Nuffield Health North Staffordshire Hospital

Quality Report

Clayton Road,
Newcastle,
Staffordshire,
ST5 4DB
Tel: 01782 625381
Website: www.nuffieldhealth.com/hospitals/north-staffordshire

Date of inspection visit: 3 July 2018
Date of publication: 31/08/2018

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health North Staffordshire Hospital is operated by Nuffield Health. Facilities include 38 individual patient bedrooms each with en-suite facilities. The hospital has three theatres; two with ultra clean air flow systems and one general theatre.

The outpatient department has 12 consulting rooms, a clinical room for minor procedures, a treatment room and a phlebotomy room. A phlebotomy room is a room that is used to collect bloods from patients.

The hospital provides mostly surgical services but also carries out some medical care services, including chemotherapy services. The two most common procedures performed were therapeutic arthroscopies, which can also be referred to as 'keyhole surgery' and total hip replacement. The hospital does not undertake surgical procedures on children under the age of 16 years.

We conducted a focussed follow up inspection on 3 July 2018; surgery was the only core service inspected.

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

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

Throughout this inspection we also followed up on concerns raised at the previous CQC inspection conducted in February 2016. We found:

- On the last inspection we told the hospital they must ensure that surgical safety procedures are consistently carried out in theatre and theatre documentation and observational audits are routinely carried out, and staff are made fully aware of the findings to provide ongoing assurance.
- During this inspection we saw the surgical safety procedures were consistently carried out. The hospital had introduced regular observational audits which were carried out by senior staff and the staff were made fully aware of the results.
- On the last inspection we told the hospital they should ensure that all medication is secure in theatre.
- During this inspection we found that medication was stored securely within theatres in line with best practice guidance.

We rated this hospital as good overall.

We found good practice in relation to surgery:

- We found incidents were managed appropriately. Staff were aware of how to report incidents; and supported to do so. Learning was shared to all staff; including learning from incidents which had occurred within other Nuffield Health locations.
- Infection prevention and control was well managed; and was regularly audited to ensure staff compliance.
- Staff undertook a range of mandatory training subjects, including appropriate safeguarding training for their grade. We saw that staff training compliance was above target.
- Staff were assessed for their competency to undertake their roles. Staff received yearly appraisals.

Summary of findings

- Patient outcomes for certain surgical procedures were measured using the Patient Reported Outcome Measures Tool (PROMs) however; the location did not collect this information directly to explore efficacy of treatment. Instead consultants used the recorded data as part of their appraisals.
- Staff were consistently caring and respectful towards patients. We observed direct patient care whereby staff were compassionate and engaged with patient needs.
- The hospital had recently been nominated for a Health Service Journal award (awards ceremony was July 2018) for their 'prehab' service which promoted patient health and wellbeing both pre and post-surgery to enable enhanced recovery.
- Staff worked to meet patients' individual needs including dietary requirements; spiritual needs and helped them access support.
- Staff told us of an improved culture throughout the surgical services. A proactive approach to management had enabled staff to develop better relationships with senior management.
- We found the senior management of the hospital were proactive and sought to rectify concerns quickly. During our inspection we raised concerns. Within a week, we received an in-depth action plan to manage and mitigate such concerns as detailed later in this report.

We found areas of practice that require improvement in surgery:

- The hospitals management of medicines was not always in line with best practice. On three occasions staff had not accurately recorded the specific quantity of patients' own medicines.
- The hospitals record keeping was not consistently in line with best practice. We saw examples of re-admissions not being recorded appropriately and sensitive information being left on the front of patient records.

Following this inspection, we told the hospital that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good** 	Surgery was the main activity of the hospital. The hospital provided an outpatient service but we did not inspect it on this occasion. The service carried out general surgery and orthopaedics. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

Nuffield Health North Staffordshire Hospital

Services we looked at:
Surgery

Summary of this inspection

Background to Nuffield Health North Staffordshire Hospital

Nuffield Health North Staffordshire Hospital was opened in 1978, located in Newcastle Under Lyme close to the M6. The Hospital is one of 31 in the Nuffield Health Group. There are 38 individual patient bedrooms each with en-suite facilities. The hospital has three theatres; two with ultra clean air flow systems and one general theatre. The outpatient department has 12 consulting rooms, a clinical room for minor procedures, a treatment room and a phlebotomy room. Since the last inspection, the hospital has opened a new computed tomography/ magnetic resonance imaging (CT/MRI) scanning facility. The new imaging service was being provided in partnership with a private diagnostics service provider.

Catering and estates management services were outsourced. The hospital provides mostly surgical services but also carries out some medical care services, including chemotherapy services. The two most common procedures performed were therapeutic arthroscopies and total hip replacement. Over half of all the activity at the hospital is NHS funded.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two other CQC inspectors, an assistant inspector and a specialist advisor with expertise in theatres.

Information about Nuffield Health North Staffordshire Hospital

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

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

During the inspection, we visited the wards and operating theatres. We spoke with 15 staff including; registered nurses, health care assistants, medical staff, operating department practitioners, and senior managers. We spoke with five patients. During our inspection, we reviewed six sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected three times, and the most recent inspection took place in February 2016, which found that the hospital good overall.

Activity (January to May 2018)

- In the reporting period January 2018 to May 2018, there were 713 inpatient episodes, 1611 day cases and 720 surgical outpatients cases. Funding was 45% NHS, 39% insured and 17% self-pay.
- Seventeen children between the ages of 16 and 18 years were treated as an inpatient or day case in the same period and one child aged under 16. The child under 16 years was an outpatient who was kept in for observation.
- There are 170 doctors working under practising privileges at the hospital. There are 176 full time equivalent staff are employed, including 48 nurses.
- The registered manager had been in post since June 2013, and was also the controlled drugs accountable officer.

Track record on safety

- No never events

Summary of this inspection

- Between October 2017 and March 2018 217 incidents were reported, none were considered a serious incident.
- No serious injuries

No incidences of hospital acquired Meticillin-resistant staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (c.diff)

No incidences of hospital acquired E-Coli

Between 26 July 2017 and 26 July 2018 there were 50 formal complaints made to the hospital.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Staff carried out the World Health Organisation (WHO) safer surgery checklist out in line with best practice. Senior staff audited this regularly to ensure compliance and deal with any problems.
- Staff managed incidents well. The hospital had no never events or serious incidents in the last two years. Staff felt supported to report incidents and learning from incidents was disseminated amongst staff.
- The hospital was clean, modern and well maintained throughout. They had policies and processes in place to manage infection control and these processes were regularly audited.
- Staff had access to all appropriate equipment for all the surgeries they carried out and this equipment was serviced and well maintained.
- Staff used appropriate post-operative checks to see if patients were deteriorating. This included appropriate policies for the management of sepsis.
- Staff managed safeguarding appropriately. The staff had appropriate levels of training and they could give examples of where they had followed safeguarding procedures.
- Nursing staff levels were appropriate for the services delivered. The staff used minimal bank and agency staff to ensure continuity for patients.
- The hospitals mandatory training level was at 91% which was well above the target of 85%

However, we also found the following issues that the hospital needs to improve:

- The hospitals management of medicines was not in line with best practice. The records of patients own medication did not match the quantities actually in medication trollies and staff were not able to know the exact amount of medication they had in stock in the clinic room.
- The hospitals record keeping was not in line with best practice. We saw examples of re-admissions not being recorded appropriately and sensitive information being left on the front of patient records.
- The hospital was using modified early warning scores (MEWS) which was not in line with best practice.

Summary of this inspection

Are services effective?

Good

We rated safe as good because:

- Nuffield health had developed a 'prehab' programme to start preparing people for surgery prior to admission.
- The hospital had all the procedures and practices in place to ensure the care and treatment provided by staff was in line with national guidance.
- Staff managed pain in line with best practice. They used pain scores to assess patients and patients we spoke with told us staff checked pain regularly and provided pain relief when needed.
- Staff managed nutrition and hydration of patients in line with best practice. Nil by mouth was discussed with patients pre-operation. Patients also told us the food offered was of excellent quality post operation.
- Patient outcomes for certain surgical procedures were measured using the Patient Reported Outcome Measures Tool (PROMs) however; the location did not collect this information directly to explore efficacy of treatment. Instead consultants used the recorded data as part of their appraisals.
- The hospital had a 100% completion rate for staff appraisals which included all staff groups. Staff also told us that they found the hospital appraisal process beneficial and meaningful.
- The multidisciplinary working between staff was good. All staff we spoke with reported positive working relationships at the multidisciplinary meetings and in patient care.
- There was a registered medical officer (RMO) on site 24 hours a day, seven days a week. There was also pharmacy and physiotherapy input seven days a week.
- All hospital policies were up to date and easily accessible for staff.
- Consent was managed in line with best practice. Patients were provided with the relevant information prior to the operation and consent was gained again directly before the procedure.

However, we also found the following issues that the hospital needs to improve:

- The hospital was not using Q-PROMS in cases of cosmetic surgery.

Are services caring?

Good

We rated safe as good because:

Summary of this inspection

- Staff provided compassionate care to patients. All patients we spoke with told us they were given compassionate care. All interactions we observed between staff and patients were positive. Staff carried out patient comfort assessments regularly to check how patients were feeling.
- Staff provided patients with information in an easily understandable format so they could make decisions about their care and treatment.
- Patients were given emotional support by staff. Staff were also able to refer patients for psychiatric or psychological support if it was required.

Are services responsive?

Good

We rated responsive as good because:

- Services were delivered in a way which took patients individual preferences into account.
- The hospital had arrangements in place to deal with emergencies. There was a service level agreement (SLA) with the local NHS trust to deal with these emergencies.
- Access and discharge from the hospital was well managed. The admission process and care pathways were the same for NHS and private patients. Discharge packs included all the relevant information for patients.
- The hospital met the individual needs of patients. The hospital could meet dietary, religious and special needs of patients that used the service.
- The hospital dealt with complaints in an effective way. They responded compassionately and in a timely manner, always explaining any changes in practice because of the complaint.

Are services well-led?

Good

We rated well-led as good because:

- The hospital had clear vision and values and a strategy which we staff demonstrate whilst we were on site.
- The hospital had good quality assurance and risk management systems in place. These included medical advisory committee (MAC) meetings and clinical governance meetings. The hospital had a comprehensive risk register which it updated regularly.
- The hospital had an honest and open culture. All staff we spoke with said they could speak freely and would always report any concerns to senior management.
- Senior managers, including the theatre manager and matron supported staff. All staff we spoke reported positive, supportive relationships with area managers and senior managers.

Summary of this inspection

- The hospital engaged with both patients and staff. There were quarterly patient forum meetings. There were monthly staff group meetings along with informal coffee meeting between staff and the hospital director.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

- We reviewed training records for all staff as of 26 June 2018. The hospitals mandatory training target was set at 85%. The trust met this target in all areas apart from intermediate life support (64%), Aseptic non touch technique (ANTT) foundation theory (79%) and practical manual handling (84%). Basic life support training was at 93%. The overall average was 91%. This represents an improvement from the last inspection where theatre staff training compliance was at 82%.
- Sepsis was part of the mandatory training programme. Since induction in November, 67% of staff have completed training. It is now part of the annual mandatory training update for staff.
- All staff we spoke with told us they felt well supported to complete their training which was either classroom based lectures or e-learning.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. Staff demonstrated a good understanding of safeguarding and could explain the process they would follow if they identified abuse.
- Safeguarding adults and safeguarding children and young people level one training was mandatory for all staff. The mandatory training target set by the hospital was 85%. Safeguarding adults training compliance was above target at 94%. Safeguarding children and young people level one was also above target at 96%. Nurses and operating department practitioners (ODPs) undertook safeguarding children and young people level 2 training, this was also above the target at 96%.
- All staff had undertaken Prevent training and they had five staff members who had undertaken 'train the trainer' training so they could deliver this subject to staff.
- The hospital director and matron were required to carry out safeguarding children and young people level three training as safeguarding leads. They were both up to date with this.
- The matron was able to give examples of where they had safeguarded an adult with regards to a cosmetic procedure they wanted to undertake. They also gave an example of where they safeguarded someone who was unable to speak English from being coerced into an operation.
- We were shown a young person's risk assessment, which was completed for 16 to 18 year olds which assessed the patient's ability to understand the treatment to be given. This assessment recorded 'gaining or not gaining' their informed consent and was in place to protect them from receiving treatment which they had not consented to. It also explained that they had entered a predominantly adult area.

Cleanliness, infection control and hygiene

Good

Surgery

- Staff showed us the hospital had appropriate policies and procedures in place to manage infection prevention and control. These policies and procedures were up to date and available on the intranet. We observed staff complying with these polices whilst on site.
- Adequate hand-washing facilities and hand sanitising gel were available and we observed staff washing their hands and using sanitising gel. The 'bare below the elbows' policy was observed by all staff during clinical interventions and staff were seen to follow the hospital's infection prevention and control policy by washing their hands between seeing patients and wearing correct personal protective equipment, such as gloves and aprons.
- Information provided by the hospital identified that there had been one incident of Methicillin-resistant Staphylococcus aureus (MRSA) in the between 1 July 2017 and 30 June 2018, this was identified as being cross contamination at the NHS trust. There had been no incidents of Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile in the same time period.
- According to the trusts internal infection prevention audit carried out in July 2017 the trust scored 100% on hand hygiene, 97% on cleanliness and 92% on decontamination of equipment. We saw action plans in place to address any issues that were raised by the audits. A new audit was planned to be undertaken in July 2018.
- Between 1 June 2017 and 30 June 2018 there were nine surgical site infections at the hospital.
- The offsite hospital sterile services department ensured that appropriate equipment was available for surgeons. The system promoted the correct flow of dirty to clean equipment, which reduced the risk of contamination.

Environment and equipment

- All areas of the hospital were observed to be clean and theatre and ward cleaning schedules were completed. The 2017 Patient Led Assessment of the Care Environment (PLACE) score for cleanliness was 99.51% which is slightly above the national average of 98.38%.
- The ward and theatre were modern and well maintained. The 2017 Patient Led Assessment of the Care Environment (PLACE) score for condition, appearance and maintenance was 93.1%, which was slightly below the national average of 94.02%.
- Resuscitation equipment was available on the ward and in theatre. Records showed that the equipment had been checked daily, with the seal on the trolley being broken and replaced to check the contents. There were no gaps in the equipment checks. This was checked on inspection and also found to be complaint.
- Staff told us suitable and sufficient equipment was available to support the surgical procedures undertaken. All equipment was serviced and maintained appropriately.
- All waste was managed appropriately in line with best practice.
- Patient moving and handling equipment was available on the ward. This had been maintained and serviced appropriately.
- We saw that the hospital participated in medical device and equipment forums to discuss medical device incidents and concerns. The hospital used a live action plan to manage the replacement and change of equipment. The service submitted data to the National Joint Registry database which records implants and protheses used.

Assessing and responding to patient risk

- During pre-admission patients were assessed, considering the planned procedure, for risks to their well-being. A patient would not be considered for surgery at the hospital if they had a severe illness or disease.
- There were 13 unplanned transfers out of the hospital between 01 July 2017 and 30 June 2018. The most common reason was due to cardiac events of which there were four. Full investigations were undertaken for each one of these events.
- The hospital had a service level agreement with the local acute NHS trust if patients needed to be transferred as an emergency. We heard of one example when this process had worked efficiently and successfully for the patient.

Good

Surgery

- We observed that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was embedded in daily practice and consistently adhered to. This process, recommended by the National Patient Safety Agency should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery. The service had made improvements from the last inspection when this process was consistently carried out.
- We observed two surgery checklists and both times all the staff were accurately following the WHO checklist.
- Since the last inspection a more regular and rigorous audit programme of the WHO checklist has been introduced, which included monthly observational audits by senior managers. Staff also received updated training following the previous report. The most recent observational audits in June 2018 showed all elements were completed correctly apart from in one case where the anaesthetist was not present for the sign in process as he arrived late.
- Whilst in recovery, patients were monitored by the surgeon and anaesthetist. When the patient's condition was stable, the recovery nurses then made the decision that they were safe to return to the ward based on their scores. The ward nurse then received a handover from the recovery nurse and reassessed the patient.
- On the wards, the Modified Early Warning Score (MEWS) was used to identify any deterioration in patients; this process recorded patient observations enabling early recognition of signs of deterioration which would require escalation to the medical team. The patient's consultant and the hospital matron were also informed when an escalation had occurred. The use of MEWS was not in line with best practice.
- If a patient shows any signs of sepsis during the deteriorating patients checks then staff told us they would do the 'Sepsis Six', followed by a top to toe assessment.
- When a patient was required to return to theatre during working hours this was facilitated by the theatre and bookings team. When required out of hours, the ward nurses would call the on call theatre team. At weekends, an on call nurse manager was available from 7pm on Friday night until 7am on Monday morning. A member of the senior management team was also on call 24-hours a day, seven days a week for advice and support. Patients' resuscitation status was recorded and monitored during consultations.
- We saw that care records contained recorded outcomes for specific risk assessments that included; the development of pressure ulcers and blood clots and the risk of falls and malnutrition. However, fully completed individual risk assessments were not recorded in care records which meant staff would be unable to identify the specific areas where risk may have changed and managers could not check that these assessments were being completed correctly. For example, the staff recorded patients as being at risk of developing blood clots, but the actual risk factors specific for each patient were not always recorded. We fed this back to the management team who told us they had raised this with the provider and work was in progress to improve the completion and recording of risk assessments.
- The hospital reported five incidents of hospital acquired venous thromboembolism (VTE), a blood clot in a vein, between 1 July 2017 and 30 June 2018. No specific trends were identified. We saw that following a change to National Institute of Health and Care Excellence (NICE) clinical guidelines in 2018; the hospital management team including the medical advisory committee (MAC) had initiated a working group to ensure that assessment of and treatment for VTE was consistent with national standards. This was shared and ratified with the Nuffield Health Group.
- We saw one set of record of a patient who was having cosmetic surgery. They contained evidence that the appropriate psychological checks had taken place.

Nursing and support staffing

- During our inspection we saw that the staffing levels were sufficient to protect patients from avoidable harm. The hospital used a basic staffing tool to meet patient acuity or individual dependency needs. Whilst on site we saw hospital rotas and they matched what was needed on the wards and in theatres.
- Staff told us that they felt staffing was sufficient and the skill mix was correct; on some occasions, when patients became unwell or the wards were busier; bank or agency staff could be requested. Staff rarely had to work over their scheduled hours.

- Since the last inspection the use of bank and agency staff had been reduced due to targeted work being undertaken to plan the rota more efficiently. Bank and agency use across the hospital was at 15.2%, in wards it was 18.6% and in theatres it was 12.6%.
- Handovers took place between day and night shifts and any concerns around potential risks were raised to ensure patients were safe.
- Nursing staff worked on a day/night shift rotation. Senior nursing staff were required to be on the out of hour's on-call rota. Staff told us when they worked over their scheduled hours they almost always got their time back.

Medical staffing

- A resident medical officer (RMO) was on the hospital site 24 hours a day, seven days a week. The RMO offered medical support to the nursing staff; although nursing staff told us they had no problems contacting individual consultants for information or advice. The RMO was informed of all patient theatre lists and we saw that they were included in staff handovers. This ensued they were aware of the nature and acuity of all patients in the hospital. The RMO had advanced life support (ALS) training.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged cover from another consultant with practising privileges at the hospital, in the event that they were not available.

Records

- The hospital used a paper-based system to record patients' care pathways. These documents covered the patient journey from admission through surgery to discharge.
- Records we looked at were mostly appropriately completed. They clearly showed procedures undertaken, with anaesthetists' and physiotherapists' input. However, two care records were not adequately completed. In both cases; the patient had returned to the hospital to address a minor post procedure complication. However, neither record had the readmission information recorded. In other records, we also found extra continuation sheets had also been stapled to the front of medical records which were not secure. Some entries had also been written in green ink which is not compliant with best practice guidelines for record keeping. We raised this with the hospital management team during the inspection who reported they were aware of concerns with regards to poor record keeping; and were working to improve this. They also sent a detailed and thorough action plan post inspection to address these concerns.
- The hospital did monthly records audits. We saw record keeping improved from 71.7% in February 2018 to 99.16% in April and 96.38% in May 2018.

Medicines

- The hospital had an on-site pharmacy; pharmacists visited the ward five days a week to check and re-stock the medicine supply. There was pharmacist support available at weekends.
- On the wards, patients' medicines were securely stored in one of three mobile trolleys, depending on the area in which they were being cared for. However patients own medication was not recorded correctly in two out of the three medicines administration records that we viewed. One patient's record was marked 'box' which we were told indicated a full box however, when we checked these medicines not all the boxes were sealed and full. One patient, following admission, had their medication recorded then been discharged from the service following their procedure. On re-admission this patient's medication had not been re-counted and recorded. One patient had the number of medicines recorded, however two out of the five medications we checked had the incorrect amount recorded. All patients we spoke with reported that they had received the right amount of medicines and received them on time. This included patients who are referenced above as having their medicines recorded incorrectly.
- Patients on the wards could either be given medicines from the stock on the ward or their own personal medicines. Both of these were stored in the same trolley. The ward stock amounts were topped up by the pharmacy. There was no specific check done on the amount of each medicine in the trollies. The pharmacy did three monthly audits of the ward stock but they had no more regular checks in place. This was an issue as during those three months no one checked on the exact amount of medicines stored on the ward.

Good

Surgery

- We highlighted the above concerns with the hospital management team at the time of inspection. Following this, the hospital sent over a detailed and thorough action plan to address the inconsistencies with medicines management raised in this section.
- All controlled drugs on the ward were stored securely in a locked cupboard in the clinic room. We checked the quantities of three of these drugs and they matched records held by the ward.
- In theatres, the controlled drugs cabinet were stored safely and securely in line with national guidance.
- All fridge checks on both the ward and theatre were done automatically by sensors. If the fridge temperature dropped outside of acceptable levels, a message was sent to the pharmacist so they could respond.
- We checked medicines kept in the ward fridge there was some medication that had been left in there despite the patient being discharged in May. Ward staff told us they would return the medication to pharmacy so it could be disposed of.

Incidents

- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers There have been no never events or serious incidents at the hospital in the last two years.
- There were 217 incidents reported by the hospital between 1 October 2017 and 31 March 2018. The most common themes were patient incidents, property and staff. Where incidents involved patients; the most commonly reported incidents involved documentation.
- Staff told us they felt supported to report incidents. When incidents needed to be reported staff were given sufficient time to complete the report on an electronic incident reporting tool, and managers gave them feedback after investigations were completed.
- Staff told us that since the last inspection, dissemination of learning from incidents has improved. Details and action plans are discussed at quality and safety meetings and learning is shared to all staff groups via team meetings.
- There have been no cases of mortality at the hospital in the last three years. Mortality and morbidity is discussed with the clinical commissioning groups on an individual basis when necessary.
- There was no specific duty of candour training at the hospital but information on duty of candour was available to staff. There was a duty of candour policy. There had been no serious or moderate harm incidents in the last 12 months so duty of candour had not needed to be used. We did see on incident reports that patients had been apologised to when operations were cancelled or delayed.

Safety Thermometer (or equivalent)

- Safety thermometer data was recorded electronically. For the six months prior to the inspection; the ward area achieved 'green' which meant they met the hospital target for avoiding patient harm such as pressure ulcers or venous thromboembolism (VTE).
- One incident of patient harm was investigated; this involved a pressure ulcer which was identified at the six week follow up appointment after surgery. The hospital investigated to ensure post operative patient care was adequate to prevent pressure ulcers.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- Hospital staff followed local policies and procedures such as wound care pathways and specific consultant post-operative preferences.
- The hospital had processes in place to ensure that they did not discriminate on the grounds of protected characteristics. The hospital had an up to date equality and diversity policy. Equality and diversity training was part of the mandatory training programme.
- We saw that the hospital had systems in place to provide care and treatment in line with national guidance, such as National Institute for Health and Care Excellence (NICE) guidance, including CG24 blood transfusion and CG28 Diabetes, adult management.

- Care pathways supported surgical procedures that were undertaken, for example gynaecology, and hip and knee replacement.
- Nuffield health had a programme to start preparing people for surgery called 'prehab'. They did this by way of pre-habitation preparatory coaching sessions led by physiotherapy, consultants, nursing and wellbeing teams in a relaxed non-clinical environment at the Nuffield wellbeing centre.
- When reviewing patient records, we saw that cosmetic surgeons following the Professional Standards for Cosmetic Surgery; for example enabling a 'cooling off' period between the initial consultation and taking consent to undertaking surgical procedures.

Nutrition and hydration

- We looked at two completed fluid balance charts within the six care records we reviewed which recorded the times and amounts of fluid that the patient had received and their recorded urine output. However, for one of the patients whose cumulative balance was supposed to be checked every night one entry was missing.
- All patients that had eaten at the time we had spoke to them told us the quantity and quality of food was exceptional and staff had regularly offered cold and hot drinks throughout the day and night. We saw that patients had access to drinks and snacks at all times.
- 'Nil by mouth' details were discussed with each patient at their pre-admission assessment and confirmed with them in writing, this was evidenced in the care records. The hospital did not carry out routine nutrition and hydration audits as patients were all short stay, instead they risk assessed on an individual basis.
- The hospitals 2017 Patient Led Assessment of the Care Environment PLACE audit identified a score of 94.4% for ward food, which was above the England average of 91.2%.

Pain relief

- All patients we spoke with reported that their pain was managed well and they were regularly asked about it. Patient records also indicated that pain management had been discussed with patients and pre and various intra operative options were available.
- We saw that pain relieving medicines were recorded on the patients' administration charts and given when required. We saw that pain scores were recorded to demonstrate the effectiveness of pain relief and patient comfort level.

Patient outcomes

- The hospital recorded Patient Reported Outcome Measures (PROM) data. PROMs data is used along with other outcome measures such as patient satisfaction and staff feedback in consultant appraisals. The hospital also has to disclose to obtain accreditation with major insurers too as a quality marker once per year.
- All readmissions either to the hospital or an NHS trust were recorded on an electronic data collection system, as were patient returns to theatre. Between 1 July 2017 and 30 June 2018 six returns to theatre had been reported. Three of these resulted in no harm and three of these resulted in low harm. The main reason for re-admission was haematoma of which there were four cases.
- Between 1 July 2017 and 30 June 2018 there were ten readmissions within 28 days of surgery. Eight of these resulted in no harm and two of them resulted in low harm. The main reason for this was for pain/nausea of which there were four cases. During the same period, there were 34 recorded day case conversions to overnight stay; nine of these were due to patients returning from theatres late and seven were due to nausea post operation.
- Between 1 July 2017 and 30 June 2018 there were 39 delayed discharges recorded, the main reasons for this were mobility issues (12 cases), lateness returning from theatre (7 cases) and pain post operation (6 cases).
- The hospital contributed to the Private Hospital Information Network (PHIN) as of March 2018; therefore was 75% compliant by the time of the inspection.

Competent staff

- NHS consultants received individual appraisal summaries and provided evidence of mandatory training from their NHS employer. Consultants who worked solely in the private sector completed the Nuffield Health mandatory training programme including an annual appraisal. The hospital used an

electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process.

- There were 170 doctors working under practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital. We looked at 16 randomly selected personnel files for medical practitioners and found that all had current appraisal information. All the files we looked at had up to date revalidation information.
- Staff told us and we saw that all new staff, including temporary staff, received induction training; we heard that this included a 'meet and greet' session in all departments, providing staff with an overview of all hospitals areas. New staff were supernumerary to the ward and theatre staffing levels during their planned induction, which was tailored to their previous experience.
- Ward and theatre staff confirmed that appraisals took place regularly and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in 2017/18, including administrative and clerical staff. Objective setting amongst staff for 2018/19 was under way. All staff we spoke with said the appraisal process was beneficial and positive. Bank staff do not have formal appraisals but have regular 'catch ups' as per policy.

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and therapies planned. All surgical staff we spoke with told us they found the process positive.
- All staff reported that medical and nursing staff, therapists and pharmacist staff worked in partnership on the ward. Ward rounds took place on a daily basis. There was also a morning meeting between staff representatives from all areas of the service to discuss any patient risks for the day so they could be prepared to respond.
- When patients were discharged, the hospital worked well with external services. A letter was sent to GPs after discharge. The surgeon consultants could also refer to a psychiatrist and psychologist if requested.

Seven-day services

- Theatres were used flexibly by all consultants within a six-day service. Theatres were open from 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday.
- There was a registered medical officer (RMO) on site 24 hours a day seven days a week.
- Theatres were also available for emergency purposes 24-hours a day, seven days a week. To support emergency events, theatre staff were part of an 'on call rota' including a senior manager each night. Out-of-hours pharmacy advice was available.
- Consultants visited their patients daily as part of the pre- and post-operative care pathway. The nursing staff told us they had good working relationships with the consultants and had no hesitation in contacting consultants at any time to discuss their patient's condition or care.
- There was always at least one physiotherapist available on the ward seven days a week. Where required, additional physiotherapy resource could be provided.

Health promotion

- We found that health promotion was enabled through the 'pre-hab' programme which was provided to all surgical patients. This focussed upon pre-surgery assessments with physiotherapists which would enable patients to be at their optimum health to undertake their procedure, and to recover at an enhanced rate. For example areas covered included pain management and mobilisation.

Access to information

- Policies we looked at were accessible, current and referenced good practice guidelines and made reference to professional body guidance.
- All patients had discharge letters sent to GPs. Staff were able to access patient test results; such as blood test results, within patient records and electronically.

Good

Surgery

- Individual nursing records were accessible in the patient's own room when the patients were on site. After discharge records were stored securely in the hospital and could be accessed at any time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were provided with relevant information including the benefits and risks of procedures at the initial consultation. Patients re-confirmed their consent to procedures at the pre-admission assessment and on the day of surgery. Cosmetic surgery patients were given a 10 day cooling off period in line with cosmetic surgery national guidance. Patients we spoke with told us the consultant had discussed the procedures during their assessment. We saw evidence of consent being discussed and obtained within patients' records. Consent to treatment training was at 92% which is above the hospitals target of 85%.
- All staff we spoke with understood mental capacity and deprivation of liberty safeguards. Mental Capacity Act (MCA) training was at 93% and Deprivation of Liberty Safeguards (DoLS) training was at 89%, which are both above the mandatory training target. The hospital refers any mental capacity assessments to the local NHS trust.
- In the young person's risk assessment we saw reference to understanding that 16 and 17 year olds can make decisions about their care and provide consent if they express full understanding.
- Staff clearly understood Nuffield Health's policies for the resuscitation of patients and 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions. The policy stated that unless otherwise requested, all patients that had a cardiac arrest were to be attempted to be resuscitated.

Are surgery services caring?

Good

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

Compassionate care

- All patients we spoke with reported that they had received compassionate care and were treated with kindness, dignity and respect throughout their stay. We saw patients had their preferred names noted on the front of their care records.
- We observed staff interacting with patients in a dignified and respectful way. Staff were seen knocking on closed doors before entering rooms.
- The hospital released monthly patient satisfaction scores. The average score for likelihood to recommend the service to friends or family between December 2017 and May 2018 was 91%. This was above the Nuffield Health target of 90%.
- Staff carried out assessments of patient comfort and the scores were noted in records. This was a standardised way of understanding how the patients were feeling after surgery. The hospitals audit figures for this showed 83% had been completed.

Emotional support

- Patients were given emotional support from staff throughout their stay in the hospital. Staff could refer patients to psychiatrists and psychologists if they deem it necessary or the patient requests it. Patients' needs were always assessed by staff to ensure they are emotionally stable.

Understanding and involvement of patients and those close to them

- We saw that information was provided in a way patients understood. Patients told us they knew the reason for admission, including the risks involved, and this was explained to them during their initial consultation and again on admission. They told us the consultant ensured they fully understood the reason for the surgery or procedure. Patients followed the same admission process and received the same information for day care or inpatient care.
- All patients had a named nurse and felt listened to by staff.

Good

Surgery

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- Services were planned and delivered in a way that took people's needs and preferences into account. Admission dates for each patient were planned during consultations to include patient choice and inpatient or day case bed availability. The booking co-ordinator and theatre manager arranged the operating lists for theatre in collaboration with each consultant surgeon's secretary.
- The physiotherapy team planned individual treatment schedules from admission to discharge. Following discharge patients could attend the Nuffield Recovery Plus programme. Rehabilitation was based on patients' assessed needs; this included support from physiotherapists, personal trainers and consultants to promoted enhanced recovery. This service was not available to NHS patients.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance. The hospital had a Service Level Agreement (SLA) with the local NHS trust with regards to dealing with emergencies that may arise.

Meeting people's individual needs

- Patients got all the information they required prior to their procedure or surgery. They told us they understood the reason for their admission to hospital and staff had clearly explained the risks and benefits to them.
- Consultants could refer patients to a consultant psychiatrist or clinical psychologist if they required it.
- Discharge packs which included post-operative advice and guidance including a GP letter, check-up appointment, medication information and wound care advice were provided to patients.
- There was a variety of leaflets available for the surgical procedures on offer at the hospital. We saw that nurses and consultants gave information leaflets to patients to ensure they were fully informed about their procedure or the surgery.
- Dietary preferences were noted and a choice of meals was offered. The service covered cultural needs and vegetarian/vegan meal options. Hot and cold drinks were offered throughout the day.
- Interpreting services were available, when required. They could have face to face interpreters in consultations with patients if they were needed.
- Visiting times were specified that the best time to visit was between 2 – 4 and visitors should stay no later than 9pm. However, staff told us when necessary this could be flexible depending on the physical and emotional needs of the individual patient.
- The hospital had access to chaplaincy services that covered a number of religions if it was requested.
- All patients had individual bedrooms, private en-suite facilities, a television and thermostatic controlled heating.
- The needs of patients living with dementia or those who had a learning disability were identified at pre-assessment. Staff gave us examples of tailoring patients care based on individual need such as; patients with dementia were always in rooms next to the nurse's station.

Access and flow

- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- From 1 July 2017 to 30 June 2018, the hospital achieved the target of 90% of admitted patients beginning treatment within 18 weeks of referral. During the same period, the hospital exceeded the 95% target of non-admitted patients beginning treatment within 18 weeks of referral. The hospital achieved 100%.
- Between 1 April and 30 September 2017 there were 12 cancelled operations. All surgeries were re-scheduled and a full apology was given to patients where

appropriate. The most common causes of cancellation were equipment failure or previous surgeries over running, of which there were four and three cases respectively.

Learning from complaints and concerns

- We saw 'How to make a complaint' booklets around the hospital, available for patients to read.
- Between 26 July 2017 and 26 July 2018 there were 50 formal complaints made to the hospital. 22 of these complaints were not upheld, 17 were upheld, eight were partially upheld and three were still open at the time of inspection.
- We reviewed six complaints files whilst we were on site. We saw the hospital responded in a timely manner, responded to patients compassionately.

Are surgery services well-led?

Good

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

Leadership

- Managers have the skills, knowledge and experience to manage the service. Managers demonstrated the ability to understand the challenges they faced and developed plans in order to deal with these challenges.
- Since the last inspection there had been a new matron and theatre manager and all staff we spoke with told us they had a positive impact on the service.
- We heard that the hospital director, senior management team and the matron were very visible, speaking with the nursing staff and ward managers when possible. We were told by all staff that they senior staff members were seen almost every day.

Vision and strategy

- There was a clear vision and strategy for the hospital. Staff throughout the service were clear on their contribution to the hospital achieving its vision. The hospital had a clear strategy for 2018/19 where it set out its nine aims to continue to improve whilst recognising the limitations of the site and health economy.
- The hospital had a set of values they referred to as 'Connected'. These were based around being connected to patients, relatives, staff and other parts of the health economy. We saw that staff and the hospital demonstrated these values when providing care to patients.

Culture

- Staff on both the ward and theatre felt well supported, respected and listened to by their managers. They told us about the friendly, inclusive culture of feeling like one family. 33.3% of staff had worked at the hospital for over 10 years and they were proud to demonstrate their commitment to the management and patients. Staff turnover rate for 2017 was 13%.
- Staff told us they felt proud and positive to work for the organisation. They told us the things they were most proud of and for most staff it was the teamwork and the care they deliver.
- A learning culture was described where staff development was supported and encouraged. Staff had one day a month dedicated to further learning and team meetings. Staff told us that this day was well utilised and was well supported by managers and senior leaders.
- All staff we spoke with felt able to raise any concerns and speak out about any victimisation or abuse if they witnessed or experienced any.
- The senior management team told us they had an open door policy which the staff we spoke with confirmed. Staff felt they could approach any of the team with confidence that their issues or concerns would be dealt with confidentially in a respectful, compassionate way.

Governance

- We saw a robust quality measurement system in place, which were managed by the senior management team. The matron for the hospital took the lead and captured clinical data from the central database to present the clinical governance quarterly and annual reports to the senior management team. These reports identified trends and variances of all patients admitted to the hospital generating an incident report when a variance was noted. The report included complaints, incidents and patient satisfaction survey results. A comparison was made with previous reports and other hospitals in

the group including readmission rates and extended lengths of stay. The clinical governance report was also shared at the Medical Advisory Committee (MAC) and Quality & Safety Committee.

- All staff we spoke with understood the management structure at the hospital and knew who they were accountable to.
- Monthly business review meetings were held with the heads of each department invited. Workload and staffing were discussed along with use of agency staff and recruitment.

Managing risks, issues and performance

- There was one risk register for the whole hospital which logged all the issues identified on site. It categorised the issues and had a clear risk rating system on mild, moderate or severe with a green, amber and red colour rating. The hospital identified dates to review the issues before they were closed. The matron had oversight of the risk register and we saw that mitigation was in place for the risks and they had review dates for each of the issues.
- There were 170 doctors working under practising privileges at the hospital. We looked at 15 randomly selected personnel files for medical practitioners and found that all the files had up to date employment information references, identification and GMC check. All files also had a copy of the practising privileges contract. The hospital used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process.
- The Medical Advisory Committee (MAC) held meetings every three months. We saw that agenda items discussed included the hospital risk register, updates to National Institute of Health and Care Excellence (NICE) guidelines, and shared learning across the Nuffield Group. Practicing privileges were discussed; with a robust framework in place to manage consultants who were not practising regularly at the hospital. The senior management team reported they felt supported by the MAC to address any concerns regarding consultant practice.
- The hospital had a regular audit programme which involved staff of this hospital and other Nuffield Hospitals doing a variety of audits across the service. Action plans were developed for any learning points that came from these audits.

Managing information

- The hospital produces robust quarterly reports which includes service performance measures and these are monitored in staff and MAC meetings. These include benchmarking data which compares the hospital to all Nuffield Healthcare locations nationally.
- We saw that patient records were stored securely; although some records viewed did have confidential information stapled to the front page which may have easily become separated.
- There are effective arrangements in place to ensure that data and notifications are submitted to external bodies when required.
- Staff records were kept safely and securely.

Engagement

- We saw minutes of the patient forum group, which was held quarterly at the hospital and chaired by the hospital director. We saw evidence of the hospital taking concerns raised seriously. The hospital also reported on patient satisfaction scores to the patient group.
- The hospital director held monthly informal coffee mornings where all levels of staff could attend to discuss hospital issues in a relaxed atmosphere. Staff we spoke to about this told us they were beneficial and positive.
- Monthly staff and team meetings were planned and held on the same day as the learning days. Attendance was high and staff were able to discuss any issues and changes in policy and guidance. Meeting minutes were stored on the hospital intranet and paper copies were placed on the notice board.

Learning, continuous improvement and innovation

- The hospital 'pre-hab' programme, as discussed earlier within the report, had been nominated for a Health Service Journal (HSJ) award in the category of 'Best

Good

Surgery

Product or Innovation for Patient Safety – private hospitals'. The winners were announced in July 2018; and the hospital did not win on this occasion; however were one of seven finalists.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital 'pre-hab' programme, as discussed earlier within the report, had been nominated for a Health Service Journal (HSJ) award in the category of 'Best Product or Innovation for Patient Safety – private hospitals'. The winners were announced in July 2018; and the hospital was one of seven finalists.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that medicines are managed correctly in line with best practice and records of amounts of medication in storage are accurate.
- The provider should ensure that records are kept in line with best practice, they need to make sure no confidential information is on display, risk assessments are recorded consistently and re admission is correctly documented.
- The provider should ensure it uses a national early warning score system rather than the modified early warning scores (MEWS).
- The provider should ensure it uses Q-PROMs as an outcome measure in cases of cosmetic surgery.