeting. The minutes of the meeting in December showed a suggestion made that all clinical staff to complete an online antimicrobial eLearning programme.
- The hospital had monthly medicine management and medical gas committee meetings where any national guidance and safety alerts were reviewed and actioned.
- Additional audits monitored medicine reconciliation, omitted doses and mission of critical medicines.
- Staff managed medical gasses in line with national guidance. gas cylinders were correctly stored and secured to the wall external to the building. There was a completed planned preventative maintenance programme for the manifolds completed under service level agreement by an external company every three months. There was a check made of compressor, suction and anaesthetic gas scavenger.
- Liquid nitrogen stores were maintained by another third-party contractor and maintenance records for this were available.

Incidents

Good

Surgery

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. An electronic system for reporting incidents was in place. Staff understood the mechanism of reporting incidents and received training during induction.
- The hospital reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There was a total of 540 clinical incidents in the reporting period August 2017 to July 2108. The percentage of low and no harm incidents was 95% of all incidents reported. This suggests a good reporting culture at the hospital. Moderate harm incident rates were 4.8% and there was one serious incident.
- 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. In theatres learning from incidents were seen to be shared at the monthly team meeting including any incidents nationally within the Nuffield group.
- On the ward incidents were discussed at ward handover and at team meetings. The minutes of the meeting in October 2018 showed discussion of patient safety concerns including incidents, investigations and learnings.
- A current duty of candour policy was in place and the hospital clinical strategy included a statement about the importance of being open and transparent when reporting and investigating and learning from incidents. Staff understood the principles of Duty of Candour regulations and were confident in applying the practical elements of the legislation and were able to give examples where this had been done.
- There were copies of the most recent clinical governance newsletter which showed the number of reported incidents and current themes. There was a report on the actions resulting in an improvement in patient falls and reminder to all staff about the importance of patient confidentiality as there had been an increase in information governance breaches reported. There was information for staff on the severity of incidents and an explanation of root cause analysis investigation.
- We looked at three most recently completed root cause analysis. These showed a thorough investigation using an appropriate methodology and had risk rating completed before and after actions had been put in place. The action plan demonstrated issues and short comings and shared learning. Areas of good practice were highlighted.
- However, there was no evidence that human factors were considered. Action plans focussed on reinforcement of exiting pathways/policy/practice rather than considering how they might be amended. There was no recording that duty of candour was considered or rationale for rejecting or implementing this.
- All medication incidents were reported, and an action learning tool was in place to facilitate reflection and learning, as well as provide support to staff involved in medication incidents. Every member of staff involved in a medicine's administration incident meets with their line manager to discuss the incident, and the harm or potential harm to the patient. Contributory factors are identified, and any identified risk reduction measures implemented.

Safety Thermometer

- **The service used safety monitoring results well.** The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- The hospital collected safety information including medication information and this forms part of the hospital clinical audit dashboard. All data collected was shared nationally across all Nuffield hospitals and benchmarked data collection and trends.
- Safety thermometer information was seen on the ward and staff were aware of results; for example, the recent focus on the reduction of patient falls through better completion of falls risk assessment.

Are surgery services effective?

Good

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

Good

Surgery

Evidence based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Policies in theatre and wards were in date and easily accessible on the hospital intranet. Policies and guidelines were developed in line with current legislation and nationally recognised evidence-based guidance and were available for staff to review in hard copy at the point of care. In addition, there were local policies, for example the fire policy.
- We reviewed ten of the service's policies and standard operating procedures and saw all were within their review dates. These included the equality, diversity and inclusion policy and practicing privileges policy. There was clear version control, ownership and review dates recorded.
- Current National Institute for Health and Care Excellence clinical evidence guidance was seen to be discussed at the governance meeting and theatre team minutes referenced the guidelines most relevant for the department.
- Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with the venous thromboembolism in adults: reducing the risk for patient in hospital National Institute for Health and Care Excellence (NICE), quality standard (QS) three, statement five.
- National Institute for Health and Care Excellence (NICE), clinical guidance (CG) 65, for hypothermia: prevention and management in adults having surgery was followed. On the ward there was a notice on the patient's door reminding staff about monitoring the patient's temperature before going to theatre. The temperature was checked again in the anaesthetic room and then every 30 minutes if the operation took longer than 30 minutes. This was important as keeping patient's warm lowers the risk of complications following surgery.
- There was a plan for corporate audit for example but not limited to looking at safety measures such as the completion of VTE assessment. In addition, there was a local audit plan which was displayed in all departments we visited. On the ward this included but was not limited to blood transfusion, pain management, night experience and risk assessments.
- Local audit results were reviewed at a monthly audit meeting. Staff told us there was attendance from all departments and local initiatives to improve audit results were ensuring patients received information about how to minimise the risk of VTE.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- The Malnutrition Universal Screening Tool was used during the patient assessment process, to assess the patient's risk of malnutrition and if a patient was at risk, or had a specific dietary need, they were referred to a dietitian.
- Patient catering was outsourced to a third party. Catering staff told us that they were part of the ward team and could access dietary support from the nursing staff or from the dietitian. The food service started at 07.00 in the morning until 8.30 in the evening. Out of hours nursing staff had access to toast, soup, sandwiches and fruit for patients returning from theatre.
- Ward staff had introduced a hydration chart to ensure patients received enough to drink when they did not require a strict fluid chart. This was in use for number of patients on the day of inspection and we noted they were fully completed.
- Patients commented food was excellent, there was a good choice and if they did want something else off menu this was always accommodated.
- The patient feedback survey in November 2018 showed 95% of patients were satisfied with the quality of the catering service. The patient led assessment assessments of the care environment showed a score of 95% percent for overall quality of the catering service against a national average of 90.5%.
- Staff assessed a patient's vomiting and nausea after their surgery and medication could be given to relieve symptoms if necessary. Patients were given anti-sickness medicine intravenously in the recovery area if they complained of feeling sick post operatively.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.** Staff used the National Early Warning score (NEWS) scale. On checking patient records, we noted that the scoring for pain was completed at regular intervals.

- Patient records showed that consultants prescribed medication appropriate to manage post-operative pain. In theatres post-surgery we observed staff were checking that patients were comfortable and not in pain.
- For more complex surgery patients might receive a regional or spinal block before surgery or a patient controlled analgesia device might be used when the patient could self administer pain relief. The method of pain relief would be discussed with the patient by the consultant and staff had received training on these methods of pain management.
- On the ward patients told us they had regular pain relief. Staff explained what the medication was and why it was important to take it as prescribed.
- The patient feedback survey in November 2018 showed 72% of patients felt staff responded promptly if they reported pain or discomfort and did everything they could. A further 24% had no pain and no patients reported that the staff did not respond.
- An audit of 19 patient records focussed on pain management carried out in November 2018 showed a good level of pain scoring by staff but made five recommendations based on results. Those responsible for actions was clear and all actions were fully completed.
- A separate audit on the day surgery ward showed that patients received pain medication within five minutes of requesting it.

Patient Outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** The service took part in national audits including National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMs) with consent being obtained at pre-assessment. The hospital reported collecting data for hip and knee replacement surgery, inguinal hernia repair and varicose vein surgery.
- The number of cases that the hospital were completing was not sufficient to generate a PROMs report.
- Theatre staff demonstrated how national joint registry data was collected and patient records showed consent being obtained.
- The hospital monitored any unplanned transfers and recorded 11 in the reporting period. There were six cases of unplanned readmission within in 28 days of discharge and there were a total number of five unplanned returns to theatre
- These cases were reviewed, and any trends were discussed at the governance meeting.
- There were nursing audits undertaken by the department that fed into monitoring patient outcomes such as recording of pain, pressure ulcers, hand hygiene, and falls. The focus on falls reduction had resulted in a decrease to four in the three months leading up to December 2018 compared to six months previous when there had been nine falls in a three month period.
- Staff had access to a current clinical audit plan which detailed all audits undertaken and who was responsible for completion.
- The hospital took part in the Public Health England (PHE) surgical site infection surveillance service (SSISS) for hip replacement, breast implants and spinal decompression. This allowed the hospital to benchmark its infection rates against other hospitals and identify areas for improvement.
- The data collected for the year 2018 has shown that the hospital had one surgical site infection following a hip replacement. Three other surgical site infections for other periods showed poor intraoperative temperature monitoring. Actions taken to this were clearly documented and audited to improve compliance and effectiveness.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held meetings with them to provide support and monitor the effectiveness of the service. Hospital data showed 100% of all staff on the surgical ward and in theatres had an appraisal in 2018.
- Staff learning and development needs were assessed during appraisal and staff were supported to complete this with the support of their manager. Nursing staff told us they were supported with revalidation.
- The hospital had up-to-date assurances around consultants' competencies and fitness to practice. We reviewed the personnel files for three consultants. The hospital director and matron interviewed all consultants applying for practicing privileges to make sure

consultants only carried out the surgery that they were skilled and competent to do so. The medical advisory committee reviewed all applications and requested more information if necessary to ensure all consultants were competent and could fulfil on call arrangements.

- The hospital had arrangements to share any concerns about a consultant's practice with the co-located NHS trust and in similar way, the trust would share any issues or concerns.
- The hospital had assurances to support the use of surgical first assistants. Surgical first assistants work closely with the surgeon to facilitate the procedure and process of surgery. The service held on file up to date personal information including curriculum vitae, disclosure barring information and level of competence of each surgical assistant.
- New staff were inducted into their new jobs. We saw records of induction and competency assessment for nursing and healthcare assistants. We reviewed three induction records, two for a registered nurse and one for a healthcare assistant (HCA). All staff had a clinical training and development passport. This showed clinical induction, training and competency assessment relevant to the staff member's role.
- Bank staff were inducted into their jobs and newly qualified staff were supported with preceptorship and told us that they felt well supported with a structured learning programme.
- There was a lead nurse responsible for planning and monitoring staff training, ensuring all staff undertook an induction to their department and completed competencies relevant to their role. On both the ward and in theatre we saw individual staff development files with a current record of training and competencies undertaken. Staff told us they felt well supported with their training and development needs.
- The hospital had an annual plan of monthly scenario training for all staff. This included but was not limited to emergency haemorrhage, resuscitation and safeguarding concern. All departments were included in the training and staff were positive about this initiative.
- Theatre staff told us that following a practice scenario dealing with a patient who had an extremely high temperature they had a real case present and staff were confident to put their training into practice. This way of training had been shared nationally and implemented across all Nuffield sites.
- All staff completed basic life support and compliance across the hospital was 97%. Intermediate life support was completed by 96% of trained staff. Clinical department leads completed advanced life support training. In theatre all recovery staff were all trained to advanced level meaning a total of 12 staff had completed that training.
- To support specialist training needs of staff, external training would be sourced. For example, an external provider had provided deteriorating patient training for clinical staff and friends of dementia had supported the training of 76 staff.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care this was evident in the wards and theatres.
- Daily multi-disciplinary team meetings took place at 09.30am. Led by the senior management team all heads of department or deputies participated, the focus was on the day's activities across all departments. Any corporate, hospital wide issues such as staffing were discussed.
- Planning for the patient's care took place at the pre-assessment clinic and staff from the clinic communicated with ward theatre staff regarding patient needs and arrangements for discharge.
- We observed a hand-over of care report between staff working the early and late shift. A 'do not disturb' sign was placed on the staff office to prevent unnecessary interruptions. Staff demonstrated professionalism and knowledge when discussing patient information, safety issues and staffing, equipment concerns were discussed, and all staff were encouraged to contribute.
- Staff we spoke with reported positive multidisciplinary working relationships with colleagues in all departments of the hospital. They also reported positive relationships with external services, including the co located NHS trust hospital.
- All clinical staff reported good working relations with the consultants in charge of the patient's care.
- On discharge if the patient required any further care from their GP this was seen to be detailed in the discharge letter and information could be sent electronically to the doctor's surgery for the attention of the nurse or other allied health care professional.

Good

Surgery

Seven-day services

- The hospital opened 24 hours a day, seven days a week with no periods of closure. Operating theatres opened six days a week and closed on Sunday except for any emergency cases. The on-call rota for theatre showed four members of staff being available.
- Pharmacy provided a service Monday to Friday 8amto 6pmand Saturday 8am to 12pm and supported this with a 24 hour, seven days a week on call service. The imaging and physiotherapy service had an on-call service out of hours.

Health promotion

- The hospital had readily available information for patients to help them manage their wellbeing. We saw patient information leaflets in the ward area covering health promotion topics. These included how to prevent deep vein thrombosis and preventing infections.
- A ward notice board had information for patients, staff and all visitors to the ward on the importance of drinking plenty of water, healthy eating habits, importance of rest and sleep and hand hygiene for visitors.
- Staff at pre-assessment explained that they discussed with patients their operation, health and risks to identify additional support or intervention for patients who may require it such as physiotherapy or dietitian services.
- The advice hubs on the hospital website contained information on subjects such as lifestyle management, emotional wellbeing and weight loss amongst other health promotion topics.

Consent, mental capacity act and deprivation of liberty safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** They followed the service policy and procedures when a patient could not give consent.
- All staff were required to follow the corporate policy for consent. The policy was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, roles and responsibility. This policy was six months outside its review date. Following the inspection, the hospital informed us that these policies had been updated.
- The corporate policy for mental capacity and deprivation of liberty safeguards was a similar period beyond its review date.
- Training on consent was provided to clinical staff as part of their mandatory training requirement and 100% of eligible staff had completed this.
- All nursing staff had completed Deprivation of Liberty safeguards training and 99% had completed training on the Mental Capacity Act.
- In the most recent user's survey, 95% of patients stated they received a clear explanation of risks and benefits before their treatment.
- We reviewed six consent forms for surgery and they were all completed and signed and dated. All forms outlined the possible complications and had no abbreviations. In theatre we saw that the consent form was checked as part of the safer surgery checklist.
- Patients undergoing cosmetic surgery were seen by their consultant and an explanation was given about the surgery and expected outcome. Time was given for the patient to consider giving their consent and a two week cooling off period between the patient agreeing and undergoing surgery was in place in line with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (2016).

Are surgery services caring?

Outstanding ☆

Our rating of caring improved.We rated it as **outstanding.**

Compassionate care

- **Staff cared for patients with compassion**. Feedback from patients confirmed that staff treated them well and with kindness and the care they received exceeded their expectations. Patients were very positive about the care they had received from staff. They described staff as "amazing," "caring," "kind," and "like my second family."
- There was a strong visible patient centred culture. Staff took time to interact with patients and those close to them in a respectful and considerate way. One patient told us that she did not eat her food one evening. She told us that staff took time to find out why and offer

other options. One patient told us that she had lost her appetite and suddenly got a craving for cake at 10pm one evening. She reported that this was no trouble for staff and her request was "delivered with a smile."

- Another patient told us that she had elective surgery on her birthday. This was because her recent experience at the hospital had been so positive. She told us that the theatre staff sang "happy birthday" before the surgery commenced. Staff sang "happy birthday'" on her return to the ward and presented her with a birthday cake to celebrate the occasion.
- Staff recognised and respected the totality of patient's needs. A patient told us that her family came to visit her a few days following her surgery. She told us that staff supported her in getting dressed for the occasion.
- We also noted the patient experience feedback data for November 2018. This was displayed on a notice board on the ward area, and 95% of patients said they would recommend the hospital to family and friends.
- Patients were asked to give feedback to staff following their experience of endoscopy or surgery, the manager told us this enabled them to ensure constant improvements to the service in line with feedback. Patients were asked six questions related to caring. They were asked if staff introduced themselves, if the procedure was explained to them, about nausea, pain and dignity. We saw positive results and observed that results were shared with staff in those departments.
- Consideration of patients' privacy and dignity was consistently embeded in everything staff did. We observed staff respecting 'do not disturb' signs on patients' doors. We saw staff knocking on doors, waiting for permission to enter, and closing patients' doors before starting and finishing conversations.
- The hospital had a policy regarding privacy and dignity, including chaperoning. This was to promote and support the privacy and dignity of all patients and clients. We observed signs in the hospital highlighting that chaperones could be requested.
- The most recent Patient Led Assessment of the Care Environment (PLACE) audit scored privacy, dignity and wellbeing at 94.6%. This compared to the national average of 84%

Emotional support

- **Patients emotional needs were highly valued by staff and they supported patients to minimise their distress.** We observed a patient stop a member of staff in the corridor and ask a question about her care. The staff member escorted the patient to her room, to have the discussion in private
- All staff wore badges confirming their name and role. Every room on the ward area had a 'welcome pack.' This included information on how to identify staff by the colour of their uniform. The ward areas also had notice boards with photographs of staff alongside their name and role.
- Staff understood the impact that a person's care, treatment or condition had on their wellbeing. We spoke to a patient who had been transferred from an NHS hospital. She told us how she had been very distressed on transfer due to her pain and anxiety. The nurse and porter kept talking to her during the transfer and this made her feel reassured. She told us that she was seen quickly, her pain was managed effectively, staff were calm and seemed in control. She told us staff were aware of her emotional needs, they stayed with her as long as she needed, and this made her feel safe and secure.
- Staff told us that there was a private area in oncology which patients could use for worship. Staff would identify a room on the ward if this area was not available. This supported patients to worship when they chose to.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment. Relationships between people who use the service and those close to them and staff were strong caring, respectful and supportive.**
- Patients told us that family were included in the planning and receiving of their care. One patient told us that her nurse always waited until her husband arrived to discuss her care and any discharge planning. The nurse made sure he was happy and confident with the plan and he felt ready for her to go home.
- Patients told us that staff took time to explain information to them and their loved ones. They told us that staff answered their questions and made sure they understood information.

Good

Surgery

- Patients were encouraged to rest between 1.30 and 2.30pm and discouraged visiting during this period. However, visiting times were flexible. Arrangements could be made for family and carers to eat with patients and stay over.
- On the ward there was a day room for patients and visitors which was open 24 hours. This had a television and drinks machine. Staff and patients told us there was no pressure to use it.
- Patients' had telephones in their rooms which allowed them to contact their family.
- An elderly patient told us that she and her husband had always saved for "a rainy day." They had decided to use this saving to pay for planned surgery. She told us that the payment had been discussed with them in a private and sensitive way, in advance of the surgery. She told us she had not felt pressured and was given plenty of time to discuss the payment with her husband. She told us "it was money well spent."

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- Pre-assessment staff had access to an online patient information system. This allowed them to give the patient information specific to their condition or surgery.
- There were display boards in most areas with general information about staff and the hospital. There was information about rules for visiting patients, such as handwashing, respecting privacy and dignity, visiting, and meal times.
- We were told that the hospital was considering ways of working collaboratively with the local NHS. At the time of our inspection, the service did not treat any NHS-funded patients. All patients either paid for their own treatment, or this was funded through medical insurance. The Hospital Director told us they were considering the possibility of offering services to NHS-funded patients in the local area. This would help the local health system manage waiting lists and give local people more choice where they received their care.
- Surgery services were planned and delivered to meet individual patient needs and the needs of the community. The hospital worked with the local NHS trust to manage periods of increased surgical activity. The hospital had an agreement to take a small number of patients to convalesce from the co -located NHS trust when there were capacity issues. This enabled the trust to free up several beds for admission.
- Patients and visitors could access the site and navigate the hospital. The hospital was a short walk from local bus routes. The hospital provided free car parking for patients. Staff parked off site enabling patients to park at the hospital and there was a parking attendant to monitor parking and assist patients and visitors in finding a space. Signposting around the hospital was satisfactory.
- The hospital offered suitable facilities for patients and visitors. The waiting area in main reception was clean and had enough comfortable seating. There was a hot drinks machine with a selection of teas and coffees, as well as drinking water. There was free wireless internet access, and there were magazines for patients to read while they waited.

Meeting people's individual needs

- **The service took account of patients' individual needs**.
- Staff told us that they never used family or friends to interpret. We were told that they always used interpreters when patients did not speak English. Interpreters could be used for face to face and telephone appointments. Staff tried to ensure that they used the same interpreter for each patient.
- We noted that there was a staff guide to the 'Customs of Religious Culture and Practice.' This was to help staff understand different cultural and religious practices. It was also to ensure patient care was sensitive to religious cultures and practices.
- Patients with complex needs, such as learning disabilities, autism or living with dementia, received care through a coordinated multi-disciplinary approach.

- The pre-assessment team notified the ward sister when there was a planned admission of a patient with a learning disability or other complex needs. This allowed the ward staff extra time to plan for the admission.
- There are four designated rooms for patients living with dementia. We were told that patients living with dementia could have one to one care, or a family member could stay with the patient and this would be discussed at pre assessment or on admission. We were unable to observe this during the inspection.
- The hospital has maintained the initiative of using a blue pillowcase on the beds of patients living with dementia and memory concerns. The blue pillowcase is a visual reminder to all staff that these patients may need more support and assistance.
- All staff attend mandatory training on dementia awareness. We observed notice boards with information about the signs and symptoms of dementia and how to discuss concerns and support services.
- Staff on the ward could access chairs, wheelchairs and raised toilet seats for bariatric patients. The patient beds supported weights up to 250kg.
- Staff told us that patients' needs were identified and dealt with promptly. Every patient had a named nurse who completed hourly checks during the day and two hourly during the night. Some patients had more frequent checks, depending on their needs. We were told that patients who required additional care stayed in rooms nearer to the nurses' station. One patient told us "I never need to use the call- bell because the nurses check on you so often."
- A patient told us that she did not feel isolated staying in a single room. This was because she was checked so frequently. Patients only shared rooms when clinically necessary, such as in acute dependency unit where they were separated by screens.
- The hospital had a service level agreement with the local trust to offer support from specialist nurses. Patients having complex surgery would receive counselling and advice before and after surgery.
- Staff told us that they contact the patients' consultant if they have any concerns about the patient's mental health. The consultant would make a direct referral to a psychiatrist when needed.
- The service made adjustments for patients' food preferences with a range of menu choices. Catering staff and patients told us they could ask for food that was not on the menu and requests were accommodated.
- We saw a bookstand with a wide range of McMillan information and booklets. This was for patients and family experiencing or supporting a loved one with cancer.

Access and flow

- **People could access the service when they needed it**. Waiting times for the referral to treatment, and arrangements to admit, treat and discharge patients were in line with good practice
- As an independent hospital there were few capacity issues. Waiting times generally reflected patient preferences rather than capacity. In general, patients had their surgery within four weeks of the decision to operate.
- Staff in pre-assessment also offered evening and Saturday appointments to offer increased choice for patients.
- The pre-assessment team of nurses saw all patients, following and initial referral. This is a change to the previous inspection. The pre-assessment team has expanded its service to include patients who are having a local and general anaesthetic.
- There was a clear pathway when patients were admitted to the hospital. Patients reported to reception when they arrived at the hospital for an operation or procedure. They were either directed to the day ward or the in-patient ward. The patients were prepared for their operation or procedure in either location. They waited to be escorted to theatre or the endoscopy unit. After their operation or procedure, they were transferred to the recovery room to ensure they were stable and comfortable. They were discharged home or escorted to the day ward for an overnight stay.
- Consultants offered patients a choice for their date of surgery as they have set days on which they operate. Consultants operated on a Saturday and early evening to offer increased choice. Staff try to make sure all patients are discharged from theatre by 9pm. This ensured they are not returning to the ward too late.
- The on-call team were required to be within 30 minutes travel time to the hospital. This allowed them to respond to patients' needs promptly.
- Patients we spoke with told us that nurses had kept them informed of the approximate time of their operation. None of them had experienced any delays.

- There were adequate discharge arrangements. Patients were given information on discharge, so they knew who to contact regarding concerns or in an emergency.
- Patients who had a general anaesthetic were called the day following discharge. This was to ensure they were recovering as expected, and notes were made of the discussion.
- Staff told us that they informed the patients' GP following their discharge. Their GP was informed of their treatment and any follow up advice/arrangements for example if they required follow up care in the community.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with staff.**
- Nuffield Guildford recognised that the expectations of patients were not always met. Patients who had any concerns with their care were encouraged to raise their concerns so that they could be addressed. These issues were managed through the complaint's procedure. The hospital director was responsible for the management of complaints, the matron led on any complaints that were of a clinical nature.
- Patients knew how to raise a concern. There was information on how to raise a concern/make a complaint in all areas. This was in the welcome packs, information boards and displayed as patient leaflets. Complaints could be made verbally or in writing directly to the organisation.
- Staff told us that the ward sister and matron completed regular ward rounds to talk to in- patients about their care and experience. This allowed them to address any concerns immediately and identify any themes.
- Staff were aware of complaints relating to their department and could describe changes to practice because of local complaints. Theatre staff described a recent patient complaint due to an implant not arriving in time. This resulted in cancellation of a procedure for an in-patient. Patient information was changed to explain that procedures would not be booked at very short notice. This was to ensure all equipment was in place.
- We saw that complaints were a standard agenda item at the clinical governance meetings, senior management and hospital board meetings. Complaints were an agenda item so that they were regularly reviewed and monitored.
- Patients complaints were all tracked to ensure they were managed in-line with their complaints policy and ensure all complaints were closed.
- Complaints were generally responded to in a timely way and in line with their complaints policy.We reviewed five recent and completed complaints files. We found they were investigated, and remedial actions were taken. The tone of the response letters was compassionate, and they contained apologies. When appropriate, financial compensation was offered.
- However, in three of the complaints the escalation process was not made explicit. One informal complaint was not followed through which was not in-line with their complaints policy and following the inspection it was explained this was due to the complainant being away and requesting a face to face meeting which was being organised

Are surgery services well-led?

Good

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

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- There was a clear organisational structure which showed the hospital was led by the hospital director who had taken over this position in January 2019 having previously held a corporate role with Nuffield Health.
- Reporting to the hospital director were four senior managers responsible for finance, operations, sales and services and the matron who was responsible for all clinical services.
- Each clinical department had a manager who was supported by the ward and theatre sisters. Leaders felt they had the necessary skills and knowledge required to lead the service effectively. They understood the challenges to quality.

- Ward sisters and department managers told us they felt well supported and that the senior management team were approachable.
- Staff described ward sisters and theatre managers as visible, approachable and supportive and were clear about the management structure. They knew who their line manager was and their own responsibilities within the structure.
- The Nuffield organisation collected anonymous feedback from staff regarding leadership. We noted the annual results for Nuffield Guildford for 2018. Eighty-nine members of staff completed the survey. Fifty six percent of staff said, "we put patients, staff and colleagues at the heart of everything we do." Twenty nine percent neither agreed or disagreed, and 15% disagreed.
- The overall results of the leadership for the hospital were positive. Any negative feedback from staff were included in an annual leadership action plan.
- During the inspection we observed ward and department teams to be organised, and staff were positive about the team work across the hospital.
- Staff told us they felt well supported by their immediate line manager. They felt there was a clear management structure within the hospital and leaders and senior staff were very approachable. If there were any concerns within the hospital, staff would go to their line manager and seek support.
- Following our inspection, the hospital told us leaders actively shared their leadership experience by promoting staff development through the Nuffield academy future leaders apprenticeship programme, but we were unable to confirm this on our inspection.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**

- As part of a large independent healthcare provider Nuffield health have a corporate strategy to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a provider and partner."
- The company values of Caring, Aspirational, Responsive and Ethical, were displayed on posters around the hospital and staff recognised this as being the values of the hospital. Staff spoke about the importance of putting patient needs first and were proud to work at the hospital.
- The hospital submitted a current clinical strategy which referenced the corporate strategy and values and demonstrated how this would be taken forward by the hospital to provide a framework for the service to develop.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff described the management team as approachable and matron was often in the clinical areas. Staff told us that they feel confident to speak up if there is an issue of concern.
- Staff told us they felt supported, that they work together well as a team and do not feel the structure is hierarchical. Staff described the culture as very supportive of learning and development with good opportunities for personal development.
- The hospital had a staff support policy which included an overview of how staff could be supported including the employee assistance programme which provided support services including counselling.
- Several staff mentioned that the hospital is family friendly with good flexibility of working times. Managers were supportive of staff who had their own health needs and time was given for staff to attend appointments. Staff returning to work after illness were offered reduced working days until fully recovered.
- Staff supported each other. A pregnant member of staff told us that her colleagues were very supportive. They made sure that she always got her meal breaks on time. The ward sister ensured she had time off for her appointments, and her shift work was considered to support her wellbeing.
- Staff told us that culture was supportive and caring. We were told that their work-load was considered if their previous shift had been very busy and an opportunity was given to debrief and discuss difficult cases. They received acknowledgements and thank-you message from the senior staff. They always received any time owing in lieu.
- The hospital had an 'Equality, diversity and inclusion' policy which was due for review in October 2021. The

policy outlined the Nuffield Health zero tolerance position regarding discrimination and victimisation of staff with protected characteristics. Senior staff were aware of the policy and confirmed that discrimination was not tolerated at the hospital.
- Staff were aware of the corporate whistleblowing policy and felt able to approach and discuss any concerns with the manager. The policy included a confidential phone number and email address that was supported by an independent organisation staff could call for advice at any time that allowed all staff members to discuss any concerns in confidence.
- Patient records contained a statement that patients signed which showed they were aware of the terms and conditions of the services being provided in line with the requirement of the Competitions and Marketing Authority order 2015.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- There were clear lines of accountability from the departments to the integrated governance committee also functioning as the hospital board. Managers and department leads were able to describe the systems and processes of accountability.
- The clinical governance committee, chaired by the matron, met monthly. Minutes showed all clinical departments involved and key areas of activity were covered including incidents, infection prevention and control, clinical outcomes and patient experience. This group reported through to the board. Ward and theatre staff had documented meetings in their department to discuss any incidents and complaints and attended the clinical governance meeting.
- The hospital quality and safety committee minutes showed all key areas of patient safety were covered including incidents, risk register, updates on national guidance, infection prevention and control, clinical outcomes and patient experience. We saw that where an action was required a person would be named responsible, this made sure that actions that arose during the meeting were completed, and the assigned person held accountable. This group reported through to the board.
- A corporate governance structure for infection prevention and control was in place. At hospital level there was a plan for monthly infection prevention meetings, quarterly anti-microbial (drugs used to treat infections due to bacteria, viruses or fungi). stewardship meetings and two monthly water safety meetings.
- The medical advisory committee made up of consultant representatives and the hospital senior management team met quarterly. The minutes showed presentation of a clinical governance report including incidents, patient safety, outcomes complaints and feedback. Consultants practicing privileges applications were discussed and ratified.
- The medical advisory committee reviewed any applications for consultants to carry out new procedures which would be granted if the consultant submitted evidence of efficacy of the procedure and training.
- We reviewed three consultant personnel files. We saw an effective recruitment process for these consultants and completed checklists to ensure a consistent approach to recruitment checks. This included occupational health checks, evidence of photographic identification, curriculum vitae (CV), completed reference checks, Disclosure and Barring Service (DBS) checks and interview records. We also saw evidence of up-to-date medical indemnity insurance and evidence of current registration with the Information Commissioner's Office (ICO).
- The hospital sent emails when expiry of any documents was due. For all three consultants there was current registration with the General Medical Council (GMC) and an up-to-date appraisal. Files were well kept and easy to navigate and incorporated a checklist ensuring good oversight.
- The service had a number of service level agreements to provide catering, waste management, maintenance and specialised services. We reviewed four of these and all were current, dated and signed.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- Staff had access to a current corporate risk management strategy with definitions of risk and setting out a template and scoring system to be used when assessing risk.

- There was a risk register to record risks within the hospital. Each risk was given an initial risk rating and a current rating after risk reduction strategies had been put in place. There were 14 risks recorded on the risk register, which were categorised as low, moderate or high risk.
- Out of the 14 risks 10 were classed as minor risks and four as moderate. The risk register had an explanation of the risks, and existing risk controls and actions were completed for each identified risk. The risk register and actions taken were discussed at the Hospital board meeting
- At department and ward level staff could identify risks within their own area and what had been done to lessen that risk. For example, in theatre staff were aware of concerns about water quality and the importance of regular flushing and what actions to take in the case of a positive result.
- The senior management team were clear about the challenges the hospital faced and were committed to improving the patients' journey and experience. Where risks existed, there were plans to address this.
- Where local audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed, and re-audit programmes undertaken to ensure improvements to patient outcomes.
- Safety alerts sent to the hospital were triaged by the matron and sent to the appropriate department. Actions taken were recorded at department level and collated by matron. The most recent safety alert was on display in theatre.
- The hospital had access to trust infection prevention and control policies and procedures and took part in the auditing of clinical practice. This was in line with National Institute for Health and Social Care Excellent, quality standard 61, statement 2 says 'organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems. We found the service controlled infection risk well, and staff followed policies to protect patients against cross infection.
- There were processes for the stewardship of antimicrobials. We saw there were guidelines in place, which could be accessed by staff. We saw regular audits were undertaken by the pharmacy department to review antimicrobial usage; this was then fedback at the Hospital Medicines Management and Medical Gas committee. This was in line with National Institute for Health and Social Care Excellent, quality standard 121, statement five.

Managing Information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- . The electronic clinical incident system was widely used by all staff and enabled sharing of information and identification of severity of events and trends across the hospital. This allowed shared learning and development of safe working practices.
- The local clinical dashboard allowed local audits to be shared electronically to support continued improvement of practice. We saw these included but were not limited to, falls, news scoring, safe surgery checklist completion and medicine administration. The metrics were presented in a way that departments could see how they were performing in each area, monitor trends and improve and make changes to practice.
- Information governance training was part of the hospital's statutory and mandatory training requirement for all staff. Data supplied to us showed that 98% of staff had completed this. Cyber security training was completed by 100% staff.
- When staff left their workstation computer screens were locked so that no patient information was left on display and therefore patient records kept confidential.
- As part of the Nuffield Healthcare information is submitted to Private Healthcare Information Network (PHIN).

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- Patients had access to the hospital website which contained clear information about facilities and services provided and was easy to use. The website also included information about open evenings when potential patients could visit the hospital, meet the specialist medical staff and ask questions.

- Patients were able to feedback about the service using a patient questionnaire which included the friends and family test asking patients to rate the quality of the care and whether they would recommend the hospital to friends and family.
- For the six months from July 2018 to November 2018 the response rate was between 20 and 26%. Results across the same six month period showed a score of patients that would recommend the service to family and friends ranged between 95% to 99%.
- Minutes of the patient experience group demonstrated individual patient attendance and feedback about specific services and care. The matron had considered how to get more feedback and had sent out letters inviting past patients to join a group but there had been no uptake.
- The hospital produced a patient experience newsletter for staff explaining recent patient feedback, the positive and the negative. The final section set out what had been learnt and changes to be made. Staff were invited to join the patient experience group to deliver those changes.
- Annual staff engagement was completed, and Guildford Hospital scored higher in most categories than other Nuffield hospitals with equality and inclusivity being scored at 8.54 against a hospital score of 8.25. When asked 92% of staff stated they would be working at Guildford hospital for the next year and 89% would recommend Nuffield Health to friends and family, this equalled the score at other Nuffield hospitals.
- There was an action plan in response to the staff engagement questionnaire with actions designated to individuals and evidence that actions had been completed. We noted that a staff engagement committee had been established and that regular staff engagement events were planned because of the feedback
- The matron wrote to individual staff informing them of positive patient feedback. There were rewards for staff for long service and staff spoke of social events organised by their own departments.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.** Multi-disciplinary working and learning was evident at regular governance meetings. There was evidence of ward to senior management communication.
- The hospital had a comprehensive local audit programme, which allowed departments to benchmark and improve performance. We saw action plans being implemented because of noncompliance found.
- The implementation of scenario training on a regular monthly basis appropriate to each department was welcomed by staff and seen as a means of learning and developing clinical practice.
- Each member of the clinical staff had laminated prompt cards appropriately sized that they could be carried in the pocket. Each of the nine cards contained prompts to general information such as the hospital values or practical actions to take in response to sepsis or communication in an emergency.

Good

Services for children & young people

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

Are services for children & young people 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 lead children's nurse and matron monitored nurses' mandatory training. A training matrix showed all nurses complied with their mandatory training.
- All nurses within children and young people services were trained in paediatric basic life support. The paediatric lead nurse had current European paediatric advanced life support completion, which is an advanced course to paediatric immediate life support (PILS) so PILS is not required. Medical staff who had contact with children had paediatric basic life support.
- Following our inspection, the hospital told us the children and young people lead nurse delivered paediatric basic life support training to staff across the hospital, ensuring all employees are able to deliver this treatment, if required, but we were unable to confirm this on our inspection.
- Staff told us they were given time to complete their on line mandatory training at work and attend face to face training. We saw a spreadsheet monitoring compliance which senior staff used to remind staff to complete training.
- Staff were aware and trained for assessing sepsis which was mandatory. A visible teaching board about sepsis located by the nurses' station displayed latest guidance, policies and information.

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 access to a current joint Children, Young People and Adults Safeguarding Policy. This policy contained information on what actions staff should take if they were concerned about a patient's safety.
- All staff we spoke with had knowledge of how to safeguard children. The senior management team, lead children's nurse and the matron were trained at level three safeguarding children and all other nurses had received level two training.
- All registered medical officers who were onsite twenty-four hours a day had received training in level three safeguarding children.
- The service provided adult and child safeguarding training to all staff, including non-clinical staff. All staff had completed their training. After our inspection, the hospital told us that there were dedicated children and young person link nurses in relevant departments but we did not see this on our inspection.
- All children's nurses had completed level two childrens safeguarding. The lead childrens nurse, matron, theatre manager, theatre deputy manager and senior sister had completed level three childrens safeguarding training in line with the intercollegiate guidance. All heads of clinical departments had a date booked to attend.

- The hospitals governance team had developed a pocket-sized booklet for staff which gave information about key elements of safeguarding.
- The safeguarding policy incorporated female genital mutilation. This provided staff the guidance on reporting and, this complied with mandatory reporting requirements. All Staff demonstrated an understanding of the need to report and how this was done.
- The safeguarding policy contained guidance on child sexual exploitation. This provided staff the guidance on reporting and complied with mandatory reporting requirements. All Staff displayed knowledge of child sexual exploitation and knew how and when to report.
- Staff reported the lead nurse and matron were always available for staff to discuss safeguarding concerns. Staff were able to contact the corporate safeguarding children's lead who supported all departments within the organisation, if required.
- The matron had oversight of all nurse staffing recruitment. They carried out disclosure and barring checks on all nursing staff and identified any disciplinary concerns. The corporate team have oversight of the medical staffing recruitment. The matron checked the level three children's safeguarding, paediatric basic life support and disclosure and barring for all staff prior to the commencement of their employment.
- There were no required children safeguarding alerts raised and staff had not identified any safeguarding concerns during the reporting period August 2017 to July 2018. However, staff we spoke with were aware of the process and how to escalate or raise a safeguarding alert and knew who to contact.
- The lead nurse or matron had responsibility for contacting local authorities or other agencies for children who had identified safeguarding concerns and were already known to these services. We did not see evidence of this as no safeguarding concerns had been raised during the reporting period.
- Staff had contact details for safeguarding out of hours services should they need to contact the local authority.
- Orange wrist bands were provided to parents, carers, and relatives at the face to face pre-assessment which gave opportunity for the staff to meet the child and their family. Staff told us there would always be someone at the nurse's station/front desk to greet visitors on entry to the children's department.
- The wrist bands allowed staff to identify visitors and ensure the child's safety. Staff reported they escorted all visitors to the child's room and made sure they were happy for the visitor to stay. The hospital's local abduction policy reflected arrangements of visitors to the hospital and the supervision of children.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well.** Staff kept, equipment and the premises clean. They used control measures to prevent the spread of infection.
- All areas we visited in the clinic were visibly clean and tidy. All chairs were wipeable and in a good state of repair. The two children's rooms had laminate flooring and en-suite facilities.
- All clinical staff were bare below the elbows to prevent the spread of infection in line with national guidance. Staff had access to personal protective equipment such as gloves and aprons, these were available in sufficient quantities.
- There were alcohol hand cleansing gels at the entrance to the ward and throughout the clinical areas. Posters in the clinical area emphasised the importance of hand hygiene. The children's rooms clearly displayed child-friendly pictorial posters and highlighted the importance of washing hands.
- The service undertook monthly hand hygiene audits of observational checks made of staff practice. All checks showed staff complied with good practice and audits were 90% and above.
- The housekeeping department who were employed by the service carried out cleaning. Housekeepers reported directly to the operations manager who monitored the completion of cleaning records and checked records were signed, we saw the last three months and they were completed with no gaps.
- The outpatient's department had responsibility for their children's toy area. Nursing staff cleaned the toys provided in the children's rooms and pre-assessment area at the end of each day. We saw a ''we are clean'' sticker on the toy box. We saw the check lists and audits which showed completion of daily cleaning for the last three months with no gaps.
- For our detailed findings infection prevention and control and storage of cleaning products, please see the safe section in the surgery report.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- All children's rooms were bright and visibly clean. The rooms were child friendly and had age appropriate decoration.
- Resuscitation trolleys were in the corridor opposite the nurse's station. Both adults and childrens trolleys were available. The Childrens trolley was visibly clean and contained in date medicines and single use equipment. A checklist showed the service had carried out weekly checks and fully completed the checks for the last three months.
- Staff had access to a childrens defibrillator in recovery which was maintained in line with the manufacturer's recommendations. The service had carried out safety checks and displayed the next service date. This complied with electrical safety testing guidance.
- The service had equipment suitable for use with children. The service used the children's consultation room for appointments in outpatients. We saw children's equipment used for children, including weighing scales, height measure and blood pressure cuffs. All had labels on stating they had been checked and were in date.
- For our detailed findings on waste management please see the safe section in surgery report.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- The hospital saw children aged three to 18. The service completed face to face pre-assessments which included the paediatric consultant and a children's nurse.
- The service had admission criteria for surgery. The children and young people's service standard operating procedure, ''Criteria for children and young people going under surgery'' excluded patients with complex needs and did not accept acute emergency admissions, however children would be assessed on an individual basis. Therefore, the service was not routinely treating children and young people with complex needs.
- An up to date policy was accessible to staff for child sepsis management and staff were aware of this and knew how to monitor and escalate deterioration. However, there were no cases of sepsis during the reporting period, so we did not see evidence of this in the records.
- Guidance for emergency transfers of the deteriorating patient was accessible to staff and staff we spoke with had knowledge of this process. There was a standard operating policy with local NHS hospitals to accept these patients.
- We saw completed age specific, Paediatric early warning signs (PEWS) were used at pre-assessment and followed the child to theatre and recovery. Staff we spoke with knew how to escalate concerns however there was no evidence of this in the notes as there were no concerns escalated in the reporting period.
- After our inspection, the hospital told us there was an ongoing audit of Paediatric Early Warning Score system to ensure compliance and that outcomes were shared at audit meetings but we were unable to confirm this.
- Children's nurses monitored the recovery process for children in line with ''Guidance on the provision of paediatric anaesthesia services 2017''. Parents we spoke with confirmed that the childrens nurse was present during recovery it was also documented in the patients records.
- The pre-assessment appointment assessed risk and safety by completing; a World Health Organisation safety assessment, nutritional assessment, cannula assessment, height and weight of the child that was recorded on the prescription chart. All notes we reviewed had these completed.
- All clinical leads attended a daily safety meeting at 9.15am. They discussed staffing, patients, theatre lists, risks and appointments to ensure safe practice.

Nurse staffing

- **The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe from avoidable harm and to provide the right care and treatment.**
- Elective inpatient surgery was provided for children aged three to 16. The service was managed by a Lead Nurse for children and young people and there were also three dedicated substantive paediatric nurses. Children's care was planned, delivered and supervised by the children's nurses. The senior ward staff, who were on duty managed the day ward area and supported the children's nurses.

- The provider had a current Children in Hospital Policy which set out the staffing requirements. It included a service and staffing grid which set out the Nuffield Health approach to setting safe levels of staffing. The hospital met or exceeded this requirement.
- We reviewed rotas which showed most shifts had only one children's nurse; one on an early shift and one on a late shift, with an overlap of two nurses on shift in the middle of the day. The children's nurse on shift was also be responsible for supporting the outpatient department. The serviceworked to thethree to one ratio nurse patient ratio recommended in the guidance and one shift showed, three nurses on duty when there were eight patients present.
- The hospital submitted evidence that all children were pre-assessed and staffing would be flexed according to need. A children's nurse was present at all stages of the child's journey and a children's nurse was present on admission, and before and after surgery. All staff and families we spoke with stated this took place.
- Two regular paediatric bank nurses were used when required. They had provided regular cover to the service for around two years and were reported to have had a full induction into the service when they started although we did not see evidence of this.
- If bank staff were not available agency staff were used. However, in the last 12 months only two shifts were covered by agency nurses.

Medical staffing

- Medical staffing was managed corporately by the organisation. However, the matron reported that they had sight of level three safeguarding children and paediatric life support. There was a service line agreement (SLA) with the local NHS trust that contact to their paediatrician was available to the registered medical officers and childrens nurses both day and night if required.
- For our detailed findings on medical staffing please see the safe section in the surgery report.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- Paper records of patient notes were kept on site. We looked at eight sets of patient records and saw they were comprehensive with patient history and a treatment plan. Staff dated and signed records in line with Nursing and Midwifery Council and General Medical Council guidance. Hard copies of paper notes were stored in the medical records department.
- Records were kept securely. Records were kept in a locked filing cabinet in the children and young person's nurse's office until the post-operative one/two-day phone call was made. They were then sent to be archived in medical records department.
- All the records we reviewed were complete and contained all healthcare professional's input. However, we were told that at times the consultant's notes were not always incorporated into the main patient's notes.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines**. Patients received the right medicines at the right dose and at the right time.
- We saw prescription charts in patient records, all were completed correctly and in line with national guidance for prescribing for children; Professional Guidance on the Administration of Medicines in the Healthcare Setting "Royal Pharmaceutical Society January 2019".
- We saw staff had documented any allergies and the weight of the child.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. 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.
- There were no reported incidents for children and young people's services for the reporting period August 2017 to July 2018. However, staff we spoke with knew how to report an incident and the process. The service discussed incidents at leadership meetings and highlighted these in the 'heads up safety meeting' which took place each morning.
- There were no reported never events for the reporting period. Never events are serious patient safety incidents

that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.
- For our detailed findings on medicines please see the Safe section in the surgery report.

Safety Thermometer (or equivalent)

- **The service used safety monitoring results well.** Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.
- Safety performance was monitored at paediatric governance meetings. A local children and young person's governance subcommittee took place quarterly which was then reported into the Clinical Governance committee, so the children and young person's service could be incorporated into the wider hospital safety monitoring.
- Data was routinely gathered from follow up calls to all patients for patient experience feedback, to monitor the outcome of surgery and experience.
- We were not provided with evidence of specific children and young person's data as we were told they did not routinely gather it.
- For our detailed findings of the safety thermometer, please see the safe section in the surgery report.

Are services for children & young people effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- Staff had access to local and corporate policies through the hospital intranet. Staff we spoke with knew how and where to access these policies and procedures to do their jobs. All policies and procedures we saw were within their review date.
- The hospital had developed it policies on current evidenced based practice. This included; The Royal College of Nursing (RCN) and the National Institute for Health and Care Excellence (NICE). For example, the childrens resuscitation policy referred to the Resuscitation Council UK, and the hospitals standard operating procedure for nutrition and hydration referred to the RCN 2014 guidance malnutrition screening.
- We saw up to date policies and guidance for procedures, which was accessible for all staff in the 'Consultants folder'. Staff reported they accessed this when required or when updates had taken place.
- Staff told us the governance lead supported staff with policy guidance updates and support to ensure safe, good quality, and best practice was adhered too. Paediatric governance meeting minutes we saw showed best practice was discussed and actioned.
- After our inspection, the hospital told us the provider had developed a national children and young people leads forum which allowed for benchmarking of services and greater opportunity for shared learning and service development. We were not told about this on our inspection so were unable to confirm this.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service made adjustments for patients' religious, cultural and other preferences.
- The hospital policy was to starve patients six hours prior to admission except for clear fluids which was in line with national guidance. Children were scheduled first on the theatre list to avoid extended periods of fasting.
- Nutritional assessments in line with best practice were completed at the pre-assessment and food preferences were discussed. There was a standard child friendly menu, but all dietary needs were met if 'non-menu' items were requested to accommodate, preferences, allergies and intolerances.
- We were told the hospital staff had access to a dietitian for additional support for patients if needed. Staff we spoke with had not referred to the dietitian but where aware of the process.
- Patients' fluid and food intake was monitored. We saw completed food and fluid charts in patient records we reviewed.
- Families had access to free tea, coffee and snacks in the day room.

Good

Services for children & young people

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.** They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Folders containing information and tools for assessing pain were visible and available in the children's rooms. There were different age appropriate assessment tools, some pictorial with child friendly wording and for older children there was simplified wording.
- An audit of 35 children during the reporting period showed that 80% felt their pain was managed well and 20% of children experienced no pain at all.
- Records showed that pain was regularly reviewed and managed by the nurses and escalated when needed.
- Prescription charts showed that pain relief was prescribed in line with guidance. We were told nurses administered the medicines but were not able to observe this as there were no planned admissions during our inspection. All patients we spoke with reported that their pain medication was managed well.
- We were told the pain specialist nurse was available for additional support if there was a concern with managing pain. However, they had not been required to refer to this nurse during the reporting period.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- The hospital monitored outcome data for children and young people by recording re-admissions, re-operations and infections. There were none reported for the reporting period. We saw governance meeting minutes for the reporting period which supported this.
- Post-operative telephone calls were made to all patients-families' one-two days after discharge, a standard template was used to make sure all relevant questions were asked. A further call was made at 90 days post discharge, this also monitored the effectiveness and outcomes of surgery. Evidence was seen of both the calls made as was an audit for patient outcomes.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- All children's nurses had up-to-date appraisals and records confirmed this.
- Staff Competency assessments were up to date and showed that nurses were competent in areas relevant to their role. For example, completion of paediatric early warning scores/charts (PEWS), using medical devices and medicine management.
- All registered nurses working with children and young people were trained in paediatric intermediate life support. Registered medical officers working at the hospital had completed the European paediatric advanced life support course (EPALS).
- The service checked staff had current professional registration and the matron had oversight of this. We were told that all nurses were up to date with revalidation, this gave assurance they were fit for practice.
- There was a competency system across clinical areas and a dedicated Clinical Practice Educator that supported staff competence and learning.
- We were told the children's lead nurse carried out simulation training quarterly in other departments within the hospital to update staff with best practice for children.
- Staff we spoke with said they were encouraged to develop their skills and knowledge. The lead nurse had been supported to complete a degree relevant to her practice.
- Student nurses were supported to develop their knowledge by being given opportunities to plan and present a teaching session relevant to children and young people. We were told it was a positive and encouraging environment and they felt very supported in being able to develop and learn.
- For our detailed findings of staff competency including consultant practicing privileges, please see the effective section in the surgery report.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care.

Good

Services for children & young people

- The hospital had a multidisciplinary paediatric meeting which took place quarterly. This was a range of health professionals, including nurses, physiotherapists, consultants and radiologists.

Seven-day services

- The hospital performed mostly day surgery for under 18-year olds. Children who stayed overnight would always be cared for by a registered paediatric nurse. The children's services were available Monday to Friday with occasional outpatient appointments on Saturdays.
- For our detailed findings of seven-day services please see the effective section in the surgery report.

Health promotion

- **The service promoted healthy living with its patients.** We saw a health promotion board located in the corridor outside the children's rooms. It promoted sleep and displayed research, good sleep tips and information for parents and child friendly information. Staff told us the childrens nurses regularly changed and updated the information on the board.
- We saw information leaflets for children and families such as general information about anaesthesia, healthy eating, internet guidance aimed at parents for keeping their children safe, hand hygiene and a book designed by the hospital for younger children and their visit to the hospital.
- The book produced by the service was ''Archie and Theo's special day out''. It focused on a child's journey to hospital and hand hygiene. Staff at Nuffield designed it and included colourful illustrations, large print and language aimed at children. These were seen readily available in the corridor by the children's rooms and in the outpatients' department.
- After our inspection the hospital told us the children and young people team support the 'SWAP' programme, the Nuffield Health School Wellbeing Activity Programme. This programme focussed on providing health promotion and wellbeing support to school aged children but we were unable to confirm this on our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**
- Consultants had gained consent and assessed using Gillick competence for children under the age of 16. Children under the age of 16 can consent to their own treatment if they can understand fully and appreciate what is involved in their treatment. This is known as being Gillick competent.
- Where the child was not competent to consent the parent or guardian had signed on their behalf. We saw eight sets of records and all had completed consent forms.

Are services for children & young people caring?

Good

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

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- Staff communicated with patients in a kind and respectful way. Patients told us they were made to feel welcome, that no question went unanswered and they felt fully informed about their elective admission based on the patient's own needs. The service encouraged patients and their families to attend face to face pre-assessments so they could meet the child and their family.
- Patients were introduced to all healthcare professionals involved in their care, in line with NICE QS15 Statement 15. Patients told us ''no question was a silly question'' they got to know the nurses and doctors and felt confident and happy with the care and treatment they received.
- There was a designated pre-assessment consultation room for children which provided privacy, patients told us they felt respected and their dignity was maintained during examinations.

- All staff introduced themselves and built positive relationships with the patient and their families. Patients told us they got to know the nurse that cared for them and felt reassured and well cared for.
- Nurses were encouraging and supportive toward the patients and their families. Nurses we spoke with all stated the importance of building a relationship with the patient and their families to fully understand their perspective and preferences. Staff felt there was time and multiple opportunities to do this with all elective admissions.
- The service had a chaperone policy. We were told that paediatric nurses were always notified prior to an appointment if they were required to chaperone. Staff told us a paediatric nurse would always be present during children's outpatient appointments, a procedure or examination, radiology and at pre-assessment appointments. Patients we spoke with confirmed this and patient records we reviewed showed this took place.
- Patients were satisfied with the service provided, 30 childrens patient experience surveys were reviewed from January to May 2018. Fourteen children that were under nine years filled in the tick box survey (Nuffy bear) and 16 children over none years completed the young person's evaluation survey. 100% scored the service 10/10 for overall experience.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Children were often anxious at the pre-assessment stage and this was usually related to not knowing what was going to happen. Part of the pre-assessment was for the child and their family to see where they would be staying and look at the equipment for anaesthesia to ease anxiety.
- The service gave children and their families a welcome pack during pre-assessment. This included age appropriate information and guidance for the child, guidance about the procedure both before and after the procedure. This was in line with the Department of Health's quality criteria for young people friendly healthy services.
- Parents were encouraged to be in the recovery area to minimise their child's distress. Standards for Childrens Surgery; The Royal College of Surgeons (2013). Parents told us "the nurse came straight to get me so we could be there when our daughter woke up from the anaesthesia".
- Review of the feedback form completed by 35 children showed 85% attended a face to face pre-assessment. This allowed the patient and their family to build a relationship with staff and familiarise themselves with the environment. Quotes included; ''I met the nurse at pre-assessment who would be looking after me on the day of the operation which made me less worried''. A parent stated ''It helped settle my daughter who was so anxious'' and ''Staff were so helpful and informative which gave us all reassurance''.
- Family members where encouraged to be with the patient and could stay at all times. They could spend the night with the child in their room on a bed if an overnight stay was required. The service did not set visiting hours and family visits took place at times suitable to them.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff communicated with patients and their families in a way that they understood the diagnosis, care and treatment. This was in line with NICE QS 15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
- Patients had the opportunity to look around the ward and the room before their stay. The nurse present at the pre-assessment was the nurse providing care for the child on the day of the procedure. We were told this is usual practice and would only change due to staff sickness.
- Detailed information about the operation or procedure was discussed and written information given to the child and their family during the pre-assessment appointment.
- Parents told us it was "excellent" how staff involved them and communicated with them. They said their child was the focus and staff adapted the language they used to the child's level and gave time for their child to ask and answer questions.
- Patients felt cared for and staff understood their individual needs. Patients told us during

pre-assessment they were made to feel their opinion really mattered, their thoughts, anxieties and concerns were acknowledged and supported in an encouraging and kind manner. For example, verbal feedback from a teenage patient "I really felt listened too and that I was treated with respect". We reviewed 35 completed feedback forms for children aged three to 15 and 100% said they felt prepared and fully informed about their stay in hospital.

- Parents we spoke with reported they felt fully involved in the development of the plan of care and had full understanding of it. Feedback for patient involvement in their care, understanding their care and being fully aware of what was going to happen was 100%.
- Feedback forms showed 70% of patients felt completely prepared for their operation, 30% felt quite prepared and 100% felt completely prepared to go home.
- We saw price lists available on the hospital website and a dedicated phone number to enable discussion about costs. Patients we spoke with told us they received clear information about costs before their appointment.

Are services for children & young people responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- The environment was child friendly. We saw that the children's rooms were all decorated with a Monkey motif. The monkey theme continued throughout children's areas, for example, an X-ray room, theatre recovery area and the pre-assessment room.
- The outpatient department waiting area had a children's play area with a variety of toys, books and games for all ages. They were visibly clean, and the area was bright and child focused. The designated outpatients' consultation room for children continued with the monkey motif decoration and had a variety of toys, books and games for all ages.
- The ensuite facilities in the children's rooms were responsive to children's needs. There were footstools to support children with reaching the sink and child friendly signs and posters to encourage good hand hygiene by informing of what germs were on their hands.
- We saw the service listened to patient feedback and acted on their feedback. Patients had suggested the use of an iPad, a DVD player and older children's games. Staff responded to these requests and they were now in place for the children to use. Patients also had access to free WI-FI in the hospital.
- We saw was child focused literature. For example, there was brightly coloured pictorial posters on the wall outside the children's rooms encouraging and informing of good hand hygiene. We saw a children's information board in the corridor which had information accessible to all ages about sleep.
- For our detailed findings of meeting the needs of local people please see the responsive section in the surgery report.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Staff told us they aimed to pre-assess all patients face to face to gain a full holistic assessment and ease the child and families' anxiety. In the reporting period, they achieved 80% of completing face to face assessments, with the aim of achieving 100% in the coming months. We saw pre-assessments documented and completed in all patients notes we reviewed. They were comprehensive and provided details about the patient's physical health, mental health and social needs.
- We saw individualised care plans in the records. Staff adapted to the needs of the child following the pre-assessment and developed an individualised plan of care.
- Identification of individual needs took place at the pre-assessment. All parents and staff we spoke with confirmed the pre-assessment was holistic and explored all the patients' needs. If further support was required during admission this would be explored during pre-assessment.
- The service could cater for cultural food choices food, this would be discussed in the pre-assessment to the child's nutritional needs.

Good

Services for children & young people

- Patients and families who had English language as a second language had access to an interpreting service. Staff knew how to access this service and we saw referral information displayed in the nurse's office.
- Patients who suffered with hearing loss and used a hearing aid could access hearing loops when required.
- The children and young people services did not have the training or facilities to support patients with a severe learning disability or who were living with a disability. However, each child would be assessed on an individual basis to see if the hospital could meet the child's needs. Admission processes ensured patients with complex needs which could not be met were not treated at the hospital.
- We were told that a nurse within the team had knowledge of a sign language used by people with learning disabilities. and used this when necessary.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Hospital data showed during the reporting period a total of 2,668 outpatient appointments; 233 of which were day case discharges and 32 inpatient discharges for children and people services.
- The children's and young people's service was flexible in the service it offered. For example, outpatient appointments were offered in the afternoons and at weekends, so attendance could be outside of school hours.
- Staff told us the pre-assessment appointments were scheduled around the inpatient list for the day and school hours to ease accessibility for children and their families. A parent told us that arranging the initial appointment was 'so easy and quick'. They were seen within a matter of days following contact with the hospital.
- Pre-assessments usually took place one week before the operation. However, staff would telephone patients if they did not have the opportunity to attend the hospital. The standard for pre-assessment, was two weeks maximum and three days minimum.
- Discharge procedures were explained at the pre-assessment to allow full understanding for the children and their families. We saw evidence of this in the eight patient records we reviewed.
- Follow-up support showed100% of the survey participants knew about aftercare, knew about medication and knew who to contact if worried. Patients were sent home with a fact sheet detailing relevant information about their aftercare and who to contact if they were worried. The nurse made a phone call to the patient 48 hours and 90 days after discharge.
- Discharge summaries were routinely sent to the patients GP when discharge took place, this was evident in the notes.
- Parents we spoke with told us they waited no longer than five to ten minutes at their outpatients' appointment. Staff told us if there was a delay they kept the patient fully informed.
- We were told by staff that they would prioritise urgent cases when required. For example, if a patient needed to be seen following discharge home and it was highlighted during the 48 hours follow up call, staff would discuss with the consultant and an urgent appointment would be made if required.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The children and young people's service did not receive any complaints during the reporting period.
- Leaflets about how to make a complaint were displayed in the outpatient area, however there were none visible near the inpatient children's rooms.
- Staff we spoke with were aware of the complaints policy and had knowledge of how to escalate concerns with a senior nurse/matron.
- Staff knew how to manage a verbal complaint and explained the process for advising patients to make a formal complaint.
- For our detailed findings of learning form complaints and concerns please see the responsive section in the surgery report.

Are services for children & young people well-led?

Good

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

Good

Services for children & young people

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care**.
- The children and young people services was led and managed by the lead children's nurse who had been in post for three years. Line management was provided by the quality and governance lead to the lead nurse. The lead nurse had leadership and management responsibilities for the three children's nurses in the team.
- The matron had oversight of and all staff we spoke with reported the senior leadership team were visible and approachable. All staff we spoke with felt they could raise a concern should they need too.
- The lead children's nurse supported staff and raised children's safeguarding concerns when required. The matron was the designated safeguarding lead for attendance at the local safeguarding board. However, this was reported to have ceased due to restructure within the local authority. We were told regular enquiries were being made to the local authority to gain clarity of when the meetings will commence.
- For our detailed findings of leadership please see the well-led section in the surgery report.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- Staff we spoke with were proud of the children's and young people service they offered and the environment they delivered the service in. We were told they wanted to continue to improve the service based on feedback and the needs of patients.
- For our detailed findings of vision and strategy please see the well-led section in the surgery report.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff we spoke with said it was a great place to work and they felt valued and respected.
- We were told "everyone is so helpful and happy, which makes working here a pleasure".
- Staff were aware of the whistleblowing policy and felt able to approach and discuss any concerns with the manager.
- For our detailed findings of culture please see the well-led section in the surgery report.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- A local children and young person's governance subcommittee took place quarterly which was then reported into the Clinical Governance Committee. A paediatric consultant was part on the committee and it also included, Quality Care Partners (QCP) and leadership from the lead children's and young person's nurse.
- Paediatric governance meetings took place quarterly. We saw meeting minutes, the agenda included; safeguarding, incidents, activity, clinical issues and any other business, actions from previous meetings were discussed and current actions were given a time limit and a member of the meeting would take ownership of the outcome.
- Medical Advisory Committee (MAC) meetings took place quarterly and children and young people services was represented by a consultant paediatrician who also attended the governance subcommittee. We reviewed meeting minutes and during the reporting period no governance concerns were raised for the service. These forums reviewed best practice, national guidance, patient feedback, complaints, incidents and lessons learned.
- For our detailed findings of governance please see the well-led section in the surgery report.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- Feedback gained from patients by children and young people services was used to improve quality and reduce risk. Action plans were produced following audit of feedback and were now completed.

Good

Services for children & young people

- The 90-day contact made to discharged patients and families informed staff what went well and what could have gone better which gave assurance and highlighted areas for improvement.
- Children and young people services was an agenda item on the risk management committees across the hospital, but no concerns of risk were highlighted during the reporting period.
- For our detailed findings of managing risks, issues and performance please see the well-led section in the surgery report.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- For our detailed findings of managing risks, issues and performance please see the well-led section in the surgery report.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- The service completed a children's patient experience audit, to understand children's and young people's experiences. It included all aspects of inpatient care, from consultation through to pre-assessment, care before and after surgical procedure.
- We saw the audit had facilitated different methods for a varied age group and was completed by 30 children. The service had completed the actions following the outcome of the audit to allow improvements to be made. These being; child friendly menus, staff to develop their knowledge further in surgery and pre-assessment and business cards made for main reception so patients and their families could be given these and directed with ease to the children and young people department.
- The service encouraged children to complete feedback forms giving the option to describe their experience in pictures and words. These were age-specific; under age nine and age nine l and over. We saw a number of these completed on a display board outside the children's rooms. This was in line with Department of Health, 'You're welcome: Quality criteria for young people, friendly health services, 2011'.
- The service carried out child friendly patient satisfaction surveys to measure patient outcomes. We saw two examples for the reporting period and both were 100% satisfied.
- For our detailed findings of engagement please see the well-led section in the surgery report.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- A book was written by a staff member 'Archie and Theo's day out to the Nuffield hospital Guilford. It educated children on the importance of hand washing. This helped educate young children the importance of hand washing.
- For our detailed findings of learning, continuous improvement and innovation please see well-led section in the surgery report.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services 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.**
- Mandatory training for staff covered topics including manual handling, fire safety and medical devices. We saw that outpatient staff compliance across 26 topics ranged between 95% and 100%. Physiotherapy staff compliance ranged between 90% and 100%.
- All staff had access to an online system for training. The system was able to give the outpatient manager an overview of performance and gave prompts when staff were due to re-take or refresh their training. The hospital matron could also see mandatory training performance and would send emails to department managers reminding them if any staff were approaching their due dates.

Safeguarding

- **Staff understood how to protect patients from abuse.** Staff had training on how to recognise and report abuse, and they knew how to apply it**.**
- All members of outpatient staff had received safeguarding adults training and safeguarding children training level one. The service recorded that 19 members of staff were eligible for safeguarding children level two training, and all 19 members of staff had completed this.
- All members of physiotherapy staff had received safeguarding adults training and safeguarding children training to level one. The service recorded that eight members of staff were eligible for safeguarding children level two training, and all eight members of staff had completed this.
- The outpatient safety board displayed who the safeguarding lead and champions were for the hospital. There were also posters and flowcharts for the PREVENT strategy which was part of anti-terrorism training, and what to do if female genital mutilation (FGM) was suspected.
- Staff told us they had received training on safeguarding and would feel confident in how to report an incident should it arise.
- For further information regarding safeguarding see information under this sub-heading in the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.**
- All staff we saw in the outpatients and physiotherapy departments were bare below the elbows to prevent the spread of infections in accordance with national guidance.
- Hand cleansing gel was available at the main entrance of the hospital and throughout the outpatients department. We spoke to patients who told us they saw staff clean their hands before their consultation.
- The outpatient department staff completed observational hand hygiene audits. The audit was completed with a minimum of ten staff members from the last twelve months and included measures such as

whether staff were using the correct hand cleaning technique, and whether they were bare below the elbow. The result of the most recent audit completed in June 2018 showed more than 90% of staff observed were compliant with good practice.

- Outpatient and physiotherapy staff received infection prevention and control training as part of their mandatory training package. We saw that 97% and 90% of staff respectively had completed this training, with 100% of staff for both services having completed the practical element of this training.
- We reviewed three consulting rooms in the outpatient department and found no concerns. We saw that in all of these rooms, waste was segregated, "I am clean" stickers were used to indicate equipment that was ready to use, hand sinks were available for hand washing and sharps bins were signed and dated in line with best practice. Personal protective equipment such as gloves and aprons were available, and consumable items were checked and found to be within their expiry dates.
- The outpatient department was cleaned in the evening and overnight to minimise disruption to patients and staff during the day when clinics were being held. All medical equipment was the responsibility of the nursing and healthcare assistants to clean after each use, and everything else was the responsibility of the housekeeping team. The service used brightly coloured 'I am clean' stickers to easily identify which pieces of equipment had been cleaned and when.
- There were cleaning checklists on the back of clinic rooms within the outpatients department and we saw these had daily checks documented for April. We looked at previous months documentation for rooms two, three and four and saw regular gaps on the rota which landed on the weekends. Often some of the clinic rooms were not used at the weekends. However, this was not marked on the checklists, therefore it was unclear if the rooms had been cleaned and not documented, for example on the Saturday clinics, or whether the rooms had not been used. We discussed this with the outpatient manager who acknowledged this needed to be marked on the checklists going forwards.
- The housekeeping team manager audited the cleanliness of hospital departments on a rotational basis. We saw the most recent outpatient department cleaning audit from December 2018 which scored 96%. The house keeper explained that any score from 90 – 100% was considered very good, 80-90% was good, and a score lower than 80% would require significant improvements.
- The hospital matron was the director of infection prevention and control and there was an Infection prevention lead nurse for the hospital. The outpatient department also had an infection prevention lead nurse.
- We saw flowcharts displayed on the outpatient safety board for what to do in the event of a sharps or splash injury. The outpatient manager told us that there had been one sharps injury sustained in the last 12 months and that the correct procedure had been followed.
- The hospital participated in the patient led assessment of the care environment (PLACE) audits. See information under this sub heading in the surgery section for results of the PLACE cleanliness audit.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment generally kept people safe.** However, some substances subject to the control of substances hazardous to health (COSSH) regulations 2002 were not stored securely.
- The waiting areas for the main reception outpatient waiting areas were carpeted, and some of the chairs available were upholstered with fabric, which could not be easily cleaned should a spillage occur and could be an infection risk if bodily fluids came into contact. There was a risk assessment and standard operating procedure available to mitigate the risks of carpeted areas. However, the procedure for cleaning contaminated soft furnishings was not clear as it referred to using the carpet washer to clean the soft furnishings. Following the inspection, the provider told us that all housekeepers were aware of how to clean the soft furnishings should they need to.
- The outpatient department had three sluice rooms. These rooms were not signposted or lockable. There were lockable cupboards inside, but these were not locked at the time of our inspection. In two out of the three sluice rooms checked, we found a substance subject to COSSH unlocked. There was a COSHH risk assessment on the wall of the sluice room for the substance, but this did not define that this should be locked. We fed this back to the manager on the day who

advised they would investigate this. Later during the inspection, they advised that key pad locks would be ordered for the sluice rooms and following the inspection they confirmed these had been installed.

- The minor operations rooms had designated COSHH cupboards which carried 'hazardous' warning stickers, were labelled as to what was stored inside and locked.
- The outpatient service used naso-endoscopes which are thin flexible tubes fitted with cameras to look inside the ear, nose and throat. The nasoendoscopes were decontaminated at an external facility, so once used, were packed and collected by a courier who then replaced the dirty nasoendoscope with a clean one. If the nasoendoscopes were to be used more than once during a clinic, a three-step cleaning system was used to decontaminate these which we saw the log books for. However, the scopes did not have documented leak testing. This was not compliant with HTM 01/06 The safe decontamination of flexible scopes, part E. Following the inspection, the provider sent us adapted record sheets to enable leak testing to be documented as part of the decontamination process.
- Resuscitation trolleys containing emergency equipment to be used in the event of a patient cardiac arrest were situated throughout the hospital. There was an adult resuscitation trolley in the outpatients department. We found this to be sealed, with clearly labelled drawers for airways; breathing; circulation and medicines, alongside a list of what was in each. The attached sharps box was signed and dated in line with best practice.
- There was a daily checklist seen for January 2019 to April 2019 which was completed up to and on the day of our inspection, however, weekends and non-working days were not marked in the checklists. Following the inspection, the provider sent us updated checklists where the non-working days were clearly marked and signed which meant these were fully complete. On the adjacent wall there were lists of locations of emergency medicines not located in the trolley, local guidelines and a flowchart for transfer of patients requiring emergency or higher-level care.
- There was a paediatric resuscitation trolley adjacent to the adult resuscitation trolley in the outpatients department. This was managed by the paediatric staff. See information under this sub-heading in the children and young people's report.
- The outpatient department used lasers for certain treatments. The lasers were kept by and were the responsibility of the theatre department and brought to the outpatients department only when required in the clinic. The hospital had both an external laser protection advisor (LPA) and internal laser protection supervisors who had the correct training to be competent in this role and we saw certificates showing their competency.
- A safety audit completed by the LPA in February 2019 found the department was fully compliant in practical safety including equipment issues and environmental factors, and nearly fully compliant in administrative compliance which included record keeping associated with the lasers.
- The hospital participated in the patient led assessment of the care environment (PLACE) audits. See information under this sub heading in the surgery section for results of the PLACE environment audit.

Assessing and responding to patient risk

- **There were systems and processes to assess, monitor and manage risks to patients.**
- Acutely unwell patients would not generally visit the outpatient department. However, if a patient deteriorated whilst in the department, there were two resident medical officers (RMOs) on site at all times. Staff told us RMOs were responsive when called, dependant on urgency and need of patients on the wards.
- Outpatient staff received training to enable them to deal with life support scenarios. Senior staff nurses completed immediate life support training and basic life support training, all other staff completed basic life support training. Training compliance data showed that 97% of outpatient staff had completed basic life support training and 95% had completed immediate life support training. Outpatient staff also completed paediatric basic life support training, and training compliance data showed that 100% of staff had completed this.
- The outpatient manager told us about scenario training that was completed monthly for the staff. A recent example of training was where an emergency call was put out in the clinic room opposite the pharmacy department, and the pharmacy department were involved in the resolution of the scenario.
- Staff told us about an incident in the car park where the resuscitation trolleys could not easily be moved to the car park where the patient incident occurred. As a result of this, emergency grab bags were now stocked and available containing some emergency items that could be easily moved across the hospital site.

Good

Outpatients

Nurse staffing

- The outpatient service staff was made up of two sisters, three senior staff nurses, seven staff nurses and nine healthcare assistants. The outpatient service also had full time administrative support. Staff told us they felt that there were always enough staff available to meet the needs of patients and during our inspection we observed this to be the case.
- Bank staff were rarely used in the outpatient department and there was only one staff member on the bank for the outpatients team. The usage ranged between 1% and 4% between December 2017 and November 2018. For healthcare assistants, bank staff were used between January and February 2018 (3 and 4%) but no other months. No agency staff were used in the department.
- The outpatient shift pattern ran from 7:30am until 3:30pm, and 1:30pm until 8:30pm. This meant there was adequate time between 1:30pm and 3:30pm to ensure handover and any catch up or meetings that were required. There was a daily meeting with all the heads of departments to discuss any issues including staffing.
- There were nine physiotherapists, five bank physiotherapists to support weekend cover, and one physiotherapy assistant.

Medical staffing

- **The outpatient department had access to a range of medical staff who could provide appointments across a range of specialities. Resident medical officers were available to provide medical cover to the outpatient department should there be an emergency.**
- The hospital employed 190 doctors and dentists under practicing privileges. Four resident medical officers (RMOs) were provided by an external agency and were not directly employed by Nuffield Health, two of which always on site 24/7.
- For further information regarding medical staffing see information under this sub-heading in the surgery report.

Records

- **Staff kept detailed records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care.
- Outpatient records were paper based. At our previous inspection, there had been incidents where patient notes had been removed from the hospital by consultants which was not in line with best practice. At this inspection, staff told us that this no longer occurred in the outpatients department.
- Outpatients and physiotherapy staff received information governance training as part of their mandatory training package. We saw that 100% of staff had completed this training.
- A care record audit was completed by the outpatient service in February 2019. The aim of the audit was to assess the quality of ten patient records who had a minor operation within the department. The audit found that all records audited were satisfactory and contained evidence of risk assessments, consent forms and that all entries were legible. One action point was found in the recording of the time not being in the 24 hour clock, as per the hospital policy. An action point was set up to remind all staff of this at the following team meeting.
- We reviewed five sets of records of patients who had a minor operation or procedure in the outpatient department. We found that the care record (pathway) was completed in all sets and was dated and signed. Records of the numbers of swabs and sharps used were documented at the beginning and end of the procedure to ensure none were left in the treatment site. The operational notes were kept by the surgeons and copies were in the patient's record. However, three out of five of these had been initialled and not signed by the surgeon which was not in line with best practice.
- Physiotherapy patient notes were fully electronic, and we saw that the calendar for booking patients could be anonymised so that it did not display names for appointments, protecting patient privacy.
- The physiotherapy notes system could monitor when the clinical notes were documented on the system and what time frame it took to complete these. The system would flag if individual staff members had taken longer than target to document their notes on the system and this could be discussed as part of a personal development records (PDR) process.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and sore medicines.**

- The pharmacy service was based on site within the outpatients waiting area, and was open Monday to Friday 8am to 6pm, and on Saturday 8am to 12pm. Consultants who prescribed medicines for patients did so on a hospital prescription, and patients could take their prescription to the pharmacy department to be dispensed.
- The pharmacy department had oversight of all the medicines fridge temperatures and ambient room temperatures in the outpatients department and the rest of the hospital. We observed a real-time electronic system that displayed the minimum and maximum temperature ranges for each fridge and the current temperature. When temperatures fell outside of this range, an alarm sounded, and an email was sent to the pharmacy team detailing the error and which fridge or room this corresponded to. We saw examples of previous alarm notifications, with the most recent error reported in April 2019 which was listed as a probe failure. Staff told us the system worked well.
- Prescription pads were kept in a locked medicines cupboard until they were needed for a consultant clinic. A log book was kept which detailed how many prescription pads were signed out, what serial numbers were contained in the book, along with the date and time. At the end of the clinic the pads were signed back in again, noting the same information. We saw that the prescription log book in room 12 was appropriately completed.
- Registered nurses held the keys to the medicines cupboard which was in line with best practice.
- We checked 20 medicines in the cupboards and saw that these were all within expiry, and boxes that were close to their expiry date were pulled to the front of the cupboard and had the expiry highlighted.

For our detailed findings on medicines please see the Safe section in the surgery report

Incidents

- **There were a low number of incidents reported for the outpatient service, and those reported were of low or no harm.**
- There were no never events reported for the hospital. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Data provided to us prior to the inspection indicated that no incidents had been reported for the outpatient department. We spoke to the outpatient manager during the inspection who told us that only two incidents had been reported in the last 12 months. However following the inspection, the provider informed us that 26 incidents had been reported for the outpatients department between January 2018 and December 2018. This meant it was not clear if the outpatient manager was aware of all the incidents that had been reported in the service.
- We saw that outpatient incidents were included in the monthly clinical governance reports. In the November clinical governance report that a patient from a nearby hospital was found in the toilet in the outpatients department and required escorting back to a nearby hospital. In the October clinical governance report there were three information governance incidents where confidential waste had been placed in the general waste within a consulting room.
- Outpatient and physiotherapy staff had training in the electronic incident reporting system as part of their mandatory training package. Staff we spoke to told us they were confident in how to use the reporting system and that they had received training on it. We saw that 100% of staff had completed this training.

Are outpatients services effective?

We do not rate effective in outpatients.

Evidence-based care and treatment

- The pathology department was an evidence based United Kingdom Accreditation Service (UKAS) accredited. UKAS accreditation ensured that staff within the department were competent and that the equipment used was safe and fit for purpose.
- Current National Institute for Health and Care Excellence (NICE) guidance was a standing agenda item on the clinical governance meeting that was held monthly. This highlighted new or updated guidance that would be relevant to the departments. For example, staff in

physiotherapy described a NICE guideline that had been changed regarding lower back pain. This had significant changes compared to previous guidance including the removal of acupuncture.

- The service had a local audit programme that included a chaperone audit, waiting times and hand hygiene. The physiotherapy department completed a records audit that was based on the Chartered Society of Physiotherapy guidelines. We saw the March 2019 results for this and saw that all elements had a score of 80% and above, which was rated as 'green'.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs.**
- There were hot and cold drinks available in the outpatient waiting areas for patients. Staff also offered patients biscuits when they were waiting for long periods of time.
- For information on advice given to patients at pre-assessment such as fasting prior to a minor operation or procedure, see information under this sub-heading in the surgery section.

Pain relief

- **The outpatient department did not routinely assess or monitor patient's pain unless this was part of the specific speciality such as physiotherapy. Pain management clinics ran in the outpatient department for patients who were experiencing chronic or long term pain.**
- Following the inspection, the provider told us that pain would be assessed in outpatients where relevant, such as if a patient complained of pain or was undergoing a procedure.
- The physiotherapy department monitored pain levels as part of their consultations and we saw these documented on the electronic patient records. We spoke to patients in physiotherapy who told us that they were asked about their pain levels during their consultations.
- There was a pain management clinic that ran as part of the outpatients department.

Patient outcomes

- **Staff monitored the effectiveness of treatment.**
- Whilst the outpatient department did not specifically monitor patient outcomes, the other specialties such as surgery contributed towards Patient Reported Outcome Measures (PROMS) to assess the quality of care delivered to patients in hip and knee replacements. For further information on this please see this section under the surgery report.
- The physiotherapy service routinely monitored patient outcome measures such as range of movement, pain scores and quality of life measures in order to establish the effectiveness of treatment. The effectiveness of the outcomes could be monitored through the physiotherapy records system and we saw that between January 2018 and January 2019, 88% of patients had a good outcome registered which was better than the target set of 75%. These outcomes could be benchmarked against other Nuffield providers, and the Nuffield Guildford branch was performing better than the Nuffield average of 77% of patients recording a positive outcome.

Competent staff

- **The service made sure staff were competent for their roles.**
- Appraisal rates for nurses and healthcare assistants in the outpatient department were 100%. Appraisals and continuous professional development (CPD) were tracked on an online system and we saw examples of staff clinical and business objectives, CPD and any development they would like to undertake over the coming year.
- Outpatient staff were given an induction pack that they worked through as new members of staff. This included a range of topics not limited to: departmental structure, opening times, parking on site, wellbeing, uniform, and a four, eight and 12 week review to be completed with their line manager. We spoke to new members of staff who told us how useful this induction book was and that it contained useful extras such as how to use the telephone system which helped them during their first weeks of work.
- The outpatients manager kept an electronic 'competency tracker'. This showed an overview of various staff competencies such as in the use of a three-step cleaning process for nasoendcopes. The overview demonstrated what staff were up to date and those who were approaching needing a refresher.

- In the physiotherapy department, we saw competencies that the physiotherapy assistant was completing. This included fitting crutches and post-operative shoes. We saw examples of personal development reviews and objectives.

Multidisciplinary working

- **Whilst there were no specific multidisciplinary meetings, there was a multidisciplinary clinic that staff of different kinds worked together for to benefit the patient.**
- There were no specific multidisciplinary meetings held in the outpatients department. However, staff told us they were able to call on the expertise from other departments in the hospital if required.
- The outpatient manager explained that when a new consultant started working with the outpatient department, they arranged a brief meeting to discuss the consultants needs and to ensure both the consultant and outpatient nurses and HCAs understood expectations of each other.
- There was a bariatric clinic where dietitians, consultants and specialist nurses worked together to benefit the patient.

Seven-day services

- **The outpatient department did not provide seven-day services.**
- As the outpatient or physiotherapy departments did not provide urgent or acute services, it was not available seven days a week. The majority of clinics operated between 8am and 6pm Monday to Friday with additional clinics running on Saturday mornings.
- The pathology department was open 8am to 6pm, Monday to Friday. There was an on-call service 6pm until 8am for urgent samples that required processing. At weekends the pathology team were on call 24 hours a day for urgent samples.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.**
- We reviewed five sets of notes of patients who had a minor operation or procedure in the outpatients department. We found that all consent forms had been signed by both the consultant and the patient. However, two out of the five forms we reviewed did not have the risks of the procedure documented.
- Outpatient and physiotherapy staff had training on the Mental Capacity Act 2005 (MCA) as part of their mandatory training package. The MCA contains the law that applies to anyone who lacks the mental capacity needed to make their own decisions about their medical treatment**.** We saw that 100% of eligible staff had completed this training.

Are outpatients services caring?

Good

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

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- The hospital participated in the Friends and Family Test (FFT) and the recommendation rate for the hospital between June and November 2018 ranged between 95% and 99%.
- The outpatient department carried out a monthly patient satisfaction survey, however the response rates for these surveys was low. Between January and February 2019, the overall recommendation rate for the outpatients department was 100%, however, only 25 responses had been returned each month. This equated to a less than 2% response rate. The March survey had a 100% recommendation rate and a slight improvement in number of responses at 45 returned, however this was still a low response rate compared to the number of patients visiting the service.
- Physiotherapy patients were sent a satisfaction survey via email following their appointment. We saw that the overall recommendation rate between April 2018 and March 2019 was 90%, which was better than the target of 70%. The average response rate was 25%.
- We observed reception staff greeting patients in a friendly, open manner and patients we spoke with told us they thought the reception staff were very welcoming. Patients were offered drinks whilst waiting for their appointment.

Good

Outpatients

- There were posters displayed around the departments advising visitors to respect patient and visitor privacy and to not take photographs whilst inside the hospital. Clinic rooms had 'busy/free' signs on the doors and we observed staff knocking and waiting before entering clinic rooms. Patients told us that they felt their privacy was respected at all times during their appointment.
- However, we saw that the area for measuring height and weight was in an area adjacent to three secretary offices, which meant that privacy during measurements may not always be maintained. Following the inspection, the hospital told us they had moved the height and weight area to a new location to better protect patient privacy.
- The hospital participated in the patient led assessment of the care environment (PLACE) audits. See information under this sub heading in the surgery section for results of the PLACE privacy and dignity audit.
- Staff introduced themselves to patients and all nursing and HCA staff wore name labels on their uniform which enabled patients and visitors to easily identify which staff member was providing their care.

Emotional support

- **Staff provided emotional support to patients.**
- A chaperone audit was completed in January 2019. Five patients were sampled, and it was established that patients did not see the posters in the waiting rooms offering chaperones and this was not specified in patient appointment letters. The outcome of this was that the colour of the paper was changed to a bright green and was displayed outside each clinic room. All said they were offered a chaperone, and all accepted this.
- Green chaperone posters were seen outside all clinic rooms in OPD and in physiotherapy.

Understanding and involvement of patients and those close to them

- **Staff supported patients to understand their condition and make decisions about their care and treatment.**
- Patients told us that they felt involved in decisions about their care and that they received enough information regarding their treatment. They said they felt included in their treatment and plan of care.
- Patients told us they did not feel rushed during their appointments and that they had the opportunity to ask questions. Physiotherapy patients were given a longer initial consultation of 45 minutes to ensure they had time to ask questions following their assessment.
- Patients told us they were given an expected timescale and likelihood for their recovery; this was helpful to them as it helped them to manage expectations. Physiotherapy patients told us that they were offered exercise reminders sent to them via email, as there was a lot to remember during their appointment time. They were also told that they could reply via email if they had any questions or queries regarding the exercises given.
- We reviewed five sets of notes of patients who had a minor operation or procedure in the outpatients department. We saw that after-care advice was recorded in the patient notes.

Are outpatients services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people.**
- The majority of patients using the service were privately funded. Between August 2017 and July 2018, 19,198 private patients attended for a first appointment compared to 44 NHS funded patients.
- Clinics ran in the outpatient department between 8am and 9pm Monday to Friday, and on Saturdays until 3pm. This allowed patients who worked office hours during the week to attend at a time that suited them, and we spoke to patients who told us they were able to get appointment times that suited their needs.
- Physiotherapy patients could be seen at the hospital or at a nearby Nuffield gym depending on what suited the patient. Physiotherapy appointments were held both on the hospital site and at a nearby Nuffield gym between 8am and 8pm Monday to Friday, and on Saturday mornings at the gym site. Whilst the physiotherapy

department tried to focus post-operative recovery at the hospital site, and outpatient physiotherapy at the gym site, they could be flexible in delivering the service to meet the needs of the patient.
- There were a range of physiotherapy specialists available including hand, women's health, orthopaedic and musculoskeletal. The physiotherapy manager gave an example of how they had been adapting their clinics to meet the needs of the patients, recognising the increase in the amount of spinal surgery patients that were coming to the hospital for surgery.
- For further information, see information under this sub-heading in the surgery section.

Meeting people's individual needs

- **The service took account of patients' individual needs.** Staff made reasonable adjustments to help patients access services.
- The physiotherapy department offered longer initial appointments to patients to allow time to fully assess the patient and to allow time to ask questions. We spoke to patients who told us that they felt listened to, not rushed and able to ask questions during their consultations.
- As a result of patient experience feedback, one of the physiotherapy consulting rooms was no longer used as patients had fed back they felt it was too small.
- Staff could access an interpreting service for patients who did not speak English as a first language. We saw the telephone number and process for this displayed on the outpatients safety board.
- The main waiting area in the outpatients department had a hot and cold drinks machine, television and a range of newspapers, magazine and information leaflets to read. There was also an area for children who were waiting containing toys and activities to help whilst they were waiting for their appointment.
- There was an internet username and password that patients could use whilst they were waiting in the hospital.
- We spoke to staff about dealing with patients who may have additional physical or mental health needs, staff told us that they were mindful to treat everyone as an individual and work with carers. A health care assistant was leading on putting together a 'hidden disability' awareness folder to assist staff with disabilities that may not be obvious. Staff are informed of additional needs on the clinic lists. If patients are sensitive to light, such as those waiting for the eye clinic, the dementia waiting room is lowly lit which can assist such patients. HCA is putting together a sensory box – funds being approved, spoken with charity – providing with leaflets.
- There was a separate waiting room in the outpatients department that had been set up specifically for dementia patients. This had several dementia friendly features such as brightly coloured toilet seats and grab rails in the toilet to help dementia patients easily see them. There were also dementia friendly signs on the toilets that were large and had coloured pictures of a toilet on them, to help patients recognise what was in the room. This waiting room could also be used for patients who needed a quiet area to wait or those that found busy environments distressing, or for patients who found bright areas uncomfortable, for example if they were coming to the eye clinic, as the room contained no natural daylight.
- At the time of our inspection, 78 members of staff had completed training to increase their awareness of dementia and how it could affect both patients and their relatives and carers. There were dementia resource folders available in the waiting room that contained information and leaflets about the disease and some practical advice and tips for carers.
- There was disabled parking and access on the hospital site. Wheelchairs were available at entrance of the hospital for those patients who had limited mobility.
- Bariatric clinics were held every other week. However only one bariatric chair was seen near the height and weight area, no other bariatric chairs were available in the main clinic waiting areas. Couches in the clinic rooms had a weight limit that ranged between 158kg and 222kg which allowed bariatric patients to safely use them. Following the inspection, the provider told us that there was a second bariatric chair available at all times and they had since purchased a third to ensure availability at all times.

Access and flow

- **People could access the service when they needed it and received the right care promptly.**
- The majority of activity at the hospital (79%) was within the outpatients department. The majority of patients seen in the outpatient department were aged 18 and over.

Good

Outpatients

- Physiotherapy patients could be referred by GPs or could self-refer. Referrals could also come from surgeons at the hospital, for example those having hand surgery could be referred to the hand physiotherapy as part of their follow up and rehabilitation.
- The outpatient service completed waiting times audits. The February 2019 results were that 83% of patients were seen within 0-15 minutes of being checked in, 16% were seen within 15 – 30 minutes and 1% were waiting between 30 and 60 minutes. Staff told us if there were delays in clinic they informed patients when checking in and endeavoured to keep them informed whilst waiting. If staff were aware of a long delay, for example if a consultant theatre list overran, secretaries would try to ring ahead to warn patients. Patients we spoke with on our inspection told us they were seen quickly.
- Staff told us that when patients did not attend for their appointment, they would inform the named consultant and their medical secretary who would then contact the patient. However, there was no hospital policy for this, which meant there may not be a robust process for ensuring patients who did not attend were followed up or discharged appropriately.
- Appointment cancellations made by the hospital were rare and the service told us that only one cancellation had been made during the last 12 months. This had been due to a mis-communication with the consultant, however this was not reported as an incident on the data that we were provided with.
- The Nuffield patient information leaflet promised patients assessment within 48 hours and treatment within two weeks. Patients we spoke with told us they were offered appointments quickly and these were flexible to meet the needs of the patient.
- Due to the rapid access for appointments, the outpatient manager did not have the ability to plan rotas or clinics more than one to two weeks in advance. Most appointments were booked through the consultant secretaries and the secretaries would then update the outpatient administrative staff who booked the clinics.
- The service did not monitor the turnaround time of letters sent to patient's GPs following their outpatient appointment. Staff told us that clinic letters to GPs varied in time depending on the consultant. Some were turned around in one day, others could take up to two weeks.
- The pathology department could process bloods, urine, microbiology and fluid samples on site. The deputy manager told us that samples were generally processed the same day unless they arrived after 5pm.

Learning from complaints and concerns

- **People could give feedback and raise concerns about care received.** The service treated concerns and complaints seriously and investigated them.
- Between December 2017 and November 2018 there were eight complaints to the hospital, none of which were related to the outpatients department. Staff told us that most complaints were concerns that were dealt with verbally if raised at the time and this prevented them escalating to formal complaints.
- The Hospital Director held overall responsibility for complaints, however the matron led on any complaints where there were concerns about clinical aspects of patient care. The complaints policy stated that all complaints should be acknowledged within two days and responded to within 20 working days. No complaints were referred to the ombudsman or Independent Healthcare Sector Complaints Adjudication Service in the last 12 months.
- We saw comments and formal complaints leaflets and information on how to complain available in the waiting room areas.

Are outpatients services well-led?

Good

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

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality, sustainable care.**
- There were clear lines of leadership and accountability. The outpatients manager had been in post for a year and worked full time over four days. They reported to the hospital matron who reported to the hospital director. The outpatient manager managed the sisters and senior staff nurses, and the senior staff nurses managed the staff nurses and healthcare assistants.

- The physiotherapy manager had been in post for four years and reported to the matron as a direct line manager but had support from regional physiotherapy leads for clinical supervision.
- The outpatient and physiotherapy department managers attended monthly leadership team meetings. These meetings discussed high-level issues such as human resources, finance and the performance of the business. It also gave the opportunity for each department manager to give an update on their department and any issues.
- Staff spoke highly of the management in the outpatient and physiotherapy department and described them as supportive and having an open-door policy. Staff we spoke with gave examples of when they had been supported by the management for long term health conditions and managing returns to work.

Vision and strategy

- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action.
- The overarching Nuffield strategy was to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner".
- Whilst there were no additional visions or strategy for the outpatients or physiotherapy departments, we spoke to managers who described growing and improving their services.
- The outpatient manager described that since being in post they had tried to ensure outpatient staff were more outpatient focussed, rather than being an additional service. Staff we spoke with confirmed that they felt the focus in their department had changed and was more focussed on them working in their own department.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff told us they felt supported as individuals in their roles but also as part of the wider hospital team. Examples of this included support being offered to staff from other departments, and staff from different roles working together to achieve their outcomes.
- Healthcare assistants reported being well supported by nursing colleagues, and housekeeping staff spoke of being supported by administrative staff and other colleagues. Staff described the culture being an improvement from previous roles they had worked in and feeling happy to be part of the hospital.
- The outpatient manager had introduced a "wellbeing" basket in the outpatient office. This contained personal hygiene items for staff to use such as spare hairbands, deodorants and sanitary items.
- Staff told us that they had access to a counselling service, and that this was a useful benefit of working at the hospital.

Governance

- **Leaders ensured there were structures, processes and systems of accountability for the performance of the service.**
- Monthly reports were produced for the clinical governance group meeting. These included data on incident trends and themes, number of complaints, patient experience results, new or updated hospital policies and NICE guidance. The managers of the outpatients, physiotherapy and pathology department all attended these meetings. An annual governance report was produced which detailed the data over the previous year.
- Data provided to us prior to the inspection indicated that no incidents had been reported for the outpatient department. We spoke to the outpatient manager during the inspection who told us that only two incidents had been reported in the last 12 months. However, following the inspection, the provider informed us that 26 incidents had been reported for the outpatients department between January 2018 and December 2018. This meant it was not clear if the outpatient manager was aware of all the incidents that had been reported in the service.
- Incidents were a standing agenda item on the outpatient team meeting minutes, but none were reported or discussed in the January and February team meeting minutes. In the March team meeting, two incidents were discussed where a nasoendocope was used before it was wiped, and one where clinical waste was disposed of incorrectly.
- For our main detailed findings of managing risks, issues and performance please see the well-led section in the surgery report.

Managing risks, issues and performance

Good

Outpatients

- **The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- There was a hospital risk register. There were no risks specific to the outpatient or physiotherapy service on the risk register. However, there were three risk assessments that the outpatient manager highlighted to us, which were the location of a treadmill in one of the consulting rooms, the lack of a nasoendoscope washer, and one of the waiting areas being very dark and without any natural light. We reviewed the risk assessments and saw that the hazards and control measures were completed for each of these.
- For our main detailed findings of managing risks, issues and performance please see well-led section in the surgery report.

Managing information

- **The service collected information and analysed it to understand performance and to enable staff to make decisions and improvements.** The information systems were integrated and secure.
- Physiotherapy notes were fully electronic, and staff could analyse the information inputted on the system to monitor patient outcomes and staff performance.
- Outpatient notes were paper based and stored securely either on site, or at an archive site in a different location. The system for preparing notes for clinic was time consuming but staff advised that they were due to move to electronic notes in the future.
- At our previous inspection, consultants took patient notes off site, which was not secure or in line with the hospital policy. At this inspection, we were assured that this practice had stopped.
- For our main detailed findings of managing information please see well-led section in the surgery report.

Engagement

The service engaged well with patients and staff.

- The hospital participated in audits such as the Friends and Family test and Patient Led Assessments of the Care Environment. The outpatient department also ran a patient feedback survey but the response rates for this were low at the time of our inspection at around 1% response rate. The physiotherapy department sent out feedback forms via email to patients which resulted in an average of 25% response rates.
- The outpatient team met once a month for team meetings and also ad-hoc when needed. The monthly team meeting was held in two shifts to ensure that all staff were able to attend. We saw minutes from these meetings that had a standard agenda and staff had the opportunities at the end of these meetings to raise concerns, issues or updates.
- Department managers could attend manager meetings with managers from other branches. For example, the outpatient manager had attended a Nuffield outpatient manager meeting There was a group email for all outpatient managers at the meeting which encouraged joint working across the provider.

Learning, continuous improvement and innovation

- **All staff were committed to continually improving services. Leaders encouraged innovation.**
- The outpatient manager told us that they wanted to start a clinical educational half day, similar to those held in NHS organisations. This was in the planning stage, but they were hopeful that this could be rolled out in the future.
- The outpatient survey had a poor response rate with around 1% responses received from patients. The outpatient manager had secured pre-paid envelopes that the patients could take with them and post to the service to help encourage feedback.
- The service was due to move their outpatient records to an electronic system in the future. This was a system that was rolling out across the Nuffield group and staff told us they felt it was a good thing to wait for any issues to be 'ironed out' before it was rolled out in this hospital.

Outstanding practice and areas for improvement

Outstanding practice

- Oncology patients could be referred to a personal trainer at the Nuffield Health gym as part of the hospital's 'Recovery Plus' initiative. This was a personalised training programme which was part of the patient's care planning.
- The implementation of scenario training on a regular monthly basis appropriate to each department was welcomed by staff and seen as a means of learning and developing and auditing clinical practice. On at least one occasion the staff had put their scenario training into practice in a critical situation and the learning was shared nationally across the Nuffield hospitals.
- Information for children and young persons was clearly displayed on the ward in books, information leaflets, on boards and addressed general wellbeing as well as specific hospital admission information. The information was current and in line with best practice.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should check staff use a consistent system when recording patients' early warning scores and follow the hospital's escalation of the deteriorating patient procedures promptly.
- The provider should check all patient room flooring is intact and seamless between floors and walls to prevent dirt and dust which makes cleaning difficult.
- Incident investigation should take into account human factors and consider any changes to practice and report how duty of candour was exercised.
- The provider should have arrangements so all patient records include consultant notes.
- The service should make arrangements so incidents that occur in the outpatient department are appropriately documented and recorded and all staff are aware of this.
- The provider should securely store substances subject to COSHH in the outpatient department in line with regulations and risk assessments should accurately detail their storage methods.
- The provider should ensure nasoendoscopes leak tests are documented in line with best practice.
- The provider should clearly document on the outpatients department checklists for cleaning any non-working days.
- The provider should detail a complaints escalation procedure, including independent review in complaint response letters.