# Nuffield Health Chichester Hospital

## Quality Report

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

## Ratings

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

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

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

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

# Summary of findings

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

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection of Nuffield Health Chichester Hospital on the 12 and 13 July 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical services and out-patient and diagnostic services as these incorporated the activity undertaken by the provider, Nuffield Health, at this location. Catering and some imaging (MRI and CT scanning) services at this location were provided by a third party on a contract basis to the location, and were not inspected, although the interface and impact on patient care through the provision of these services was.

We rated both core services and judged that the hospital was 'good' overall.

**Are services safe at this hospital?**

The arrangements and systems that ensured patient safety before their operation were being used inconsistently. The use of the World Health Organisation Five Steps to Safer Surgery checklists and pre-operative checking were not always used in accordance with the provider's own policies and national guidance. There were no recorded incidents where patients had suffered harm as a result of this but there was an associated risk of harm occurring.

The hand washing facilities in patient bedrooms were not compliant with national guidance which increased the risk of cross infection between patients as staff went from room to room.

Systems for managing medicines, including controlled drugs, in the operating theatres were not robust enough and had failed to identify mistakes.

There were well developed systems for the reporting and investigation of safety incidents. Staff felt supported to report incidents and near misses which were then investigated thoroughly. We saw examples of where lessons learned were shared across the organisation. Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.

There were robust arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and saw that staff used these processes when patients' conditions required this. The hospital was very clear about the limitations of care it could provide, the procedures it would allow to take place and the exclusion criteria for admission.

The management of patients whose condition was deteriorating was a particular strength. We found suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues. There were sufficient numbers of nursing and support staff to meet patients' needs. There were appropriate safeguarding arrangements in place for adults and children.

**Are services effective at this hospital?**

We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice.

There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance groups at the hospital.

Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes and the hospital participated in relevant national audits although the size of the service meant that feedback from national audit programmes was limited.

There were no concerns regarding rates of unplanned admission, return to theatre or transfer to another hospital. We found arrangements that ensured that doctors and nurses were compliant with the revalidation requirements of their professional bodies.

# Summary of findings

All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided.

Systems for obtaining consent were compliant with legislation and national guidance, including the Mental Capacity Act (2005) and these were adhered to by staff.

**Are services caring at this hospital?**

We observed that patients were generally treated with dignity and respect and their privacy was maintained. We did identify that the dignity of patients in the operating theatre could have been considered more by staff and that appropriate covering should have been used when patients were exposed for an extended length of time.

Patients who share their views were very positive about the care that they received and spoke of kind and welcoming staff.

We saw that results of the friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.

**Are services responsive at this hospital?**

Services were planned to meet the needs of patients. We saw that some outpatient services operated in the evenings and at weekends to give patients flexible access to these services.

The environment allowed for patients with physical disabilities to be safely cared for. The hospital was exceeding national referral to treatment time standards.

Patients were assessed prior to admission to ensure that the hospital could safely meet their needs. Care was individualised and met the personal preferences and needs of the patients.

There was a robust complaints procedure which was well publicised and understood by staff. Complaints were investigated, actions taken to resolve issues and there was learning evident from the content of complaints.

**Are services well led at this hospital?**

We found that staff were conversant with the corporate vision and values and strove to demonstrate these in their daily work. There was an appropriate system of governance and managers knew the key risks and challenges to the hospital and were taking steps to mitigate the impact of these.

Practising privileges were received, authorised and granted in conjunction with the MAC and kept under review. There was effective governance and oversight of the consultants' performance and behaviours through the MAC and by close working with the local NHS trust, where many of them worked.

There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams. We saw examples of initiatives that were introduced to improve the patient experience and to ensure the safety and quality of care kept pace with new developments and growing expectations.

We also saw that the provider and local executive team became aware when they could not provide a service that complied with the required guidance that they made a full assessment and clearly planned decision to stop the service.

Senior managers were visible and had a thorough understanding of how services were provided at the hospital. They were open and honest about what they did well and where they knew there were areas for improvement. The executive team knew and understood their main market very well and ensured that services were developed to meet the needs of the local community.

# Summary of findings

The method for tracking medical records was reliable and we saw innovative practice concerning sharing physiotherapy treatment notes between the hospital and the Nuffield Health Fitness & Wellbeing Centre in Chichester as part of an integrated outpatient physiotherapy and rehabilitation service. The Health and Fitness centre does not provide regulated activities but is within the Nuffield Healthcare group and was used to extend access to physiotherapy services to improve patient outcomes.

Our key findings were as follows:

- There were adequate systems to keep people safe and to learn from critical incidents. Staff had a good understanding of the need to report incidents and were supported to do so. There was evidence of organisational learning following investigation of incidents.
- The adult and child safeguarding arrangements were sound and followed the current national guidance.
- The hospital environment was visibly clean and well maintained and there were measures to prevent the spread of infection. However, infection prevention and control processes were not followed consistently in the operating theatres.
- There were systems to ensure the safe storage, use and administration of medicines. These were followed properly on the wards and in the outpatient department but we identified some shortcomings in medicine management in the operating theatre.
- There were adequate numbers of suitably qualified, skilled and experienced staff (including doctors and nurses) to meet patients' need. There were arrangements to ensure staff had and maintained the skills required to do their jobs.
- There were arrangements to ensure people received adequate food and drink that met their needs and preferences.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked against other similar hospitals.
- Robust arrangements for obtaining consent ensured legal requirements and national guidance were met.
- The hospital was managed by a team who had the confidence of patients and their teams. Staff felt motivated by the management team.
- There was appropriate management of quality and governance at a local level and managers were aware of the risks and challenges they needed to address.

There were also areas of where the provider needs to make improvements.

- Ensure infection control policies and standard operating procedures are adhered to within theatres.
- Ensure adequate availability of staff hand washing facilities in line with the Department of Health's Health Building Note 00-09. Ensure the sinks in patient rooms are compliant with the Department of Health's Health Building Note 00-09: Infection control in the built environment.
- Ensure compliance of record keeping in theatres relating to Misuse of Drugs Regulations 2001 and Safer Management of Controlled Drugs: a guide to good practice in secondary care (England.)
- Standardise and improve compliance with the WHO checklist.
- Ensure that there is proper assurance of the safety, calibration, security and servicing of any privately owned clinical equipment brought into the hospital.

# Summary of findings

- Ensure that patients' dignity is protected at all times whilst they are in theatres and minimise the period that patients are exposed for prior to the procedure.

The provider should also

- Repair damage to walls within patient rooms on Northgate ward.
- Review the WHO checklist used in endoscopy.
- Improve mandatory training compliance specifically aseptic technique in theatres and Infection control and prevention.
- Ensure a robust checking process for emergency equipment on Northgate ward.
- Undertake an audit of completion of theatre documentation and take appropriate action.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

## Overall summary

Overall, we rated surgical services at Nuffield Health Hospital Chichester as good. This was because:

- The hospital had a good track record on safety. The hospital had one serious injury, no patient deaths or never events between April 2015 and March 2016.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- The hospital had effective systems to assess and respond to patient risk. This included a comprehensive use of the modified early warning system (MEWS) track and trigger flow charts to identify deteriorating patients and respond appropriately.
- The hospital participated in relevant local and national audits and contributed to national data to monitor performance such as the National Joint Registry (NJR).
- We found there were arrangements to ensure that staff were competent and confident to look after patients. Mechanisms were in place to support staff and promote their positive wellbeing. Staff were supported to maintain and further develop their professional skills and experience, and were passionate about working at the hospital.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly and adequately.
- Staff encouraged patients and their relatives or supporters to be partners in their care. Patients told us staff had time to answer questions and that they made sue that they had been understood.
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.
- Waiting times, delays and cancellations were minimal and the service managed these appropriately.
- The leadership team was knowledgeable about quality issues and priorities, and understood what the challenges were and took action to address them.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The endoscopy suite was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is a quality improvement and assessment tool for the GI endoscopy service.
- The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines

However;

# Summary of findings

- We saw examples of poor compliance with infection control policies within theatres. Infection control procedures were not given sufficient priority at all times. There was concern that theatre staff did not understand the risks associated with these issues.
- We saw poor completion of the World Health Organisation (WHO) Surgical Safety checklist in theatres.
- We saw instances where theatre practice was below expected levels.
- Relatives were used to interpret for patients during the consent process rather than an official interpreter.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Surgery** | Good | Overall, we rated surgical services at Nuffield Health Hospital Chichester as good. This was because:<br>• The hospital had a good track record on safety. The hospital had one serious injury, no patient deaths or never events between April 2015 and March 2016.<br>• Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The hospital fully investigated incidents and shared learning from them to help prevent recurrences.<br>• The hospital had effective systems to assess and respond to patient risk. This included a comprehensive use of the modified early warning system (MEWS)track and trigger flow charts to identify deteriorating patients and respond appropriately.<br>• Consultants and the Resident Medical Officer (RMO) provided 24 hour medical cover to respond to any clinical issues.<br>• The hospital participated in relevant local and national audits and contributed to national data to<br>• We found there were arrangements to ensure that staff were competent and confident to look after patients. Mechanisms were in place to support and promote positive wellbeing amongst staff who were supported to maintain and further develop their professional skills and experience, and were passionate about working at the hospital.<br>• Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly and adequately.<br>• Nursing and medical staff were caring, compassionate and patient centred in their approach. We observed ward staff maintained patients respect and dignity at all times. |

# Summary of findings

- It was easy for people to complain or raise a concern and they were treated compassionately when they did so. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.
- Waiting times, delays and cancellations were minimal and the service managed these appropriately.
- We saw that staff wanted to learn, develop and improve their skills; they were given protected time, resources and encouragement to do so.
- The leadership team was knowledgeable about quality issues and priorities, and understood what the challenges were and took action to address them.
- The endoscopy suite was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is quality improvement and assessment tool for the GI endoscopy service. Endoscopic services also demonstrated compliance with British Society of Gastroenterology (BSG) guidelines.
- The method for tracking medical records was reliable and we saw innovative practice concerning sharing physiotherapy treatment notes between the hospital and the Nuffield Health Fitness & Wellbeing Centre in Chichester as part of an integrated outpatient physiotherapy and rehabilitation service. The Health and Fitness centre does not provide regulated activities but is within the Nuffield Healthcare group and was used to extend access to physiotherapy services to improve patient outcomes.

However;

- We observed some systems and procedures in theatre that were not best practice for example adherence to infection control policies and the use of the World Health Organisation (WHO) checklists.
- We saw examples of poor compliance with infection control policies within theatres.

# Summary of findings

Infection control procedures were not given sufficient priority at all times. There was concern that theatre staff did not understand the risks associated these issues.
- Staff hand washing facilities on the wards and pre assessment fell below recommended standards.
- Staff did not comply with local infection control and prevention policies.
- We saw poor completion of the 'Five steps to safer surgery' (WHO) checklist in theatres.
- There was not a robust system in place for checking that emergency equipment was available on Northgate ward.
- Relatives were used to interpret for patients on wards and during the consent process rather than an official interpreter.

## Outpatients and diagnostic imaging

Good 

We rated the outpatients and diagnostic imaging services provided at Nuffield Health Hospital Chichester as good, because:

- There was a focus on patient safety within outpatient services. Medicines were stored safely and checks on emergency resuscitation equipment were performed routinely. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training specific for their roles. Staff had appropriate safeguarding awareness and people were protected from abuse
- People's privacy was always protected in outpatient and diagnostic areas. Staff knocked on doors before entering rooms, used curtains appropriately and were careful to avoid conversations in corridors.
- Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect.

# Summary of findings

- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- The leadership, governance and culture within the departments promoted the delivery of person centred care. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.
- The method for tracking medical records was reliable and we saw innovative practice concerning sharing physiotherapy treatment notes between the hospital and the Nuffield Health Fitness & Wellbeing Centre, in Chichester as part of an integrated outpatient physiotherapy and rehabilitation service.

# Summary of findings

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Good

# Nuffield Health Chichester Hospital

**Services we looked at:**
Surgery and Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to Nuffield Health Chichester Hospital

Nuffield Health Hospital Chichester is an independent hospital which is part of Nuffield Health. a not for profit organisation. The hospital has 6 consulting rooms, 19 in-patient and 11 day-case beds and two laminar flow theatres. There is also an endoscopy suite and a dedicated gynaecology suite. It is situated in Chichester, West Sussex in a residential area which does not have any appreciable levels of social depravation.

The registered manager was Matthew Dronsfield who was also the hospital director. The provider's nominated individual for this service was Andrew Watkins Jones.

## Our inspection team

Our inspection team was led by:

**Inspection Lead:** Terri Salt, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including:

- A radiographer
- A theatre manager
- A governance manager
- Senior nurses

## Why we carried out this inspection

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. We inspected two core services at the hospital which incorporated all the activity undertaken. These were Surgical services and Outpatient and Diagnostic Services.

## How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group. We placed comment boxes at the hospital prior to our inspection which enabled staff and patients to provide us with their views. We received 34 comments from patients and 17 from staff.

We carried out an announced inspection on the 12 and 13 July 2016.

We interviewed the management team and chair of the Medical Advisory Committee. We spoke with a wide range of staff including nurses, the resident medical officer, radiographers, consultants, and administrative and support staff.

We also spoke with 29 patients who were using the hospital.

We observed care in the outpatient and imaging departments, in operating theatres and on the wards and reviewed patient records. We visited all the clinical areas at the hospital.

# Summary of this inspection

## Information about Nuffield Health Chichester Hospital

There were 4,618 inpatient and day case episodes of care recorded at Nuffield Health Chichester Hospital in the reporting period (Apr15 to Mar 16); of these 38% were NHS funded and 62% other funded. Twenty percent of all NHS funded patients and 21% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 12,604 outpatient total attendances in the reporting period (Apr 15 to Mar 16); of these 17% were NHS funded and 83% were other funded.

The hospital has 112 doctors and dentists with practicing privileges. Thirty percent of these did not provide care to any patients in the year preceding the inspection. Forty percent of consultants had 100 or more care episodes.

## What people who use the service say

People who used the service were very positive about the care and treatment that they received. They spoke of compassionate and attentive staff who provided all the assistance and support that patients needed throughout their stay.

# 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?

Requires improvement

We found there were suitable arrangements to keep people safe. This included systems for the reporting and investigation of safety incidents. Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation. There were robust arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and saw that staff used these processes when patients' conditions required this. The management of patients whose condition was deteriorating was a particular strength. We found suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues. There were sufficient numbers of nursing and support staff to meet patients' needs. There were appropriate safeguarding arrangements in place for adults and children.

### Are services effective?

Good

We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice. There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance groups at the hospital. Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes and the hospital participated in relevant national audits although the size of the service meant that feedback from national audit programmes was limited. There were no concerns regarding rates of unplanned admission, return to theatre or transfer to another hospital. We found arrangements that ensured that doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided. Systems for obtaining consent were compliant with legislation and national guidance, including the Mental Capacity Act (2005) and these were adhered to by staff.

### Are services caring?

Good

We observed that patients were generally treated with dignity and respect and their privacy was maintained. Patients who shared their views were very positive about the care that they received and spoke of kind and welcoming staff. We saw that results of the friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to

others. We did identify that the dignity and privacy of patients being prepared for operations in the operating theatres could have been considered more by staff and that appropriate covering should have been used.

## Are services responsive?

Good

Services were planned to meet the needs of patients. We saw that some outpatient services operated in the evenings and at weekends to give patients flexible access to these services. The environment allowed for patients with physical disabilities to be safely cared for. The hospital was exceeding national referral to treatment time standards. Patients were assessed prior to admission to ensure that the hospital could safely meet their needs. There was a robust complaints procedure which was well publicised and understood by staff. Complaints were investigated, actions taken to resolve issues and there was learning evident from the content of complaints.

## Are services well-led?

Good

We found that staff were conversant with the corporate vision and values and strove to demonstrate these in their daily work. There was an appropriate system of governance and managers knew the key risks and challenges to the hospital and were taking steps to mitigate the impact of these. However, the management team had limited awareness of the Workforce Race Equality Standard (WRES) which the provider is required to publish information about by July 2017. Practising privileges were received, authorised and granted in conjunction with the MAC and kept under review. There was effective governance and oversight of the consultants performance and behaviours through the MAC and by close working with the local NHS trust, where many of them worked.

There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams. We saw examples of initiatives that were introduced to improve the patient experience and to ensure the safety and quality of care kept pace with new developments and growing expectations. We also saw that the provider and local executive team were aware when they could not provide a service that complied with the required guidance that they made a full assessment and a clearly planned decision to stop the service.

Senior managers were visible and had a thorough understanding of how services were provided at the hospital. They were open and honest about what they did well and where they knew there were areas for improvement. The executive team knew and understood their main market very well and ensured that services were developed to meet the needs of the local community.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had completed training in the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They were able to articulate the basic requirements of the legislation and understood that the Act was decision specific. Staff were clear they would seek advice if they had any concerns about a person's capacity to consent at any point.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Surgery | Requires improvement | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | N/A | Good | Good | Good | Good |
| Overall | Requires improvement | Good | Good | Good | Good | Good |

### Notes

Good

# Surgery

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

## Information about the service

Surgery is the main inpatient activity within Nuffield Health Hospital Chichester. Surgical services cover a range of specialties including orthopaedics, urology, cosmetics and general surgery. The hospital only treats adults aged 18 years and over and does not provide services for children. The endoscopy department was inspected by the surgical inspection team.

Between April 2015 and March 2016, there were 4,618 procedures undertaken. The most common procedure performed was phacoemulsification of cataract with lens implant (an ultrasonic device is use to break up and remove cataract, from the eye to improve vision and insertion of an intraocular lens.) Phacoemulsification of cataract with lens implant accounted for 627, or 13.5% of procedures. Diagnostic endoscopic examination of bladder was the second most common procedure and accounted for 370, or 8% of, procedures. The hospital also undertook a high number of orthopaedic surgeries accounting for 531 procedures.

The NHS funded 1,755, or 38% of procedures, out of 4,618 procedures.

The theatre department has two operating theatres, four recovery bays and one anaesthetic room.

Both theatres have laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). Theatre one has a separate anaesthetic room and is predominantly used for elective orthopaedic surgery, gynaecology surgery, urology surgery and general surgery. Theatre two has a separate preparation room but no anaesthetic room. It is utilised for orthopaedic surgery, gynaecology surgery, urology surgery, general surgery, plastic surgery, colorectal surgery, ophthalmology (eye) surgery, and pain procedures. In addition, it is available for emergency return to theatre situations over-night and at weekends.

The endoscopy suite comprises of a procedure room, a scope washer room with clean and dirty processing areas and a scope storage area .The suite is used for elective endoscopic procedures between Monday and Friday. Urological and general procedures are undertaken, for example examination of the bladder or stomach.

Both inpatient and day case patients recover from surgery on Pallant ward and patients who have not undergone a general anaesthetic were admitted and discharged from Northgate ward. Both wards have single bedrooms, and all patient bedrooms have ensuite bathroom facilities.

The inspection included a review of all the areas where surgical patients receive care and treatment. We visited the pre-assessment clinic, the surgical ward, anaesthetic rooms, theatres and recovery area.

During our inspection, we spoke with 22 members of staff including doctors, nurses, allied health professionals, administrative staff and the leadership team. We spoke with eight patients and two patient relatives. We also received 23 patient comment cards and nine staff comment cards. We reviewed 20 sets of patient records. Before, during and after our inspection we reviewed the hospital's performance and quality information including meeting minutes, policies and performance data.

Good

# Surgery

## Summary of findings

Overall, we rated surgical services at Nuffield Health Hospital Chichester as good. This was because:

- The hospital had a good track record on safety. The hospital had one serious injury, no patient deaths or never events between April 2015 and March 2016.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. The hospital fully investigated incidents and shared learning from them to help prevent recurrences.
- The hospital had effective systems to assess and respond to patient risk. This included a comprehensive use of the modified early warning system (MEWS) track and trigger flow charts to identify deteriorating patients and respond appropriately.
- Consultants and the Resident Medical Officer (RMO) provided 24 hour medical cover to respond to any clinical issues.
- The hospital participated in relevant local and national audits and contributed to national data to drive improvements in patient care at local level and throughout the wider healthcare system.
- We found there were arrangements to ensure that staff were competent and confident to look after patients. Mechanisms were in place to support and promote positive wellbeing amongst staffwho were supported to maintain and further develop their professional skills and experience, and were passionate about working at the hospital.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients' safe at all times. Any staff shortages were responded to quickly and adequately.
- Nursing and medical staff were caring, compassionate and patient centred in their approach. We observed ward staff maintained patients respect and dignity at all times.
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so. We saw evidence the service learnt from complaints and made improvements to working practices where appropriate.
- Waiting times, delays and cancellations were minimal and the service managed these appropriately.
- We saw that staff wanted to learn, develop and improve their skills; they were given protected time, resources and encouragement to do so.
- The leadership team was knowledgeable about quality issues and priorities, and understood what the challenges were and took action to address them.
- The endoscopy suite was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is quality improvement and assessment tool for the GI endoscopy service. Endoscopic services also demonstrated compliance with British Society of Gastroenterology (BSG) guidelines.
- The method for tracking medical records was reliable and we saw innovative practice concerning sharing physiotherapy treatment notes between the hospital and the Nuffield Health Fitness & Wellbeing Centre in Chichester as part of an integrated outpatient physiotherapy and rehabilitation service. The Health and Fitness centre does not provide regulated activities but is within the Nuffield Healthcare group and was used to extend access to physiotherapy services to improve patient outcomes.

However;

- We observed some systems and procedures in theatre that were not best practice for example adherence to infection control policies and the use of the World Health Organisation (WHO) checklists.

Good

# Surgery

- We saw examples of poor compliance with infection control policies within theatres. Infection control procedures were not given sufficient priority at all times. There was concern that theatre staff did not understand the risks associated these issues.
- Staff hand washing facilities on the wards and pre assessment fell below recommended standards.
- Staff did not comply with local infection control and prevention policies.
- We saw poor completion of the 'Five steps to safer surgery' (WHO) checklist in theatres.
- There was a higher rate of surgical site infections (SSI's) in breast and hip surgery compared to other NHS hospitals.
- There was not a robust system in place for checking that emergency equipment was available on Northgate ward.
- Relatives were used to interpret for patients on wards and during the consent process rather than an official interpreter.

## Are surgery services safe?

Requires improvement

**We rated safe as requires improvement because:**

- Systems, processes and standard operating procedures were not always reliable and their use was not fully embedded. We also observed poor practice in theatres, in relation to adherence with the World Health Organisation five steps to safer surgery checklist.
- Patients were at an increased of suffering harm because of poor theatre infection prevention and control practices. There was concern that theatre staff did not understand the risks associated with poor practice as they failed to challenge staff not following the correct procedures.
- There were no dedicated hand hygiene sinks in patient bedrooms. The taps on the ensuite bathroom sinks on the wards were not lever or sensor-operated and staff needed to twist them on and off with their hands. We saw the two bathrooms in the pre-assessment rooms were also being used as storage areas, making it difficult for staff to access the sinks.
- We examined two controlled drug registers within theatres and saw block signing of controlled drugs by anaesthetists and the absence of two signatures.
- Openness and transparency about safety was encouraged. When something went wrong, there was an appropriate thorough review or investigation which involved relevant staff and people who used services. Lessons were learnt and communicated widely to ensure improvement in other areas in addition to the services that were directly affected.
- The identification and management of patients at risk of unexpected deterioration was a real strength of the service. Every MEWS chart we looked at over a period of six months was fully completed and scored. There was evidence in patient's medical records that escalation processes had been followed and that there was a timely review of the patient by senior medical staff. Where necessary patients were transferred to a local NHS acute hospital for review.

- Safety issues such as slips, trips and falls were monitored throughout the service and opportunities to learn from external safety events were identified. The hospital gave safeguarding sufficient priority because staff received safeguarding training to an appropriate level although the safeguarding training was below the hospitals target, staff knew how to escalate safeguarding concerns.

**Incidents**

- The hospital did not report any never events between April 2015 - March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The hospital did not report any deaths in April 2015 - March 2016.
- Reviewing incidents was a standard agenda item on the quality and safety committee and health and safety committee meetings; we saw evidence of this in the meeting minutes. This ensured that themes from incidents were highlighted and new incidents discussed.
- There were 210 clinical incidents that occurred in surgery or inpatients between April 2015 - March 2016. For the same period the assessed rates of clinical incidents were not high when benchmarked against other independent acute providers and was within the expected limit when compared to other Nuffield Health Hospitals.
- Of the 210 incidents 74.9% resulted in no harm to the patient, 21.9% resulted in low harm, 1.9% resulted in moderate harm and 0.5% (1) resulted in severe harm.
- There was one serious injury reported between April 2015 - March 2016. This involved a patient who underwent a knee replacement and subsequently developed a serious infection. A full root cause analysis (RCA) was undertaken and that because the patient had been admitted to two different acute NHS hospitals following discharge it was not possible to determine where the infection was contracted. We reviewed the RCA and saw it was a complete and thorough investigation which informed the patient of their findings and identified lessons learnt.
- Between April 2015 – March 2016 there was 80 non-clinical incidents, 74% occurred in surgery or inpatients and 26% in other services.
- The hospital used an online software system for reporting incidents, which fully linked complaints, incidents and risk reporting. All the staff we spoke to stated that they were encouraged to report all incidents, however minor.
- Heads of departments investigated incidents with oversight by the Quality and Safety Committee. Staff told us that the relevant manager fed back to the team with learning from incidents at monthly team meetings. At the team meetings one incident that had occurred was discussed and lessons learnt and possible changes to local policies were discussed. We saw copies of the theatre team meeting minutes confirming this. We were given an example of this when a specimen in theatre was lost and the local policy was amended to reflect lessons learnt.
- Staff told us that if things went wrong it was used for learning and they were treated fairly and respectfully.
- We saw root cause analysis investigations (RCAs) were completed as part of the investigation of incidents. We reviewed some examples of RCAs and they were thorough. Lessons learned had been identified and there was action logs for completion when identified learning actions had been completed.
- Action plans were monitored through the Quarterly Integrated Governance Committee. Lessons learned were also shared across the Nuffield business group.
- The duty of candour (DoC) relates to a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The DoC was an integral part of the mandatory training programme. With the exception of one staff member, staff knew what the DoC meant and could describe their responsibilities relating to it. We also reviewed a RCA report and saw evidence that staff had applied the DoC appropriately.
- As there had been no inpatient deaths between April 2015 to March 2016 the hospital did not carry out

mortality and morbidity review meetings as a matter of course. This was, in part, due to the low number of patients treated and the consequent low numbers of patients that would fall into these categories.

**Safety thermometer or equivalent (how does the service monitor safety and use results)**

- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to hospital inpatients. These include falls, new pressure ulcers, catheter and urinary tract infections (UTIs) and venous thromboembolism (blood clots in veins). .
- Safety thermometer information was displayed in the Matrons office but not on the wards, which is standard practice.
- The venous thromboembolism (VTE) screening rate was 100% which was better than the national target of 95% between January 2015 – December 2015.
- The hospital reported one case of VTE for surgical inpatients between April 2015 - March 2016.
- Between April 2015 – March 2016 the hospital reported no pressure ulcers.
- The hospital reported two slips, trips or falls between December 2015 and February 2016.

**Cleanliness, infection control and hygiene**

- Healthcare establishments are required to demonstrate compliance with infection prevention criteria as detailed in The Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance (Department of Health 2015).
- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile, between December 2015 - February 2016.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment; local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. In the PLACE audit 2016, Nuffield Health Chichester hospital scored 92% in relation to the cleanliness and general building maintenance of the hospital.
- There were infection prevention and control policies and procedures in place; however they were not always adhered to.For example, we observed staff not wearing two pairs of gloves during orthopaedic surgery.
- The policies were readily available to staff on the hospital's intranet and in resource folders. Infection prevention and control was included in the mandatory training programme.
- We saw a variety of risk assessments and cleaning protocols for clinical equipment. These included guidance on cleaning frequency and competency assessment tools used by staff.
- A management structure was in place for cleanliness which was led by the hospital's director of infection prevention and control (DIPC) and site decontamination lead. This included 'method statements' which gave specific instructions on how to clean a variety of equipment for example radiators, bedpans and beds.
- Decontamination and sterilisation of instruments was managed in a dedicated facility off site. The facility was responsible for cleaning and sterilising all re-usable instruments and equipment used in the operating theatres, ward and clinics. Staff said there was a good working relationship with this facility. In theatres there was a member of staff dedicated to manage instrumentation.
- Infection prevention and control reports were a standard agenda item on the integrated governance committee meetings.
- There were various standard operating procedures (SOP's) for decontamination of instruments for example flexible endoscopes, alongside SOP's/guidelines in specific techniques, for example, inserting a urinary catheter.
- Areas we visited were tidy and visibly clean.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with "Five moments for hand hygiene", from (WHO) guidelines on hand hygiene in health care. We saw that posters which

demonstrated the correct hand hygiene technique were displayed by all sinks. Disinfection wipes were readily available for cleaning hard surfaces in between patients; we witnessed staff using these.

- Regular infection prevention and control audits had taken place. Between December and July 2015 the score was consistently 98% and above.
- Infection prevention practical training (hand hygiene) had been completed by 88% of staff. There was an infection prevention audit report and action plan for 2016.
- There was a member of staff on the ward and in theatres who were the infection control link practitioners. They attended regular meetings and cascaded information to staff via departmental meetings.
- Equipment was marked with a sticker when it had been cleaned and was ready for use.
- We saw that some of the patient areas had carpets which were subject to the appropriate cleaning regime to minimise an infection control risk.
- We saw a risk assessment for carpets in clinical areas. There was control measures on the risk assessment relating to cleaning of carpets following a bodily fluid spillage.
- Waste in all clinical areas was separated into different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, Control of Substances Hazardous to Health Regulations (2002) and Health and Safety at Work Regulations (1974).
- The clinical waste unit was secure and all clinical waste bins we looked at were locked.
- The cleaning of the hospital was undertaken by a team of housekeepers. Cleaning equipment was colour-coded and used appropriately; we saw evidence of cleaning rotas and checklists. Staff spoke highly of the standard of work undertaken by the housekeepers.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We checked 12 sharp bin containers and all were clearly labelled to ensure appropriate disposal and traceability.
- There were no posters displayed in theatres or wards of what action must be taken if a staff member sustained a sharps injury.However staff were able to explain the process to us and were able to locate the helpline telephone number.
- We saw records of a deep cleaning and filter change schedule of the theatres. It was reported that the deep cleaners who came into clean the theatres said that they were the cleanest theatres they visited
- At the pre-operative assessment stage, which was undertaken via telephone or face to face, patients were risk assessed to decide whether a patient needed to be screened for MRSA. For example, if patients had previously had MRSA or had frequent admissions to other hospitals they would be screened.
- We saw there was an antimicrobial stewardship policy which ensured appropriate use of antibiotics.
- The hospital was compliant with the Department of Health guidance (2014) recommending: “All patients admitted to high risk units and all patients previously identified as colonised with or infected by MRSA, should be screened for MRSA. In addition, local risk assessment should be used to define other potential high MRSA risk”.
- The hospital reported three surgical site infections (SSIs) between April 2015 – March 2016: one primary hip arthroplasty, one primary knee arthroplasty and one breast. The assessed rates of SSIs (per 100 surgeries) for primary hip arthroplasty and breast was not high when compared to other NHS Hospitals.
- We noticed that sharp safe cannulas (a thin tube inserted into a vein) and sharp safe hypodermic needles (hollow needle) were being used. These devices reduce the risk of a member of staff receiving a sharps injury.
- We saw in theatres there was a map which demonstrated clean and dirty areas. This meant staff were aware of which areas they were permitted to enter.
- The endoscopy suite was separate from other areas. It had separate clean and dirty utility areas and was designed to facilitate flow from dirty to clean areas. This demonstrated adherence to the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope Reprocessing Units, QPSD-D-005-2.2.

- Staff transported dirty endoscopes from the procedure room to the dirty area in a covered, solid walled, leak proof container in line with Health and Safety Executive standards for endoscope reprocessing units.
- A clear decontamination pathway for endoscopes was demonstrated. There was an area where dirty scopes were passed through to the cleaning area. We saw that there was a washing sink and a rinsing sink as well the washer machine. The wash machine was also able to carry out leak tests on the scopes. There were two drying cupboards and a storage cupboard for the endoscopes.
- Staff kept full scope-tracking and traceability records. They indicated each stage of the decontamination process was occurring. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014). Testing of all washers was done on a daily basis. Filters were checked once a week. All equipment in the washing room was regularly serviced. Information about when the next service was due was available.
- We were told that water sampling was undertaken from the final rinse cycle, which was tested for its microbiological quality at least weekly. This was in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.
- All taps and showers were tested twice weekly and run for two minutes at their maximum velocity.This was done to prevent legionella bacteria developing.

However,

- We observed scrub practitioners in theatre undertaking orthopaedic operations wearing one pair of gloves this is contrary to the IP 02 policy: "Double gloving is recommended during some exposure prone procedures (EPPs) e.g. orthopaedic/gynaecological surgery".
- NICE guidelines CG74 Surgical site infections: prevention and treatment also state: "Consider wearing two pairs of sterile gloves when there was a high risk of glove perforation and the consequences of contamination may be serious". Due to the nature of instruments (often sharp) used for joint replacements the risk of glove perforation was high.
- The World Health Organisation information sheet also recommend double gloving in long surgical procedures of more than 30 minutes, for procedures with contact with large amounts of blood or body fluids, and for some high-risk orthopaedic procedures. It was important for staff to protect their hands from injury and wearing two pairs of gloves provided a thicker barrier against accidental piercing of the gloves .In addition by wearing two pairs of gloves if an accidental breach of the outside glove occurs there is another pair underneath, this helps prevent the introduction of bacteria.
- We saw three members of staff in theatres wearing masks around their necks rather than fitted to the face. One member of staff had a used mask in their pocket. This is contrary to the IP 02 policy: "Masks must be removed or changed at the end of a procedure/task or if the integrity of the mask is breached, e.g. from moisture build-up after extended use or from gross contamination with blood or body fluids." The IP 02c policy also states: "dispose of all PPE, including disposable masks/face protection, safely and immediately following use into appropriate receptacles". This meant that staff were not adhering to the provider's own policy.
- We observed an operation in theatre one where staff placed surgical instruments outside of the laminar flow (clear air) area. This may have compromised sterility of the instruments and increased the risk of infection to the patient.
- On 11 occasions we saw members of staff unnecessarily entering the laminar flow area. It is recommended that once the surgeon is inside the laminar flow area only the patient, scrub nurse and surgeon remain in this area. This could inadvertently render equipment unsterile and could introduce bacteria.
- The hospital had a policy whereby staff roles were identified by the colour of the scrub suits they were wearing, 'blue' while staff were attending theatre and 'red' for all other areas. We saw four members of staff outside the theatre department wearing 'blues' scrub suits this is contrary to the Nuffield Health IP 02 Standard Infection Prevention Precautions Policy: "The wearing of blue scrub suits (those worn by the intra operative scrub teams) outside theatre is not permitted except in emergency situations for example, Cardiac Arrest".

- We saw recovery staff entering the operating theatre to help transfer the patient to their bed in 'red' scrub suits, which were meant to be worn outside the theatre. This is also contrary to the IP 02 policy meaning that the staff were not adhering to the provider's own policy.
- In theatres, we saw a member of staff attach a sterile blade to a blade handle (used to make an incision) with their fingers. This is not considered best practice due to the risk of injury from the blade. The Association of perioperative practice (AfPP) recommend a five step process and this had not been followed.
- We saw in theatres that nine sterile instrument trays were not checked to see if there were any holes in the outside wrapper. Any breach in the wrapper could mean the sterility of the instruments could not be assured and posed an increased risk of a patient contracting an infection. Prior to use sterile instrument set's external and internal wrappers should be checked to ensure they were dry, free from debris and do not have any breaches in the paper.
- Sterile instrument trays were wrapped in two layers. The outside layer should be removed prior to preparation and the inside layer should be opened by a member of staff who was not sterile, immediately prior to the sterile member of staff touching it. However, in theatre we observed a sterile member of staff touch the inside wrapper. This meant when the staff member touched the instruments that would be used during the operation they were no longer sterile, this could contaminate the instruments with bacteria.
- We saw a member of staff in theatre place four sterile instrument tray lids underneath the trolley the instruments were on. This meant their sterile gloves could have been contaminated and risked the introduction of bacteria to the sterile field.
- Sixty-eight percent of theatre staff had received training in aseptic technique and 79% of staff had completed practical infection prevention training.
- We saw in the patient rooms on Northgate ward there was no personal protective equipment available.This is contrary to the IP 02 policy: Additional PPE must provide protection to staff against the risks associated with procedures or tasks which may result in contamination of skin, eyes, mucous membranes or uniforms and must be; located close to the point of use.
- On Northgate ward some of the walls in patient rooms were in a bad state of repair with exposed plaster which meant they could not be cleaned effectively and could pose an infection control risk.
- On both wards there were no dedicated hand hygiene sinks in patient bedrooms. This is contrary to the Department of Health's Health Building Note 00-09, which states, "Healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes".
- The ensuite bathroom sinks were not suitable for the purpose of hand hygiene. This was because they had plugs and overflows contrary to the Department of Health's Health Building Note 00-09: Infection control in the built environment. This states "Clinical wash-hand basins should not have a plug or a recess capable of taking a plug", and "Clinical wash-hand basins should not have overflows, as these are difficult to clean and become contaminated".
- The taps on the ensuite bathroom sinks on the wards were not lever or sensor-operated and staff needed to twist them on and off with their hands. This risked re-contamination of hands when turning the taps off after hand washing. It is contrary to the Department of Health's Health Building Note 00-09, which states "Taps can be lever or sensor-operated and should be easy to turn on and off without contaminating the hands".
- We saw the two bathrooms in the pre-assessment rooms were also being used as storage areas, making it difficult for staff to access the sinks and put staff at risk of injury. The sinks in these rooms were also non-compliant with Department of Health's Health Building Note 00-09.

**Environment and equipment**

- There were arrangements to ensure endoscopes were decontaminated and the risk of infection to patients minimised. Staff told us the number and size of endoscopes met the needs of the service. We saw a variety of scopes available to perform a variety of examinations.
- On Northgate ward, we checked the emergency trolley. We checked 44 items and found two boxes of gloves were out-of-date. We reported this to the matron, who arranged a replacement. We saw staff had not fully

completed the trolley checklist between 1 July 2016 – 13 July 2016. The checks had only been complete on five days. This meant there was not a robust system of daily checks to ensure it was available for use in an emergency.

- On Pallant ward, we checked the emergency trolley; we checked 33 items and all were in date. We saw that on one occasion between 1 July 206 and 13 July 2016 the trolley checklist had not been completed.
- In recovery, we checked the emergency trolley. We checked 26 items and two items were out of date, we highlighted this to a staff member who arranged for replacement. We saw staff had fully completed the trolley checklist throughout June and July 2016 to provide evidence they had checked items.
- All the emergency trollies we checked were sealed with a tamper evident tag; the tag number was recorded on the trolley checklist.
- We saw that portable appliance safety testing labels were attached to electrical items showing that they had been inspected and was safe to use. We checked 31 electrical items and the PAT labels demonstrated only one item had not undergone electrical testing in the last 12 months. We saw two pieces of medical equipment which were isolated because it was not safe to use, we saw these were clearly labelled to ensure they were not used.
- The hospital had an outside medical gas cylinder storage which was compliant with: the Health Technical Memorandum (HTM) 02-01.
- We inspected the gas manifold room that housed the piped medical gas supply. This was monitored by the porters. The room was located at the back of the building. Appropriate signage was in place to notify people what was contained within. The room itself was locked and this prevented any potential sabotage to the supply of medical gases. The manifold for all three of the gases that were piped through the hospital had been inspected in May 2016. The manifold inspection records were stored in a locked cupboard in the medical gases room.
- We observed that there was no piped vacuum to the wards, this meant the ward relied upon portable suction machines, and there was one portable suction on each ward which meant if it was in use, another one was not available. There were no recorded adverse incidents related to a lack of availability which suggested one machine per ward was adequate for the services provided.
- There were an adequate number of portable oxygen cylinders. We checked six cylinders which were in date and labelled.
- We were shown the records that related to the testing of the generator. There had been two recent checks, one in March 2016 and one in June 2016. These checks were carried out by an external contractor. The generator would last up to eight hours and the diesel always remained topped up. If there was a specific problem, the local electricity company would attend within four hours to fix it.
- Theatres were fitted with an uninterrupted power supply (UPS) which meant lifesaving equipment would continue to operate in the event of a power cut.
- The maintenance engineer tested the call bells to check they worked and also to check that they could be heard and responded to by the other staff. The bells were tested in all patient rooms including theatres and the anaesthetic room.
- In theatres, we saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was not consistently adhered to. The two log books we examined were not all complete with daily signatures to confirm the safety checks had been undertaken. We asked staff why the log books were not complete, staff explained it was often because the theatre had not been in use. When theatres are not is use it must be documented within the log book to ensure a contemporaneous record of the checks.
- We checked two anaesthetic machines and these had been serviced within the last 12 months.
- Theatres and anaesthetic rooms were generally well organised, clutter free and that single use items such as syringes and needles were readily available.
- We noted there was a lack of signage in theatres for example indicating where emergency equipment was

located. However, staff who infrequently worked in the department were shown the physical location of emergency equipment as part of their induction programme.

- In theatre, the difficult intubation trolley was Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. This was of particular importance as anaesthetists who worked with in theatres on an infrequent basis would be familiar with standard equipment. There was a robust system in place to ensure daily checking of this equipment to ensure it was available for use in an emergency.
- The staff we spoke with confirmed they had access to the equipment they required to meet peoples care needs.
- Theatres used a smoke extraction system for all major surgical cases, in accordance with Health and Safety Executive Evidence which prevents exposure and harmful effects of diathermy plumes (surgical smoke) to staff. (RR922) (2012) guidelines.
- Health and Safety Control of Substances Hazardous to Health substances were stored in line with Health and Safety Executive guideline SR24.
- There was one door in theatres that staff identified as a fire door that was not marked as such and had no fire rating. It did have intumescent strips. Intumescent strips around the edges of doors or doorframes expand under high temperatures to seal the gap between the door and the doorframe, keeping out fire and smoke. When we returned to theatres the following day we observed that the door had been marked as a fire door.
- We saw the hospital used a Blood Audit and Release System (BARS) system. The BARS box is a secure, tamper-proof computer with a touch sensitive screen and hand held scanner. The BARS system is designed to control and monitor access to an external fridge containing blood products, recording the time, date and identity of the person accessing the fridge. It also recorded all activity, single and cumulative times that a blood product is out of its controlled environment.
- Three staff members told us that the BARS failed and we saw it was on the providers risk register. Staff demonstrated that there was an emergency door release button so should the system fail blood was still accessible. We were shown training records of staff who had completed training on the BARS system, however not all staff had undertaken the training. Staff could only obtain an access wipe card for the BARS system once they had undertaken the training.
- There were four units of emergency blood stored within the system. Should a patient require additional blood it was supplied by the pathology hub at the Nuffield Health Hospital Wessex and would take 45 minutes to arrive. There were no recorded adverse incidents related to delays in accessing blood in an emergency.

**Medicines**

- The Nuffield Health Hospital Chichester had a quarterly drugs and therapeutics meeting. Evidence of these meetings contained information regarding discussions of national committee topics and findings.
- Staff told us drug stocks were checked weekly by pharmacy. Drugs in theatres were ordered by theatre staff and delivered by pharmacy.
- Ward staff checked stock balances of CD's daily. We randomly checked a sample of stock in each department and found all were in date and stock balances were correct.
- Medicines were stored in dedicated medication fridges when applicable. The temperature monitoring devices were portable electronic devices placed in the fridge. The thermometer digitally monitored temperatures and the pharmacy department analysed the data monthly. In addition, staff checked and recorded the maximum and minimum temperatures daily and daily records were kept. We spoke with two members of staff, who knew the safe temperature ranges for the fridges and at what temperatures they should take action.
- We reviewed 14 prescription charts, and found them to be legible and completed appropriately.
- Patient allergies had been clearly noted on the chart and on their identity band. Staff recorded patient allergies on the patient's prescription chart. Two of the patients had an allergy, and we saw the patient wearing a wristband that alerted staff of this.
- There were accurate records of the quantity of private prescriptions (SPF100) in stock. This meant there was no potential for blank prescriptions to go missing

un-noticed. This was in line with guidance from NHS Protect which stated, "Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded".

However:

- We looked at two controlled drug registers within theatres and saw block signing of controlled drugs by anaesthetists and the absence of two signatures. We saw numerous occasions when the amount administered of a controlled drug was not recorded and the amount destroyed was not recorded. This was against hospital policy and Misuse of Drugs Regulations 2001 and Safer Management of Controlled Drugs: a guide to good practice in secondary care (England.)
- Staff were aware of this as an ongoing issue and had raised it to management. A staff member spoke of encouraging anaesthetists to record accurately but as it had not improved it had been escalated to the Medical Advisory Committee meetings (MAC) appropriately.
- These issues were also highlighted in the hospitals controlled drug quarterly audit undertaken in May 2016. The action recorded was to compile a list of the anaesthetists who were undertaking this practice and to raise at the Medical Advisory Committee meetings (MAC) and to raise it at their next performance review. Further to this individuals who had block signed were to be contacted individually and disciplined if necessary.

**Records**

- There was a Nuffield Group Health Records Standards Policy which referenced the Data Protection Act 1998 and the Access to Medical Records Act 1990.
- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- The medical records remained either in the hospital or at the secure facility managed by a third party provider. Consultants with medical secretary's off-site left Nuffield records on site and returned their own patient files to their secretary after the clinic. The majority of consultants were registered as data controllers and were therefore aware of their responsibilities.
- Any breaches in information security were reported through the incident risk management system. The group information risk manager was automatically notified and an investigation would be undertaken. Information security was a regular agenda item on committee meetings and learning/ remedial actions from any incidents was widely shared.
- When a patient was discharged from the ward area and an appointment was made for them to be seen in the outpatient department, the notes were labelled and taken to the outpatient department so that they were available for the appointment.

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- We saw that robust management controls were in place to access the CD drug rooms' cupboards. The nurse in charge held the keys on the ward and the theatre practitioner held the CD cupboard keys within theatres.
- We saw that medicines were stored in dedicated medication fridges when applicable. The temperature monitoring devices were portable electronic devices which was placed in the fridge. The thermometer digitally monitored temperatures and the pharmacy department analysed the data monthly. In addition, staff checked and recorded the maximum and minimum temperatures daily and daily records were kept. We spoke with two members of staff, who knew the safe temperature ranges for the fridges and at what temperatures they should take action.
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- We looked at the records for three patients on Pallant ward. The notes were stored securely in the patient's room which prevented unauthorised access to confidential patient data. We saw a good standard of documentation across the hospital. For example, all three patients had care plans that identified their care needs.
- We saw some patients followed standardised pathways, such as a total hip replacement pathway. This was personalised through individual risk assessments and notes made in the care plans. We saw thorough evidence of pre-assessment in all three sets of notes.
- Patient records were paper based but staff told us that an electronic patient record system was going to be introduced in the near future.
- We reviewed 13 sets of notes of patients who had undergone surgery. There were numerous occasions on theatre documentation when staff had block signed to confirm checks had been undertaken. For example on the swab needle and instrument checklist, this meant it was not possible to trace the individual who had performed the different components of the checks. In addition, some sections were missing signatures for example to confirm the swab, needle and instrument counts were correct. This meant there was no way of knowing whether these vital safety checks had been undertaken.

**Safeguarding**

- The Nuffield Health group had Safeguarding Policies (Children, Young People and Adults) which were reviewed and in date.
- The Nuffield Health group safeguarding policies had been updated to reflect changes in the national guidance for example female genital mutilation and exploitation.

- The Nuffield Health group Child Safeguarding Policy was updated in April 2016 and fully reflective of the national guidance, "Working Together to Safeguard Children 2015".
- The matron was the overall safeguarding lead for both adults and children and had completed level three training in both adults and children.
- There had been no child safeguarding referrals in the preceding year.
- There had been one adult referral made following concerns raised by a patient to the local authority. The hospital staff had investigated the concerns thoroughly with the local commissioning group. There were no substantiated concerns as it was decided there was no safeguarding issues, however the hospital had made changes to practice as a result from comments received to further improve and protect patients.
- The Nuffield Health group had a named nurse and safeguarding advisor for adults and children, who was said to be readily available for advice and consultation.
- A staff member was able to describe the process they would follow should they have any safeguarding concerns .
- Eighty three per cent of theatre staff had completed level one safeguarding children and young adults and safeguarding vulnerable adults training. Eighty-nine per cent of ward staff had completed level one safeguarding children and young adults training and 81% of staff had completed safeguarding vulnerable adults training
- Staff we spoke with confirmed they had received safeguarding training as part of mandatory training.

**Mandatory training**

- Overall mandatory training completion rates for surgical staff was 89.1%. This was better than the Nuffield Health group target of above 85%.
- There were 23 mandatory training courses for surgical staff. This was a combination of online, classroom-based and practical training. Staff completed the appropriate number and type of courses from this list relevant to their role.
- Examples of mandatory training courses covered included: information governance, medical records and infection control.
- Mandatory training was monitored and compliance discussed during appraisal, we reviewed three appraisals which included details of completed mandatory training.
- We spoke with a doctor who was employed by an external agency; they described a robust process and a system of ensuring that their mandatory training was up to date.

**Assessing and responding to patient risk**

- The hospital did not have any level two or three critical care beds. To mitigate this risk, the hospital only operated on patients pre-assessed as grade one or two in accordance with the American Society of Anaesthesiologists (ASA) grading system. Grade one patients were normal healthy patients, and grade two patients had mild disease, for example well controlled mild asthma**.**
- Pre assessment of patients was undertaken either by telephone or face-to-face by a pre -assessment nurse. The nurse had access to anaesthetists should they have any concerns or questions.
- Pre-assessment of patients for surgery included a thorough assessment of risk. We reviewed three sets of patient notes and saw evidence of falls risk assessment, dementia screening, infection prevention and control risk assessment, risk assessment for pressure ulcers and assessment of nutritional status. These assessments were vital to assess a patient's suitability for surgery and to enable staff to make any necessary adjustments to ensure safe care. For example, staff allocated patients with dementia to bedrooms closest to the nurses' station, where possible.
- The hospital used the modified early warning system (MEWS) track and trigger flow charts. MEWS is a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify patients at risk of deterioration at an early stage and provide them with additional support. We reviewed ten patients' MEWS

charts. Staff had completed all ten accurately and fully. We saw evidence of increased monitoring and intervention when clinically indicated in line with national guidance.

- We reviewed the medical records of four patients who suffered an unexpected deterioration in their condition. There was very good documentation of the care and treatment they received with timings of when the concerns were escalated and to whom. The records showed that the escalation process worked effectively and that patients were referred to the local NHS emergency services or to the hospitals own resident medical officer (RMO) or admitting consultant whose care they were under.
- Local preoperative assessment policies should ensure pregnancy status was checked within the immediate preoperative period in accordance with NICE guidelines. The check should be recorded on preoperative documentation used by staff performing final clinical and identity checks before surgical intervention. We observed there was a robust process to ensure this guideline was adhered to and it was reported all women between the ages of 12-65 were pregnancy tested. We saw evidence of this in patient notes.
- All patient notes we reviewed had a VTE assessment completed and all patients wore anti-embolic stockings.
- The hospital consistently meets their NHS contracted 95% target screening rate for VTE risk assessment between April 2015 and March 2016.
- The 14 charts we reviewed demonstrated that all were compliant with the National Institute for Health and Care Excellence (NICE) VTE guidance with a section in the front of the chart confirming a completed VTE assessment and that prophylaxis had been prescribed and administered.
- Notes contained completed neurovascular assessments and pressure area assessments were completed.
- A recent audit found that there was poor compliance with recording of patient's temperature in surgery. As a result of this all patients now have temperature management dots placed on their foreheads prior to going to theatre. These constantly monitor patient's temperature and alert staff to any changes in temperature so remedial action could be undertaken. This showed when an issue was highlighted that action was taken to ensure patient safety.
- There were three daily nursing handovers, one at the beginning of the day, one at lunchtime and the other towards the end of the day. Staff told us that the RMO attended the nursing handovers to ensure continuity of patient care.
- Theatre staff received information at theatre 'briefs' and 'debriefs' as well as at departmental meetings. Ward staff received information at staff meetings and handovers.
- There were a variety of up to date clinical standard operating procedures in the management of emergency situations. These included, for example, massive blood loss and the management of the deteriorating patient. These ensured a standardised evidence based approach to managing emergency situations. Staff we spoke to confirmed that they had access to these and were aware of the content.
- The hospital had a service-level agreement with the South East Coast Ambulance Service. This enabled them to transfer any patients who became unwell after surgery and needed critical care support. We saw evidence of agreed standards for the transfer of critically ill patients with local NHS ambulance services and NHS hospitals.
- A hospital report we reviewed on patient transfers to the local NHS hospital showed the hospital transferred four surgical patients to the local NHS hospital between April 2015 and March 2016.
- We reviewed the notes of two of the unplanned transfers and given the nature and volume of operation undertaken, both were appropriate, well managed and there were no common themes or concerns.
- Staff told us any patients who developed complications following discharge could contact the nurses on Pallant ward any time, day or night for advice.
- We observed handovers between recovery staff to ward staff, which were good and communicated all the relevant information and were documented.

Good

# Surgery

- A patient discharge criteria was in place for patients leaving recovery after their operation. This meant patients were well and pain free prior to being transferred to the ward.
- We observed theatre staff carrying out the five steps to safer surgey (WHO) Checklist for three procedures. The five steps to safer surgery checklist is an international set of safety checks for use in any operating theatre environment. These include team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre), and debrief. We identified a number of issues which related to the completion of the five steps to safer surgery (WHO) checklist:
- The 'sign in' process had been undertaken by a member of staff who was not working directly in theatre and had collected the patient from the ward. The 'sign in' part of the five steps to safer surgery checklist is usually undertaken by the practitioner who is working alongside the anaesthetist. Part of the 'sign in' process is to confirm that equipment checks have been completed and emergency drugs were available. The staff member who completed the 'sign in' section could not have known if these checks had been undertaken.
- As part of the 'sign in' process the identity of the patient should be checked against their identity wristband, their notes and their consent form, this was done on the ward by the member of staff who collected the patient. A second check was not undertaken when the patient arrived in theatre by the theatre practitioner. This meant that only one person had confirmed it was the correct patient for the correct operation and this was not a robust checking process.
- We raised this issue with the theatre manager and she explained that because there was no anaesthetic room to enable the 'sign in' to be completed in privacy it was done on the ward. It was a new process as the anaesthetic room only been removed recently and admitted the process was not ideal. During the inspection, we were provided with evidence that the hospital policy had been changed to reflect that the checks undertaken when the patient was collected from the ward does not replace the 'sign in' process.
- On one occasion we observed poor consultant surgeon engagement throughout the five steps to safer surgery (WHO) process.
- We saw on one occasion that the 'sign out' process was undertaken when the surgeon was still operating on the patient. It is meant to be carried out prior to the patient leaving the theatre but after completion of surgery.
- We saw the 'time out' process was undertaken before the patient had been prepared for surgery. The' time out' should have occurred immediately prior to the start of the operation.
- We saw staff performing the five steps to safer surgery (WHO checklist) from memory and not with the actual checklist in front of them; this meant important information could be missed. We saw staff did not always document the completion of the five steps to safer surgery (WHO) checklist immediately after it had been performed.
- We reviewed 14 completed checklists and identified 11 (78.5%) had missing information. Two were blank on the 'sign in' section and the staff who had completed them had block signed sections which meant that they did not provide a clear and contemporaneous record that the WHO checklist was being used properly.
- We saw five steps to safer surgery (WHO) audits were carried out each month. The audit included 20 patient notes and concluded that there was 100% completion of the WHO. However, during our inspection we witnessed four surgical procedures over the two days of our inspection. In all cases the WHO was not implemented in line with best practice. We saw that steps one and two of the five steps were not being audited team brief and de brief, in addition we saw that steps one and two were not documented when performed.
- There were provider specific five steps to safer surgery (WHO) checklists for different procedures, for example for eye surgery. This ensured staff checked the most important safety factors relating to a specific procedure.
- Staff in endoscopy only completed two boxes of the checklist which meant specific risks associated with endoscopy would not be identified. Staff told us that a new endoscopy checklist was being developed but didn't know when it would be in use.

- Patients who needed extra care would have district nurses follow up their treatment, we were told by a staff member that the hospital would often phone to advise the community nurses of the patients requirements and had also called GPs surgery to advise on patients who needed extra treatment such as patients with urinary tract infection (UTI). This showed the hospital had good links with outside organisations ensuring a continuity of care for the patient.

**Nursing staffing**

- The theatre department had an establishment 17.4 whole time equivalent (WTE) staff.
- There were current vacancies for one WTE advanced theatre practitioner and three WTE generic theatre practitioners. The wards had an establishment of 20.9 WTE. There was current vacancies for one ward sister and one staff nurse. We were told these posts had been recently advertised and that they had received applications
- Nuffield Health Hospital Chichester had a 20% - 35% agency use for theatre nurses between April 2015 and March 2016 this was high compared to other Nuffield hospitals. There was 6% -11% of agency use for operating department practitioners (ODP's) and healthcare assistants (HCA's).This was not higher than other hospitals that the service benchmarked against
- There was a decreasing amount of nursing agency usage on the wards between April 2015 and March 2016. The highest amount (15%) being in September 2015 and the lowest (3%) was in March 2016. There was variable amount of HCA agency usage on the wards between April 2015 and March 2016 with the highest being in September (23%) and the lowest (4%) was in March 2016.
- During the inspection, we saw staffing levels met the Association of perioperative practice (AfPP) guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.
- There was a ward manager on every day shift on Pallant ward. The ward manger told us she ensured there was always a good skill mix.
- During the night, the hospital had an on-call senior nurse rota to ensure the same level of service and to accept out of hours admissions.
- The hospital further assessed and amended staffing levels on a daily basis as needed. Staff were allocated according to patient numbers, acuity, dependency, numbers of discharges, theatre cases and number of admissions. This was reviewed at regular intervals throughout the working day/week.
- The provider reported they had no unfilled shifts during the last three months.
- The matron sought regular feedback from staff and patients to monitor staff levels were appropriate. The Shelford Safer Nursing Care Tool has been piloted within Nuffield Health group but following evaluation will not be implemented as the tool is not reliable or valid for the independent sector.
- The Royal College of Nursing (RCN) recommend one nurse to every 8 patients (RCN 2012). The service had one registered nurse (RN) for eight patients and so surgical services at the hospital were compliant with this. On Pallant ward there was one nurse to every 6 patients and the nurse to HCA ratio was above the RCN recommendation.
- The ward did not have planned versus actual staffing displayed. Staff told us that understaffing would be reported on the hospital's electronic incident reporting system.
- The staff and patients we spoke to said there were enough nurses to provide safe compassionate care.

**Medical staffing**

- There were 112 consultants who had practicing privileges at the hospital, all of whom had been undertaking work at the hospital for over 12 months. Practicing privileges is a term which means consultants have been granted the right to practise in an independent hospital and to admit patients under their care.
- Eleven consultants had their practicing privileges removed or chose to give up their privileges in the last 12 months. The most common reason being due to retirement.

Good

# Surgery

- The hospital used an international agency to provide resident medical officer (RMO) cover 24-hour, seven days a week on a rotational basis. This ensured a doctor was on-site at all times of the day and night should an emergency arise. The RMO we spoke to worked a shift pattern of one week on and one week off.
- The RMO conducted regular ward rounds to ensure patients were receiving appropriate treatment and to review their condition. We saw the RMO providing medical cover on Pallant ward. The RMO reported any changes in a patient's condition to their consultant and followed the consultant's advice regarding further treatment.
- We spoke to a RMO who confirmed support from consultants was always available and gave examples of when advice had been given via the telephone prior to attending the hospital. The RMO told us that consultant led care was available out of hours and at weekends.
- All consultant surgeons, as a requirement of their practising privileges, were required to be available and remain within a thirty minute radius of the hospital for the duration of their patient's stay or to arrange suitable cover with another consultant surgeon from the same specialty. The consultants had direct access to the ward by telephone. Surgeons were expected to visit their patients daily until the patient has met their discharge criteria or to arrange cover.
- The anaesthetist was also required to be available for the duration of the patient's stay in hospital. This ensured availability of anaesthetic cover should a return to surgery become necessary or if advice was required regarding pain relief. Staff told us anaesthetists were contactable and approachable when needed.
- The anaesthetists belong to two local anaesthetic groups. The anaesthetists are allocated by their anaesthetic secretary to provide support for the consultant surgeons who work out of their NHS trust. The on call radiology team from a local NHS trust is available for consultant to consultant advice.

**Major incident awareness and training**

- A fire evacuation exercise had taken place in May 2016 to practice evacuating the theatre department of staff and patients in the event of a fire.
- There was a provider business continuity plan available.
- Regular emergency scenario training was undertaken, the last exercise was on 6 July 2016 which was how to manage a patient that was haemorrhaging (bleeding) The scenario training was undertaken by an external person and staff were given a de-brief and feedback at the end of the session.
- Staff told us that they enjoyed taking part in the scenario training and found it extremely useful as it was rare they experienced such emergencies and it kept their skills up to date.
- A comprehensive business continuity plan available.

## Are surgery services effective?

Good

We rated effective as good in surgery because**;**

- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice and contributed to national data to monitor performance such as the national joint registry.
- The hospital offered a choice of meals and drinks and patients requiring special diets were catered for.
- Staff appraisals were up to date and there was a clear approach for supporting and managing staff. Staff completed a tracker document to confirm they had read and understood hospital policies.
- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. The medical advisory committee (MAC) reviewed patient outcomes and the renewal of practising privileges of individual consultants. It also reviewed policies and guidance and advised on effective care and treatments
- The hospital routinely collected and monitored information about people's care and treatment, and their outcomes
- Staff obtained and recorded consent in line with relevant guidance and legislation and could access the information they needed to assess, plan and deliver care to people in a timely way

Good

# Surgery

**Evidence-based care and treatment**

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines.
- Staff completed a tracker document to confirm they had read and understood hospital policies. We saw evidence of this in four staff folders which are kept on the ward for easy review. All of the trackers we saw were fully completed.
- NICE guidelines and alerts were fed through the heads of department to all staff; any issues or responses were then escalated to the Integrated Governance Committee. Subsequently policies were updated and were available on the intranet and in paper form. Compliance with the guidelines was measured by the head of department.
- We reviewed patient notes and we saw evidence that the hospital was providing surgery in-line with local policies and national guidelines, such as the NICE guideline CG74: surgical site infections: prevention and treatment. For example we saw evidence of antibiotic assessment in 11 patient notes along with a prescription of prophylactic antibiotics if needed.
- The endoscopy unit was in the process of applying for accreditation with the Joint Advisory Group on Gastro Intestinal Endoscopy (JAG). The hospital has been preparing for JAG accreditation for over four years and that an assessment was due to be carried out in December 2016. Part of the process to achieve JAG accreditation was to have a visit from a consultant and authorised engineer in April 2016. The unit was rated as Amber /Green. We saw an action plan had been put in place to address the issues raised in that review.JAG accreditation would allow the hospital to take more patients from the NHS as they would be able to undertake bowel screening.
- Comparative data from all Nuffield hospitals was routinely available to support benchmarking and we saw a positive culture of willingness to help and support.
- The hospital had regular clinical audits. A staff member told us about a rolling audit programme and was aware of the last completed audit and upcoming audits,
- A recent audit into pharmacist interventions concluded that from January to April 2016 there were no missed doses of critical medicine within a 24 hour time period. It also showed 100% of patients had the correct allergy status documented.
- The hospital provided data to the National Joint Registry (NJR). The NJR collected information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor the performance of joint replacement implants.
- The service provided breast surgery. The hospital signed up to contribute information for inclusion in the national Breast and Cosmetic Implant Registry (BCIR). Similar to the NJR, the purpose of the BCIR was to monitor the performance of implants, specifically breast implants. National implementation of the BCIR had not yet taken place at the time of our inspection. The daily responsibility for inputting information will be by the theatre administrator who currently manages the NJR. Prior to the registering on the BCIR, the hospital maintained a local implant register. In addition to this, a record of implants used is also lodged in the patient's care record. This was in line with best practice guidance.
- The hospital complied with the guidance on the National Safety Thermometer, a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The surgical ward participated in the NHS Safety Thermometer for all patients, self-pay and NHS. Senior staff conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. Information about the audits was not displayed. This is not mandatory, but is considered good practice.

**Pain relief**

- We spoke to seven patients over the two days of the inspection. All were happy with the pain relief they received and felt staff checked on them regularly to ensure their pain was managed in a timely manner.
- Patient records showed a robust system of identifying pain and patients were regularly checked following specific guidelines if pain levels increased.

- We spoke to a patient who had asked for extra pain relief following surgery; they described the response as "immediate."
- Patients had a pre-assessment for pain which helped guide post-operative pain relief. This showed that pain was well managed and considered at all stages of surgery. This included information about different types of pain relief and pain scoring. We also observed anaesthetic consultants and nursing staff discussing post-operative pain relief with patients in the recovery area.
- Patients told us they had no concerns around pain management and they knew what to do if they felt they needed further pain management.
- Discharge criteria from the recovery area post-operatively included a pain score.

**Nutrition and hydration**

- The hospital used the malnutrition universal screening tool (MUST) as part of pre-assessment screening. The MUST tool enabled staff to identify patients at risk of malnutrition and make adjustments to mitigate any risk where appropriate. We reviewed six sets of patients notes, which all provided evidence of MUST assessment.
- We saw evidence in patients notes that included a "dietary requirements record" completed as part of pre-assessment. This allowed staff to identify any special dietary requirements, such as gluten intolerance, before admission so they could advise the catering staff to prepare a suitable meal for the patient.
- An external contractor provided pre-cooked food for the hospital. We reviewed patient menus and saw a balanced diet with a variety of choices. This included options for vegetarians
- Dieticians were provided by the contractor to help patients with special dietary needs.
- Patients told us nurses offered them drinks as part of their hourly ward rounds. We also saw patients had access to a water jug at their bedside to enable them to stay hydrated.
- Staff advised patients about fasting times prior to surgery at pre-assessment and in their booking letter. The hospital aimed to ensure fasting times were as short as possible before surgery to prevent dehydration and reduce the risk of post-operative nausea and vomiting.

**Patient outcomes**

- There were several processes used to measure and audit patient outcomes; these included a quarterly internal audit programme, a monthly internal audit of surgical site infections,Patient Reported Outcome Measures (PROMS), the National Joint Register, Public Health England, the Endoscopy Management System and a number of consultant speciality specific registers such as British Association of Urological Surgeon's database.
- Patients were invited to participate in PROMs audits and data was captured for patients undergoing hip and knee replacement, hernia repair and varicose vein surgery. NHS PROMS data is not fed back to the hospital directly and very limited data was received from internal PROMs returns due to the small size of the hospital, small amount of data produced and small numbers of patients undergoing procedures.
- From April 2014 to March 2015 it was reported that out of 12 NHS patients undergoing primary knee replacement, 91% reported an improvement of their symptoms and 8% reported a worsening of their symptoms under the EQ-5D index. (Generic health status measure). The Oxford Knee Score for the same period reported 100% of NHS patients reported an improvement in their symptoms.
- From a review of 13 NHS patients undergoing primary hip replacement from April 2014 to March 2015 100% reported an improvement in their symptoms for the EQ-5D index.
- We saw evidence of an ongoing program designed to diagnose acute kidney injury(AKI); this is sudden damage to the kidneys that causes them to not workproperly. The hospital aimed to reduce the occurrence of AKI through effective fluid management, early identification of at risk patients through a robust pre-assessment process and defined pathway for treatment and transfer. It was reported in January 2016 100% of staff who administer intravenous fluids underwent further training to identify AKI.

Good

# Surgery

- Since January 2016 the hospital had commenced data collection from patients undergoing hip and knee replacement to submit to Public Health England Surveillance Surgical Site Infection surveillance audit. The return for Quarter 1 (2016) had been submitted and the first report was expected in September 2016.
- The hospitals PLACE scores were the same or higher than the England average for cleanliness, food, organisational food and ward food. However, they were lower than the England average for condition, appearance and maintenance, dementia, and privacy, dignity and wellbeing. The latter (privacy, dignity and wellbeing) being 10% below the England average.
- There were four unplanned transfers from the Nuffield Health Chichester Hospital to other hospitals from April 2015 to March 2016. This was not high when compared to other independent hospitals and within the expected range when compared to other Nuffield Health Hospitals. We saw patient notes in relation to all of these unplanned transfers and saw excellent recording of patient deterioration using the MEWS scoring.
- We spoke with a staff member who transferred one of these patients, they were able to clearly talk through the process of escalation and felt that the decision was taken to transfer the patient at the earliest possible opportunity to ensure patient safely and good outcomes.
- There were eight cases of unplanned re-admissions within 29 days of patient discharge between April 2105 and March 2016. This account for 0.17% of all admissions. This is not high when compared to other independent acute hospitals that the provider benchmarks against.
- There were four unplanned returns to the operating theatre, one between October and December 2015 and three between January and March 2016. This account for 0.9% of all admitted patients which is not high compared to other independent hospitals

**Competent staff**

- We spoke with the human resources lead for the hospital; they were able to show us that the provider had systems in place to ensure that staff were appropriately qualified and skilled.
- Resident medical officers (RMO) were supplied through an agency; part of the contract with the agency required that all mandatory training was up to date. New RMOs worked alongside an established RMO in the hospital for a week before they started working independently. We spoke to the RMO at the time of our inspection who praised this system and said it helped them settle in well.
- All employees had the necessary pre-employment checks completed prior to commencing work to ensure they were fit for practice. This included Disclosure and Barring Service (DBS) checks, references, qualification verification and an interview.
- We saw competency records for a surgical first assistant/ lead surgery practitioner. These showed that the first assistant had the correct qualifications and was competent to assist consultants during surgery and possessed the correct indemnity insurance.
- All new staff had an induction package with core competencies and knowledge that was signed off by their line manager, we saw examples of these along with compulsory online induction and 'New Starter Workbooks'. This aimed to enable staff to understand the broader purpose, vision and strategic direction of Nuffield Health and understand the business and the types of products and services offered.
- New staff were supernumerary for at least two weeks unless they were from another Nuffield hospital, in which case they had a week. This time was spent shadowing an existing staff member. We were told that if it was felt staff needed longer to fully integrate into the hospital they would be given a longer supernumerary period.
- There was a high level of staff being offered appraisal between January 2015 and December 2015 with both inpatient and theatre departments reporting 100% compliance. We saw evidence of four recent staff appraisals which were complete and documented online but also filed in individual staff folders. These folders also included information on completed training and identified areas for further development.

- There were processes in place for confirmation of practicing privileges. Consultants were offered privileges by the Medical Advisory Committee (MAC) only after human resources had received the necessary assurances.
- There was a database that highlighted where there was missing updates information for consultants already practicing and for new appointments. We saw from the MAC minutes that some consultants had been suspended from practicing at the hospital, as they had not provided the necessary paperwork. This showed the hospital was actively ensuring all staff had the necessary paperwork and took appropriate action if they did not comply.
- The hospital director and MAC chair both told us that one consultant had not been allowed to start admitting patients for a specific type of surgery as they had not provided sufficient evidence that they routinely provided the same procedure in their NHS work.
- All appraisals were shared with the trusts in which an individual consultant worked. Where the hospital director provided information for NHS appraisals, they routinely looked at data relating to that particular surgeons practice such as surgical site infections, complaints and mortality/morbidity.
- There was a robust performance management system in place. Concerns about staff performance were initially dealt with through informal discussions that were documented in the staff file. If concerns continued, the formal process was triggered in consultation with the HR lead supported by the Group Nuffield Health HR team.We were told this had never been necessary, but showed the process was in place if needed.
- An operating department practitioner (ODP) had produced an additional information file for agency workers which showed clearly where machines were located in the operating theatres so they would be able to place machines in a consistent place. This ensured a consistent working environment for all staff.

**Multidisciplinary working (in relation to this core service only)**

- Our review of records showed there were effective multidisciplinary working practices which involved nurses, doctors, pharmacists, and physiotherapists. We saw documented examples where physiotherapists had followed guidelines set by the patients' consultant.
- Consultants from some specialities worked in teams so that a consultant from the team always saw each patient daily. Usually this was the admitting consultant but might sometimes be one of the others when they were on call. On call, for some specialities, was shared between the local NHS trust and the Nuffield Health Hospital Chichester which allowed for a good understanding of where higher risk patients were and allowed for smoother planning of care.
- Sometimes an anaesthetic consultant saw a patient for the daily review, instead of the admitting consultant. This was when there were concerns about the general recovery of a patient to ensure there was a holistic consideration of their condition.
- The consultants felt the RMO employed were usually good and demonstrated sound judgement. They spoke with the RMO and gave explicit treatment plans for each patient daily. We spoke with the RMO during our inspection and he said he felt well supported by consultants and the team.
- It was felt by the MAC chair that the orthopaedic team at the hospital demonstrated very good multi-disciplinary working with streamlined patient care being delivered by nurses, physiotherapists and medical staff. Staff felt that recovery was very physiotherapy driven.
- Staff spoke of a good relationship between local hospitals and community carers. We heard of an example where a patient transfer had occurred on advice from a consultant based in the accident and emergency department at the local NHS hospital. Showing a collaborative way of working was embedded.

**Seven-day services**

- Theatre one and two both had the option of running three lists, lists ran from 8:30am-12:30pm, 1:30pm-5:30pm and an evening session from 5:30pm-8:30 pm.
- We were told occasionally theatres ran at the weekends.

- The endoscopy suite was available from Monday to Friday from 8:30 am to 8:30 pm.
- A senior nurse was on call every night and also at weekends should any issues arise.
- A part-time pharmacy service was provided on site at the Nuffield Health Chichester Hospital. A pharmacist was available on site 20 hours per week from 9am-2pm, four days a week, flexible hours to respond to the needs of the hospital. A pharmacy technician had recently been recruited to allow an increase in pharmacy hours available due to the increasing patient numbers in the hospital.
- There was no onsite dispensary but all medication was available within the departments. Outside of the pharmacist hours take home medication is dispensed by nurses and/or the RMO from a stock of pre-labelled medication located on the ward.
- A service level agreement (SLA) was in place with the local NHS Trust hospital, to provide pharmacy services, including pharmaceutical products on an occasional basis, if need arises including out of hours, Nuffield Health Chichester Hospital provided transport to pick up the medication and the bill for the medication prescribed.
- A local NHS hospital also provided medicines related information 24 hours a day, 365 days a year. Nuffield Health also had a contract in place with United Kingdom Medications Information (UKMI) to provide medicines information weekdays from 9am to 6pm. Each department held the contact details for UKMI and the local NHS hospital to enable access outside of Pharmacy hours.
- A physiotherapist was available seven days a week for any patients who needed to access this service.
- Consultants were on call should any issues arise with patients under their care. We saw a duty rota of consultants and their contact details clearly displayed in the ward office. Staff told us they never had trouble contacting consultants, if needed.
- There were appropriate cover arrangements in place for when a consultant could not attend to their own patient. We saw evidence that one consultant was not permitted to admit patients at the time of the inspection as they could not demonstrate suitable cover was in place.
- A small pathology department on site provides point of care testing for haematology and biochemistry. The RMO told us he could access this service out of hours with a nurse, if needed.

**Access to information**

- Staff had access to a range of policies. Policies were available on-line or in clearly marked folders.
- There was information on safeguarding on the noticeboards along with a duty of candour (DoC) flowchart, which clearly outlined the procedures and when to initiate them.
- In theatre, names of staff with particular departmental responsibilities were posted on the noticeboard with contact details, ensuring staff knew who to contact if they needed further support. We also saw the minutes of the last department meeting. This ensured that staff unable to make the meetings, were able to access the outcomes.
- NHS patients had their notes e-mailed directly to their GP surgery after discharge; all other patients were discharged with a letter outlining their treatment to deliver to their GP in person.
- Patients who were discharged to a residential home or other care facility would be provided with a separate letter to hand over to the care provider on arrival.
- Patient notes were stored off site. We were told that they could be delivered in as quickly as 10 minutes but routinely it took around 30 to 45 minutes.
- During the inspection we examined five sets of records from the endoscopy unit. These records were not stored on site but were available within 24 hours of them being requested. This demonstrated that the endoscopy unit also had a reliable recall system for patient notes.
- As all patients were planned admissions there was no delay in receiving patient notes as staff were aware at pre-admission which patients they would be receiving.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Good

# Surgery

- All patients over 65 all had a mental capacity assessment during pre-assessment. This showed a poor understanding of the principles of the Mental Capacity Act 2005. There should be an assumption that people have capacity unless there are grounds for thinking they might not have in relation to a specific decision (a presumption of capacity).
- We saw a copy of the hospital's Mental Capacity Assessment Form. This was intended for patients who lacked capacity to consent to treatment and had a section documenting the involvement of the patients' family and others close to them. The form recognised that while relatives and friends could not provide consent on the patient's behalf, it was important to involve them in the patient's care.
- On the endoscopy unit, if it was not known prior to a patient attending for a procedure that they might lack capacity, the consultant would make an assessment at the time. This was a more appropriate way to consider whether individual patients had capacity to consent to specific decisions but this was not recognised as such by staff.
- There were no patients with Deprivation of Liberty Safeguards (DOLs) in place during our inspection; however, staff we spoke with demonstrated a good awareness of the DOLs consent procedures and protocols.
- We saw a Nuffield Health Deprivation of Liberty Safeguards flowchart which guided staff through the process.
- We saw 14 sets of patient notes and looked at the consent forms within them. All had been completed in line with hospital policy, although five of them had illegible handwriting.
- Patients are given a Nuffield Health booklet which highlight many issues around consent, including taking time to consider all treatment options and what to do if you want to refuse treatment in advance.
- Staff we spoke with were aware of different types of consent (written, verbal and implied) and demonstrated clear understanding on obtaining consent.
- There had only been one Do Not Attempt Resuscitation (DNACPR) form used at the hospital in the year preceding the inspection. Appropriate safeguards had been put in place through recorded discussion with the patient and family. Although recovery was not expected, when the patient's condition improved further discussion was recorded and the DNACPR form was rescinded.
- Nurses on the wards and in the recovery area sought verbal consent from patients before taking observations and delivering general nursing care.

## Are surgery services caring?

Good

We rated caring as good because:

- Feedback from people who used the service and those who are close to them was very positive about the way staff treated people.
- Nuffield Health Chichester Hospital had many ways of collecting patient feedback and used this information to improve the patient experience.
- Staff treated people with dignity, respect and kindness during most interactions. Patients felt supported and cared for by staff.
- Staff encouraged patients and their loved ones to be partners in their care. Staff respected people's privacy and confidentiality at all times. The service helped people and those close to them cope emotionally with their care and treatment.
- The hospital could provide counselling services for patients, counsellors provided this service five days a week and patients' family and friends could also access the counselling service.
- However, we did see patients dignity compromised in theatre on occasions with patients' left exposed for a longer than essential period of time pre and post surgery.

### Compassionate care

- Patients were positive about the care and treatment they received. They described staff as friendly, helpful, caring, considerate, kind and respectful.
- Nuffield Health Chichester Hospital based its care of patients on the "Nuffield way of caring" which used the

nationally recognised '6C's' to deliver commitment, care, compassion, competence, communication and courage. We witnessed staff delivering highly compassionate care. We observed compassionate and caring interactions from staff.

- The hospital participated in the National Friends and Family Test scheme to gather patient feedback. Friends and family test results showed results for NHS patients of 96% and above for the period October 2015 to March 2016. A score above 50% was considered a positive indication that patients would recommend the hospital to family and friends, with 100% being the highest possible result. Response rates at Nuffield Health Chichester were lower than the England average of 40% (Independent sector) during the same period.
- A monthly patient satisfaction survey was used to obtain ongoing patient feedback on services and staff. In March 2016 the overall satisfaction rating was 95%. However in the four preceding months the result was lower than the Nuffield Health target of 95%.
- The endoscopy unit had developed it's own patient satisfaction survey. The trial started in June 2016 and 35 questionnaires were sent to patients with a pre-paid envelope, 25 of these had been returned. We read a random sample of 10, all were overwhelmingly positive
- We received 31 CQC comment cards from patients at the hospital. Some of the cards related to experiences in several areas of the hospital. There were 23 cards which related specifically to patients' experience of the wards, theatres and endoscopy suite. All the comment cards we received praised the hospital and staff. One patient wrote, "I entered the hospital to be greeted with smiles from everyone, which made me feel at ease."
- Patients told us that staff introduced themselves and addressed patients by their preferred name. Patients said the staff were very attentive, "On the ward, in theatre, in x-ray and in the clinic."
- We saw that staff respected patients' privacy and dignity. We saw staff in theatres closing the curtains around patients in recovery to protect their privacy when they needed to open the recovery door. We saw that staff on the ward always knocked on patients' bedroom doors to check the patient was happy for them to come in before they entered.
- The hospital conducted a patient satisfaction survey to help them to understand the patient experience during the period of April 2015-March 2016. The survey highlighted issues around communication, explanations around risks and benefits and outcomes of treatment. One conclusion was that better engagement was needed from consultants to make sure patients were better informed. Patients also highlighted that they felt it was increasingly busy at Nuffield Health Chichester.
- We observed staff delivering care discretely, shutting doors and always knocking before entering patient's rooms.
- There was evidence of a good rapport between patients and nurses and staff demonstrated professionalism and knowledge that provided reassurance and support to their patients during treatment.

However;

- We did see patient dignity not always being respected in theatres where we witnessed two patients unnecessarily uncovered from the waist down pre-operatively whilst awake with several members of staff present. One patient was uncovered for eight minutes with nine members of staff present. This could potentially leave the patient feeling embarrassed or vulnerable and did not demonstrate that the patient's dignity was being considered.
- We also witnessed theatre doors being opened whilst a patient was uncovered on the theatre table.

**Understanding and involvement of patients and those close to them**

- The service involved patients' relatives and people close to them in their care. We saw staff involved patients' relatives in their treatment at all stages of their hospital visit, from admission to discharge.
- Patients we spoke with were positive about the staff interaction with close family members. One patient described a nurse waiting until his spouse had arrived at the hospital so both were aware of the treatment plans and ensuring both of them were happy with his discharge plans.
- We spoke with one patient who had attended the endoscopy unit a number of times. They told us how they felt very much part of care planning. They also

spoke of how they are able to make their own choices about things such as whether they walked to theatre and when they felt well enough to leave the hospital. They also explained how their partner had felt they were included and cared for when they both attended the hospital.

- We heard how the consultant had helped the patient understand what they were doing by drawing simple diagrams as well as verbal explanations. They felt able to ask any questions about the procedures. At all times the patient said they felt they were treated with dignity and respect

**Emotional support**

- We saw staff in theatres providing emotional support to patients who were worried or anxious. For example, we saw an anaesthetist holding a patient's hand during a procedure to provide comfort and reassurance.
- The hospital could provide counselling services for patients. We saw counselling leaflets available for patients, which contained details of how to book an appointment. Trained counsellors provided this service five days a week, Monday to Friday. Patients' family and friends could also access the counselling service.
- Visiting hours were between 11am and 2pm, 3pm and 8:30pm. Although staff and patients we spoke to told us that visiting was extremely flexible and that family and friends could visit them any time during their stay.
- Patients had telephones in their bedrooms. This allowed patients to receive contact and emotional support from their loved ones while they recovered from surgery.
- Staff telephoned all patients 48 hours after discharge to check on their recovery.
- We saw a recovery nurse explaining who she was to a post-operative patient and clearly explaining what she was doing, throughout the patient's time there.

## Are surgery services responsive?

Good

We rated responsive, in surgery as good. This was because:

- The hospital planned and delivered surgical services in a way that met the needs of the local population. Services generally ran on time and delays and cancellations were minimal. Where there was delay, the service managed these appropriately.
- The service made reasonable adjustments and took action to remove barriers for people who found it hard to use or access services. Care and treatment was coordinated with other services and providers ensuring continuity of care and patients' needs delivered in a timely manner.
- We saw openness and transparency in how the service dealt with complaints. It was easy for people to complain or raise a concern. We saw openness and transparency in how the service dealt with complaints and evidence the service learnt from complaints and made improvements to working practices where appropriate.
- However, we were told by staff that relatives were used to interpret for patients who could not speak or understand English. This could lead to consent being given which was not fully informed, mis-interpretation and is not best practice. A telephone translation service was available.

**Service planning and delivery to meet the needs of local people**

- Services provided reflected the needs of the local population. The most recent census data showed there was a higher percentage of people aged 60 and over living in the local area compared to the England average. As a result the service planned surgeries to treat age-related conditions. This included eye surgery to treat age-related conditions such as macular degeneration (loss of central vision) and cataracts (Cataracts occur when changes in the lensof the eye cause it to become less transparent). The hospital also provided a high proportion of joint replacements, and orthopaedic surgery this accounted for 61% of all work at the hospital between April 2015 and March 2016.
- Patients having surgery attended for elective procedures such as hip and knee replacements and cataract surgery. Due to the elective nature of surgery at the hospital, service planning was relatively straightforward because the workload was predictable.

Good

# Surgery

- The theatre manager reviewed operating lists in advance. This ensured there was sufficient time to arrange all the necessary staff and equipment.
- Service planning in the unit was adaptable to the requirements of the patients. It was a flexible service that could react well to the addition of patients at short notice.
- Pallant ward was used for patients who required general anaesthetic and Northgate ward for all other patients. This was not exclusive and could change depending on demand.
- We heard from a patient who explained that the process from diagnosis through to treatment was handled very well and that the communication between the NHS hospital, GP, insurance company and Nuffield Health Chichester Hospital was swift and smooth.
- We saw that the facilities in theatres were appropriate for the services provided. For example, there were sufficient operating theatres and recovery space for the number and type of operations. However, we saw that the lack of an anaesthetic room in theatre two did affect the flow through the department.
- Throughout our visit, theatre lists generally ran on time. Staff delayed one patient's operation due to faulty machinery, the patient told us staff apologised for the delay and he was aware of the cause of the delay.
- We saw evidence from a staff member who had identified that patients were not informed adequately of wound and dressing care at home post-surgery. She had been on a training course to learn more around this subject and produced a booklet for patients to take home with them. This showed responsive staff who wanted to improve patient's experience.

**Access and flow**

- On arrival at the hospital, staff showed surgical patients to their rooms. We witnessed a patient being collected from reception shown to the room they would be staying in and the room's facilities, for example, the toilet and call bell.
- Patients changed and prepared for surgery in their room, staff then escorted patients to the anaesthetic room, or straight into the theatre, if patients were attending theatre two.
- There was not an anaesthetic room available in theatre two as it had been converted into a preparation room during the recent installation of laminar flow. This meant staff could prepare instrumentation required for surgery in advance reducing turnaround times. Staff told us this was a new initiative and was under constant review. We spoke to two patients post-surgery who were happy with the arrangements.
- Immediately after surgery, staff cared for patients in the recovery room. Once patients were stable and pain-free, staff took them back to the ward to continue recovering.
- Patients had a designated responsible adult to collect and escort them home from the ward after discharge. Day case patients went home the same day, and inpatients stayed on the ward for one or more nights after surgery.
- Nuffield Health Chichester Hospital reported 11 cancelled procedures for a non-clinical reason from April 2015 to March 2016. All 11 patients were offered another appointment within 28 days.
- Patients attending for an endoscopic procedure reported to reception at their appointment time and were taken to their room on the ward by the receptionist. They were admitted by the ward nurse and a consultant gained consent from the patient. The ward nurse or the consultant accompanied the patient to the endoscopy unit.
- The consultant monitored the patient, explained the use of Entonox (Entonox is a ready-to-use medical gas mixture consisting of 50% nitrous oxide and 50% oxygen for use in all situations where analgesia and sedation with rapid onset and offset is sought) and the nurse carried out observations. During the procedure there was the consultant, one trained nurse to assist the consultant and one nurse or health care assistant (HCA) to deal with the documentation.
- Referral to treatment waiting times (RTTs) for NHS-funded patients having elective inpatient surgery at the hospital showed that, on average, 93% of patients received treatment within 18 weeks of referral in from April 2105 to March 2016. This was better than the national target of 90%.
- The hospital met the RTT target for inpatient surgery in most months between April 2015 and March 2016.

Although NHS England abolished the national target in June 2015, the hospital continued to treat 90% or more of its inpatients for the majority of months within 18 weeks of referral. The worst months in this period were July and March, where they fell just short of 90% of patients receiving treatment within 18 weeks of referral. The best months were April, May and December, where 98% or higher percentage of patients received treatment within 18 weeks.

**Meeting people's individual needs**

- We saw a patient board on wards which highlighted patients that had extra needs, for example, diabetic patients and those at risk of falling. This showed that assessing peoples individual needs was being considered as soon as patients arrived at hospital.
- The hospital provided examples of individualised patient care through talking to the patient and clearly assessing and identifying their needs to achieve the optimal outcome. An example of this was visiting a patient at home to carry out MRSA swabs so that their admission was not delayed.
- Patients' living with dementia were provided with an extra health care assistant to ensure staff were able to cope with any increase in demand. Patients' relatives could also be accommodated in the hospital, if required, and were encouraged to stay with the patient.
- We reviewed four sets of patient notes that provided evidence of dementia screening.
- Staff told us patients living with dementia and their carers completed a "dementia passport" as part of the pre-assessment process. Staff on the ward told us all patients living with dementia attended surgery with their dementia passport.
- Dementia passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs. Patients with a learning disability also had individual care passports. However, we did not see any completed passports as there were no patients living with dementia or learning disabilities on the ward at the time of our visit.
- The endoscopy unit could access interpreters through language line. We looked at the policies for using relatives as interpreters. The policy was clear regarding who can and cannot act as an interpreter with particular parts around conflicts of interest and objectivity. The same principles applied to those with a hearing impairment.
- Staff understood and respected people's personal, cultural, social and religious needs. A member of staff told us they had recently adjusted the nursing routine to allow for a patients specific prayer time.
- However, we were told by a staff member on Pallant ward that they do use family members for interpretation. This is not considered best practice as hospital staff could not be sure the interpreter was correctly informing the patient about what had been said.

**Learning from complaints and concerns**

- There was a robust system in place for capturing learning from complaints and incidents. The senior management team were well informed about any complaints or incidents and changes were fed back through the heads of departments to frontline staff.
- We spoke with the complaint lead and hospital director, who both described an open and honest culture and a willingness to accept responsibility for any shortcomings.
- All complaints were reviewed and responded to by the hospital director, ideally within two days. The matron discussed concerns or complaints received with the departmental manager as soon as possible. Patients were also offered a meeting to discuss their complaint in person, in line with hospital policy.
- Consultants with practicing privileges were informed of all clinical complaints made to the hospital via the Medical Advisory Committee. We were told they would be given details of the complaint and asked to provide a formal response and were involved in any investigations.
- Incidents, risk and complaints were linked and group analysed through integrated governance reports and the electronic incident reporting system and used to inform service development and business planning.
- There was good local ownership of complaints and incidents with teams working together to resolve issues raised. We saw an example where a patient had come in

for surgery with a pre-existing leg ulcer and surgery had been delayed. The hospital now measures all patients for thrombo-elastic venous thromboembolism (VTE) stockings at pre assessment so their legs are fully examined before the day of surgery.

- We saw evidence that concerns raised through hospital survey and comment cards were acted upon. The hospital's website provided clear information on how to make a formal complaint. Printed information was also available throughout the hospital, and in patient rooms.
- The timescale for a response was 20 days or, where it was a complex situation requiring longer time to investigate, a holding letter was sent. The provider met their own timescales. In 2016, 15 complaints were received by the hospital. All except one very complex case received a response within the 20 days. This showed the hospitals targets for responding to complaints were being met.
- Hospital wide there were 32 complaints between April 2015 and March 2016. Of these none of them had been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service. All complaints are dealt with by the local management team and recorded on the incident reporting system which enables the provider to have full access.
- The last incident that the endoscopy unit had related to the wrong name being put on the wrong sample. Following the investigation into this, procedures were changed which introduced cross checking by another person. The learning was fed back to the team and the consultants practising at the hospital.
- We were told by the head of endoscopy how a member of hospital staff had become aware of a complaint that had been made about the endoscopic procedure they had. The complaint was not made directly to the hospital. The hospital then checked the patient's records and made contact with them to try to understand their concerns. The patient explained that they were in discomfort during the procedure. This was not noted in the records. As a result of this, the endoscopy unit has introduced the Gloucester comfort score. This is a method of recording discomfort during endoscopic procedures. They also improved the level of detail recorded during a procedure to allow them to move away from generic recording and recognise the individual need of each patient.

## Are surgery services well-led?

Good

We rated well-led as good because:

- The hospitals vision was delivered through the local hospital goals and objectives, and set out clear operational objectives which aligned with its strategy and vision for service provision.
- Leaders within the organisation functioned effectively and interacted with each other appropriately. Staff across the service enjoyed working at Nuffield Health Hospital Chichester and spoke of feeling valued and supported in their roles.
- Safety and quality received sufficient coverage in all relevant meetings. The hospital had a local Quality and Safety Governance Framework identifying and managing risk and where appropriate, risks were escalated.
- We saw and heard good examples of nursing leaders and managers nurturing others. The hospital director and matron were clear they wanted an organisation where staff felt comfortable about raising concerns and making suggestions for service improvement.
- The Hospital reinforced corporate messages through the regular monthly senior leadership and hospital leadership management meetings and individual departmental meetings
- We saw that staff wanted to learn, develop and improve their skills; they were given protected time, resources and encouragement to do so.
- Candour, openness, honesty and transparency were evident throughout the service. However the leadership had failed to identify some shortfalls in theatre practice.

**Vision and strategy for this core service**

Good

# Surgery

- The vision for the hospital was to be regarded by patients, consultants, insurers and staff as the first choice for patients seeking private treatment in the Chichester and surrounding areas.
- This vision was delivered through the local hospital goals and objectives, which aligned to the agreed hospital business plan and the Nuffield Health corporate strategy, governance, risk management and quality measurement. The hospital set out clear operational objective, which aligned with its strategy and vision for service provision.
- The hospital displayed it's vision, values and mission statement for staff and the public to see, however not all staff we spoke to were able to recount it.
- The hospital board reviews its strategic objectives monthly and communicates this through the hospital leadership team. There were good structures for reporting against the governance framework in place for all Nuffield hospitals with regional and national benchmarking against other Nuffield hospitals.
- Nuffield Health was in the process of redefining its overall vision and strategy to 'One Nuffield'. We were told that the hospital will be redeveloping its local vision and strategy in line with this over the coming months. The new strategy aimed to join up all aspects of the business into one complete health and wellbeing service, end to end.
- There was a clear vision for surgery, a recent decision to remove children's services and focusing on building a core service showed a clear direction.
- Nuffield Health Chichester Hospital based its care of patients on the "Nuffield way of caring" which used the nationally recognised '6C's' to deliver commitment, care, compassion, competence, communication and courage. These values did not feed into the appraisal system, but staff we spoke with felt they were embedded into everyday working

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

- The hospital had a clear diagram of the governance structure. At the centre of the structure was the Integrated Governance Committee. Eleven other committees fed into this, for example, the infection prevention committee and the staff forum committee.
- The local board (executive team) used the Nuffield assurance framework tool along with national lessons learned, national policy change and compliance with national guidance such as NICE and safety alerts.
- The board also received information from the monthly heads of departments meetings.
- Once the board had reviewed and considered the information, they produced an integrated governance report that was fed upwards via the regional structure to the provider and out to staff in the hospital via the heads of department.
- The theatre and ward manager represented surgery on the hospital's clinical governance committee. Consultant surgeons represented surgery on the Medical Advisory Committee (MAC).
- Attendance at the MAC was good and included the hospital director and the matron; meetings were cancelled if they were not well attended but this had only happened once. There was good cross speciality representation from consultants.
- Relationships between the hospital executives and MAC chair were good with regular formal and frequent informal discussions.
- We saw from the MAC minutes that the committee reviewed consultant's practicing privileges. This provided the executive team with assurance that consultants were competent to perform surgery at the hospital.
- Surgery staff reported to either the theatre manager or ward manager. Managers met with other heads of departments monthly and reported to the executive team. The hospital's integrated governance and MAC also provided quality and safety assurances to the executive team.
- The executive team consisted of the hospital director (registered manager) who had overall responsibility for the hospitals activities. The hospital director was supported by the senior leadership team which consisted of the sales and services manager, head of clinical services (matron), hospital finance manager and the theatre manager.

Good

# Surgery

- There was a good structure for reporting against the governance framework in place for all Nuffield hospitals with regional and national benchmarking against other Nuffield hospitals.
- The safety records were monitored monthly by the executive team using a Nuffield tool. This acted as a board assurance reporting tool and framework.
- The hospital had a local Quality and Safety Governance Framework to clearly identify and manage risk. The risk register was reviewed monthly by the hospital board and Health and Safety Committee. Where appropriate, risks were escalated to the Nuffield Group health and safety officer, regional director, chief nurse and medical director.
- Lessons learned were discussed and disseminated across the organisation. This was done through the head of departments. Action plans were monitored through the quarterly integrated governance committee.
- We saw a comprehensive clinical audit schedule to provide quality assurance. Audits related to surgery included hand hygiene, and the WHO five steps to safer surgery checklist.
- The theatre manager was the overall medical device user (MDU) representative for the hospital. They had monthly meetings with the overall Nuffield Health MDU, and information was cascaded via head of department (HOD) meetings and the integrated governance meetings.
- Staff told us members of the senior management team were visible and approachable. Staff reported the leadership culture made them feel valued, included and respected.
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas.
- We saw and heard good examples of nursing leaders and managers nurturing others. Regular staff meetings were held in all the departments these had a set agenda and we saw evidence of meeting minutes.
- The surgical and endoscopy departments we inspected had regular monthly meetings which had a set agenda and action points and we saw evidence of these.
- There was a provider whistleblowing policy that the executive team fully supported. The hospital director and matron were clear they wanted an organisation where staff felt comfortable about raising concerns and making suggestions for service improvement.
- The hospital told us no staff reported whistleblowing concerns in 2015. No staff reported whistleblowing concerns to the Care Quality Commission in the same period.
- The hospital took part in Nuffield Health provider visits. This was where staff from other Nuffield Health hospitals carried out internal quality inspections. Provider visits gave the hospital feedback to enable a continuous cycle of improvement.

**Leadership / culture of service related to this core service**

- There was a positive overlap of culture with a high performing local NHS trust where most of the consultants held contracts. We were told by the hospital executive and MAC chair that they understood and complied with the same expectations around behaviour and clinical practice across both organisations.
- There was a very strong 'top down' culture of acting in accordance with the duty of candour. Executive board members and staff showed an understanding of their responsibilities and a willingness to acknowledge shortcomings.
- We saw good local leadership from the theatre manager and ward managers. All staff we spoke to were very positive about their leadership. None of the staff we spoke with said they had experienced bullying from their colleagues or managers.
- The staff we spoke to were extremely proud to work for the organisation and felt that the care they provided was excellent. Staff told us it felt like a 'family' working at the hospital and it is a supportive place to work.
- Staff told us they felt able to raise concerns and felt that the hospital was transparent with a "non-judgemental, no blame" culture. We heard there was a strong culture of openness from junior to senior staff, clinical and non-clinical.
- Staff told us the culture of the service was focused on meeting the needs of patients.

Good

# Surgery

- The inpatient wards reported low rates of staff sickness, with less than 20% sickness rates across all staff groups between April 2015 and March 2016.
- The lowest sickness rate was 0% amongst all staff in October, November, December 2015 and January 2016, and the highest was 15% amongst healthcare assistants in August 2015.
- The theatre department also reported low rates of sickness, with less than 20% sickness rates across all staff groups between April 2015 and March 2016.
- The lowest sickness rate was 0% for example in April and May 2015, and the highest was 18% amongst operating department practitioners (ODP's) healthcare assistants in September 2015.
- There was a 17% staff turnover for nurses working in theatre department between April 2015 and March 2016. This figure was higher than the average staff turnover of other independent acute hospitals that the provider benchmarks against. It was explained that this was primarily due to staff retirement and maternity leave.
- The staff turnover for ODPs and theatre health care assistants was 18%. This figure was higher than the average staff turnover of other independent acute hospitals the provider benchmarks against.
- There was a 7% staff turnover for inpatient nurses in the same time period; this was not high when compared to the average staff turnover of other independent acute hospitals that the provider benchmarks against.
- There was no staff turnover for inpatient health care assistant in the same period.
- There was a 100% completion rate of validation of registration for nurses working in theatre departments in the reporting period between April 15 and March 2016.
- We were not provided with validation of registration for ODP's.
- We saw there was a 100% completion rate of validation of registration for doctors working under practicing privileges in the same period.

**Public and staff engagement**

- Patients and the public were given a wide range of information from the hospital's website for example information regarding NHS choices, self-funding options and performance outcomes.
- The endoscopy unit had developed it's own patient satisfaction survey. The trial started in June 2016 and 35 questionnaires were sent to patients with a pre-paid envelope, 25 of these had been returned. We read a random sample of 10, all were overwhelmingly positive. We did however see that there was no option for the patient to give full details of any issues they may have encountered, which would have enabled the hospital to discuss any concerns further.
- Organisational changes and regular updates were cascaded to all staff via monthly online newsletters ('In the loop') and weekly hospital bulletins.
- The Hospital reinforced corporate messages through the regular monthly senior leadership and hospital leadership management meetings and individual departmental meetings. In addition, new staff were provided with an induction pack setting out Nuffield Health and local hospital objectives and directing staff to appropriate policies, training and health & safety requirements. We saw examples of these during our inspection.
- We received nine comment cards from staff and visiting consultants at the hospital. All the comments written were positive and praised the care given to patients, the teamwork and the culture within the hospital.
- Staff wrote that the care of patients was paramount and that patients satisfaction survey results drove further improvements.
- The comments were positive about the local managers, in particular the endoscopy manager and one of the ward sisters. Staff talked about being supported by their managers and colleagues.
- There were notice boards in the staff rest room which gave information for staff about training opportunities, staff meetings minutes, and the results from audits and incidents.
- We saw that there was a staff forum committee. Staff told us they could raise issues for discussion and resolution through a network of methods for example monthly team meetings.

Good

# Surgery

- We were given examples of the hospital investing in their staff to improve their health and wellbeing for example an employee health surveillance service for staff, private health insurance and reduced price gym membership. However, we heard that the staff rest room in theatres was re decorated and paid for by the theatre staff as the hospital would not pay for it to be undertaken.
- Staff were recognised for their contribution they made to the hospital through its 'Staff Recognition Scheme'. The hospital also provided independent support to all staff through its 'Employee Assistance Programme'.
- All staff had the opportunity to access further training and development through the Nuffield Health Academy.
- Staff social events were arranged for all staff, including those employed through the third party contractors. In the week of the inspection there was a staff canal boat trip and we heard about afternoon tea at a local private members club for staff being presented with long service awards.

**Innovation, improvement and sustainability**

- We spoke to a nurse that had identified a need for greater patient information on wound care before discharge. The staff member had attended further training and produced a booklet which was being reviewed at the time of our inspection.

Good

# Outpatients and diagnostic imaging

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

## Information about the service

Nuffield Health Hospital Chichester provides a range of mostly surgical services including orthopaedics, general surgery, urology, gynaecology, cosmetic surgery, ophthalmology (eye), adult ear, nose and throat (ENT) and gastroenterology.

The outpatient and diagnostic imaging departments offer additional specialist services where assessment, treatment, monitoring and follow-up are required.

Orthopaedics, dermatology, ophthalmology and ENT were among the most attended clinics last year, accounting for 55% of all outpatients seen. There were 12,604 attendances in the reporting period (April 2015 to March 2016), of which 17% were NHS funded and 83% were either 'self-paid' or funded by medical insurance. In addition to these consultant-led clinics, the department provides a physiotherapy service through a combination of in-house treatments and outpatient physiotherapy based at the Nuffield Health Chichester Fitness and Wellbeing Centre. The latter service was not part of this inspection. Outpatient facilities comprise five general consulting rooms, two ophthalmic rooms and two minor treatment rooms. All are based on the ground floor of the hospital and share a waiting area with diagnostic imaging. The outpatient sister also manages the pre-assessment service, situated in two rooms on the first floor.

The imaging department includes magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, fluoroscopy (ophthalmology rooms) and an x-ray area. MRI and CT scanners were part of a mobile service sited in the hospital grounds and provided by an external contractor. This facility was not part of this inspection.

The MRI facility operates four days a week and the CT facility operates one day per week. The outpatient physiotherapy service is provided by the Nuffield Health Fitness & Wellbeing Centre and operates seven days per week. Inpatient physiotherapy and pre-assessment services were available seven days a week.

The outpatient inspection took place over two days, 12-13 July 2016, during which we visited a range of services. During the inspection, we spoke with nine members of staff, which included consultants, managers, nurses, administrative staff and allied health professionals.

We spoke with six patients and reviewed comment cards from other visitors and their relatives. We also reviewed documentary information such as meeting notes and policy papers. In addition, we took into account feedback from discussion and written communications from stakeholders. During our visit, we observed activities, staff interaction with people using the service, checked equipment and the patient environment and reviewed patient records.

Good

# Outpatients and diagnostic imaging

## Summary of findings

We rated the outpatients and diagnostic imaging services provided at Nuffield Health Hospital Chichester as good, because:

- There was a focus on patient safety within outpatient services. Medicines were stored safely and checks on emergency resuscitation equipment were performed routinely. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training specific for their roles. Staff had appropriate safeguarding awareness and people were protected from abuse
- People's privacy was always protected in outpatient and diagnostic areas. Staff knocked on doors before entering rooms, used curtains appropriately and were careful to avoid conversations in corridors.
- Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- The leadership, governance and culture within the departments promoted the delivery of person centred care. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.
- The method for tracking medical records was reliable and we saw innovative practice concerning sharing physiotherapy treatment notes between the hospital and the external rehabilitation site.

## Are outpatients and diagnostic imaging services safe?

Good

We rated the safety of outpatient and diagnostic imaging services at Nuffield Health Hospital Chichester as good. This was because:

- People were protected from avoidable harm and abuse. There were robust systems in place for the prevention and control of infection, safeguarding people from abuse and medicines management.
- There were appropriate safeguarding arrangements in line with current national guidance. Staff demonstrated a good understanding of the provider policy and there were embedded systems to identify and act upon any concerns about patients' safety.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities and were supported to report concerns, incidents and near misses. Opportunities to learn from incidents locally and corporately were identified.
- There were sufficient staff with appropriate skills to ensure people were safely cared for.

**Incidents**

- Five clinical and three non-clinical incidents occurred within Outpatient and Diagnostic Imaging services in the last year. No trends or patterns were apparent. The incidents per 100 outpatient attendances were lower than similar independent hospitals that CQC holds data about.
- The hospital reported no never events or serious incidents between April 2015 and March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. Providers are obliged to report never events for any patient receiving NHS funded care and the occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.

Good

# Outpatients and diagnostic imaging

- There were no incidents reported to the Care Quality Commission concerning the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).Imaging staff had a good understanding of the need to report any IRMER incidents
- Staff described how learning from incidents took place at local and corporate level. We saw meeting minutes and nursing and physiotherapy staff appraisal records that confirmed this.
- Staff were clear about their obligations under duty of candour and gave appropriate responses to scenario-based questions. There were no incidents that would trigger a formal duty of candour (DoC) response. DoC requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. Duty of candour was incorporated into the mandatory training program (business ethics) and according to records supplied by the hospital, all imaging and outpatient s staff had completed the training.

**Cleanliness, infection control and hygiene**

- Overall, we found that the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015) was complied with in outpatient and diagnostic imaging services.
- No cases of Methicillin Susceptible Staphylococcus aureus (MSSA), Clostridium difficile (C. diff) or Escherichia coli (E. coli) were reported in the last year. These rates are all below the England average for similar healthcare institutions.
- All areas were tidy, visibly clean and uncluttered. An in-house team of housekeepers carried out the cleaning and we saw examples of cleaning schedules and checklists that had been completed.
- Staff participated in infection control training as part of their annual mandatory training program. One hundred per cent of staff had attended training in the last year.
- Staff had access to and were observed using personal protective equipment such as gloves and aprons in all areas visited. All sizes of gloves were readily available in purpose-made dispensers.
- Hand gel was available at all outpatient waiting areas and we saw staff using the gel.
- Clinical wash-hand basins were installed in all clinical areas. These were medium or large integral back-outlet basins with mixer taps and no plugs as recommended in Health Building Note (00-10 (2013): Part C – Sanitary assemblies). We saw guidance posters on hand hygiene displayed above soap dispensers in rooms and toilets. These served to remind staff of the correct hand hygiene procedures to reduce the risk of infection to patients.
- An infection control link nurse was nominated for each area and their activities coordinated through an infection control sub-committee of the Medical Advisory Committee (MAC). We saw examples of completed infection control audits. These audits help the managers and staff to assess the effectiveness of their infection control measures and to pinpoint any areas that might require improvement.
- Waste in clinic rooms was separated and in different coloured bins used to identify categories of waste. This allowed the hospital to safely handle biological or hazardous waste safely and was in accordance with HTM 07-01, Control of Substance Hazardous to Health (COSHH) and Health and Safety at Work Regulations.

**Environment and equipment**

- The outpatient environments we observed supported the safe delivery of diagnosis, treatment and care. For example, consultation rooms were well lit, air-conditioned and equipped with appropriate levels of sterile consumables held in covered trolleys and storage racks.
- All rooms had call buzzers fitted so emergency assistance could be quickly summoned.
- There was access to emergency equipment, including, oxygen and resuscitation items. We saw evidence that staff had inspected and checked this equipment daily and that emergency drugs were checked monthly by pharmacy.

Good

# Outpatients and diagnostic imaging

- Patient examination couches, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provided assurance that items were controlled and maintained in accordance with manufacturer recommendations and policy guidelines.
- We saw sharps bins available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). The bins were secure containers, clearly marked and placed close to work areas where medical sharps were used. The bin labels included clear instructions for staff on safe disposal.
- We checked several devices in each of the 10 rooms we visited. Electrical devices were labelled with the dates of the most recent electrical safety testing. This provided a visual check that they had been examined to ensure they were safe to use. An exception was observed in Consulting Room 2, where labels were missing from a portable electric radiator and a wall mounted x-ray viewer. We informed the sister in charge, who reported our findings to the maintenance engineer.
- One consultant brought their own ophthalmic laser into the hospital. The records relating to this were incomplete. The document history could not provide full assurance that the device had been cleaned, maintained and calibrated in accordance with the manufacturer's recommendations.
- The departmental health and safety file was reviewed and contained copies of relevant and in-date risk assessments. Each document had signed staff lists attached, which indicated that staff were routinely reading latest updates. The file also contained staff "hand monitoring" forms designed to help managers detect any staff developing skin reactions to latex gloves or cleaning agents. The file and records were clearly presented and complete.
- Safety signage and visual warning lights were displayed externally on rooms where x-ray or laser procedures took place. This helped to keep staff and patients safe by deterring people from entering when procedures were underway.
- Maintenance contracts with external providers had been arranged for larger items of technical equipment, such as ophthalmic examination tables. We saw examples of equipment files and computer records containing these details.
- Single use items of sterile equipment were readily available and stored appropriately in all areas checked. Instruments used for patient treatment that required decontamination and sterilisation were processed through the off-site sterile supplies department.

**Medicines**

- Each consulting room contained a copy of the British National Formulary (BNF) Issue 71, which is the latest edition in print. The BNF is updated in book form twice a year and details all medicines that are generally prescribed in the UK, with information about indications and dosages, contraindications, cautions and side effects. It is considered an essential adjunct to safe prescribing and the availability of the latest copy indicted that an appropriate level of support was provided to the consultant in clinic.
- We saw medicines kept in outpatients were stored in a locked cupboard and a registered health professional held the keys. This was in line with standards for good medicines management and prevented unauthorised access to medicines.
- Medicines were removed from the locked cupboards by the nurse at the start of clinic and placed in unlocked clinic rooms with doctors in attendance. During clinic, medicines were the responsibility of the consultant in the clinic.
- Doctors' hand wrote prescriptions on private prescription (SPF100) forms. Each prescription had a serial number on it. A registered nurse gave a pad to each doctor at the start of clinic who kept the pad in an unlocked clinic room. The pads were then checked and stored in a locked room at the end of clinic. This reduced the chance of a prescription form being lost or stolen.
- Medicines requiring refrigeration were stored in locked fridges. We saw the temperature of medicine fridges was

monitored daily and the fridge temperature remained within range. This provided assurances that staff stored refrigerated drugs within the correct temperature range to maintain their function and safety.

- In imaging, we saw patient group directions (PGDs) for the contrast media being used. These were in date and correctly completed. PGDs are documents permitting the supply of prescription-only medicines (POMs) to groups of patients, without individual prescriptions.

**Records**

- The hospital supplied information that showed five percent of patients were seen in outpatients without all relevant medical records being available, which is higher than other hospitals we hold data for. Staff confirmed these figures when we spoke to them but denied this affected patient care as records were obtainable from the archive with a few hours if needed. Imaging and x-ray records were stored and retrieved electronically.
- Patient records for first appointments were brought to the clinic by individual consultants. A copy of the appointment record was then kept with the patient's medical records at the hospital. Where the patient had prior contact with the hospital, the records were retrieved from the archive facility by an OPD administrator or medical secretary.
- We were told that all Nuffield files relating to an admission in the last six months remained in the hospital's Medical Record facility. For patients last seen prior to this, their medical records were stored off site by a third party contractor and in urgent cases; these records could be retrieved within three hours. We saw this in practice when we reviewed medical records at the hospital. Correct completion of accurate and contemporaneous medical records formed part of the practicing privileges agreement for all consultants. Consultants were registered as data controllers and any breaches in information security were reported through the incident risk management system. We were informed that the Nuffield Group Information Risk Manager was automatically notified in this event and a formal investigation followed.
- The consultants' medical secretaries co-ordinated the information about patients when they had been seen in other hospitals or by their GP previously.
- We saw that when a patient was discharged from the ward area and an appointment is made for them to be seen in the outpatient department, the notes were labelled and taken to the outpatient department so that they were available for the appointment.
- The physiotherapy notes we reviewed comprised of paper and electronic records. Physiotherapy outpatient treatment notes were scanned in and made available to the physiotherapists in the Nuffield Health Chichester Fitness and Wellbeing Centre. Likewise, progress reports were attached to the record and the physiotherapist at either location could add date and time recorded notes to the file and email each other. This meant staff could access up-to-date records for patients who attended appointments at both locations. We were told this arrangement was unique to this hospital as none others in the Nuffield group had outpatient physiotherapy performed off site.

**Safeguarding**

- Training data provided to us before the inspection showed 100% compliance with safeguarding training for both adults and children at level one.
- There were no safeguarding concerns reported to the CQC in the last year and we saw that the hospital had ceased accepting children in October 2015. The hospital were aware that although children were not actively treated this did not negate the statutory duty and apart from the matron and ward manager, the OPD sister and another nurse in the outpatients department had completed level three training, which was appropriate for this type of service.
- Nursing, radiology and physiotherapy staff we spoke with demonstrated a good awareness of what to do if they had safeguarding concerns and who to contact should they require advice. We were shown a prompt sheet for reporting female genital mutilation (FGM), which had been produced as part of the corporate policy. Similarly, we saw safeguarding and FGM flow-chart posters prominently displayed on the OPD staff notice board to remind staff of the correct processes.

**Mandatory training**

Good

# Outpatients and diagnostic imaging

- All staff completed mandatory training using online learning and assessment programmes. Compliance rates were monitored and staff advised when necessary.
- Training data showed that OPD achieved 100% compliance in 21 subjects such as manual handling and fire safety. Staff achieved 80% in Basic Life Support (BLS) and Intermediate Life Support (ILS). This was worse than the Nuffield Health target of 85%.
- The four radiology staff achieved 100% in all topics except BLS, incident reporting and infection control (75%). One newer radiographer was due to complete these topics and similarly, a new physiotherapist (one of two staff) had to complete safeguarding and infection control. Managers described action plans to remedy these shortfalls.
- The Duty of Candour and Mental Capacity Act 2005 were integral parts of the mandatory training programme.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.

**Assessing and responding to patient risk**

- During the inspection, the third-party CT scanner failed. Six patients had already arrived and another six were expected. Attempts were made to contact those not already at OPD and we saw a robust and appropriate response based on clinical priority.
- One urgent case (scan requested in less than seven days) was transferred to the local NHS facility that day. Others were given the option to stay or rebook and the facility planned to extend it hours when repaired.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff, which indicated they had read the rules. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored in folders in each room.
- We observed good radiation compliance during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) for patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required, which complied with IRMER.
- The Radiation Protection Advisor, provided as part of a contract with a London-based NHS trust, performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks. This helped to assure the hospital that equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IRMER 2000. We saw complete and accurate records of these checks during our visit.
- Lead aprons limit exposure to radiation to keep patients safe. We saw lead aprons available in all imaging areas of the department.
- Signs advising women who may be pregnant to inform staff were clearly displayed (in 24 languages) in the diagnostic imaging suite, in line with best practice. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.
- We saw three-point identification checks for patients taking place. This helped ensure that patients received the test ordered by the doctor and prevented excessive exposure to ionising radiation. In addition to this, additional checks were undertaken to ensure patients did not receive more than one screening scan in a 12-month period.
- Immediate or emergency assistance could be summoned by the use of the hospital 'crash call' or resuscitation team. Medical assistance was provided by the RMO and the patient's consultant.
- There were clear and known protocols in place for the transfer of patients to the local NHS accident and emergency facility by ambulance.

**Nursing staffing**

- Nursing cover was calculated dependent on the number of clinics running and the numbers of patients attending clinic as well as other factors such as procedure support and chaperoning. We were shown electronic rostering for staffing which indicated forward planning.
- The outpatient clinics were staffed by registered nurses and health care assistants. According to data provided,

the ratio of nurse to health care assistant showed an appropriate skills mix to meet the needs of patients. We saw sufficient staff present during our inspection and we saw that no agency nurses or health care assistants had worked in the department in the three months before our visit.

- Based on hospital data, the use of bank staff for outpatient nurses and health care assistants was not high in comparison to other independent acute hospitals.
- Nursing staff turnover was 28% last year, making it higher than the average staff turnover of other independent acute hospitals. We were told this figure has stabilised since and the sickness rates for nurses and healthcare assistants were not high when compared to similar independent hospitals.
- The hospital reported they had no unfilled shifts during the last three months. This meant the service had sufficient nursing staff on all shifts to provide appropriate care and support.

**Medical staffing**

- Radiology consultants were on-site during clinic hours to cover urgent work and the reporting requirements for the hospital. In addition, the radiology consortium provided an on-call service utilising image sharing computer software.
- OPD clinics were timetabled to suit each specialist's availability and obligation as part of the consultant's practicing privileges contract. Consultants in clinic were supported by the RMO or consultant colleagues in cases where urgent or additional medical support was required.

**Professions Allied to Medicine**

- According to the radiology manager, it was difficult to recruit radiographers to a smaller department offering less specialities than a larger health organisation. We were unable to determine staff turnover for this area as figures supplied were consolidated with other staff groups. We were told that turnover and sickness was generally low.
- The department was currently training an outpatients' health care assistant to help with ultrasound lists, which would improve the department's capacity to provide scans in future.
- Staff from the department provided a mobile x-ray service to the operating theatres.

**Major incident awareness and training**

- We saw notice board displays showing recent fire and evacuation simulations. Staff also described participating in biannual regular cardiac arrest medical emergency simulations.
- We were able to observe the business continuity response of the diagnostic imaging department as they successfully managed the failure of the CT machine through a technical fault.

## Are outpatients and diagnostic imaging services effective?

Overall we rated the Outpatient and Diagnostic services as 'Good' for effectiveness. This was because;

- There was evidence of good multidisciplinary team working in clinics, within the diagnostic imaging department and across the specialities. Where people received care from different practitioners, this was co-ordinated effectively.
- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. The results of audits, such as hand hygiene audits, were used to inform and improve service delivery.
- 'Pause and check' posters were displayed on imaging suite walls to act as a visual reminder for staff to complete patient identification checks prior to imaging.
- Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as required.
- Peoples' care and treatment was planned and delivered in line with current evidence-based guidance, standards and legislation. Staff in all areas had a good awareness

of Nuffield Health policies which were based on National Institute for Health and Care Excellence (NICE) guidelines and we saw Royal College of Radiology standards being demonstrated in their imaging practise.

**Evidence-based care and treatment**

- Policy documents had been written and updated regularly by Nuffield Health and cascaded to the hospital for implementation. These were available on the hospital intranet as well as in files located in the OPD staff office. We also saw examples of local policies and standard operating procedures such as a laser rules statement and local rules.
- We saw that policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. New NICE guidelines are sent to the hospital monthly by the quality care team. These were assessed within the hospital for their relevance by the MAC and cascaded, including to Consultants.
- Practice was developed with consideration for NICE guidelines, such as Total hip replacement and resurfacing arthroplasty for end-stage arthritis of the hip, Technology appraisal guidance [TA304]
- The hospital had a Medical Advisory committee, which met quarterly to review clinical performance, incidents or complaints and obtain feedback from the consultant body on new developments and initiatives from within the various specialities.
- Staff followed the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists (RCR) Standards in the speciality areas we visited. We saw evidence of checks and audits that demonstrated the department monitored compliance with these guidelines. For example, we saw annual x-ray dosage and referral card audits, which were completed and satisfactory.
- Audits included environmental, hand washing and infection control checks and the results of these were shared among staff. We observed examples shared in monthly team meeting notes and on staff notice boards.
- We also saw examples of clinical audits that changed practice, such as an audit of hip dislocations following total hip replacement surgery. The results of the audit supported literature reviews that questioned the effectiveness of physiotherapy interventions focused on training patients to use modified furniture and advice on hip precautions. After presenting the results to the MAC, new guidelines were implemented. We were shown a presentation on this topic delivered to local physiotherapists in January 2016 as part of the hospital's continuous professional development programme.

**Pain relief**

- The OPD had stocks of pain relieving medication, which was available to give to patients, on prescription by a consultant, as required.
- Staff described a pain assessment tool where patients were asked to score discomfort based on a range from 0-10, however we did not observe any instances in clinic where patients complained of pain. The use of a pain scoring system allows staff to give appropriate medication or support with alternative pain management techniques and review the effectiveness of the intervention.

**Patient outcomes**

- We saw examples of physiotherapy and radiology outcomes listed in electronic records. There were a variety of processes described to measure and audit patient outcomes, including a quarterly internal audit programme and National Joint Register.
- The hospital also used a propriety computerised reporting system to provide data on patients who required readmission, transfer to another hospital, unplanned return to theatre, infections, incidents relating to a thrombolytic event or other significant events.
- The radiology department was not currently accredited by The Royal College of Radiographers Imaging Services Accreditation Scheme (ISAS) but the Nuffield Group was looking into this and had an initial meeting with ISAS to work towards achieving accreditation by 2019.

**Competent staff**

- We spoke with the HR lead for the hospital, who was able to show us that the provider had systems in place to ensure that staff were appropriately recruited.

Good

# Outpatients and diagnostic imaging

- All employees had the necessary pre-employment checks completed prior to commencing work. This included Disclosure and Barring Service (DBS) checks, references, qualification verification and an interview.
- The hospital reported 100% completion rate of validation of registration for doctors and dentists working under practicing privileges and 81% for nurses in the reporting period April 2015 to March 2016.
- All new staff had an induction package, which included core competencies, and knowledge that was signed off by their line manager. We saw examples of this in the staff files we reviewed.
- All staff had annual appraisals and we saw examples on staff files we reviewed. Regular appraisal allowed the hospital to identify and monitor staff performance and personal development.
- There was a robust performance management system in place. Concerns about staff performance were initially dealt with through informal discussions that were documented in the staff file. If concerns continued, the formal process was triggered in consultation with the HR lead supported by a third party HR support partnership. We were told this had never been necessary.
- Staff had training in the newly implemented dementia care policy.
- There were processes in place for confirmation of practicing privileges. Consultants were offered privileges by the medical advisory committee (MAC) only after HR had received the necessary assurance documentation.
- There was a database that highlighted where there was missing updates information for consultants already practicing and new appointments.
- We saw from the MAC minutes that some consultants had been suspended from practicing at the hospital, as they had not provided the necessary paperwork.
- The Hospital Director and MAC chair both told us that one consultant had not been allowed to start admitting patients for a specific type of surgery, as they had not provided sufficient evidence that they routinely provided the same procedure in their NHS work.
- All appraisals were shared with the NHS trust in which a consultant worked. Where the Hospital Director provided information for NHS appraisals, they routinely looked at data relating to that particular surgeon's practice such as surgical site infections, complaints and mortality or morbidity.

**Multidisciplinary working (related to this core service)**

- In addition to reporting to the hospital management, radiology and physiotherapy managers also worked with regionally based professional leads.
- Staff across the hospital worked together in a multidisciplinary approach. There was consistent evidence of close collaboration across different services within outpatients and diagnostic imaging.
- Staff told us they felt well supported by other staff groups and there was good communication within the teams. We heard positive feedback from staff at all grades about the "great team" and "excellent teamwork" within the hospital generally.
- We were told that effective communications were also maintained with the mobile imaging service and physiotherapists based at the wellbeing centre and we saw examples of emails, professional development events and meeting notes to support this.

**Seven-day services**

- Outpatients and imaging were open six days a week. The MRI facility operated five days a week, as did the external outpatient physiotherapy service. Inpatient physiotherapy and pre-assessment services were available seven days a week. The hospital had a formal arrangement with the radiology consortium for out of hours on call advice, which was supported by an electronic picture archiving and communication system (PACS).

**Access to information**

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet. Overall, staff were positive about the intranet and reported managers communicated effectively with them via e-mail.
- We were given examples of information shared with the local NHS Trust, such as consultant to consultant advice from the radiology consortium, which was based at a local hospital.

Good

# Outpatients and diagnostic imaging

- Access to blood tests results and imaging was provided electronically. We were shown examples of reports communicated from the Wessex Pathology Laboratory, which was the "cluster laboratory" for this and another two Nuffield Health Hospitals in the region.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- We saw consent documented in the medical records and saw forms in consultation rooms but did not directly observe this aspect of a formal consultations in OPD or have an opportunity to see interventional imaging during our visit. We saw examples of verbal consent demonstrated in the x-ray room and treatment rooms.
- The provider had a policy to guide staff in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA). We did not observe any situations where this policy needed to be applied during the inspection. Nursing staff we spoke to demonstrated awareness of how the Mental Capacity Act 2005 related to their practise and were aware of who to contact if they required guidance.

## Are outpatients and diagnostic imaging services caring?

Good

We rated the outpatient and diagnostic services at Nuffield Health Hospital Chichester as good for caring. This was because:

- People were treated with kindness, dignity, respect and compassion whilst they received care and treatment. Feedback from patients and relatives that we spoke to during our inspection visit was entirely and enthusiastically positive.
- Patients felt supported and informed at all stages of their care. Staff took time to explain the possible options and treatment plan with patients, and their relatives. The costs involved were also discussed openly.
- Patients and relatives commented very positively about the care provided to them by the staff from the clinics we visited. They talked about consultants who listened and had time to answer questions.
- Feedback was sought from patients and used to monitor and improve care delivery. Any negative feedback was responded to and action taken, where possible to address the concerns.

**Compassionate care**

- We observed staff being compassionate and caring. This was supported by the patients we spoke to as they expressed positive views about their experiences at the centre.
- We received 31 comment cards from patients who had recently visited the hospital. Nineteen cards related specifically to the outpatient's department.
- The comments we received were very positive and praised the hospital staff and environment. Patients talked about staff being, "Warm and professional". One radiology patient we spoke to said the "staff couldn't do more" and similar positive comments were received from the physiotherapy patients.
- The NHS Friends and Family Test (FFT) is an anonymous patient satisfaction survey created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. The hospital scored 100% for inpatients and 98% for outpatients. This showed that patients were positive about recommending the hospital to their friends and family.
- Several patients told us that staff and their consultant had the time to explain things in detail and allowed time for any questions. Patients reported feeling part of the decision-making about their treatment and care.
- We saw radiology staff ensuring that patients' dignity was maintained despite the need to wear examination gowns during the imaging process.
- Consulting and clinical treatment room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. All clinic room doors had 'free/engaged' signs and we observed staff using these.

**Understanding and involvement of patients and those close to them**

- Staff photographs and names were clearly and legibly displayed on the waiting room wall and we saw patient satisfaction scores displayed in the hospital main entrance.

Good

# Outpatients and diagnostic imaging

- Patients told us that the consultants took time to make sure they had understood the options available, what the treatment involved and the longer term implications. Patients were given explanations of what each option meant in terms of risks and outcomes.
- A range of literature and health education leaflets were also on display in the waiting area.
- The radiology suite had safety notices in several languages.
- New reading glasses in assorted magnifications were on display at the reception desk and were freely available to any visitor to allow them to read the information that was displayed or to read a newspaper whilst they were waiting.

**Emotional support**

- Patients told us that staff and consultants working in the outpatient clinics were approachable and "had the time to explain everything". Information such as side effects of medicine were also made clear.
- We saw relatives being invited to accompany patients into consultation rooms, which indicated that the hospital encouraged a friend or partner to attend the appointment in order to provide emotional support.
- Chaperones were offered and available whenever required. Nurses were usually present during consultations and provided further information or reassurance when necessary.

## Are outpatients and diagnostic imaging services responsive?

Good

We rated the outpatient and diagnostic services at Nuffield Health Hospital Chichester as good for responsive. This was because:

- People's needs were met through the way services were planned and delivered. For NHS patients, referral to treatment times was better than the England average for 10 out of the last 12 months.
- Patients were kept well informed of waiting times in some clinics and delays rarely occurred.
- Services had been planned and were being delivered to meet the needs of individual patients. Staff were empathetic and understood the needs of their patients.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.

**Service planning and delivery to meet the needs of local people**

- A wide range of outpatient services were available to meet the needs of the client group.
- The environment provided was appropriate and patient centred, with comfortable and sufficient seating, toilet and refreshment facilities.
- Outpatient clinics were supported by diagnostic and pathology services including Magnetic Resonance Imaging (MRI) scans, x-ray, Computerised Tomography (CT) scans and ultrasound scans. Although some services such as MRI and CT scans were outsourced, these facilities supported clinical decision-making by the treating specialists.
- The imaging department used picture archiving and communication system (PACS) technology. This enabled the hospital to quickly store, retrieve, distribute and view high-quality medical images. For example, the department was able to share images with the local NHS hospital, if the need arose.
- Evening and Saturday outpatient clinics were routinely offered, which afforded additional choice and convenience to patients and particularly those that worked or had childcare commitments during the week.

**Access and flow**

- GPs referred the majority of new patients attending the department. We were told that physiotherapy and referrals from other registered practitioners were also accepted by insurers.
- Follow up appointments were arranged according to the request of consultants and the needs of patients.
- Opening hours for outpatient clinics varied and specific clinics were held on different days and at variable times to ensure that there was provision for patients with restricted availability.

Good

# Outpatients and diagnostic imaging

- Referral to Treatment Time (RTT) for non-admitted pathways were between 91% and 100%.There was a noticeable dip in performance in June 2016 but this was very much a one off.

**Meeting people's individual needs**

- Free car parking was provided on-site for the convenience of visitors.
- Hearing loops were available in the waiting area, which helped those who used hearing aids to access services on an equal basis to others.
- We observed the waiting room and clinic areas to be accessible to all including wheelchair users, although we saw a lack of space in the x-ray room that limited wheelchair mobility.
- Both imaging and clinics shared the use of the OPD reception desk. We saw no signs of congestion during our visit.
- Patient Led Assessments of the Care Environment (PLACE) for July 2015 showed the hospital scored 74% for dementia, which was lower than the England average.
- Adults in vulnerable circumstances, such as those living with a learning disability or dementia were identified at the pre-assessment stage and steps were taken to ensure they were appropriately cared for. Dementia passports were used to help easily identify patients extra assistance and we saw other features that were designed to help patients with sensory or mobility disabilities. For example, level access from the car park, wide internal doors and spacious rooms for wheelchair users and the provision of a hearing aid loop for those wearing aids.

**Learning from complaints and concerns**

- We spoke with the complaint lead and hospital director, who both described an open and honest culture and a willingness to accept responsibility for any shortcomings.
- There was a robust system in place for capturing learning from complaints and incidents. The senior management team were well informed about any complaints or incidents and changes were fed back through the heads of departments to frontline staff.
- Consultants with practicing privileges were informed of all complaints made to the hospital via the Medical Advisory Committee.
- There was good local ownership of complaints and incidents with teams working together to resolve issues that arose. Complaints and concerns were responded to effectively, support was offered and a full investigation completed. Face-to-face resolution was offered to all people raising complaints.
- Concerns picked up through the survey and comment cards were acted upon.
- There was a very strong "top down" culture of acting in accordance with the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. Executive board members and staff showed an understanding of their responsibilities and a willingness to acknowledge shortcomings.
- The matron discussed any concerns or complaints received with the departmental manager as soon as possible.
- All written complaints were acknowledged within two days of receipt.
- The timescale for a response was 20 days or, where it was a complex situation requiring longer time to investigate, a holding letter was sent. The provider met their own timescales. In 2016, 15 complaints were received by the hospital. All except one very complex case received a response within the 20 days.
- Where complaints involved clinical care, the consultant responsible for the patients' care was contacted and involved in the investigation.
- All complaints were reported to the provider via the regional reporting structure. This enabled Nuffield Healthcare hospitals to learn from complaints within the group.

Good

# Outpatients and diagnostic imaging

## Are outpatients and diagnostic imaging services well-led?

Good

We rated the outpatient and diagnostic services at Nuffield Health Hospital Chichester as good for well-led. This was because:

- There was a clear vision and focused strategy to deliver good quality care.
- The governance framework ensured staff responsibilities were clear and that quality, performance and risks were all understood and managed.
- The leadership and culture reflected the vision and values of the organisation, and encouraged openness and transparency and promoted good quality care.
- The senior management team (SMT) were highly visible and regularly engaged with staff and patients.
- Services continuously sought to improve and develop novel approaches to capacity issues such as the external rehabilitation physiotherapy service.

However;

- A consultant was bringing his own laser onto the premises and using it for treatments. The level of assurance around the maintenance and calibration of the laser was insufficiently robust. The risk associated with privately owned clinical equipment had not been identified on the risk register

### Vision and strategy for this core service

- Staff we spoke to were clear about the values of the organisation and were committed to working towards achieving the broad vision and strategy.
- Staff showed a good understanding of the Nuffield values program called “EPIC” (Enterprising, Passionate, Independent & Caring) and told us they had been engaged in the consultation process and cascade.
- Some staff could describe the recent change of directors at corporate level, although this appeared less well known.
- Staff knew that the hospital was planning to purchase their own MRI scanner and the hospital was working to achieve this during the next financial year (2017/18).
- Locally staff were also positive about a hospital wide strategy of ‘growing their own’ as a means to ensure planned succession and sustainable staffing. Support and training, up to sponsored professional training was available for staff who wished to develop their careers.

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

- Nursing, radiology and physiotherapy leads all reported to the Head of Clinical Services (Matron) who, as part of the hospital senior management team was accountable to the Hospital Director.
- There were good structures for reporting against the governance framework in place for all Nuffield Healthcare hospitals with regional and national benchmarking against other hospitals in the group.
- The provider had an electronic incident reporting system that fully linked complaints, incidents and risk reporting.
- The safety records were monitored monthly by the executive team using a Nuffield Healthcare tool. This acted as board assurance reporting tool and framework.
- Lessons learned were discussed and disseminated across the organisation. This was done through the head of departments. Action plans were monitored through the quarterly Integrated Governance Committee.
- Lessons learned were also shared across the Nuffield business group through the regional reporting structure.
- Whilst patient forums were not directly involved in business planning and service development we did see several good examples of where learning from complaints had led to changes in services and processes.
- There were very clear lines of accountability and responsibility with explicit and effective information flow pathways.
- There was an organisational and local risk register that was overseen by the departmental manager. However, the use of a privately owned laser on patients using the

service did not appear on the local risk register and there was insufficient assurance that the laser was serviced and calibrated. There were no incidents recorded that related to the use of the laser but there was a risk associated with the lack of assurance.

- The local board (executive team) used the Nuffield Healthcare assurance framework tool along with national lessons learned, national policy change and compliance with national guidance such as NICE and safety alerts.
- The assurance tool required the board to receive information from the Integrated Governance Committee, which in turn received information from specialist feeder groups such as the infection control group and Medical Advisory Committee (MAC).
- The MAC was pro-active and worked closely with the senior management team to ensure that all consultants working at the hospital met the requirements of their practising privileges. We saw that the practising privileges were suspended or removed where a consultant had not provided the necessary paperwork around their appraisals.
- The board also received information from the monthly heads of departments meetings.
- Once the board had reviewed and considered the information, they produced an integrated governance report that was fed upwards via the regional structure to the provider and out to staff in the hospital via the heads of department.
- Any updates to NICE guidance or safety alerts were sent monthly from the clinical care partners and shared via the heads of department meetings.

**Leadership / culture of service**

- All staff that we spoke with felt that the care of patients was at the core of how they provided services in the OPD. They took pride in making sure patients' needs were met and went out of their way to resolve difficulties.
- All staff we spoke to felt managers and the hospital SMT were approachable and they could discuss any issues with them. The executive team fully supported a provider whistleblowing policy. The Hospital Director and matron were clear they wanted an organisation where staff felt comfortable about raising concerns and making suggestions for service improvement. Staff told us that they felt comfortable and confident in raising any concerns with management.
- Some staff had accepted additional roles and responsibilities. We met examples such as a health care assistant acting as the unit Health & Safety representative. These were seen by both managers and staff as positive examples of opportunities to increase personal learning and development.
- In addition to recent values training, the hospital operated a staff recognition scheme and we saw recent examples of achievement and recognition awards on display on the department.
- The executive team fully supported a provider whistleblowing policy. The Hospital Director and matron were clear they wanted an organisation where staff felt comfortable about raising concerns and making suggestions for service improvement. Staff told us that they felt comfortable and confident in raising any concerns with management.

**Public and staff engagement**

- At all levels, the staff we spoke to expressed pride in their teams and the services they provided. As part of the inspection process, comment cards were circulated to all departments. There were five cards returned by staff that worked in the outpatient department. All were very positive about the culture and teamwork at the Hospital.
- Staff wrote that they enjoyed coming to work and that they were passionate about the care they gave to patients. We read that staff were proud to work at the hospital. One staff member said, "We don't skip things or cut corners, no matter how busy we are".
- The organisation held annual long service and staff awards events which recognised and valued commitment by individual staff members.

**Innovation, improvement and sustainability**

- We were told that vision and values events were regularly held in order to celebrate staff achievements and enhance communications. We saw evidence of formal and informal social events that supported the positive comments about the work culture we observed.

# Outstanding practice and areas for improvement

## Outstanding practice

The method for tracking medical records was reliable and we saw innovative practice concerning sharing physiotherapy treatment notes between the hospital and the Nuffield Health Fitness & Wellbeing Centre in Chichester as part of an integrated outpatient physiotherapy and rehabilitation service. The Health and Fitness centre does not provide regulated activities but is within the Nuffield Healthcare group and was used to extend access to physiotherapy services to improve patient outcomes.

The quality of completion of NEWS charts was exemplary, with every chart we looked at being an accurate record of the patients observations and the assessment of the risks associated with changes in their condition. The management of the patients with unexpected deterioration was timely and appropriate with external advice being sought whenever needed. onm s ruis

## Areas for improvement

### Action the provider MUST take to improve

- Ensure infection control policies and standard operating procedures are adhered to within theatres.
- Ensure adequate availability of staff handwashing facilities in line with the Department of Health's Health Building Note 00-09.
- Ensure the sinks in patient rooms are compliant with the Department of Health's Health Building

Note 00-09: Infection control in the built environment.

- Ensure compliance of record keeping in theatres relating to Misuse of Drugs Regulations 2001 and Safer Management of Controlled Drugs: a guide to good practice in secondary care (England.)
- Standardise and improve compliance with the WHO checklist.
- Ensure that there is proper assurance of the safety, calibration, security and servicing of any privately owned clinical equipment brought into the hospital.

### Action the provider SHOULD take to improve

- Repair damage to walls within patient rooms on Northgate ward.
- Review the WHO checklist used in endoscopy.
- Ensure patients dignity is preserved in theatres.
- Improve mandatory training compliance specifically aseptic technique in theatres and Infection control and prevention.
- Ensure a robust checking process for emergency equipment on Northgate ward.
- Undertake an audit of completion of theatre documentation and take appropriate action.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control<br>Failure to comply with providers' own policy and best practice guidance.<br>Failure to ensure optimal theatre infection prevention and control practice at all times.<br>Inadequate availability of handwashing facilities for staff. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010<br>Inadequate assurance regarding safety of privately owned equipment brought in for use on patients.<br>Inadequate assurance of the safe management of medicines, including controlled drugs. |

| Regulated activity | Regulation |
|---|---|
| Surgical procedures | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>Failure to ensure that people's dignity was protected at all time in the operating theatre and recovery area. |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

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