Nuffield Health Warwickshire Hospital

Quality Report

The Chase
Old Milverton Lane
Leamington Spa
Warwickshire
CV32 6RW
Tel: 01926 427971
Website: www.nuffieldhealth.com/hospitals/warwickshire

Date of inspection visit: 6, 7, 14 and 21 December 2016
Date of publication: 10/03/2017

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?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

Nuffield Health Warwickshire Hospital is operated by Nuffield Health. The hospital has 42 beds. Facilities include three operating theatres, an endoscopy suite and x-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected all four of these services.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 6 and 7 December 2016, along with unannounced inspections to the hospital on 14 and 21 December 2016.

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

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

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

Services we rate

We rated this hospital as good overall.

We found good practice in relation to medicine:

- Staff understood their responsibilities to report incidents and were aware of the duty of candour regulation of being transparent, open and honest. Lessons learned from incidents were shared among the team.
- Areas were visibly clean, tidy and staff complied with infection prevention and control policies, such as hand washing.
- Equipment was appropriately maintained and cleaned in line with guidance.
- Staff monitored patients appropriately during procedures and used the national early warning scores to detect clinical deterioration.
- Patients were pleased with the care received and were kept informed and involved in the treatment plans. We saw patients being treated with dignity and respect.
- Staff we were able to describe their responsibilities related to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and patient's consent was obtained in line with hospital policy.
- We found there was appropriate local leadership, a positive working culture and a governance meeting structure within medical services.

We found good practice in relation to surgery:

- Incidents were reported, there was feedback for staff and lessons were learnt.
- There were processes in place to ensure that the hospital was clean.
- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.
- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance.
- The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured.
- Patients were treated with dignity, compassion and empathy.
- Theatres managed operating lists with flexibility, to meet patient's individual needs.
- There were no waiting lists and patients were seen within one to two weeks from their referral.
- There was a clear governance structure in place with committees for medicines management, infection control and health and safety.
- Staff we spoke with were motivated and positive about their work, and described all members of the senior management team as approachable and visible.

We found good practice in relation to services for children and young people (CYP):

- Investigations of incidents, comments and complaints identified where improvements were needed and these were acted upon in CYP services.
- Staff complied with infection prevention procedures and healthcare-associated infection rates were low.
- CYP had their needs assessed, care planned and delivered in line with national guidelines.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits.
- CYP were assessed through pre-assessment clinics for their suitability to undergo treatment at the hospital.

Summary of findings

- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Health Act 2005 and the Children Act's 1989 and 2004.
- Governance arrangements ensured appropriately trained staff cared for CYP at all times.
- Parents and children we spoke to told us how caring and supportive staff were and how staff went out of their way to make the hospital 'child friendly'. This was also reflected in the positive feedback in patient satisfaction surveys completed by children and their parents.

We found good practice in relation to outpatients and diagnostic imaging:

- There was a good track record of safety in the outpatients and diagnostic imaging departments.
- There was a positive attitude towards learning from incidents and sharing learning with other departments.
- All staff had an understanding and awareness of duty of candour principles.
- There were good processes in place to ensure that equipment was stored, maintained and used safely.
- Care was planned and delivered in line with national guidance and best practice guidelines.
- There was an effective process of cyclical audits to identify areas for improvement and best practice.
- Staff worked together to plan and assess care for patients.
- Patients we spoke with told us that staff were kind, caring and respectful.

We found areas of outstanding practice in surgery and services for CYP:

- The hospital held regular open events for the public, whereby, they could visit the hospital and attend sessions about a variety of procedures or conditions, such as varicose veins.
- A consultant surgeon would hold 'lunch and learn' sessions with the local GPs, to discuss what procedures they carried out at the hospital.
- A large toy car was stored in the play area for children who wanted to drive themselves to theatre for their operation rather than walking or being transported on a hospital bed.
- CYP attending pre-assessment were shown the type of equipment that would be used when they were admitted to hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on 'Nuffy Bear' (Nuffield Heath toy bear) and were able to familiarise themselves by playing with the equipment.
- A CYP satisfaction survey had been developed to capture service user feedback from children, young people of all ages and their parents. The survey responses were small (six) as this was a pilot of a small service. All responses were positive and praised the care and support of all the staff the child and their parent had come in contact with throughout their care episode. The survey encouraged younger children to draw their experiences on the form. For example, a child had depicted themselves as having 'new super powers' following their surgery. The survey had been piloted, and following a review would be circulated to all CYP attending the hospital in early 2017.

We found areas of practice that require improvement in medicine:

- Audit results for the endoscopy and oncology patients were not captured separately in the hospital's local audit programme. This meant that information for medical services to assess the effectiveness of care and treatment they provided, was not available.
- We were not assured that the oncology service routinely collected and monitored information about the outcomes of patient's care and treatment to ensure that the intended outcomes were achieved.
- Medicines were not always stored at an appropriate temperature in the clinical room on the oncology unit. However, actions were being taken to reduce the risk of reduced efficacy of medicines.
- There were inconsistencies with the documentation of the World Health Organisation safer surgery checklist in endoscopy.

We found areas of practice that require improvement in surgery:

- Not all risks were identified on the hospital risk register.

Following this inspection, we told the provider 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.

Ted Baker

Summary of findings

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. Medical care at this hospital included endoscopy and oncology services. The endoscopy service provided upper and lower gastrointestinal endoscopy, urological endoscopic investigations and urodynamic investigations. The oncology service offered an ambulatory chemotherapy service to patients who attended for treatment on a day case basis. We rated this service as requires improvement. It was rated requires improvement for effective and well-led, and good for safe, caring and responsive. • Audit results for the endoscopy and oncology patients were not captured separately in the hospital's local audit programme. This meant that information for medical services to assess the effectiveness of care and treatment they provided, was not available. • We were not assured that the oncology service routinely collected and monitored information about the outcomes of patient's care and treatment to ensure that the intended outcomes were achieved. • The provider recognised that the oncology service was not meeting the national guidance regarding improving outcomes for patients with haematology cancers. We saw that appropriate actions were being taken to address this situation. • Medicines were not always stored at an appropriate temperature in the clinical room on the oncology unit. However, actions were being taken to reduce the risk of reduced efficacy of medicines. • There were inconsistencies with the documentation of the World Health Organisation safer surgery checklist in endoscopy.

Summary of findings

However:

- Staff understood their responsibilities to report incidents and were aware of the duty of candour regulation of being transparent, open and honest. Lessons learned from incidents were shared among the team.
- Areas were visibly clean, tidy and staff complied with infection prevention and control policies, such as hand washing.
- Equipment was appropriately maintained and cleaned in line with guidance.
- Staff monitored patients appropriately during procedures and used the national early warning scores to detect clinical deterioration.
- Patients were pleased with the care received and were kept informed and involved in the treatment plans. We saw patients being treated with dignity and respect.
- The oncology service offered pre-assessment appointments for patients before they started chemotherapy treatment.
- Healthcare records were easy to access, well completed and included the use of care pathways and risk assessments.
- The endoscopy service used an electronic management system, which enabled on-going audit and procedure reports to be provided to the patient at the end of the endoscopy.
- Staff we were able to describe their responsibilities related to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and patient's consent was obtained in line with hospital policy.
- We found there was appropriate local leadership, a positive working culture and a governance meeting structure within medical services.

Surgery

Good

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.
Staffing was managed jointly with medical care.
We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

- Incidents were reported, there was feedback for staff and lessons were learnt.
- There were processes in place to ensure that the hospital was clean.
- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.
- There were safe systems in place to manage medicines.
- Staff we spoke with were able to tell us what steps they would take if they were concerned about potential abuse to their patients or visitors.
- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance.
- Pain was assessed and managed pre and post operatively. Effective tools were used.
- The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured.
- Patient records showed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.
- Patients were treated with dignity, compassion and empathy.
- Theatres managed operating lists with flexibility, to meet patient's individual needs.
- There were no waiting lists and patients were seen within one to two weeks from their referral.
- There was a clear governance structure in place with committees for medicines management, infection control and health and safety.
- Staff we spoke with were motivated and positive about their work, and described all members of the senior management team as approachable and visible.

However:

Summary of findings

- Staff turnover was higher than the average for independent hospitals. This had been recognised by the hospital and had plans in place.
- Not all risks were identified on the hospital risk register.

Services for children and young people

Children and young people's (CYP) services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as outstanding. We rated it outstanding for caring and responsive. Safe, effective and well-led were rated good.

Outstanding ☆

- A large toy car was stored in the play area for children who wanted to drive themselves to theatre for their operation rather than walking or being transported on a hospital bed.
- CYP attending pre-assessment were shown the type of equipment that would be used when they were admitted to hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on 'Nuffy Bear' (Nuffield Heath toy bear) and were able to familiarise themselves by playing with the equipment.
- A CYP satisfaction survey had been developed to capture service user feedback from children, young people of all ages and their parents.
- Parents we spoke with felt informed and their children were treated as individuals.
- Staff provided information for parent and children in suitable formats.
- Parents and children we spoke to told us how caring and supportive staff were and how staff went out of their way to make the hospital 'child friendly'. This was also reflected in the positive feedback in patient satisfaction surveys completed by children and their parents.

Summary of findings

- Investigations of incidents, comments and complaints identified where improvements were needed and these were acted upon in CYP services.
- Staff complied with infection prevention procedures and healthcare- associated infection rates were low.
- CYP had their needs assessed, care planned and delivered in line with national guidelines.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits.
- CYP were assessed through pre-assessment clinics for their suitability to undergo treatment at the hospital.
- Areas used were not dedicated solely for use by CYP. However, CYP had their individual needs assessed and plans were put in place to meet those needs wherever possible. This was to make the hospital stay less traumatic.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Health Act 2005 and the Children Act's 1989 and 2004.
- Governance arrangements ensured appropriately trained staff cared for CYP at all times.
- There were processes and procedures in place for staff to manage CYPs pain and to ensure their hydration and nutrition needs were met.
- There was CYP representation at leadership and local meetings at the hospital.
- CYP champion roles were in place in all departments to ensure engagement and understanding of CYP issues across the hospital.
- There were systems in place to ensure staff were competent to provide effective care. Annual appraisal and registration checks were carried out. Emergency scenario training to care for the sick child had been implemented hospital wide.

Summary of findings

Outpatients and diagnostic imaging

Good 

Overall, we rated the outpatients and diagnostic imaging service as good because:

- There was a good track record of safety in the outpatients and diagnostic imaging departments.
- There was a positive attitude towards learning from incidents and sharing learning with other departments.
- All staff had an understanding and awareness of duty of candour principles.
- There were good processes in place to ensure that equipment was stored, maintained and used safely.
- Care was planned and delivered in line with national guidance and best practice guidelines.
- There was an effective process of cyclical audits to identify areas for improvement and best practice.
- Staff worked together to plan and assess care for patients.
- Patients we spoke with told us that staff were kind, caring and respectful.
- There were effective governance arrangements in place to support the delivery of quality care and the hospital's strategy.

Summary of findings

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Good

Nuffield Health Warwickshire

Services we looked at
Medical care; Surgery; Services for children and young people; and Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Warwickshire Hospital

Nuffield Health Warwickshire Hospital is operated by Nuffield Health. The hospital opened in 1981. It is a private hospital in Leamington Spa, Warwickshire. The hospital primarily serves the communities of Warwickshire. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since February 2016.

The hospital also offers cosmetic procedures such as dermal fillers. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC inspection manager,four CQC inspectors, and four specialist advisors with expertise in surgery, paediatrics and governance. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Nuffield Health Warwickshire Hospital

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

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

During the inspection, we visited the ward, theatres, outpatients department, x-ray and diagnostic imaging. We spoke with 24 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 20 patients and 17 relatives. We also received 62 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 26 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 in the past. The most recent inspection took place in February 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016, there were 8,211 inpatient and day case episodes of care recorded at the hospital; of these 11% were NHS-funded and 89% other funded.
- 45% of all NHS-funded patients and 17% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 18,785 outpatient total attendances in the reporting period; of these 74% were other funded and 26% were NHS-funded.

223 medical staff including surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Resident medical officers were supplied through an agency, worked on a week on, week off rota. The hospital employed 36.3 full time equivalent (FTE) registered nurses, 21.7 FTE operating department practitioners and care assistants, and 66.9 FTE other hospital staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There were no never events reported from July 2015 to June 2016.

Summary of this inspection

- Clinical incidents in the reporting period included 165 no harm, 68 low harm, five moderate harm, no severe harm and one death.
- There were no serious injuries reported from July 2015 to June 2016.
- There were no incidences of hospital acquired Meticillin -resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA) or E-Coli reported from July 2015 to June 2016.
- There was one incidence of hospital acquired Clostridium difficile reported from July 2015 to June 2016.
- There were 24 formal complaints received by the hospital from July 2015 to June 2016.

Services accredited by a national body:

- None

Services provided at the hospital under service level agreement:

- Archiving of medical records
- Catering
- Facility management
- Laundry services
- Magnetic Resonance Imaging
- Medical equipment management
- Resident medical officer
- Security
- Shredding services for confidential waste

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Staff we spoke with understood their responsibilities to report incidents. Incidents were discussed with staff to share learning and prevent reoccurrence.
- Staff understood their responsibilities to meet the duty of candour and be open and honest with patients when notifiable incidents occur.
- There were processes, systems and policies in place to maintain hygiene standards and ensure that infection control practices were carried out in line with hospital policy and national guidance.
- Areas were visibly clean and tidy and had access to the equipment required to deliver care and treatment.
- Equipment that we checked, were found to have been appropriately maintained and electrical safety tested. There was appropriate resuscitation equipment available in the case of an emergency.
- Patients' records were managed and stored in line with the hospital's policy. Patient records we looked at were structured, legible, complete and up to date.
- Staff understood their responsibilities to safeguard people from abuse. Staff had received training in adult and children's safeguarding to appropriate levels for their roles.
- There were processes in place to assess risks to patients and to monitor and maintain patients' safety. Pre-assessment consultations identified patients who were unsuitable to be treated at the hospital or required care and treatment to be adapted to meet patients' individual needs.
- Staffing and skill mix was planned so that patients received safe care and treatment at all times. Arrangements were in place for handovers and shift changes to ensure patients were safe.
- All patients were admitted under the care of a named consultant. Consultants provided care for patients under practising privileges. The hospital had arrangements in place to ensure consultants had appropriate skills and experience to care for patients.
- A resident medical officer was on duty 24 hours a day and the hospital had an out of hours rota for anaesthetists to provide 24 hour cover for patients post-operatively. There was a service level agreement for emergency transfer arrangements with the local NHS trust.

Summary of this inspection

- There was a major incident and business continuity plan, which listed key risks that could affect the provision of care and treatment. Each department carried out regular cardiopulmonary resuscitation scenario training.
- There were processes and systems in place to ensure that medicines were managed correctly, including recording, handling and safe administration. However, medicines were not always stored at an appropriate temperature in the clinical room on the oncology unit. Actions were being taken to reduce the risk of reduced efficacy of medicines.

However:

- There were inconsistencies with the documentation of the World Health Organisation safer surgery checklist in endoscopy.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Audit results for the endoscopy and oncology patients were not captured separately in the hospital's local audit programme. This meant that information for medical services to assess the effectiveness of care and treatment they provided, was not available.
- We were not assured that the oncology service routinely collected and monitored information about the outcomes of patient's care and treatment to ensure that the intended outcomes were achieved.

However:

- Care and treatment was assessed and delivered in line with evidence-based guidance.
- The hospital had a structured clinical audit programme to monitor compliance to protocols and guidelines. Results that were available showed good performance and improvement plans in place when needed.
- The hospital had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured.
- Staff used a pain assessment scoring tool to assess the level of patient pain. Patients told us their pain was managed effectively by staff.
- Patients' nutrition and hydration needs were risk assessed and a specific care pathway was implemented if the patient's clinical condition required it.
- Staff were qualified and had the skills they needed to carry out their roles effectively.

Summary of this inspection

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patients care and treatment. Care was coordinated between pre-assessment, ward and theatre staff.
- Staff we spoke with said they had access to the information they needed to deliver effective care and treatment to patients in a timely manner.
- Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients. All the consent forms that we checked, were appropriately completed, dated and signed by the patient and consultant.
- Staff were aware of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

Are services caring?

Good

We rated caring as good because:

- Patients were extremely positive about the care and treatment they received at the hospital.
- Patients were treated with dignity, compassion and empathy. We observed staff providing and communicating care and treatment in a respectful manner.
- Staff made sure that patients dignity and privacy was protected at all times.
- Patients told us that they felt well informed about their care and treatment and knew when they would receive test results or if a follow-up appointment was required.
- Children and young people attending pre-assessment were shown the type of equipment that would be used when they were admitted to hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on 'Nuffy Bear' (Nuffield Heath toy bear) and were able to familiarise themselves by playing with the equipment.
- Patients were given information about who to contact if they had any concerns or questions after their appointment. The hospital held regular open events to give patients and their loved ones the opportunity to discuss specific conditions and receive support and counselling advice.
- The hospital submitted data to the Friends and Family Test. The hospital had a response rate of 28% to 55% from January to June 2016. Scores were between 93% and 99%, of patients recommending the hospital to their family and friends.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- Information about the needs of the local population was used to inform how services were planned and delivered.
- Services were planned and delivered to take into account the individual needs of its patients, for example, age, disability, gender, religion or belief.
- Patients had timely access to initial assessment, diagnosis or urgent treatment and could access services at a time to suit them.
- Patients were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. Processes were in place to deal with unexpected outcomes.
- Patients were provided with appointment times to suit their commitments. For children and young people this could be before or after school and between school terms.
- A large toy car was stored in the play area for children who wanted to drive themselves to theatre for their operation rather than walking or being transported on a hospital bed.
- Patients' procedures were only cancelled or delayed when necessary. Appointments were offered within 28 days of the cancellation.
- The service had a range of leaflets and bespoke information regarding certain procedures.
- Information on how to raise complaints and concerns was displayed in the areas we inspected. We saw evidence that complaints were managed in line with the hospital policy and that the hospital learnt from complaints.

Are services well-led?

Good

We rated well-led as good because:

- Staff we spoke with were motivated and positive about their work.
- Managers demonstrated clear leadership principles in line with the Nuffield Health set values. Staff spoke told us they felt respected, valued and well supported by their managers.
- There was a culture of candour, openness and honesty. Staff told us they felt able to raise concerns and were encouraged to report incidents. There was also an up to date whistle-blowing policy in place.
- Staff were clear about the corporate strategy and values. There was no specific strategy for individual services.
- There was a clear governance structure in place with committees for medicines management, infection control and

health and safety, which fed into the clinical governance committee. There was also the which had separate meetings to discuss the consultants' professional registrations and appraisals.

- Routine audit and monitoring of key processes took place across the hospital to monitor patient outcomes, with the exception of medicine
- Patient's views and experiences were gathered and acted on to shape and improve services and the culture. The hospital held regular open events for the public, whereby, they could visit the hospital and attend sessions about a variety of procedures or conditions, such as varicose veins.
- Staff were sent a monthly newsletter, which provided updates on new developments, training opportunities and upcoming events.
- A consultant surgeon would hold 'lunch and learn' sessions with the local GPs, to discuss what procedures they carried out at the hospital.

However:

- Although identified risks were placed on the risk register, with mitigating actions implemented. Not all risks had been identified, assessed or mitigating action taken.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Good	Good	Good

Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both outpatients and diagnostic imaging.

Requires improvement

Medical care

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

Are medical care services safe?

Good

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

Medical care at this hospital included endoscopy and oncology services. There were a small number of patients admitted to the ward for medical care, for relevant findings regarding inpatient care, please see the surgery report.

The endoscopy service provided upper and lower gastrointestinal endoscopy, urological endoscopic investigations and urodynamic investigations.

The oncology service offered an ambulatory chemotherapy service to patients who attended for treatment on a day case basis.

We rated safe as good.

Incidents

- Staff we spoke with in medical services understood their responsibilities to report incidents and we saw evidence of when this had occurred. For example, there was a copy of an electronic incident report in a patient's healthcare record. This had been completed by oncology nursing staff who were reporting a patient's reaction during chemotherapy treatment.
- We saw evidence in meeting minutes for medical services, that incidents were discussed to share learning and prevent reoccurrence. Staff could provide examples when reporting incidents had led to changes. For example, staff used a stamp to add endoscopy specific items to their documentation of procedures, such as the patient's comfort score. This was in response to incidents when patients had complained of discomfort during procedures.
- Staff we spoke with in medical services understood their responsibilities to meet the duty of candour and be open and honest with patients when notifiable incidents occur. For our detailed findings on the duty of candour, please see the safe section in the surgery report.
- The oncology team had set up new meetings in August 2016, to discuss service specific issues. We saw in the minutes of these meetings that it was planned to discuss patients' mortality and morbidity at the February 2017 meeting.

Cleanliness, infection control and hygiene

- There were arrangements in the areas we inspected in medical services, to comply with infection prevention and control procedures.
- We observed staff adhering to policies, such as 'arms bare below the elbow' to allow effective handwashing and using personal protective equipment (PPE) appropriately. For example, wearing apron and gloves when inserting a peripheral venous access (drip). Staff cleaned their hands in line with World Health Organisation five moments for hand hygiene.

- There were appropriate handwashing facilities in procedure rooms and patient's rooms for the oncology service and clinical flooring had easy to clean skirting, in line with infection and prevention guidance such as Department of Health, Health Building Notes.
- There were arrangements in place in the endoscopy service to clean scopes and equipment in line with guidance, including Health Technical Memorandum 01-06: decontamination of flexible endoscopes. For example, we saw, used scopes were placed in a tray with a red plastic cover to indicate potential hazard. There was a separate 'dirty' room adjacent to the endoscopy room where used scopes were cleaned and processed through a disinfecting machine. There was a clean area, outside of this room where scopes were stored.
- The endoscopy service carried out routine monitoring such as water testing, in line with Health Technical Memorandum 01-06: decontamination of flexible endoscopes. We saw that staff took appropriate actions according to the results and reported adverse results as an incident. Staff recorded the results to help identify any trends.
- We saw that oncology patients had assessments completed in their healthcare records for the risk of carbapenemase-producing enterobacteriaceae (CPE) bacteria in the gut, as part of oncology patient's initial assessment. CPE infections can be difficult to treat because they are resistant to antibiotics. This meant that staff would be aware of patient's CPE risk and take action as required.

Environment and equipment

- The areas we inspected in medical services were visibly clean and tidy and had access to the equipment required to deliver care and treatment.
- Resuscitation equipment was available on the adjacent inpatient ward for use in the case of an emergency.
- There were equipment and resources available for medical services to deal with accidents and spillages. This included separate toxic waste bins, emergency eyewash and spillage kits in line with Control of Substances Hazardous to Health Regulations.
- Equipment that we checked in medical services, were found to have been appropriately maintained and electrical safety tested.
- There were arrangements in place to receive advice and support with the specialist cleaning equipment used in endoscopy. We observed during the inspection, that there was an error code for a machine and engineer assistance was requested. There was a return call within five minutes and advice was provided to troubleshoot and resolve the issue.
- There was a tracking system used to log equipment and scopes used in the endoscopy unit. This would enable traceability as required.
- The oncology patients had access to recliner chairs in the rooms, which they could use instead of the bed during treatment.

Medicines

- There were processes and systems in place for the oncology service to manage chemotherapy medicines. The pharmacist checked all prescriptions and monitored for errors. The pharmacist recorded all interventions that they made.
- Consultants prescribed the chemotherapy treatments against the British Oncology Pharmacy Association guidelines. The prescribed chemotherapy regime was sent to the pharmacy, which was based in the hospital.
- We saw that the pharmacist had records of all the chemotherapy regimes used by the consultants at the hospital. The records were maintained and any changes were agreed through the medicines management forum. The pharmacist also kept patient chemotherapy treatment profiles for checking new prescriptions against to avoid errors.
- The chemotherapy medicines were made up by another provider in an aseptic unit and were couriered in to the hospital. The medicines were transported in cytotoxic transportation bags.
- The hospital's pharmacist explained that the chemotherapy service had expanded and the volume of work meant that another pharmacist may be required. The deliveries of the chemotherapy often arrived usually while the pharmacist was on the morning ward round with the resident medical officer (RMO). This issue had been escalated to managers and entered on the hospital's risk register.

- The oncology unit had a clean utility room, which had keypad access and was used to securely store medicines and intravenous fluids. Medicines that required refrigeration were stored in a fridge and the temperature was monitored and recorded. The ambient room temperature was also monitored. Records showed that this had often been higher than the recommended temperature. During the unannounced inspection, we found that the ambient room temperature had been above the maximum recommended temperature (25 degrees) for 14 consecutive days. Staff had not reported nor appeared to have taken any action regarding this. When we discussed this with staff, they thought that remote temperature monitoring was in place, alerting pharmacy directly. Unfortunately, this monitor (we saw in place) had been isolated to prevent continual alarming. We raised this issue with the hospital director and pharmacist who explained that mitigating actions were being taken. This included having low medicine stocks held in this area and increased stock rotation due to potential reduced medicine efficacy. An air conditioning unit was to be fitted at the end of January 2017.
- We saw that staff documented a patient's allergy status on chemotherapy treatment prescription charts. The chemotherapy treatment prescription charts included information to guide staff including a checklist for blood tests to be taken and what action to take in the event of a reaction.
- The endoscopy unit had emergency medicines available in the room for use in the event of patient's deterioration. We checked these, found they were in date, and stored securely when the room was not in use.
- We noted that medicines that were used for endoscopy procedures. For example, sedation were checked thoroughly against the prescription and signed for following administration.
- Staff documented the ambient room temperature of the endoscopy procedure room each day and it had been within acceptable limits.

Records

- Staff documented patient's care and treatment on care pathways. Care pathways are a way of setting out a process of best practice to be followed in the treatment of a patient with a particular condition or with particular needs. Risk assessments were embedded in these. For example, there were risk assessments for malnutrition, patient moving and handling, and development of pressure ulcers completed in the oncology records we checked.

Safeguarding

- Staff we spoke with in this core service understood their responsibilities to safeguard people from abuse.
- For our detailed findings on safeguarding please, see the safe section in the surgery report.

Mandatory training

- Staff we spoke with in this core service had completed their mandatory training for their roles.
- For our detailed findings on mandatory training, please see the safe section in the surgery report.

Assessing and responding to patient risk

- The endoscopy service used the World Health Organisation (WHO) safer surgery checklist process embedded into a care pathway, to reduce the risk of patient safety incidents and harm. We observed that there were inconsistencies with the usage of the checklist. For example, we did not see the 'time out' section of the checklist complied with. We raised this during the inspection with the theatre manager. They acknowledged that audits of the WHO checklist had not been carried out in the endoscopy unit and they would address this.
- We observed during our unannounced inspection, that there had been an audit tool designed for use in the endoscopy suite. We also observed a much stronger performance with the WHO checklist and saw that ongoing monitoring had been arranged.
- However, we checked seven forms in the briefing log folder in the endoscopy room. The documentation of pre-list team briefing and post-list debriefing was found to be inconsistent on all seven forms. Despite this, we observed briefings undertaken appropriately, including any anticipated risks. This meant that we could not be assured that the document was being used to capture the briefings and debriefings that were taking place. In response to this, the provider developed a standard operating procedure to guide staff on the correct way to complete the briefing logs.

- Patients undergoing endoscopy procedures were monitored appropriately for signs of clinical deterioration. For example, heart rate, oxygen saturation and blood pressure. Staff checked the patients' observations frequently and documented them on a chart. The chart incorporated an early warning scoring system. This was calculated to help to identify when action needed to be taken. We observed that the scoring system was correctly calculated and documented. For our detailed findings on please see this section in the surgery report.
- There was a buzzer available in the endoscopy procedure room for staff to call for assistance in an emergency.
- Before attending for chemotherapy treatment, patients were invited to attend a pre-assessment appointment with one of the nurses from the oncology unit. Staff would begin to complete assessment documentation for the care and treatment. This included for example, risk of patient falling, current medicines, baseline observations and allergy status. This meant staff would have the relevant information to individualise a patient's care and treatment and reduce the risk of harm.
- At the pre-assessment appointment, patients at the oncology service would be provided with patient held information packs. This included contact details for the oncology service, their consultant and the names of the nursing staff. Patients were also given alert cards to carry, which explained that they were at high risk of sepsis, which is a potentially life threatening condition. The card contained advice for healthcare professionals and the contact details for the service. Patients said that staff had informed them of potential side effects from treatments and symptoms to look out for.
- We saw in a patient's healthcare record, that appropriate action had taken place when a patient had a reaction during their chemotherapy treatment. Observations had been taken and recorded. The RMO had been called and they attended and assessed the patient. The oncology nurse had contacted the patient's consultant and a plan of care had been documented.
- There was a standard operating procedure for the oncology service. This stated that if a patient was unwell they were advised to contact their consultant in the first instance, who would then liaise with the oncology nurses as necessary. We discussed this with the oncology lead nurse during the inspection. The patients were advised that they could contact the service or ward at the hospital for advice (out of hours) or their consultant. They had a triage process in place for when a patient contacted the service to guide staff to the appropriate care and treatment required. The triage process was based on the United Kingdom Oncology Nursing Society. The lead oncology nurse for the service explained that they worked extremely closely with the consultants and they liaised almost on a daily basis. We saw evidence of this close working in patients' healthcare records that we reviewed.

Nursing staffing

- During our inspection of medical services, the actual staffing met the planned level.
- The oncology service opened from Tuesday to Friday for day case based care and the planned staffing was two chemotherapy-trained registered nurses on duty. Ward staff were not routinely involved in the care and treatment of oncology patients. The lead oncology nurse was employed by the hospital on a permanent basis. The other oncology trained nursing staff were supplied by an agency. The two agency nurses that were provided both worked regularly for the service and were familiar with the policies and procedures. They initially received local inductions to the service.
- The endoscopy service planned staffing level was for two trained nurses. The endoscopy service was available on weekdays (Monday to Friday, day case provision only). There were three endoscopy- trained registered nurses, who worked in the endoscopy unit, one of which also worked in the theatre department. The lead endoscopy nurse maintained the rota. This was planned to provide cover for the booked endoscopy sessions.
- The nursing staff used virtual handover strategies in medical services, such as communication books and emails due to providing day case based care. This meant staff coming on duty each day had the relevant information they needed to provide safe care and treatment.

Medical staffing

Requires improvement

Medical care

- This hospital had one inpatient ward, which provided care and treatment for mainly surgical patients.
- When the RMO or nursing staff needed to seek advice or support out of hours, they contacted the patient's named consultant. Consultants were required to be no more than 30 minutes away according to the terms of their practising privileges. The hospital carried out a formal risk assessment if a consultant did live outside this travel time. If a consultant was aware they would be absent, they informed key senior staff at the hospital in writing and confirmed their cover arrangements. This was part of their practising privileges agreement.
- There were five clinical oncology consultants employed by practising privileges for the oncology service. They were able to provide treatment for specialities including breast cancer, gynaecological cancers, colorectal, upper gastrointestinal and urology cancers.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- We saw that patient's care and treatment in medical services was provided in line with evidence-based guidance. Guidance and best practice were embedded into the care pathways used to guide staff regarding patient's care. For example, there was a care pathway document for oncology patients and endoscopy procedures were documented on a 'day and overnight surgery care pathway'.
- The endoscopy service used an electronic endoscopy management system. Details about procedures were entered contemporaneously and this enabled ongoing audit. For example, global rating scale (GRS) audit report could be generated. The GRS is a tool that enables endoscopy units to assess how well they provide a patient-centred service.
- Staff told us and we could see that the endoscopy service was preparing for an assessment to achieve Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver the service against recognised patient centred standards.
- The medical advisory committee meeting minutes for October 2016, showed that there had been a gap analysis undertaken. This was to identify where there were gaps in meeting guidance from the National Institute for Health and Care Excellence (NICE). The provider recognised that the oncology service was not meeting the NICE guidance from May 2016 regarding improving outcomes for patients with haematology cancers. The guidance stated there should be a minimum of three consultants, to ensure challenge and cover arrangements. The hospital had one consultant with practising privileges providing haematology cancers service to two current patients. We could see that actions were being taken to address this. This included not admitting any new patients requiring this type of care to the oncology service until provisions met the guidance.
- The hospital had local audit programmes in place that included infection prevention, health and safety, clinical indicators, medicines management. As patients care in this core service was provided from the main ward where the audits took place, they were included in the overall hospital audit schedule. However, audit programme results for the endoscopy and oncology patients were not captured separately. This meant that information for medical services to assess the effectiveness of care and treatment they provided, was not available.

Pain relief

- The endoscopy team would assess the patient's level of discomfort during and following a procedure using a comfort score. The rating was agreed with the consultant who performed the procedure and entered into the electronic management system. This system enabled audit data to be generated. Nursing staff also documented a patient's comfort score in the healthcare record.
- We saw that the oncology care pathway used to guide treatment, included a pain scoring tool embedded in the observation chart. This used a numerical scale from zero to 10, for a patient to rate their pain. The presence

of pain was also part of the Eastern Cooperative Oncology Group (ECOG) modified toxicity grading in the care pathway. This was a pre-treatment assessment carried out to evaluate how a patient's disease was progressing and determine appropriate treatment plans. Care pathways that we checked during the inception were appropriately completed regarding a patient's pain relief.

- Patients within medical services, told us they were comfortable and not in pain.

Nutrition and hydration

- We saw that patients could access appropriate nutrition and hydration in medical services.
- Patients nutritional and hydration status was assessed by oncology nurses as part of the treatment (ECOG) modified toxicity grading in the care pathway. This was a pre-treatment assessment carried out to evaluate how a patient's disease was progressing and determine appropriate treatment plans.
- There were nutritional assessments tools in care pathway document used to guide care and treatment in medical services. This included interventions, such as increased monitoring of daily food intake, referring to patient's consultant and referral to a dietitian. There was a service level agreement with the local NHS trust for a dietitian to visit if needed.
- Patients were starved appropriately prior to undergoing endoscopy procedures. We saw that they were offered drinks when they were recovered back on the ward.

Patient outcomes

- We requested details of any audits completed of patients' outcomes of chemotherapy regimes for the oncology service including survival and mortality. At the end of the chemotherapy course, consultants provided patients with follow-up consultations usually every six or 12 months for up to five years. However, the team maintained that due to the small number of patients seen by the service, any data would not achieve meaningful statistics.
- We asked for audits and patient outcomes data relating to medical patients, however, the hospital did not provide this. This meant we were not assured that information about the outcomes of patients care and treatment was routinely collected and monitored to ensure that the intended outcomes were being achieved.

Competent staff

- There were processes in place regarding medical staff working at the hospital and within medical services under practising privileges agreement. For our detailed findings on practising privileges, please see this section in the surgery report. We noted there was not an oncology representative on the medical advisory committee. However, the provider advised that oncology was represented by the physician representing non-surgical specialties such as general medicine.
- Staff in medical services were up-to-date with the requirement to attend an annual appraisal to evaluate and plan professional development. Due to teams within medical services being small and specialised, the leads ensured that they maintained links with other clinical staff providing similar services. For example, the endoscopy lead nurse explained how they linked up regularly with the endoscopy staff at the nearby NHS trust.
- Staff who administered chemotherapy had received specialist training and their competencies updated annually. The lead nurse for oncology was up-to-date with competencies to provide chemotherapy care and treatment. The lead nurse told us they had been very well supported with professional and training needs since joining the hospital. For example, they attended the UK oncology nursing society annual conference in November 2016.

Multidisciplinary working

- We saw there were good working relationships between medical services and other departments and disciplines to deliver effective care and treatment. This included pharmacy, physiotherapists, diagnostic imaging, the outpatient department and the ward. For our detailed findings, please see this section in the surgery and report.
- We saw in the healthcare records that oncology patients' treatments were discussed at cancer multidisciplinary team meetings at NHS providers.

- There was a service level agreement with a community healthcare provider for oncology patients to receive care and treatment when required in their homes.

Access to information

- The electronic endoscopy management system allowed staff to access information about the service, activity, consultant performance and details of patient's procedure results. The system also was used to generate reports immediately following the procedure and copies were provided for the patient, medical notes and the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- Staff we spoke with in medical services were able to describe their responsibilities related to consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, although they did not often care for patients who lacked mental capacity.
- We observed that patient's consent was obtained in line with hospital policy and documented prior to endoscopy procedures taking place. The consent forms were also checked with the patient as part of pre-procedure checklist.
- During the inspection, we checked eight oncology patient's healthcare records. We found that patient's consent had been formally obtained and documented prior to starting their treatment plan.
- All the consent forms that we checked, were appropriately completed, dated and signed by the patient and consultant.

Are medical care services caring?

Good

We rated caring as good.

Compassionate care

- We observed staff and patient interactions were kind and respectful. Staff introduced themselves and asked patients for their preferred name. A patient told us that all the staff at the hospital were polite and called them by their title rather than their first name.
- Staff made sure that patients dignity and privacy was protected at all times. For example, staff provided patients who were having an endoscopy procedure with disposable 'dignity' underwear. Staff ensured that patient were wearing these and dressing gowns (that were provided) prior to walking along to the procedure room.
- A patient came into the office after their chemotherapy treatment to say goodbye and thank the lead oncology nurse. It was clear that appropriate strong bonds had been formed between the patient and nurse.
- The oncology service collected patient experience feedback. The results showed monthly scores from 80% to 100% for the year of 2016. It was reported in the minutes of the oncology group meeting for November 2016, that the overall satisfaction score for the service was 97%.

Understanding and involvement of patients and those close to them

- Patients that we spoke with had been kept informed about treatment options and procedures. They felt that they were involved in treatment and care decisions and were given enough information in order to do this. For example, patients told us in the oncology service that they knew what their blood test results were. Another patient explained that when certain side effects were experienced they were able to discuss with the consultant about trying a different treatment dose.
- Patients told us that staff in the oncology unit also spoke with and reassured their visitors and relatives.

Emotional support

- The oncology service had access to a breast care specialist nurse who worked to support patients on a temporary (bank) basis.

- The oncology service offered a pre-assessment appointment for patients prior to starting their treatment. Staff felt that this was important to enable them to provide emotional support right from the outset.
- Oncology patients that we spoke with said the nurses made them feel as though they were their only patient.
- The endoscopy staff were adept at making patients feel at ease particularly before and during a procedure. The consultant performing the procedure would also tell the patient what to expect and explain if they were feeling some discomfort that they were safe and not in danger. There was an unhurried, friendly approach by staff in the service.

Are medical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The oncology service was set up approximately 12 months ago for four days a week, between the times of 8am and 4pm. Previously, the oncology service was outsourced and open for two days a week.
- The oncology service was situated at a quiet end of the inpatient ward. This area had very little through traffic and patients had the use of private en-suite rooms during their treatment.
- There were no visiting restrictions for the oncology service and we saw that relatives were able to wait in the patient's rooms while they were having their endoscopy procedure.
- The endoscopy service provided day case sessions from 8am to 5pm during the period Monday to Friday.
- Patients for endoscopy procedures were admitted to the inpatient ward and had use of private en-suite rooms during their stay.
- Relatives and visitors were offered hot and cold drinks and could use the hospital's restaurant.

Access and flow

- We spoke with patients who were attending the endoscopy service. They said there had been minimal waiting times, both from referral to attending the appointment and on the day of the procedure. We saw staff arranged patients to have had staggered arrival times throughout the day, to keep waiting to a minimum. Patients told us that they were able to arrange appointments to suit them.
- Prior to treatment, nurses from the oncology service invited patients to attend a pre-assessment appointment.
- We requested details of any audits undertaken to demonstrate patients' access to treatment and waiting times for the oncology service. However, this was not provided.
- Following endoscopy procedures, the patient and the patients GP were provided with a copy of a report detailing immediate findings and whether biopsies were taken.

Meeting people's individual needs

- We requested details of any transition arrangements to NHS services for patients who were receiving chemotherapy treatment at the hospital and then required end of life care. However, this was not provided.
- Staff in medicine had a flexible approach to meeting patients' individual needs. For example, staff arranged for an oncology patient who had an access device inserted at the hospital in preparation for starting chemotherapy treatment the next day, to stay overnight rather than travel home.
- Patients' preferences were met as far as possible. For example, a patient told us 'I arrive to find my orange squash waiting for me'.
- Patients held their own oncology personal folder. This contained lots of information including contact details of support organisations. Patients also had their own chemotherapy record.
- Patients for the oncology service used single ward bedrooms with en-suite facilities.

Learning from complaints and concerns

Requires improvement

Medical care

- There were no complaints received by the provider from February to August 2016 specifically about medical services.
- Patients we spoke with in medical services had no complaints about the service they were receiving. They said they would be happy to raise any issues if necessary directly with the staff.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership and culture of service

- A senior nurse led the oncology service. They reported to the matron of the hospital and we could see that they worked well together and supported each other.
- The oncology service was fairly recently set up at the hospital and the senior nurse was passionate about the service they provided to patients.
- The endoscopy service had a lead nurse who reported to the theatre manager. The theatre manager was the line manager for all the endoscopy staff. The endoscopy lead nurse role was to drive the service towards being Joint Advisory Group (JAG) accredited, as well as the day-to-day running of the service. They attended the endoscopy group meetings and maintained communications with the consultants who provided sessions for the endoscopy unit.
- We found there was appropriate local leadership and positive working culture within medical services. Leads were visible, experienced and knowledgeable in their specialised fields.

Vision and strategy for this this core service

- Staff were clear about the corporate strategy and values. The hospital underpinned its service delivery with six core values, which were: we believe that commercial gain can never come before clinical need, we believe in no nonsense, we believe in being straight with people, we believe in taking care of the small stuff, we believe that caring starts with listening and we believe in you.
- Staff told us the strategy was to extend the hospital and that this would include a new oncology unit. We saw that this was discussed in oncology forum meetings. Staff and patients were being involved in the planning for this. Feedback forms had been tailored to ask patients specific questions about what would be important considerations for a new oncology unit.

Governance, risk management and quality measurement (medical care level only)

- The governance processes were the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- The oncology service had recently set up and commenced specialist meetings called the oncology forum. There had been two meetings so far August and November 2016. The forum had been set up formally with terms of reference, which included the responsibilities of the members, minimal number of meetings per year and how the group fitted in the governance structure of the hospital. However, consultants had not attended the meetings. We discussed this with the lead oncology nurse, who advised that this had not been possible so far due to clinical commitments.
- We were not assured that the oncology service routinely collected and monitored information about the outcomes of patient's care and treatment to ensure that the intended outcomes were achieved.
- The endoscopy used group meetings minutes showed that standing items on the agenda for discussion included governance and regulations, staffing, infection prevention and control, health and safety, medicine management, clinical outcomes, incidents and complaints.
- We noted that the drying store cupboard to store scopes in the endoscopy room was out of action. This meant that the scopes had to be decontaminated more frequently so that they were fit to be used. Endoscopy staff told us that managers were aware. The provider had experienced delays outside of their control regarding replacement equipment. The senior management team had made reasonable attempts to resolve the situation. However, this had not been documented on the hospital's risk register.

- We could see that when the provider recognised the oncology provision for haematological cancer treatment did not meet Haematological cancers: improving outcomes National Institute for Health and Care Excellence guideline (May 2016), actions were taken to was address this. Matron advised, and we could see that the issue had been escalated to the medical advisory committee. This meant that governance processes were in place in order to provide care in line with national guidance.
- However, there was no specific oncology service representative present at medical advisory committee (MAC). This was provided by the physician representative. The provider advised that not all individual specialties practised at the hospital were represented at the MAC, which was in line with the practising privileges policy and should issues be raised about any specialty which did not have a representative at the MAC, advice was sought from a consultant in that specialty.
- There appeared to be a misunderstanding between pharmacy department and the oncology service regarding the clean utility room ambient temperature monitoring. See the medicine section of the medical care report for details. However, mitigating actions were in place and the issue would be resolved with the planned installation of an air conditioning unit at the end of January 2017.
- The hospital's risk register was based on departments not on specialties, so there was not a separate risk register for medical services. We saw that risks related to the pharmacy service supporting the oncology provision were identified on the departmental risk register with appropriate mitigations and monitoring in place.

Public and staff engagement

- The oncology service engaged with the public through meetings. There were three meetings of the oncology support group in 2016 in the months of March, June and November. The numbers of attendees were small, from three to five people. Staff told us that they were well received.
- The endoscopy team held quarterly staff meetings, which were also attended by consultants. The main focus was preparation for JAG accreditation for the service.

Innovation, improvement and sustainability

- The leads of the oncology and endoscopy services were both exploring improvements to services. In endoscopy for example, this was driven by benchmarking their service so that they would be successful at achieving JAG accreditation when assessed in 2017. For oncology, the focus had been embedding the new service and getting the basics right, such as the consent process and documentation. Another permanent member of nursing staff was also joining the oncology team to ensure the sustainability of the service for the future.
- We saw in meeting minutes, such as the MAC, that themes and trends regarding incidents were reported. This included in October 2016 MAC that there had been an increase in incident reports related to water quality monitoring results by endoscopy staff. Further information was provided by the hospital, which showed that the endoscopy service carried out routine monitoring such as water testing, in line with Health Technical Memorandum 01-06: decontamination of flexible endoscopes and staff took appropriate actions according to the results. This meant that the MAC were receiving oversight information such as incident trends, to make sure the services provided high-quality care. However, it was not clear if medical services were included in the hospital's local audit programme. Therefore, we could not be assured that the effectiveness of care and treatment provided was evaluated.

Good

Surgery

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

Are surgery services safe?

Good

The main service provided by the hospital was surgery. Where our findings on surgery services also apply to other services, for example, management of waste, we do not repeat the information but cross-reference to the surgery report.

We rated safe as good.

Incidents

- In the reporting period; July 2015 to June 2016, there were no never events or serious incidents. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- In the same reporting period, there was one expected death; this was a patient with a palliative condition. No root cause analysis was needed, due to the palliative nature of their condition and this was reflected in the patient's records.
- There were 163 clinical incidents reported from July 2015 to June 2016 by the theatre and surgery teams. Each incident had been reported and investigated in accordance with the service's procedures for incident management. The majority were classed as no harm or low harm.
- Staff were aware of the process for reporting any identified risks and incidents to staff, patients and visitors. Incidents were logged on the hospital's electronic reporting system. Staff were able to discuss incidents they had reported and gave examples of how they received feedback. One example given to us was, an incident where a patient needed a naso-gastric tube (a tube inserted through the nose into the stomach to support enteral feeding or to aspirate stomach contents), the correct tube required was not available. This was reported as an incident and transport was arranged for the patient to the local NHS trust to gain the correct tube, so treatment was not delayed. The outcome from this incident was the correct naso-gastic tubes were ordered regularly. Staff told us they were encouraged to report incidents. They told us they received feedback following incidents they had reported and their line manager or matron provided this.
- Reported surgical incidents were reviewed and investigated by the ward and theatre managers. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron. Learning was cascaded from the governance committee meetings.
- Staff told us that incidents and complaints were discussed during daily handovers and monthly staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes. A 'lessons learnt' sheet was used by staff to discuss specific issues.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For independent providers, the duty came into force on 1 April 2015. The duty of candour is a regulatory duty that relates to

openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff we spoke with were aware of being open and honest with patients. They provided examples of when they had discussed incidents with patients, such as reasons for a wound infection or theatre cancellations.

Clinical Quality Dashboard

- The service had effective systems in place for monitoring risk from venous thromboembolism (VTE). A VTE is a blood clot that forms within a vein. Safety was monitored using a risk assessment, with all patients being assessed for their risk of developing VTE. Records showed that VTE screening rates were 83% from April to June 2016 and 90% from January to March 2016. The target for the hospital was 95%. We saw evidence of VTE assessments discussed in the medical advisory committee (MAC) meetings; the matron was reviewing the VTE documents, which were to be circulated to all consultants for approval. Consultants said, that once the electronic staff records were implemented the data would be much easier to capture.
- There were no incidents of hospital acquired VTE or pulmonary embolisms from July 2015 to June 2016.
- We looked at 10 patient records. All had VTE assessments completed appropriately. If patients were identified as a risk for VTE, adjustments were carried out such as, anti-thrombolytic stockings and prophylactic heparin.

Cleanliness, infection control and hygiene

- The matron was the director of infection prevention and control lead for the hospital, supported by an infection prevention coordinator who had specialist training in infection prevention and control (IPC).
- There were link nurses for IPC across all departments. IPC nurses in the Nuffield Health group acted as a resource and support for the hospital. The hospital had a service level agreement with consultant microbiologists to provide expert IPC advice and guidance. The infection prevention expert advisory committee (IPEAC) met quarterly.
- The IPC team meeting monthly. The matron, two microbiologists, infection prevention practitioners and infection prevention assistants attended this meeting. Key points discussed at these meetings were, department cleaning audits, IPC training and surgical site infections.
- Patients were asked to complete a medical questionnaire before they attended the hospital for a procedure. The questionnaire contained a section about infection risks including any previous MRSA (which is an antibiotic resistant bacterium) or Clostridium difficile (this is a bacterium that infects the gut and causes acute diarrhoea) infections. This meant the service could make any necessary arrangements related to infection prevention and control prior to the patient's arrival. There were no reported cases of MRSA; however, there was one episode of Clostridium difficile at the hospital from July 2015 to June 2016. There was an incident report and a full root cause analysis carried out. This showed that the infection presented two days after discharge and was due to the broad-spectrum antibiotics the patient was prescribed. Learning from this was seen, including, all stool samples were to be tested in line with the National Institute for Health and Care Excellence (NICE) guidelines and consultants to make clear on the medication prescription charts when patients change from intravenous antibiotics to oral.
- The ward had a designated side room for patients with a suspected or known infectious illness. It had its own room to store and clean commodes and other toileting equipment, with its own 'dirty' sluice to dispose of bodily waste. This removed the risk of cross contamination. The room would have clear signage on the door, to make all staff and relatives aware of infection risk. Relatives of an infectious patient would be told and shown how to use the personal protective equipment.
- The ward areas, theatres and clinical areas appeared visibly clean and tidy.
- Hand hygiene posters were on display next to all sinks to remind staff of the correct procedure for hand washing.
- Alcohol hand gel was available on the entrances to the ward and theatre departments, as well in patients' bedrooms. We observed staff using the hand gel between each patient contact and all staff were compliant with the 'arms bare below the elbow' policy.
- Hand hygiene audit data showed 100% compliance for the ward in May 2016, however, theatres showed 86% compliance. IPEAC meeting minutes showed that they

had carried out competency assessments and a 'hand hygiene awareness' day as an action from this audit. We did not have any data of audits to show if this had improved results.

- We observed compliance with IPC policies, for example hand washing and the use of personal protective equipment.
- The ward was in good repair and had comprehensive cleaning schedules in place, which were seen to be consistently completed.
- All 42 bedrooms and clinical rooms were compliant with the Health and Building Note 00-09: Infection control in the built environment, 2013. This states no carpets are to be used in areas where frequent spillage is anticipated.
- The operating theatres were found to be visibly clean and tidy, and the daily cleaning records were consistently completed. The service had appropriate facilities and systems to meet the NICE CG74 regarding to surgical site infection. There were three main theatres; two of these had laminar airflow ventilation, which are systems to reduce the risk of airborne contamination and exposure to chemical pollutants in surgical theatres. For information regarding the endoscopy suite, please see the medicine report.
- For the period from July 2015 to June 2016, there were four reported surgical site infections (SSIs). These four infections were in gynaecology, breast and two for orthopaedic related surgery. The rate of infections during gynaecology procedures was worse than the rate of other independent hospitals. However, primary knee arthroplasty, other orthopaedic and trauma and breast procedures were better than the rate for other independent hospitals. There were no SSIs resulting from primary hip arthroplasty, revision hip arthroplasty, revision knee arthroplasty, spinal, urological, cranial or vascular procedures.
- All four SSIs had root cause analysis (RCAs) carried out. We reviewed the root cause analysis from the gynaecology infection. This was observed to be comprehensive, with detailed learning and sharing to staff following the investigation.
- The segregation and storage of clinical waste was in line with current guidelines set by the Department of Health, Management and disposal of healthcare waste (07-01) 2013. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and were in accordance with the current guidelines.
- There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). This complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations) 2013.
- Equipment cleaning assurance labels indicated that re-useable patient equipment was clean and ready for use. Commodes we inspected were clean, labelled and ready for use; clean equipment was stored in a separate clean utility room. All cleaning products were stored appropriately, in line with the Control of Substances Hazardous to Health guidelines 2003.
- The theatre department had a clear flow for the disposal of their clinical waste and used instruments. Policies were in place to support staff in the disposal of waste and staff we spoke with understood how to identify different types of waste and the methods that should be used to dispose of it safely.
- Staff in theatres were observed to be wearing appropriate theatre clothing. When theatre staff left the department, they applied disposable coats and changed their footwear to prevent contaminating their theatre gowns.
- Staff completed mandatory training in infection prevention annually. Reports showed that 97% of staff in theatres and on the wards were compliant.
- The hospital's annual patient led assessment of the care environment (PLACE) for February to June 2016, scored 99% for the cleanliness of the hospital, compared to the England average of 98%.

Environment and equipment

- Each area we inspected was bright, well organised and free from clutter. However, because of storage issues in theatres, an area with equipment and trolleys had partially blocked a fire escape. We raised this with the hospital management team at the time of inspection and when we returned for our unannounced inspection, this issue had been rectified.
- There was appropriate resuscitation equipment available in the case of an emergency. There were resuscitation trolleys situated in the recovery room and two on the inpatient ward. The resuscitation trolleys were all well-organised and had a tamper evident seal in place. We saw records indicating the trolleys and their contents were checked regularly in line with hospital

policy. Theatres also had a difficult airway trolley available. We saw a comprehensive list of items which should be available on the trolley and a clear checking procedure that was completed daily.
- The storage of instruments and equipment within the theatre department was well organised.
- An outsourced company managed equipment servicing. Equipment such as anaesthetic machines and blood pressure machines, had labels showing they had been serviced and when their next service was due.
- Staff told us all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- In the hospital's medical devices quarterly audit for April 2016, surgery scored 100% for the equipment being 'fit for purpose'.
- There were two hoists available on the ward to assist with patient moving and handling when required. This had been serviced and cleaned.
- The hospital did not carry out bariatric surgery, however, there was a bariatric weighing scale available for use in the pre-assessment clinic to gain a patient's body mass index score (BMI), to see if were eligible for surgery. The hospital had guidelines that said they would not operate on a patient with a BMI of 40 and above.
- Patients who needed implants, such as breast or hip prosthesis, had this clearly recorded in their notes alongside appropriate details such as device number and size. This enabled all implanted devices to be tracked in case any faults developed and showed which patient received which type of implant and when.
- The hospital's PLACE score for the condition, appearance and maintenance, was 98%, compared to the England average of 93%.

Medicines

- The hospital had an onsite pharmacy. This was open Monday to Friday 8.30am to 4.30pm. Out of hours, the resident medical officer (RMO) and a registered nurse would check and sign medications out against the prescription. A standard operating procedure was available for this practice.
- The pharmacist reviewed all medication prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. We saw an audit of medication records (we were not told how many records were looked at) for June 2016 that showed that there were zero missed doses and two missing allergy status's, these had been reported as incidents, no harm came from the errors. We looked at 10 medication records and saw that these were completed correctly, including patients allergy status. There were no missed doses evident.
- Pharmacy technicians replenished medication stocks, checked expiry dates and provided guidance to staff and patients.
- The pharmacist attended the patient ward round every Monday to Friday morning with the RMO. The pharmacist would explain medications to the patients and their family ready for when they were discharged.
- There were local microbiology protocols for the administration of antibiotics, and the clinical prescribing staff were able to describe how to use them and where to find them. The pharmacy manager was the hospital's official antibiotic steward. An antibiotic steward seeks to achieve the optimal clinical outcome related to antibiotic use, to minimise toxicity and other adverse events and limit the selection for antimicrobial restraint strains. This reduces the risk of antibiotics becoming less effective.
- Medicines, including controlled drugs (CDs); medications with strict legal controls to prevent them from being misused, were stored safely and securely in theatres and in the wards. Staff carried out daily checks on CDs and medication stocks to ensure medicines were reconciled appropriately.
- Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperature, we saw that the daily checks were completed fully. Staff knew what to do if fridge temperatures were out of range. We saw the standard operating procedure for this, and it was available with the daily recording sheet.
- Emergency medications were stored in secure containers in the resuscitation trolleys. These were all in date.

Records

- The hospital had an on-site medical records department and used an electronic tracking system to locate medical records. All medical records were archived after

two years with an outsourced company. The hospital told us that from June to September 2016, no patients were seen without their medical records. If this did occur, an incident report would be submitted.

- We looked at 10 patients' medical records. These were structured, legible, complete and up to date. Clinicians signed them in accordance with good practice in record keeping.
- Clear pathway documents were used throughout the patient journey. Risk assessments were used from the start of the patient's journey in pre-operative assessment through to admission on the wards. Risk assessments included VTE, nutrition, pressure care, falls, moving and handling and infection control risk.
- We checked the quarterly audit the hospital carried out in June 2016, on compliant medical records and the ward scored 93%.
- Staff compliance with mandatory training for health record keeping was 100% for ward staff (including pre-assessment staff) and 97% for theatre staff. The theatre and ward staff also completed mandatory training on information governance. Staff on the ward and theatres were 100% compliant with this training.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet and the head of department for surgery had hard copies in a folder for staff to access if needed. The policies included details of how to manage suspected abuse and details of who to contact for further help and guidance.
- Staff we spoke with were able to tell us what steps they would take if they were concerned about potential abuse to their patients or visitors. The hospital had a named safeguarding lead for adults, who was accessible.
- Staff received mandatory training in safeguarding of vulnerable adults and children. Children's safeguarding is reported in the services for children and young person's report.
- Staff compliance levels in safeguarding adults level 2 training was at 100% for ward staff (including pre-assessment) and 91% for theatre staff. The hospitals training target was 85%.

Mandatory training

- The service had a mandatory training programme that included basic life support, infection control, manual handling, fire safety, information security, data protection and safeguarding. There were also specialist subjects specifically for ward and theatre staff, such as blood transfusion.
- The head of each department was responsible for ensuring staff attended mandatory training. Status of staff compliance of training was checked on an electronic training tracker.
- Staff confirmed that they were allowed protected time to complete mandatory training, including attending annual resuscitation and scenario training.
- Senior managers told us that that training programmes were embedded and robust due to Nuffield Health training academy programmes.
- The hospital maintained that the target for completion of mandatory training was 85%. This was achieved for all subjects except immediate life support (ILS) for theatres. Where there was non-compliance, we observed that staff were booked onto upcoming courses. Staff in theatres and wards completed paediatric life support and compliance figures for this are reported in the services for children and young person's report.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Risks were managed positively.
- Anaesthetists and the pre-assessment nurses calculated the patient's American Society of Anaesthesiologists (ASA) risk grade as part of their assessment of pre-operative patients. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six levels, with level one being the lowest risk. The hospital predominately undertook procedures for patients graded as level one or two.
- Staff carried out risk assessments to identify patients at risk from harm. Patients at high risk were placed on appropriate care pathways and care plans were put in place to ensure they received the right level of care.
- Staff used the modified early warning score (MEWS) to recognise when a patient's condition was deteriorating. This tool ensured that any deterioration was identified early and appropriate steps were taken. All nursing staff carried out routine monitoring based on the patient's individual needs and as specified by the surgeon. The matron told us that the hospital was introducing the

National Early Warning Score (NEWS) system, which was an alternative system to MEWS that is used across the NHS. The registered nurses had all undergone training ready for the new system. The NEWS system was to be implemented in October 2016; the Nuffield Health group had delayed this. Staff could not tell us when it was due to commence.

- MEWS risk assessments and sepsis screening tools were used, and we saw evidence of full completion. The staff members we spoke with were aware of the escalation procedures.
- Where a patient's health deteriorated, staff were supported by medical staff and a trained RMO. The RMO was a registrar level doctor who was on duty 24 hours a day and on site to attend any emergencies. The hospital had a transfer agreement in place with the local NHS trust if patients required care and treatment above what the hospital could offer. For acutely unwell patients, staff would call '999' for an urgent ambulance. A full hand over was given to the receiving hospital via telephone.
- If patients required closer monitoring on the ward, but did not need to be transferred to the local NHS trust, the ward used a high dependency trolley. This would be taken into the patient's room and patients would be nursed one to one. It had the relevant equipment and documentation that the nursing team may need to use to look after these patients, without leaving the room.
- An anaesthetist was on site at all times when patients were in the recovery room post-operatively.
- We observed three theatre teams undertake the World Health Organisation (WHO) 'five steps to safer surgery' procedure. This is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the procedure. We observed good levels of communication and involvement when carrying out these checklists.
- We saw the surgical safety operating list briefings were displayed on the theatre wall. This was good practice and provided information about the WHO checklists and how to carry them out appropriately.
- The WHO checklist audit report for July to September 2016 showed 90% to 100% compliance. We looked at medical records before September 2016 and saw that the checklists were completed appropriately.
- A supply of blood was available at the hospital for use in an emergency, such as a major haemorrhage, which is excessive blood loss and can be life threatening. The hospital had a clear policy and procedure to follow.
- Ward staff telephoned patients 48 hours after they had been discharged, to check on their well-being and progress post-operatively. Patients were also given a helpline telephone number to ring in the event of any issues or to ask questions. Telephone enquiries were documented in a 'patient query' record book and further appointments were then made, if for example, patients needed a wound check due. Patients could be seen in the outpatients department the next day. Capacity would be made to see these patients as a priority.

Nursing and support staffing

- Daily activity, including the number of theatre cases booked and how many major or minor procedures were planned, helped to assess the correct number of nurses required for each shift. Therefore, staffing and skill mix was planned so that patients received safe care and treatment at all times.
- The inpatient department planned staffing using a guideline of 1:4 nurse to patient ratio. Staffing was reviewed daily for the forthcoming shifts and adjusted according to clinical need and capacity.
- We looked at the electronic rota system and found staffing numbers and skill mix was appropriate for the complexity of the patient caseload.
- Theatre staffing levels were based on nationally recognised guidelines, such as the Association for Perioperative Practice guidelines. During our inspection, we found that the actual staffing met the planned staffing levels. We saw evidence that there were no unfilled shifts from April to June 2016.
- At the time of inspection, the inpatient department (which included oncology nurses) had 20.4 full time equivalent (FTE) registered nurses in post and 6.5 FTE healthcare assistants. The vacancy rate was 17% with vacancies of 4.1 FTE, for registered nurses. This was slightly worse than the average for other independent hospitals, of 15%. There were no vacancies for healthcare assistants.
- The head of department (HoD) for inpatients told us that they had three registered nurses starting in January 2017 and one in February 2017.

- The theatre department had 13.6 FTE registered nursing posts and 11.7 FTE healthcare assistants and operating department practitioner (OPD) posts. ODPs support operating theatre staff and provide care to patients at all stages of an operation. At the time of inspection, theatres did not report any vacancies.
- Use of bank and agency for inpatient wards and theatres was worse than the average for other independent hospitals from July 2015 to June 2016. The use of bank and agency for the inpatients ward was 26% and for theatres, the rate was 25%. The high level of agency and bank usage was predicted to fall following the recruitment of new registered nurses.
- We saw evidence that agency nurses, who had not worked at the hospital before, completed an induction. An agency nurse who had worked in the hospital before, but not for several months, still had a completed induction on arrival for the first shift.
- Staff turnover was worse than the average of other independent hospitals from July 2015 to June 2016, for inpatients and theatres. Both HoDs told us this was because of the workforce reaching retirement age.
- If additional staffing (above normal levels) was required, the HoD of each department made a request to the hospital matron for approval. The head of inpatients told us this was always approved.
- There were formal on-call arrangements for theatre staff to cover out of hours, should an unplanned return to theatre be required, including arrangements to allow adequate rest the following day. The hospital adhered to the recommendations of the Association for Perioperative Practice with regard to numbers of staff on duty during a standard operating list.
- Nursing handovers occurred twice a day and included discussions around patient needs, medication, present condition and the plan for discharge. If patients needed transfer to another facility, the staff would use the 'situation, background, assessment, recommendation' approach, and document in the patient's records. No patients needed transfer during our inspection so we were unable to observe this in practice.
- The inpatient and theatre HoDs met briefly, immediately before morning and afternoon theatre lists to share information regarding equipment and other resources required, or if there was anything specifically patient related. For example, if they knew a patient was very anxious, this would be discussed, including any actions to help reduce the patient's anxiety.

Medical staffing

- All patients were admitted under the care of a named consultant. There were 223 consultants employed by local NHS trusts, who provided care for patients at Nuffield Health Warwickshire Hospital under practising privileges. The term practising privileges refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there.
- Between July 2015 and June 2016 13 consultants had practising privileges removed due to nine resignations and four withdrawals. One consultant was suspended due to concerns about their practice at another Nuffield Health.
- RMOs were employed through an agency. They worked a one week on, one week off rota, 24 hours a day, then handed over to the next receiving RMO. The handover took an hour and the RMO we spoke to said this was adequate time to discuss each patient in detail. The RMO had received induction training. Their duties included monitoring patients on the ward, prescribing medications, cannulation and taking blood samples. The RMO told us that they were never asked to complete procedures they did not have the skills to undertake.
- Staff we spoke with described the procedure for on-call arrangements for the anaesthetists and surgeons out of hours. When the RMO and nursing staff needed to seek advice or support out of hours, they contacted the patient's named consultant. Consultants were required to be no more than 30 minutes away according to the terms of their practising privileges. The hospital carried out a formal risk assessment if a consultant did live outside this travel time. If a consultant was aware they would be absent, they informed key senior staff at the hospital in writing and confirmed their cover arrangements. This was part of their practising privileges agreement.
- The hospital had an out of hours rota for anaesthetists to provide 24 hour cover for patients post-operatively and there was a service level agreement for emergency transfer arrangements with the local NHS trust.
- Consultants who were new to the hospital received an induction from the senior management team.
- The RMO attended the evening nurse's handover to ensure that patient care and treatment was discussed for the night. The RMO said they felt supported by the

ward staff and medical teams and they could contact the consultant or anaesthetist responsible for a particular patient if further advice or support was needed.

Emergency awareness and training

- There was a major incident and business continuity plan, which listed key risks that could affect the provision of care and treatment, for example, adverse weather and disruption to staffing. Guidance for staff in the event of a major incident was available in the theatre and ward areas, and staff knew where to locate this.
- Each department carried out regular cardiopulmonary resuscitation scenario training. This was unannounced and took place at weekends and out of hours. The managers would choose areas of the hospital such as the x-ray rooms, outpatients department and the basement.
- Monthly tests took place on the backup generator and routine fire drills were undertaken.
- Staff completed mandatory training in fire safety and compliance with this was 100% for the inpatient and theatre staff.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Nuffield Health care pathways were based on national guidance from organisations such as the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetics, and Great Britain and Ireland and the Royal College of Surgeons. We saw the service used standardised care pathways for specific procedures for all patients undergoing surgery.
- Policies referenced national guidance and staff we spoke with were able to access these on the intranet. Nursing staff assessed, monitored and managed care on a day-to-day basis using nationally recognised risk assessment tools, for example falls, malnutrition and pressure damage.
- The hospital reviewed compliance with NICE guidelines, as they were issued. Progress with compliance was monitored on a monthly basis. We looked at eight clinical policies and all were up to date, ratified appropriately and had clear review dates.
- Local audit outcomes were reported to the clinical governance committee and submitted to the head office to inform benchmarking tools across the Nuffield Health group. The inpatient department and theatres completed quality assurance audits on a quarterly basis. These included venous thromboembolism assessment, falls, World Health Organisation safety checklist, healthcare records, infection prevention and control, catheter management and discharge. The senior management team, through staff meetings, shared the results of the audits.
- Results that were available showed good performance and improvement plans in place when needed.
- Staff in theatres and inpatients used enhanced care and recovery pathways that were in line with national guidance. These included for example, integrated care pathways specific for hip or knee replacements and a day case pathway under general anaesthetic. The day case pathway included the predicted American Society of Anaesthesiologists (ASA) scoring. Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. A review of medical records and discussions with the clinicians on duty confirmed this during our inspection.
- There was a sepsis screening and management policy in place, which was up to date and reflected national guidance on quality standards for sepsis.
- The hospital recorded all implants on the theatre implant register. Orthopaedic implants were also recorded on the relevant National Joint Registry (NJR) record. The service followed guidance regarding the recording and management of breast implants. Patients signed a consent form agreeing they were happy for their details to be stored on the central database. Relevant paperwork was carried out at time of the insertion and inputted into the National Breast and Implant Register by senior theatre staff, within 24 hours of the procedure.

Pain relief

- Information about the medicine prescribed, including how to use it and any side effects was discussed with

patients prior to surgery in the pre-assessment clinic and following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relief medication following surgery.
- Pre-assessment staff discussed the patient's level of pain and discomfort as part of their assessment. This assessment continued once the patient was admitted to the ward prior to their procedure.
- Staff used a pain assessment scoring tool to assess the level of pain both as part of their routine observations and at a suitable time after they had received their pain relief medication. The post-operative pain management policy provided the pain assessment score and guidance for staff to follow.
- The ward used the Abbey pain score, this was a specific pain tool used to measure the pain in people living with dementia who cannot verbalise.
- Our review of 10 patients' records found the assessment system was used appropriately and the pain scores were recorded regularly.
- Regular and as required pain relief was prescribed on all the prescription charts we reviewed.
- Patients told us their pain was managed effectively by staff.

Nutrition and hydration

- Patients were required to fast in preparation for their surgical procedure. Pre-operative fasting guidelines were based on the recommendations of the Royal College of Anaesthetists with patients on morning or afternoon lists fasted appropriately.
- Patients' nutrition and hydration needs were risk assessed and a specific care pathway was implemented if the patient's clinical condition required it.
- Post-operative nausea and vomiting was managed by a regime of intravenous fluid and anti-sickness medication. The balance of the patient's body fluid level was recorded until patients were fit enough to eat and drink normally.
- There was a service level agreement with the local NHS trust for a dietitian to visit if needed. This was for the colorectal patients, but could be available for any other advice or support.

Patient outcomes

- The hospital took part in national clinical audits for which they were eligible. These included patient reported outcome measures (PROMs), National Joint Registry (NJR), Commissioning for Quality and Innovation (CQUINs) and the National Confidential Enquiry into patient Outcomes and Death (NCEPOD). The delivery of day surgery was consistent with the British Association of Day Surgery (BADS). BADS promotes excellence in day surgery and provides information to patients, relatives, carers, healthcare professionals and members of the association.
- The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. Clinical audit and risk assessments were carried out to facilitate this.
- The hospital participated in the national PROMs for primary hip replacement and knee replacement. For 2015 to 2016 the scores for primary hip and knee replacements showed the percentage of patients that had improved for each procedure and was similar to the England average.
- All patients undergoing joint replacement were consented to have their prosthesis registered on the NJR. Following this, they were reviewed in an outpatient clinic and the outcome of surgery was recorded and the register updated. Data from July 2015 to June 2016 showed that there had been 469 total completed operations reported to the NJR and the consent rate was 91%.
- The hospital reported five unplanned readmissions within 28 days of discharge from July 2015 to June 2016. This was better than a group of similar independent hospitals, which submitted data to the CQC for the same period. The hospital identified no trends and the information was shared at the quality and safety committee and medical advisory committee meetings.
- There were 12 cases of unplanned returns to the operating theatre in the same reporting period. We saw evidence of all the formal investigations and 10 were documented as minor reasons. The two returns to theatre which were documented as moderate harm had full root cause analyses completed. All returns to theatre were entered onto their electronic reporting system and analysed for trends by the management and governance teams. Results of this analysis had resulted in additional communication and learning to all staff, which was disseminated through all staff meetings.
- The hospital had 14 unplanned transfers to the local NHS trust from July 2015 to June 2016. This data was similar when compared to a group of similar independent hospitals, which submitted data to the

CQC. In each case, the decision to transfer was made by a clinician for valid clinical reasons and the patients were transferred in accordance with the hospital's policy for transferring critically ill patients. The transfers were all logged onto the electronic reporting system and all were recorded as low harm. All patients were discharged home from the local NHS trust.

Competent staff

- Staff were qualified and had the skills they needed to carry out their roles effectively.
- All staff received a structured induction programme and new staff we spoke with felt supported in joining the organisation.
- Staff were supported to deliver effective care through appraisals and support from their individual team leaders and head of departments.
- We saw new hospital staff undertook an induction which included a corporate induction and a local orientation. Competencies were also required and these were recorded once completed in a competency booklet. We saw evidence of these completed competencies in staff members' induction files.
- Staff underwent an annual appraisal. Compliance for the inpatient department (including the oncology and pre-assessment nurses) and theatres was 100%.
- All inpatient and theatre nurses were reported to have their professional registration validated, and they were supported through the revalidation process. The registered nurses who worked in the inpatient department (including oncology and pre-assessment nurses) had their own individual notebook, which was kept in their coffee room, to document episodes for reflection on an ongoing basis. Therefore, when they came to revalidate, they could recall these episodes to document formally for the Nursing and Midwifery Council revalidation process.
- Senior theatre staff had undertaken training on a recognised course to act as first assistant to the surgeon and their continued competence was reviewed as part of their annual appraisal. This training need was identified through the appraisal process and we saw that they had a further three places secured at the local university.
- One of the pre-assessment nurses we spoke with described how valuable their appraisals were and they had been given development opportunities, such as, a leadership course and a clinical assessment course. These would help improve clinical skills in assessing patients and help support them to lead the small pre-assessment team. The nurse told us that they supervised the healthcare assistants in carrying out extended roles.
- Newly recruited nurses were given a period of supernumerary time, in which to work closely with their peer mentor and complete their competencies. This period had been increased from two weeks to three. If an individual staff member needed additional time, this was given. The head of the inpatients department told us this helped with retention of staff.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were employed by other organisations, such as the NHS. Their annual appraisals were carried out with their employer. It was the responsibility of the medical advisory committee (MAC) to ensure consultants were skilled, competent and experienced to perform the procedures they undertook. The MAC checked registration with the General Medical Council and on the relevant specialist register, plus carried out Disclosing and Barring Service (DBS) checks and indemnity insurance. DBS is a criminal record check and indemnity insurance is designed to protect professionals when they are found to be at fault for a specific event. We saw evidence that this was discussed and reviewed in the MAC meeting minutes.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patients care and treatment. Care was coordinated between pre-assessment, ward and theatre staff. This ensured all teams were involved in effective care delivery.
- We saw evidence of robust multidisciplinary working, and communication between the staff in theatres and the ward. Staff told us they had a good working relationship with consultants and the RMO.
- We found there were handover and transfer processes in place to ensure consistent multidisciplinary care delivery when patients were moving between teams or services, including referral and discharge.
- Ward and theatre staff carried out 'safety huddles' on a daily basis to ensure all staff had up to date information about patient risks and concerns.

- The inpatient staff including pre-assessment, liaised with local trusts, local authorities and GPs to ensure the arrangements for discharge were considered prior to elective surgery taking place.
- Patient records showed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.
- We found the service liaised with patients, their families and carers when discussing and planning discharge. Patients told us they were included in the planning process and staff ensured vulnerable patients were supported appropriately on their return home.
- Information about all of the treatment a patient had received during their stay in the hospital was communicated to the referring GP when they were discharged from the service.
- The hospital hosted GP training talks that were presented by consultants and this allowed best practice to be shared with a multidisciplinary approach.

Seven-day services

- Consultants were on call seven days a week for patients under their care. Patients were seen daily by their consultant, including weekends.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.
- The ward accommodated overnight patients seven days a week and ward staffing levels were suitably maintained during out of hours and weekends. The RMO provided out of hours medical cover for the inpatient department 24 hours a day, seven days a week.
- The hospital had three operating theatres open six days per week. Operating times were from 8am to 8.30pm Monday to Friday, and 8am to 4pm on a Saturday. There was an on-call rota for key staff groups to support the service out of hours.
- There was access to radiology out of hours. Inpatients would still receive vital x-rays at weekends, so not to delay any treatment.
- The pharmacy was open Monday to Friday from 8.30am to 4.30pm. Outside of these hours the RMO could dispense medications for patients on the ward, or if needed to take home.
- There was a pathology laboratory onsite, which enabled the hospital to carry out their own blood testing seven days a week.

Access to information

- Staff we spoke with said they had access to the information they needed to deliver effective care and treatment to patients in a timely manner. These included test results, risk assessments and medical and nursing records.
- Staff could access information needed about a patient at any time, through their medical records. Medical records contained detailed information from admission and surgery through to discharge. There was appropriate information when the patient was referred to the hospital and this enabled clinicians to have all relevant information, including test results, prior to a patient's first appointment.
- Staff said they had access to GP referral letters when patients attended pre-assessment clinic.
- Staff could access policies and procedures through the hospital's intranet. Computers were available in the ward and theatre areas.
- Care summaries, such as discharge plans, were sent to the patient's GP at point of discharge, to ensure continuity of care. GPs also received letters informing them of the cosmetic treatment and implants to be performed on their patient prior to surgery being undertaken.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients.
- There was a robust consent policy for staff to follow. This outlined that consultants should seek consent from patients undergoing surgery during the initial consultation process and again on the ward during admission before the procedure. We saw from patient records that this had been obtained in agreement with the policy.
- We saw that patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure in case they wanted to change their mind.
- We found policy and procedures to be in place, which ensured that capacity assessments and consent was

obtained by the appropriate clinician. Patients undergoing surgery were informed about consent as part of the pre-assessment process and were given information regarding risks and potential complications.

- We observed the consent process was part of the local audit programme. Results from an audit carried out in July 2016 showed a compliance of 100%. However, the audit for September 2016 had slipped to 83%. We saw a plan to continue auditing 10 sets of notes for two months and share the results with the MAC.
- Staff were aware of the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Training records showed that the inpatient staff (including oncology and pre-assessment nurses) and theatres had training in consent, DoLS and the MCA. Compliance was 100% for the inpatient staff. For theatre staff, compliance was 90% for consent and DoLS training and 100% had completed training on the MCA.
- Staff told us the majority of admitted patients had the capacity to make their decisions. Patients that lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Where patients could not provide informed consent, the staff would make decisions in the best interests of the patients and involve the patient's representatives and other healthcare professionals.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing and communicating care and treatment in a respectful manner.
- Staff spoke with patients discreetly to maintain confidentiality. Patients were given gowns and slippers to maintain their dignity when being transferred between the ward and theatres. Once patients were in the recovery room curtains were closed to ensure privacy and dignity.
- All inpatient bedrooms were single person and en-suite, which ensured that patients' privacy and dignity was maintained throughout their stay. We observed staff knocking on doors and waiting for a reply before entering.
- We spoke with eight patients. All the patients thought staff were kind and caring and said they could not fault the service. Two patients told us that they had received fantastic care and had had a positive experience during their stay at the hospital and would recommend it to any of their friends or family.
- A patient who had been to theatre told us, "It has been the little things that have made the difference, the nurse who walked me to theatre kept reassuring me all the time, she was really pleasant and put me at ease". Another patient who had been both a private and NHS funded patient told us, that on both occasions they received the same level of care and compassion.
- All patients were encouraged by staff to be independent and mobile where possible. Staff would encourage patients to sit out of bed and eat their meals, so that they could feel as normal as possible.
- During the theatre cases we observed in the inspection, staff maintained the patient's dignity whist they were under anaesthetic and only exposed the skin and body areas when it was necessary.
- The hospital submitted data to the Friends and Family Test. This was a method used to capture patient's perceptions of the care they received and how likely they were to recommend the service to their friends and family. The hospital had a response rate of 28% to 55% from January to June 2016. Scores were between 93% and 99%, of patients recommending the hospital to their family and friends.
- CQC patient feedback gained prior to our inspection was positive. Comments included that staff were caring, friendly and professional, staff maintained dignity and privacy and staff were able to answer all questions.

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took into account additional support they may need to help them understand and be involved in their care and treatment. For example, if the patient required an interpreter to help them understand or support with their mobility, this was recorded accordingly.

Good

Surgery

- Costs were explained during the booking process and through to discharge and patients were given a copy of their treatment options and associated costs.
- Patients told us that staff spoke with them about their care and treatment in a manner they understood and included their families or friends when required.
- Patients also spoke positively about the information they received in the form of written materials, for example, the information regarding the surgical procedure they had.
- We saw that the head of the department and nursing staff were visible on the inpatient ward and patients were able to speak with them when needed. We observed that medical staff took the time to explain to patients and relatives the next stages in the plan of care. We observed patients in theatres and the anaesthetic room being given information in a way that would reduce their concerns or anxieties.

Emotional support

- Staff spoke compassionately about their patients and had a clear understanding of the impact that a patients care, treatment or condition would have on their well-being. They also understood that this could also affect the people close to the patient, both emotionally and socially.
- Staff in theatres were reassuring and maintained a calm environment.
- Patients had a named nurse who looked after them during each shift. The named nurse ensured they were available for their patients to voice any concerns or anxieties.
- Patients told us staff listened to any of their concerns and provided signposting to other services if needed, for example, counselling or support services.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of the population they served and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including orthopaedic, cosmetic and general surgery.
- The hospital had a commitment to private patients as well as working in partnership with the NHS, and it ensured that services commissioned to them were safe and of high quality. To achieve this, the senior management team listened to patient feedback, acted on audit results, observed national guidance and accepted recommendations from various hospital committees.
- Theatres provided patients and consultants with increased flexibility, with theatre lists Monday to Friday until 8.30pm and Saturdays, 8am to 4pm.
- Patients we spoke with confirmed they were given a choice of appointment times and were able to schedule procedures at a time convenient to them.
- The heads of department for theatres and inpatients had regular meetings with the matron to discuss the numbers of expected patients to ensure there were sufficient bed spaces and staff allocated.
- There were 42 inpatient single rooms. The hospital had three main theatres, two with laminar flow and an endoscopy suite; this ensured that planned services could be delivered to patients. Theatre one was planned to have its air flow upgraded to laminar flow, this would increase the hospital's capacity to admit more trauma and orthopaedic elective cases.

Access and flow

- Patients had timely access to initial assessment and treatment.
- The referral time to treatment (RTT) was used for tracking times to treatment for NHS patients. This target was for 90% of patients to begin treatment within 18 weeks of the original referral. This target was abolished in June 2015. From July 2015 to June 2016, the service was achieving RTT times of 73% to 94% of patients treated within 18 weeks from their original referral date. There was no formal mechanism similar to the RTT for the private patients, however, we saw that were no waiting lists and patients were seen within one to two weeks from their referral.

Good

Surgery

- The majority of patients were referred to the hospital by their GP. Patients were given a choice of dates for their procedures and those we spoke with did not highlight any concerns with this process.
- The hospital's admission policy ensured that patients received a pre-operative assessment. All patients were assessed which meant patients could be identified as being safe for surgery, which helped to avoid any unnecessary cancellations. Patients with co-existing conditions were identified during this process and then given further tests, for example blood tests, or diagnostic imaging.
- Patients with multiple comorbidities were assessed by a consultant anaesthetist and if they were deemed unsuitable for surgery, their admission was deferred. An exclusion criteria was used which followed National Institute for Health and Care Excellence guidelines.
- Patients' procedures were only cancelled or delayed when necessary. The service cancelled 14 procedures for non-clinical reasons from September 2015 to September 2016. All were offered another appointment within 28 days of the cancellation. The hospital gave reasons for the cancellations, the main ones being specialist equipment not delivered on time and theatre lists overran. There were 8,211 patients admitted for theatre from July 2015 to June 2016, this accounted for 0.2% of patients cancelled.
- Patients' records showed staff had completed discharge checklists, which covered areas such as medication, communication provided to the patient and other healthcare professionals, for example, GPs. This ensured patients were discharged in a planned and organised manner.
- If there was need for patients to return to theatre for a further procedure, the hospital had an on call theatre team.

Meeting people's individual needs

- Services were planned and delivered to take into account the individual needs of its patients, for example, age, disability, gender, religion or belief.
- Discharge planning started at the pre-operative assessment stage. Length of the patient's stay was discussed and this helped patients plan for any additional support required at home.
- The pre-assessment team told us that information was sent to the ward regarding details of any special requirements for the patient, for example, if the patient lived alone and could not be discharged late in the evening.
- Patients living with dementia were identified during the pre-assessment stage. All patients who were screened positive for living with dementia followed a dementia care pathway. Staff had received training in looking after patients living with dementia. The inpatients department used the 'about me' booklets and a sticker would be on the front of the notes to identify this individual need.
- Patients with a learning disability had a 'hospital passport'; this included individualised information, such as, their likes and dislikes, their interests and their favourite type of drink. This was started at the pre-assessment stage.
- A specific room was used for patients living with dementia, a learning disability or mobility issues. This room had a large bedroom and a 'wet room' bathroom.
- Carers and relatives were encouraged to stay with patients living with dementia or a learning disability. If a carer was unable to stay with the patient, then the ward staff would ask for additional staffing whilst the patient was an inpatient, to provide one to one care.
- Patients living with dementia or a learning disability were invited to have a tour of the hospital and the room they would be staying in, so they could become familiar with the surroundings before they were admitted. Staff encouraged them to bring in items of their own from home, such as pillows and pictures of their family. The chef would be told of the patient's favourite food before admission.
- Staff gave us an example of a patient living with dementia who lived two hours away, so the hospital arranged for them to be admitted the night before, to reduce anxiety and confusion of leaving very early in the morning.
- Family and carers were allowed in the anaesthetic room to reduce anxiety and to calm patients if needed.
- There was a designated dementia notice board in the staff room. This had advice and ways to support patients living with dementia.
- Patients who required translation services would be identified at the pre-operative assessment stage and the hospital could access a telephone translation service for interpreters and translation.

- The service had a range of leaflets and bespoke information regarding certain procedures. For example, certain consultants had specific guidelines on the patient's post-operative care, so there was specific patient leaflets individually tailored.
- The patient led assessment of the care environment (PLACE) audit from February 2016 to June 2016 scored 93% for patients living with dementia and 93% for patients with a disability. This was above the England average of 80%.
- A chef at the hospital prepared the food freshly. There were two hostesses that worked in the inpatient department. They would attend handover to see which patients were nil by mouth and or had any allergies. There was an allergens folder to show the patients, if they were concerned any allergens were in the meals prepared.
- Patients told us the menus were designed and presented in a way that made them feel they were in a restaurant. The menu had nutritional information that explained the benefits specific foods had; for example, this food contains nutrients that help wound healing.
- A patient we spoke with told us that they liked their porridge thick and the hostess made a note of this and it was made individually for their liking.
- Furthermore, in conjunction with staff meeting patient's individual needs, the head of the inpatient department had also introduced extra measures to support a staff member's individual needs.
- The hospital had Wi-Fi, this enable patients to keep in contact with friends and relatives.

Learning from complaints and concerns

- Information on how to raise complaints and concerns was displayed in the areas we inspected.
- Patients could raise formal concerns with a letter direct to the hospital director (HD). This would be acknowledged within 24 working hours by a letter from the HD. Patients could also raise concerns via the patient satisfaction survey and the HD's personal secretary would contact them within two working days. The hospital website also had an enquiry and complaint proforma.
- The service had reported 24 complaints in the reporting period of July 2015 to June 2016. The themes of complaints were, communication, regarding discharge advice and administration errors. The assessed rate of complaints was better than the rate of other independent hospitals. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service. We saw evidence that all complaints had all been logged and investigated in accordance with the hospital's complaints policy.
- The hospital's general manager had overall responsibility for the management of complaints. Complaints were logged on the electronic incident reporting system and investigations were carried out by the heads of the department and provide the results to the hospital matron. All staff involved were sent copy of the complaint and gave a statement if required.
- The complaints policy stated complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints. Where the complaint investigation took longer than 20 working days, staff were required to send a holding letter explaining why a response had not been sent. This process had not needed to be done.
- Staff told us information about complaints was discussed at team meetings to raise awareness and aid future learning. We saw evidence of this in the meeting minutes.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership / culture of service related to this core service

- The hospital was led by a senior leadership team that included the hospital director, the finance director and the matron. Despite some confusion amongst the senior leadership team regarding if there was joint accountability for the service, we were able to conclude that the hospital director was primarily accountable for the service. The team had regular contact with each other due to the relatively small nature of the hospital. The senior leadership team were supported by heads of departments.
- The overall lead for surgical services at the hospital was the matron. Theatres and the inpatient department (including pre-assessment and oncology nurses), were

led by a head of department. Both managers were established; the head of theatres had been at the hospital for 20 years and the head of inpatients was appointed two years ago. The medical advisory committee (MAC) chairperson was the lead for the medical services for surgery.

- Staff we spoke with were motivated and positive about their work, and described all members of the senior management team as approachable and visible. They told us there was a friendly and open culture. The matron's office was based on the ward area; this meant that staff and patients could easily access them to discuss any concerns or issues. We saw evidence of this during the inspection.
- Manager's accessed courses ran by the Nuffield Health Academy, including coaching, leadership skills and difficult conversations.
- Staff were confident that managers had the skills, knowledge, experience and integrity that they needed to lead the departments.
- The heads of each department demonstrated clear leadership principles in line with the Nuffield Health set values. Staff spoke told us they felt respected, valued and well supported by their managers.
- There was a culture of candour, openness and honesty. Staff told us they felt able to raise concerns and were encouraged to report incidents. There was also an up to date whistle-blowing policy in place. Staff attended training on whistle blowing as part of their mandatory training. Compliance for inpatients was 100% and for theatres, it was 97%.

Vision and strategy for this this core service

- The Nuffield Health's strategy was to 'achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner'. Nuffield Health was in the process of redefining the overall vision and strategy to 'One Nuffield', which aimed to join all up all aspects of the business into one complete health and wellbeing service.
- The hospital underpinned its service delivery with six core values, which were: we believe that commercial gain can never come before clinical need, we believe in no nonsense, we believe in being straight with people, we believe in taking care of the small stuff, we believe that caring starts with listening and we believe in you.
- Staff were clear about the corporate strategy and values. To support leaders and their teams within the hospital to engage with the strategy and values, a series of personal development courses were run by the Nuffield Health Academy online.
- As part of the Nuffield Health group's quality strategy, one aim was to continue the investment in their leadership programme, with workshops ensuring their beliefs and behaviours reflected the Nuffield One strategy.
- The service did not have an individual strategy relating to surgery but the service was included in the hospital's overall strategy, which outlined the composition and function of the service, with clear objectives for the future.

Governance, risk management and quality measurement

- There was a clear governance structure in place with committees for medicines management, infection control and health and safety, which fed into the clinical governance committee. There was also the MAC which had separate meetings to discuss the consultants' professional registrations and appraisals.
- The senior leadership team had a monthly board meeting where finance, sales, objectives, risks and governance were discussed.
- The senior leadership team worked within the framework that Nuffield Health corporately set. We noted that in the hospitals annual report there was lack of detail about safety quality measures, for example, safer staffing levels. However, we were told that Nuffield Health did not ask for this information.
- Whenever the senior leadership team looked into potential cost savings they worked with staff to identify savings and ensured there was no impact on patient care, such as changing light fittings. We were told that the team assessed if any cost saving impacted up on patient care through the MAC. They reported that they had never been refused finances if it was required to provide safe patient care.
- There were various quality measures the hospital used to evaluate if care and treatment was safe. For example, the patient satisfaction survey, complaints, incidents, formal metrics that were benchmarked against other Nuffield Health hospitals and the safety thermometer for NHS patients. Some senior staff members reported

that the lack of negative outcomes was the primary indicator that the hospital was safe and that the hospital was responsive to these rather than proactively ensuring outcomes were positive.

- There was a hospital wide corporate risk register. The register identified mainly operational, legal and quality and safety risks. There were few clinical risks noted and some risks were omitted, such as the risk of medicines being stored at an incorrect temperature.
- We were not assured risks were always added in a timely way to the hospital risk register. For example, we were told by a member of the senior leadership team that one risk added to the risk register on the 22 October 2016 regarding fire compartmentalisation of the hospital, was identified the previous year but not added to the register, despite mitigating actions being started.
- The heads of theatres and inpatients recorded identified risks onto a local department risk register and we saw that these were up to date. Key risks were placed onto the hospital wide corporate risk register.
- Heads of departments had been offered informal training to complete risk registers appropriately by the matron but only one had taken this opportunity.
- We saw evidence of key organisational risks identified by the heads of department on their specific risk registers, such as, staff reaching retirement age and the risk of patients not maintaining their normal body temperature (normothermia) whilst in theatre. We saw evidence of numerous actions to mitigate this risk, such as, staff training, the purchase of warm airflow systems the patients could wear pre and post-surgery and equipment to warm the bed when patients were collected from theatre. In addition, during winter months older patients would be admitted earlier to ensure they were warm before they went for their procedure using the new equipment.
- Routine audit and monitoring of key processes took place across the inpatient and theatre areas to monitor performance against objectives. The quality improvement lead coordinated audit activity and maintained the hospital's audit schedule.
- There was a head of clinical services for the hospital, who was the lead for monitoring and maintaining any service level agreements with the local NHS trusts.
- Consultant surgeons inviting external first assistants, or other NHS staff into theatre, took responsibility to ensure assistants completed the appropriate paperwork and provided the hospital with the appropriate documents as required by schedule three of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.
- Nuffield Health made sure consultant surgeons involved in cosmetic surgery, informed their appraisers and maintained accurate information about their personal performance in line with national guidance by filling in a form prior to their appraisal, which stated the specialist procedures they had undertaken. This form was then passed to the consultant surgeon's appraiser at the local NHS trust. Once the appraisal had been carried out, the local NHS trust shared this with Nuffield Health.

Public and staff engagement

- Patient's views and experiences were gathered and acted on to shape and improve services and the culture.
- The service used the friends and family survey and the patient led assessment of the care environment (PLACE) audits to gain feedback on patients' experiences.
- The results from the questions were used to influence the way the hospital could improve their service. Any comments made by patients on the hospital website would be sent to the hospital director within 48 hours so that a response could be sent to the patient as soon as possible.
- The hospital held regular open events for the public, whereby, they could visit the hospital and attend sessions about a variety of procedures or conditions, such as varicose veins.
- Staff told us they received good communication from their managers. Staff routinely went to staff meetings across inpatient and theatre departments.
- Staff reported that they enjoyed working at the hospital. Some staff reported that they 'love working in the hospital'.
- It was stated by staff that when concerns were raised to their heads of departments, appropriate action was taken. For example, when staff raised a concern regarding certain equipment on the ward, this was taken to the matron and they managed to purchase new equipment that was standardised and up to date.
- However, in the Leadership MOT Results September 2016 (staff survey), theatre staff scored poorly (below 4.7, on a scale of 1 to 11) on 'I have regular

conversations with my manager about my development and performance'; 'I feel that my concerns, views and ideas are listened to at all times'; and 'I received praise or recognition when I do good work'.

- Overall in the Leadership MOT Results September 2016 (staff survey), the hospital scored well (above 8.1, on a scale of 1 to 11) on ' I am encouraged to focus on customer needs'; 'I recognise that my job is important to the success of One Nuffield Health'; and ' I understand and champion the mission and purpose of One Nuffield Health'.
- Staff were sent a monthly newsletter, which provided updates on new developments, training opportunities and upcoming events.
- The hospital produced an annual business plan and budget involving all staff in the business planning process. Once the plan was agreed, we saw the hospital wide objectives were shared in the monthly newsletter.
- There were regular staff briefing sessions held at the hospital for staff to drop in and share any concerns or gain information.
- A consultant surgeon would hold 'lunch and learn' sessions with the local GPs, to discuss what procedures they carried out at the hospital.
- The hospital told us they were involved in the community and their staff participated in community activities, such as garden parties held at the hospital in the summer and local 10 kilometre running events, which the hospital sponsored. There was a staff social committee for the hospital, where social events were organised.

Innovation, improvement and sustainability

- Staff we spoke to were confident in the sustainability of the surgical services. They felt that they all worked well together to provide a good standard of care and treatment.
- The hospital had robust financial planning and surgery services were a key part in the future strategy.
- The heads of theatres and inpatients were constantly striving for continuous learning and improvements. This was shown to us by means of new induction packs for student nurses and newly qualified nurses commencing employment. They were driven to improve retention of their staff and provide them with a safe environment to learn and look after their patients.
- The hospital had aims and objectives to grow their business for 2017. One of these objectives that related to surgery was to implement a new surgical technique for hip replacements. This had now started by one of the orthopaedic consultants.
- The hospital offered 'recovery plus'. This was a Nuffield Health recovery programme available free of charge to all private patients at the hospital. It was an optional enhanced recovery pathway available to over 25 orthopaedic and gynaecology procedures, which included a health MOT, a dedicated recovery coach, diet and exercise advice and a three month membership at the local Nuffield Health fitness and wellbeing gym.
- As part of the hospital's objectives for 2017, there were plans for the introduction of the electronic patient record. This was called 'project tempo', but had not been implemented at the time of the inspection.

Outstanding ☆

Services for children and young people

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

Are services for children and young people safe?

Good

Children and young people (CYP) are seen across all areas of the Nuffield Health Warwickshire Hospital including: outpatient, pre-assessment, radiology and diagnostic imaging, the hospital ward for overnight and day cases, operating theatres (all areas) and physiotherapy.

Nuffield Health Warwickshire Hospital does not undertake acute or emergency surgery admissions. Re-admissions are only accepted when all available resources that are required are available.

Children with additional pre-existing conditions for example, diabetes, epilepsy, cardiac and circulatory conditions, with the exception of mild respiratory or dermatological conditions for example, asthma and eczema, will not be operated on.

Young people aged 16 and 17 years, are pre-assessed and cared for as part of the adult service provision, unless additional support is identified at pre-assessment and CYP service cover is required.

There were 53 total inpatient cases and 168 day cases for CYP aged between three years and 17 years; and 860 outpatient attendances for CYP aged from birth to 17 years in the reporting period July 2015 to June 2016.

There is a designated CYP lead nurse who is responsible for the design and delivery of the service including operational management and the strategic development of the service. The service is delivered by regular paediatric bank and agency staff during designated paediatric weeks (twice a month).

We carried out the announced period of our inspection over two weekdays with a pre-visit at the organisations request two weeks prior to the announced inspection. A further weekday afternoon was also spent inspecting as part of the unannounced inspection.

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

We rated safe as good.

Incidents

- For the reporting period July 2015 to June 2016 the rate of clinical incidents in surgery, inpatients or other services (including children and young people (CYP) was lower than the rate of other independent acute hospitals in the same reporting period.
- A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. There were no never events or serious incidents reported in the hospital for the period July 2015 to June 2016.
- Staff understood their responsibilities to raise and record safety incidents, concerns and near misses using

the hospital electronic reporting system (the system to collect and report incidents). Investigations into incidents took place and lessons learnt were shared with staff at team and governance meetings.

- An incident was raised in June 2016 concerning a child who required emergency transfer overnight to an NHS trust. This incident was regarding a child whose condition had deteriorated. The patient was scheduled for a day case procedure and was expected to be discharged in the afternoon. However, the patient deteriorated and there was no registered paediatric nurse booked for the night shift, hence the patient was transferred to ensure they received care from appropriately trained clinicians. A registered paediatric nurse was on duty until the patient was transferred. The incident was logged appropriately, clearly described and appropriate remedial action had been taken. For example, all CYP were now required to attend a face-to-face pre-assessment clinic and a registered paediatric nurse was rostered overnight for all children undergoing surgery at the hospital. We saw evidence of this on the staff duty rotas on the alternate paediatric surgical weeks.
- Staff were able to tell us about the duty of candour regulations, which state that as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology

Cleanliness, infection control and hygiene

- CYP were cared for in en-suite single rooms. The hospital areas that saw CYP were visibly clean, tidy and free from clutter.
- There was hand sanitizer gel available at the main reception of the hospital and throughout the outpatient, ward and department areas for staff and patients use. We observed both patients and staff using these on entry to the hospital and to the wards and departments.
- In the reporting period July 2015 to June 2016, there were no reported cases of Clostridium difficile (C. difficile) a healthcare-associated infection in services for CYP. Minutes of CYP meetings recorded discussions with staff concerning compliance with infection control and hygiene policies. For example, hand hygiene and personal protective equipment (PPE). No other healthcare-associated infections, such as Meticillin Resistant Staphylococcus Aureus (MRSA), or, Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infections had been reported.
- Staff complied with hospital policies regarding infection prevention and control. This included 'bare below the elbow' and hand washing policies.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness.
- There was a system for ensuring equipment and rooms were clean. For example, 'I am clean' stickers. These were clearly visible, dated and signed to indicate cleaning had taken place on equipment and on room doors. We observed equipment for patient-care to be visibly clean and ready for use.
- Hand hygiene audits were carried out each month across the hospital. Compliance in the period from April to September was between 86% and 100% in wards and theatres.

Environment and equipment

- Specialist equipment for all age ranges cared for in the hospital, including that required for resuscitation was available and fit for purpose.
- Where children were anaesthetised, resuscitation drugs and equipment including an appropriate defibrillator were available.
- Consideration had been given regarding risks presented to children by sharing the same facilities as adults. CYP were cared for in single en-suite rooms with facilities for parents to stay with them. The CYP lead nurse had designated four adjacent rooms for CYP undergoing inpatient and day case surgery.
- The designated rooms and surrounding area had been risk assessed in October 2016, in line with the hospital safety and security of CYP in hospital standing operational procedure (SOP). Adaptations had been made to facilities and the environment for children. For example, the securing of cleaning materials which could be hazardous to children.

- However, it was identified that the hospital had not reviewed the risk assessment since November 2016. There was no review date documented on the risk assessment. We found that although the hospital had identified some CYP security risks, not all mitigating actions had been completed. For example, there were mitigating actions to 'identifying options for securing the area: keypad, electronic fob entry/exits but this had not been actioned.
- The Department of Health guidance (HBN 23 Hospital accommodation for CYP 2004) states, **"**doors to rooms that should not be entered by young children should be fitted with high-level latches." We did not find evidence of high-level latched in the ward environment. The guidance also states, "Door control systems should be provided to all entrance/exit doors to prevent accidental egress. They will also be operated from the communications base, coupled with an audio-speech facility between the entry door and the communications base for identification purposes." Although this type of security had been identified on the risk assessment, the mitigating action was incomplete.
- There were five stairwells and two lifts on the ward, which were unsecured and posed environment and safeguarding risks to CYP using the service. The hospital had implemented actions to mitigate the above risks. For example, 'Hi'visibilty wrist bands were implemented supported by a local policy in November 2016 to clearly identify parent and visitors visiting CYP following surgery. Parents and children were advised of security measures at pre-assessment and again at time of admission. The policy was monitored and exceptions were reported. Options to secure the area had been identified. For example, a keypad, electronic fob for entry/exits (which already existed in some areas) and were due to be actioned by December 2016. However, control measures for the 'risk of children leaving the ward area without staff or parental knowledge' were not explicit, but after our inspection they were added.
- Either side of the four CYP inpatient rooms were adult inpatient rooms. There had been minimal risk assessment regarding the risk to CYP. The 'Children services in independent healthcare' CQC guidance 2016, states that 'As far as possible, it is good practice that adults and children are segregated in all service areas.' The guidance acknowledges that this is not always possibly in independent healthcare and that in these cases, the provider must ensure the environment is fit for purpose and there is oversight by the registered nurse or a family member of the child/young person at all times'. At the time of our announced inspection, the provider could not demonstrate that there was oversight of the patient at all times. At our unannounced inspection, the provider had implemented processes to ensure that there was oversight by a registered nurse or a family member of the child/young person at all times.
- We were concerned that the design and use of facilities did not always promote patient safety. Patients could be left unattended, which posed several risks that the provider had either not identified or had robust procedures and processes in place to mitigate the risk. For example, the provider had not considered the risk of CYP being abducted; the provider did not have robust procedures and processes to prevent patients from being abused by other people they may have contact with when using the service, including visitors.
- We discussed our concerns with the provider and in response on the last day of the announced inspection, the provider put in place some actions to mitigate the risks. A temporary measure of an additional registered paediatric nurse was deployed to monitor children's rooms to ensure the parent/carer/guardian remained with the child at all times or the parent/carer/guardian informed a nurse if they needed to step off the ward and the nurse took appropriate steps to ensure patient safety, for example, stayed with the patient as required. Prior to our inspection this action was not explicit in the safety and security of children's SOP.
- We carried out an unannounced inspection and observed the monitoring arrangements had remained in place to mitigate the security risks to CYP using the service.
- Following the inspection the provider reviewed their safety and security of children's SOP to improve the security to protect patients. The revised SOP stated, 'Children under 16 years must not be left unattended without exception'. The revised risk assessment provided further information to support the mitigating actions the hospital had taken after our inspection. For example, an abduction SOP was to be completed in January 2017 as the provider previously had not identified abduction as a risk and therefore no SOP had

been created; and a review by a security expert was planned for the end of 2016. Following the actions taken by the hospital to mitigate the risks the additional nurse deployed to monitor children's rooms was stood down.

- There were limited facilities for CYP in outpatient services. The CYP lead nurse had created a small designated children's waiting area within the main outpatient waiting area. Few toys were available to provide diversions for younger children. WIFI access was available.
- Throughout our inspection we observed diversional toys and techniques were used with CYP attending outpatient clinics. The outpatient lead had created a trolley of appropriate toys and books and was working with the CYP lead nurse to increase diversional equipment for children. We were told the hospital was expanding the outpatient facilities in 2017 and there would be a designated waiting area for children in outpatients.
- Children's furniture was available for younger children in consulting rooms which promoted a child centred approach to the care and support of children receiving outpatient services.
- The toys and children's furniture we observed were clean. Staff were aware that toys should be kept clean. Although there was no specific policy in place, staff were aware of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance when considering infection control and cleanliness arrangements.
- The CYP lead nurse had purchased equipment suitable for CYP. For example, oxygen masks, thermometers and saturation probes for undertaking observations in children. A business case for additional equipment had been forwarded to the hospital quality and safety committee. There was sufficient equipment to maintain safe and effective care.
- Paediatric resuscitation equipment was available on the ward where CYP underwent surgery, in theatres and in main outpatients. The CYP lead nurse was in the process of creating a dedicated paediatric resuscitation trolley for physiotherapy and radiology services that were on the first floor of the hospital. Resuscitation trolleys were tamper evident and emergency equipment and drug boxes were locked in line with hospital policy. Staff clearly documented daily equipment checks.
- There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure they are safe to use.
- Personal protective equipment, including gloves and aprons were available in all patient treatment and consulting areas and were stored in a way that enabled staff to access them easily.

Medicines

- There were effective arrangements in place for managing medicines, including recording, handling, storage and safe administration.
- We reviewed three medicine charts. All charts had documented allergies. Prescriptions were appropriate for the child's weight which was documented on the chart.
- Medicines that required refrigeration were stored in a locked refrigerator and keys were held by the nurse in charge. Temperatures were checked and recorded daily.
- All medicines were prescribed in accordance with the requirements and guidance the British National Formulary (BNF) Child. Recommended doses were usually based on the weight of the child.
- Wherever possible medicines supplied to children were in liquid, soluble and tablet forms of oral medications available for administration to children.

Records

- Health care records were paper based. We reviewed three sets of health care records and found they were accurate, complete, legible and up to date.
- Medical records were stored securely in office areas and with keypad entry during clinic times and locked away overnight.
- Health care records (Nuffield Health) were compiled and included a referral letter for the CYP attendance at the outpatient clinic. If the CYP was previously an inpatient at the hospital or had undergone an outpatient procedure, their Nuffield Health care record would be available from medical records.

- All Nuffield Health care records were retained at the hospital in the medical records department, or at a secure facility managed by a third party provider. When health care records were removed from medical records, a tracer card system was in place detailing who had accessed them.
- The hospital had a plan in place to move all consultants to hospital integrated notes. There were no integrated notes for CYP currently in place.

Safeguarding

- CYP's safeguarding lead professionals were identified in the hospital and safeguarding processes were monitored to ensure staff were aware of procedures to protect CYP from harm.
- The matron was the hospital lead for safeguarding who was supported by the CYP lead nurse and the registered manager.
- Consultants with practising privileges at the hospital (consultants with authorisation from senior hospital managers to deliver care) were required to demonstrate evidence of safeguarding training to the medical advisory committee (MAC).
- Staff attendance at training for safeguarding CYP met national guidelines as set out in Safeguarding CYP: Roles and competencies for healthcare professionals 2014. The hospital identified staff that needed to complete level one, two and three training depending on their roles within the hospital. For example, level two training should be attended by all non-clinical staff and clinical staff that had any contact with CYP and /or parents/carers with CYP. In October 2016, 100% of staff had completed level one and level two safeguarding training for children.
- Level three training compliance was100% and had been completed by the matron, the senior sister on the ward where CYP underwent surgery, the CYP lead nurse and the hospital director.
- All CYP attending for in-patient treatment/surgery were required to attend a pre-operative assessment. It was a requirement of Nuffield Health policy for CYP in hospital, to identify parental responsibility for the child or young person who would accompany the CYP during their stay in hospital. Any expected or restricted visitors were also identified during the pre-assessment process and documented in the CYP care record.
- CYP were assessed about any safeguarding risks during the pre-assessment process. For example, restrictions on people who could make contact with the family, restraining or other legal orders or members of the family who might try and visit if they knew the child had been admitted to hospital.
- Parents and any identified visitors of CYP cared for on the ward were requested to wear a locally agreed and notifiable wristband at all times.
- CYP attending the hospital in the capacity of a visitor, or accompanying a parent/carer were not left unattended, particularly in public waiting areas which was in line with hospital policy.
- There had been no safeguarding concerns reported to the Care Quality Commission from June 2015 to July 2016. Staff we spoke with were able to describe how they would recognise children at risk of harm and how they would report it.
- The CYP lead nurse and the lead paediatrician had established links for advice with the local Multi Agency Safeguarding Hub (MASH) and the safeguarding lead for Nuffield Health. The lead nurse had signed up to receive updates from CASPAR which was a series of updates to practice published by the National Society for the Prevention of Cruelty to Children (NSPCC).

Mandatory training

- Mandatory training included fire safety, whistleblowing, health, safety and welfare, manual handling and infection control. Training dates were organised for staff to attend and senior hospital managers monitored compliance rates. Staff were reminded by email from the electronic training system when refresher training was due for them to complete.
- All hospital staff were expected to have safeguarding children's training level one at induction and have it refreshed every 12 months. Rates of staff completion of these training sessions were above 95%.
- Further training was mandatory for staff to complete if they cared for CYP. The resident medical officers held an

Advanced Paediatric Life Support (APLS) qualification and were on duty 24 hours, seven days a week. The CYP lead nurse was APLS and Paediatric Immediate Life Support (PILS) qualified and was supported by two paediatric bank nurses who also held the PILS qualification.

Nursing staffing

- Systems were in place to ensure that CYP were cared for by appropriately trained staff. For inpatients, the Nuffield Health CYP policy requirements were stricter than the Royal College of Nursing guidance on defining staffing levels for CYP's services (one registered children's nurse to four patients aged three or over) in that one registered children's nurse cared for a maximum of three patients.
- Arrangements were in place for handovers and shift changes to ensure CYP were safe. A communication book was in place, which recorded local changes within the hospital.
- Children who were booked to be cared for as a day case, inpatient or for an invasive procedure in outpatients, a paediatric nurse would be rostered on duty. All children undergoing surgery would have a paediatric nurse rostered overnight in case they required an overnight stay in hospital.
- The CYP lead nurse had been in post for six months at the time of our inspection. The lead nurse was responsible for the design, delivery, operational and strategic management and development of children's services at the hospital. The lead nurse had established a professional relationship with the named consultant paediatrician, which had enabled access to advice, information and support around children's services when it was required.
- The hospital deployed two registered children's bank nurses who were rostered on the alternate paediatric weeks. These nurses had completed the Nuffield Health Warwickshire Hospital induction programme and were familiar with the hospital layout and protocols.
- Gaps in the rota were filled by registered children's nurses from a designated agency. The CYP lead nurse ensured agency nurses met the criteria and protocols required to care for CYP in the hospital.
- Nursing rotas we saw showed on the allocated paediatric weeks, an appropriate number of registered children's nurses were on duty until the child or children were discharged. On the day of our inspection one registered children's nurse was on duty for one patient aged eight years. On the day of our unannounced inspection, two registered children's nurses were on duty for two children between 12 and 15 years. This meant one nurse could remain in the day case area when the other nurse accompanied the child to the theatre area.
- The CYP lead nurse told us the hospital was recruiting an additional whole time equivalent substantive registered children's nurse. This was in response to the continued increase of CYP referred to the hospital.
- The CYP lead nurse oversaw arrangements for all CYP under the age of 16 years undergoing procedures at the hospital and ensured that a registered children's nurse was in attendance.

Medical staffing

- There was a named consultant paediatrician for the hospital who ran regular clinics for CYP in outpatients and was accessible directly or via their secretary. The consultant paediatrician sat on the MAC and represented CYP services.
- The hospital had arrangements in place to ensure consultants had appropriate skills and experience to care for CYP. Experience and revalidation was monitored by the MAC and the senior management team.
- There were 14 consultants with paediatric practising privileges who worked at the hospital. Two of whom were paediatricians. Consultants were required to identify the age range of the children they treated at annual reviews. If a consultant had not treated any CYP for six months they were no longer able to treat children at the hospital.
- Anaesthetists who cared for children were required to be on call and within 30 minutes travel time to the hospital for the post-operative period of a child's recovery.

Assessing and monitoring risk

- CYP were assessed as being suitable for treatment according to hospital policy, before being accepted for

any procedure. The CYP lead nurse oversaw the pre-assessment and booking arrangements for any procedure planned for a child or young person under 16 years of age.

- Young people aged 16 and 17 years old were pre-assessed and cared for as part of the adult service provision unless issues were detected at pre-assessment which identified them as requiring CYP service cover.
- Pre-assessment would identify CYP who were unsuitable to be treated at the hospital. As an example, a child or young person with epilepsy or cardiac conditions would not be accepted for any surgical procedure at the hospital.
- Each child or young person admitted as a day case or inpatient had a care record which was specific to the needs of under 16 year olds. A paediatric early warning tool was used to identify at an early stage when a child's condition may be deteriorating. Instructions were included to guide staff in appropriate steps. The records we reviewed had the tools completed post-operatively.
- For each child we saw attending for surgery, we witnessed the appropriate completion of the World Health Organisation's checklist for safer surgery. The hospital had no critical care facilities for children or young people. Service level agreements had been developed with local NHS trusts if a child needed stabilisation of their condition. The child would be transferred back to the Nuffield hospital if their condition improved sufficiently. Service level agreements were awaiting final ratification by the MAC.
- Parents were provided with a number to call at any time, if there were any concerns when their child had been discharged. The nursing staff could contact the paediatrician or anaesthetist if further advice was needed.

Emergency awareness and training

- The CYP lead nurse had implemented emergency scenario training for registered nurses to enable them to care for a deteriorating child, which had included the use of emergency paediatric equipment. Twenty-six staff had attended the training by November 2016.
- There were emergency procedures in place on the ward, including call buzzers to alert other staff in the case of an emergency.

Are services for children and young people effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Care for children and young people (CYP) was delivered in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Staff told us they were able to access national and local guidance through information held in the office of the CYP lead nurse and via the hospital intranet.
- NICE guidance was routinely discussed and reviewed at hospital quarterly clinical governance meetings in October 2016. For example, in the minutes of the meeting in October 2016, NICE SQ122 bronchiolitis in children and QS125 diabetes in children were reported. It was noted in the minutes that a gap analysis was being undertaken to identify compliance actions required by the hospital in relation to the services being delivered to CYP. In the minutes of the CYP team meeting in September 2016, NICE guidance in relation to CYP had been discussed.
- Standard operating procedures (SOPs) had been written by the CYP lead nurse to give standard guidance for staff which detailed every phase of the patient journey from booking through to discharge. SOPs were written in line with national guidance to support the care of children in independent healthcare. For example, Standards for Children's Surgery-Royal College of Surgeons and "Safeguarding CYP: roles and responsibilities for healthcare staff" (2014).

Pain relief

- A pain management process was being developed by the CYP lead nurse that would be specific to CYP's needs. Guidance for staff was written on the individual

child's care record. It detailed prescribing guidelines for all ages and identified the level of pain, appropriate medication and the associated risks. Guidance was also included for pain relief when patients were discharged.

- Tools for assessing pain in all ages of child were available on the individual care record. They used smiley faces and 0 to10 range of pain.
- Parents told us "My child did not experience any pain following their procedure but I was advised about the analgesia they could have when they were discharged. I did not require supplies of the analgesia I was offered by the hospital as I had the same medicines at home". Another parent said "There was minimal pain experienced by my child following their surgery and they were given adequate pain relief in theatre. They were given further pain relief on the ward and I was given the same analgesia to take home".
- Topical local anaesthetic was used for children who needed intravenous cannulation to numb the area and prevent pain. This had been explained to children when they attended pre-assessment.

Nutrition and hydration

- CYPs nutrition and hydration needs were assessed at pre-assessment and documented on their care record. Where CYP had specific dietary requirements appropriate arrangements were put in place. For example, a child who was a vegetarian was able to choose their food from a vegetarian menu.
- The hospital provided suitable meals and drinks for CYP. Alternative menus were available for children to choose from to encourage them to eat and drink normally. This included foods to appeal to younger children such as fish fingers and yogurts.
- Parents told us there was a good selection of appropriate food available to their child who was able to choose what they wanted to eat.

Patient outcomes

- There were no national audits undertaken by the hospital involving CYP.
- There had been one unplanned transfer of a child in the last 12 months. A child had required an emergency transfer overnight to an NHS trust as no paediatric nurse was on duty overnight to care for the deteriorating child. This was reported as a clinical incident, investigated and the appropriate remedial actions had been taken.
- Changes to practice were put in place to promote good patient outcomes for CYP. For example, all children attended a face-to-face pre-assessment clinic to assess their suitability for surgical intervention and a paediatric nurse was rostered overnight for all children undergoing day case and inpatient surgery.
- Following the appointment of the CYP lead nurse in July 2016, children's services were incorporated into the overarching audit tool for the hospital. Ten sets of CYP notes were reviewed for the first time in September 2016 and had identified good patient outcomes for CYP. For example, 100% compliance for the World Health Organisation's check list for surgery, weights and pre-assessment checks, completion of risk assessments tools and pain assessment tools and consent.
- The review also identified that staff required education and training in the WETFLAG approach to the care of sick children. WETFLAG outlines a widespread approach to the sick child derived from advanced paediatric life support training. It provides staff with the ability to calculate appropriate weight based drugs and equipment for children whose condition was deteriorating. The CYP lead nurse was taking this forward through scenario based training sessions at the hospital.

Competent staff

- Staff reported that they had access to education and training courses relevant to their area of specialism. Evidence of this was seen on the notice boards in theatres and the ward areas.
- All staff we spoke to reported that they had completed an annual appraisal. The CYP lead nurse had been in post for six months and had undertaken the appraisal of one of the two paediatric bank staff and had planned to undertake the appraisal of the second staff member in the near future.
- Staff we spoke to reported that they were supported to complete the Nursing and Midwifery Council revalidation process.

- Regarding consultants with practicing privileges. The information shared with the responsible officer was taken into account during the revalidation and appraisal process.
- The CYP lead nurse worked alongside the registered paediatric bank nurses and had assessed their competence to care for CYP. A training passport for the bank nurses was shortly to be implemented by the CYP lead nurse.
- The CYP lead nurse had created a children's champion role in each of the hospital departments involved with children's services. For example, the ward, outpatients, theatre and radiology. The champions attended monthly meetings to develop CYP services and had commenced a training programme to increase their knowledge and skills around the care and support of CYP. For example, scenarios to manage the deteriorating child.
- Staff were able to tell us about the champion roles but the role had yet to become embedded in practice.

Multidisciplinary working

- Information regarding services for CYP was shared with all staff by the CYP lead nurse at team and ward meetings.
- Throughout our inspection we were told how the CYP lead nurse had developed strong multidisciplinary relationships with consultants, senior managers, nurses and administrative and support staff. Staff felt able to raise issues and concerns about children's services and had welcomed the opportunity to become a children's champion.
- The hospital had service level agreements with NHS trusts, such as a retrieval service for critically ill children and if a patient transfer or paediatric advice was required.
- GPs and other community staff were informed of a child or young person's consultation or procedure with details of ongoing care needs where appropriate.
- Safeguarding organisations were contacted for updates to knowledge, advice and guidance.
- The CYP lead nurse worked with all the staff that cared for CYP across the hospital. Booking and medical records staff told us how beneficial the lead nurse post was as there was now a coordinated approach to the pre-assessment and booking of children attending the hospital.

Access to information

- Information was available for staff to continue ongoing care of CYP. Consultants arranged for records to be available in the hospital at the first outpatient appointment and records were stored on site for any follow up procedures.
- Nursing records commenced at pre-assessment. This recorded any base line observations, such as heart rate and blood pressure. It documented any other clinical needs, such as allergies the nurse would need to be aware of. These records followed the CYP to the ward, theatre and continued post-operatively.
- When patients were discharged from the hospital they were given two identical hospital summary discharge letters, one for their own records, one for them to give to their GP. This was in addition to the consultant discharge letter which was sent to the GP within 48 hours. GP letters detailed the procedure undertaken and on-going care needs after discharge.

Consent

- The hospital consent policy for the examination or treatment of a child was available on the hospital intranet for staff to view. This included information to guide staff on consent issues such as where a parent was unable to consent on behalf of a child due to a lack of mental capacity, and gaining consent from young people as well as their parents. Nurses were aware of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.
- We were told when young people aged 16 and over lacked the mental capacity to make a decision, 'best interest' decisions were made in accordance with legislation. Young people were supported to make decisions by nurses and consultants. Consultants were aware of assessing young people's ability to consent for treatment using the Gillick competency guidelines (used

to help assess whether a child had the maturity to make their own decisions and to understand the implications). Staff told us they were always present with under 16 year olds.

- We witnessed explanations between consultants, young people and their parents for on-going treatment plans. Understanding was checked by the consultant who reassured the young person throughout the care episode. The consultant sought verbal consent from the young person and parent for a referral to physiotherapy. Should written consent be required regarding treatment of a child or young person, generic forms were used. They included instructions on who could consent and space for signatures from the young person and their parent (or person with parental responsibility).
- Nurses were aware of the appropriate procedures in obtaining consent, talked to children and explained procedures to children in a way they could understand. We saw examples of how nurses would seek a child's consent prior to doing anything, for example, taking a pulse.

Are services for children and young people caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- Parents and children were extremely positive about the care and treatment they received regarding inpatient and outpatient services at the hospital.
- Nurses, consultants and support staff were friendly and welcoming to children and their families and were skilled in communicating with children and young people (CYP). Children and their relatives told us how happy they were with the care throughout the hospital. They said staff were very caring, one relative said "they always felt fully informed".
- Another relative said their child had recently attended the hospital for the first stage of a two-stage inpatient treatment process. The relative said how well their child had been cared for by the nurse during their first hospital admission and had requested the same nurse to assist during their child's second admission.
- We observed the nurse undertaking the child's admission process. The nurse was calm and caring and gave a clear explanation about the medication to be administered and the effect it would have on the child in an age appropriate manner. The parent and child expressed confidence in the care and support of the consultant undertaking their treatment and felt they had been listened to and were able to raise issues or concerns.
- During our inspection we saw very good interactions between consultant paediatricians, CYP and their families. Interactions were compassionate and caring and praised the CYP which helped to allay any fears they might have.
- We observed four outpatient consultations for CYP. We noted that each child and their family were well known to the consultant paediatrician. Each child was greeted in a friendly and caring manner by the consultant paediatrician who used language that was age appropriate and took account of their clinical condition. This ensured CYP (where they were able) could understand the questions they were being asked which enabled them to participate in the consultation.
- The CYP lead nurse had developed an age appropriate patient survey for CYP who had used the hospital during the last six months. Children who had completed the surveys said "Thank you so much for looking after me so well, especially in theatre because I was terrified of needles" and "I felt a lot more confident when everything was explained to me at pre-assessment as they made me feel more confident" and "The nurse was brilliant and made me feel familiar with my surroundings so I was not so concerned about my operation".
- Parents added their own comments to the surveys and said "All staff were caring, reassuring and friendly" and "The care of my child throughout their hospital stay was excellent, I could not fault the care at all".

Understanding and involvement of patients and those close to them

Services for children and young people

- Children and their parents we spoke with felt well informed about their care and treatment.
- A child told us "I got to see the masks (for the anaesthetic) and I was told everything about my operation so I knew what was going to happen. They even rearranged my pre-assessment appointment, as my mum could not attend on the original date. They were all amazing, wonderful and awesome".
- Parents told us they were given sufficient advice following their child's discharge from hospital and knew whom to contact if their child became unwell. Parents said the information booklet they were given had been helpful and contained useful contact numbers.
- Parents understood when they would need to attend the hospital for repeat investigations or when to expect a follow-up outpatient appointment.
- All parents we spoke to told us how they were fully involved in the assessment, planning and delivery of the care and support to their child throughout the hospital experience. Parents attending the pre-assessment service praised the nurses on how they had engaged with their child during the pre-assessment process. Nurses had addressed each child's fears and concerns and had ensured that children (where appropriate) knew what was going to happen to them.
- The environment for each outpatient consultation was prepared in advance by the consultant paediatrician to meet the needs of each CYP and their family. For example, diversional equipment that was age appropriate and took into account the clinical and psychological needs of each child.
- We observed how staff explained things to parents and CYP. For example, we saw a consultant paediatrician explain a procedure to a child. We saw how this reassured the child and their parent.
- Anaesthetists visited all children on the ward prior to surgery to check consent and pre-admission details and to explain the anaesthetic procedure to the parent and the child (where appropriate). We observed that parents were given sufficient time to ask questions to ensure they understood the procedures.
- We saw evidence that parents were encouraged to be involved in the care of their child as much as they wanted to be. We heard staff engaging with CYP of all ages with age appropriate conversations.

Emotional support

- Staff were able to build relationships very quickly with parents and CYP. We saw evidence of this in all of the areas we visited who cared for CYP. For example, during observation of a pre-surgery assessment in day theatre.
- CYP requiring surgery were accompanied by their parents to the anaesthetic room and were able to stay with them until they were asleep. This ensured that parents were able to continue to provide emotional support to their children. Parents were able to see their child in the recovery area as soon as they were awake to provide reassurance and support.
- Children and parents told us they were supported by nurses and consultants if they were worried about their test results and were given the necessary time and support they required.
- We observed throughout the inspection how nurses and consultants provided emotional support to parents and families of CYP. A parent said, "The nurse held my hand throughout my child's procedure and answered any questions I had which was very reassuring". Another parent said, "I have been reassured by all the nurses and consultants involved in my child's care throughout the hospital which has really made me feel supported and cared for and exceeded my expectations".
- During conversations with consultant paediatricians it was clear they were very sensitive to parents' needs and supportive when helping them to come to terms with the long term clinical condition of their CYP.
- CYP attending pre-assessment were shown the type of equipment that would be used when they were admitted to hospital. For example, syringes, cannulas and blood pressure cuffs. Younger children had the equipment demonstrated on 'Nuffy Bear' (Nuffield Heath toy bear) and were able to familiarise themselves by playing with the equipment. Children were told that cannulas would not hurt, as local anaesthetic cream would be applied in advance. Nuffield Health children's

leaflet, 'When Nuffy met Sam' was given to children undergoing surgery and provided children with pictorial age appropriate information about their forthcoming operation as told by 'Nuffy Bear'.

Are services for children and young people responsive?

Outstanding ☆

We rated responsive as outstanding.

Service planning and delivery to meet the needs of local people

- Children and young people (CYP) accessed the following services in the hospital: outpatients, pre-assessment, radiology and diagnostic imaging, the hospital ward for overnight stays and day cases, all areas of theatre and physiotherapy.
- The hospital did not undertake acute or emergency surgical admissions for CYP. Re-admissions were only accepted when the required resources were available.
- There were 10 different surgical procedures undertaken on CYP in the hospital between July 2015 and June 2016. For example, myringotomy, tonsillectomy, adenotonillectomy, injection into joints and surgical removal of impacted teeth.
- Young people aged 16 and 17 years were pre-assessed and cared for as part of the adult service provision unless issues were detected at pre-assessment identifying them as requiring CYP service cover.
- Children with existing conditions were not operated on by the service. For example, diabetes, epilepsy, cardiac and circulatory conditions. Surgery was undertaken for children with mild respiratory or dermatological conditions. For example, asthma and eczema.
- The hospital had no critical care facilities for children and all children were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. Processes were in place to deal with unexpected outcomes. Service level agreements had been arranged between local NHS trusts to ensure CYP could be cared for if their condition deteriorated and required more specialist care.

Access and flow

- Processes were organised for care and treatment to be provide by the hospital in a timely way.
- Parents accessed services for their children at the hospital through a direct referral to the consultant for private or/self-funded care or via their health care insurer.
- CYP were provided with appointment times to suit their commitments. This could be before or after school and between school terms.
- A parent told us "The first appointment my child was given was not convenient so I spoke to the receptionist who accommodated my child's needs and made the appointment at the end of the school day".
- Parents told us throughout the inspection there were minimal waits to get an appointment for outpatient clinics. If there were delays on arrival parents and young people were notified. There were 152 children under two years of age and 724 CYP aged three to 15 years who attended outpatient clinics. This represented between 1% and 3% of the hospital's outpatient activity. There were 146 attendances by young people aged 16 and 17 years which represented 1% of the hospital's outpatient activity.
- Staff told us that if a child did not attend their outpatient appointment, the outpatient lead was identified and contact was made with the child's carer to identify the reason for non-attendance. If concerns were identified the CYP lead nurse would be informed who would undertake a follow-up. If a cancelation of a CYP outpatient clinic did occur they would be rebooked within 28 days at the latest.
- The CYP lead nurse and the bookings lead had developed a standard operating procedure for pre-assessment and surgical procedures for under 16 year olds attending for a procedure at the hospital. This ensured all booking arrangements for CYP were managed in a timely and accurate way.
- The CYP lead nurse coordinated all the pre-assessment clinic bookings and ratified every booking for a surgical procedure for all under 16 year olds at the hospital.

- There was a weekly meeting between the lead nurse and the matron to review all planned paediatric admissions to ensure there were appropriate staff on duty. CYP attended pre-assessment before they were allocated a date for the procedure.
- Surgical lists were organised as children's only lists and younger children were seen earlier than older children. This ensured that there staff and equipment set up and readily available to meet the needs of children. The target was that children would have recovered from an anaesthetic by 4pm to allow them go home at a reasonable time.

Meeting people's individual needs

- The individual needs of CYP were assessed by the CYP lead nurse, paediatrician and matron where necessary. CYP with complex needs were supported by staff to access the hospital facilities. For example, use of a hearing loop for children who were deaf and access to consulting rooms for CYP who were in a wheelchair. This was to ensure the safety and wellbeing of CYP. A wide selection of leaflets were available for CYP and their parents but were only printed in English.
- All CYP using the service were low risk on admission and did not have complex needs. The matron told us that where CYP had a mild learning difficulty this would be taken into account in line with hospital criteria. This ensured that CYP were cared for in an environment that reflected their daily routines which were discussed with parents at pre-admission and provided by the hospital where possible.
- Young people aged 16 and 17 years, were pre-assessed and cared for as part of the adult service provision, unless additional support was identified at pre-assessment, in which case, this would be provided by a registered paediatric nurse. This reflected the Nuffield Health CYP policy. Pre-assessment clinics were on Saturdays. The timings of the clinics were developed with parents who had requested Saturdays, as this did not interfere with schooling and was easier for parents with other children to attend. A parent whose child had attended the pre-assessment clinic said "The nurses provided us with invaluable information and a point of contact and communication which was very reassuring and provided an efficient link between the clinical team, the secretaries and the consultants".
- A parent said, "The only difficulty I experienced at the hospital (December 2016) was around the lack of children's trained nurses (both nationally and in this hospital) who were required if my child needed an overnight stay. The paediatric agency nurse booked by the hospital had gone off sick and therefore my child's surgery had been cancelled". The CYP lead nurse told us that it was essential for the safety of children undergoing surgery to have a children's trained nurse on duty overnight. The child's operation was rearranged within two weeks.
- CYP attending for inpatient or day case surgery received a letter giving comprehensive information in a clear and simple format. It detailed what they should expect at their admission and facilities available for them to use. It also included links to web sites about anaesthesia and staying in hospital.
- CYP were cared for in single en-suite rooms which were decorated in a child friendly way. Each room had bed linen that was age appropriate and younger children had their own 'Nuffy Bear' waiting for them when they were admitted to the ward. Children were encouraged to take DVDs, music devices or their favourite toys into hospital. Older CYP were able to access WI FI and a television during their hospital stay. Parents were actively encouraged to bring their child's favourite toys, electronic tablets and electronic gaming devices on admission which provided familiar diversion for CYP undergoing a surgical procedure.
- Younger children were able to access a play area adjacent to the rooms designated for children. The play area had recently been created by the CYP lead nurse and was awaiting delivery of additional toys and child appropriate display materials.
- A large toy car was stored in the play area for children who wanted to drive themselves to theatre for their operation rather than walking or being transported on a hospital bed.
- Screens were in place in recovery so CYP did not view adult behaviour.
- Children were given a bravery certificate following surgery and were able to take Nuffy Bear home with them. Parents were given a discharge letter and take home medicines and were provided with a copy of their

child's prescription. Information leaflets about their child's condition which included guidance on who to contact in an emergency were supported by verbal information from the nurses prior to discharge.

- Outpatient receptionists had implemented a daily record sheet following discussions with the lead nurse, which had enabled the number of CYP attending the outpatient service to be identified. The outpatient lead told us they were now able to plan outpatient services around the needs of CYP. For example, the management of diversional equipment for children.

Learning from complaints and concerns

- There was one formal complaint about the CYP service in the period June 2015 to July 2016.
- The complaint concerned a child whose condition had deteriorated overnight following surgery which had required an emergency transfer to an acute hospital, as there was no paediatric trained nurse on duty to care for them.
- We saw evidence in the minutes of clinical governance meetings of the investigation (root cause analysis) and the action plan that was put in place to ensure the changes in practice had taken place following the complaint. For example: pre-assessment arrangements for all CYP were formalised, exclusion criteria for CYP undergoing surgery who had a pre-existing condition were agreed by the paediatric service, all inpatient and day theatre cases for CYP were staffed overnight by a paediatric trained registered bank or agency nurse.
- We observed throughout the inspection the changes resulting from the complaint were embedded in practice. For example, a child whose operation had been planned for December 2016 had been postponed as the registered paediatric nurse was sick at short notice. The CYP lead nurse told us they had outlined the potential risks to the child of not having competent staff in post at night to care for their child. The child's operation was rescheduled for two weeks later.
- Staff were aware of the hospital's complaints policy and were able to advise parents, young people and families of how to complain. They would however, try to resolve the complaint at the time if appropriate.
- Notices throughout the hospital informed patients of how to raise issues or make a complaint. Young people, parents and families we spoke to said they would discuss a complaint with the consultant or nurse in charge if they needed to.

Are services for children and young people well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The children and young people (CYP) service was led by the hospital CYP lead who was based on the ward. There was a Nuffield Health CYP lead that supported the hospital lead. Staff spoke highly of the CYP lead and the difference the post had made to the care and support of CYP at the hospital. Throughout the inspection staff referred to the positive changes implemented by the CYP lead and how they had given a voice to CYP.
- We observed how the learning from the complaint in June 2016 had been implemented by the CYP lead and were now embedded in practice. For example, standard operating procedures for all aspects of CYP's care journey and the establishment of pre-assessment clinics for all CYP under 16 years of age.
- We found the leadership of CYP services provided by the hospital was good overall although some aspects of safety required improvement. For example, the lack of robust environment and safeguarding arrangements to ensure CYP were cared for in a safe and secure environment when undergoing surgery on the ward. The hospital had taken the appropriate action to mitigate the risks to CYP raised and had advised the CQC of the outstanding actions that were required to secure the ward area. However, hospital leaders need to demonstrate they are committed to an on-going programme of monitoring and review to ensure the safety of CYP is embedded in practice throughout the hospital.

- Nurses, consultants and support staff told us CYP lead nurse was visible and accessible in the hospital should they require advice and support in relation to CYP in the hospital.
- All staff told us the senior management team were approachable and visible. Staff said they saw the matron and the CYP lead nurse every day when they visited the areas where children were treated.
- Staff spoke positively about working in the hospital and described a culture that was open and friendly with an emphasis on delivering high quality care to adults, CYP.

Vision and strategy for this this core service

- There was no specific strategy for children's services as the CYP lead nurse was developing this. However, the corporate group Nuffield Health had a vision and strategy they referred to as the 'EPIC' values. These involved staff being enterprising, passionate, independent and caring.
- The CYP lead nurse spoke of a culture of quality and continuous improvement for services provided to CYP and their families. Staff expressed an ethos of working together to provide a quality service for CYP at the hospital. Staff said the lead nurse had raised the profile of children's services and the hospital was now more 'child centred' and CYP's services now had a voice.

Governance, risk management and quality measurement

- A governance structure was in place for CYP services. This included a mechanism for effective communication via the CYP service committee, the hospital's quality and safety committee and medical advisory committee (MAC).
- The CYP lead led hospital wide CYP team meetings. A work plan was in place to monitor the changes to children's services. For example, a standard operating procedure for booking CYPs inpatient and outpatient procedures.
- CYP champions were in place in all departments to ensure engagement and understanding of CYP issues across the hospital. However, the roles were yet to be embedded in practice.
- CYPs services were audited in line with the hospital overarching governance policy. The CYP lead nurse was developing an individualised audit programme that was reflective of the services offered at Nuffield Health Warwickshire Hospital to allow for continuous monitoring and enhancement of the quality of care delivered to CYP.
- Where risks to CYP were identified they were recorded on the hospital wide risk register. However, not all risk had been identified. For example, the environment where CYP were cared for in the hospital. Although the hospital had given some consideration regarding the risks presented to children sharing the same facilities as adults not all adaptations had been made. There was a lack of understanding and clarity shown by the leadership team in regard to the risk management of CYP and the areas that still posed a risk. We raised these concerns with the provider, as described in the safe section of our report. The provider responded appropriately by risk assessing the area and implementing mitigating actions to reduce the risk.
- Care of CYP were provided whenever possible on a day care basis and overnight stays were kept to a minimum. Competent paediatric registered nurses were rostered to care for children overnight during each paediatric surgical week.
- The lead nurse for CYP had developed close working relationships with acute children's services in the local area. Standards and defined arrangements for the transfer of all children were awaiting imminent ratification by the MAC.
- The hospital was part of the paediatric clinical network for Nuffield Health, and the lead nurse for CYP attended meetings every six weeks to share clinical expertise, experiences and learning.

Public and staff engagement

- Staff spoke highly of the flexibility offered by the hospital. Examples given included the support a staff member had received following the illness of a close family member, and the support on returning to work following a period of sickness.
- Staff in other areas of the hospital told us they felt included in planning children's services.

Outstanding ☆

Services for children and young people

- The CYP lead nurse had developed a monthly activity and development review of CYPs activity across the hospital. Staff in hospital departments caring for CYP told us how useful the report was and had helped to raise the profile of children's services.
- A CYP satisfaction survey had been developed to capture service user feedback from children, young people of all ages and their parents. The survey responses were small (six) as this was a pilot of a small service. All responses were positive and praised the care and support of all the staff the child and their parent had come in contact with throughout their care episode. The survey encouraged younger children to draw their experiences on the form. For example, a child had depicted themselves as having 'new super powers' following their surgery. The survey had been piloted, and following a review would be circulated to all CYP attending the hospital in early 2017.

Innovation, improvement and sustainability

- Improvement actions for children's services had been discussed between the lead paediatric staff and senior management team. The CYP lead nurse told us that equipment and facilities that required funding had always been approved by the senior management team.
- Records we saw indicated that opportunities to improve children's services were acted upon wherever possible. For example, using audit, comments from children, young people and their families, visiting other providers and views of staff members.
- Training had been developed to improve outcomes for CYP, such as using emergency scenarios and identification of the deteriorating child for adult trained nurses.
- As part of the hospital safeguarding arrangements, parents and any identified visitors of CYP cared for on the ward were requested to wear a locally agreed and notifiable wrist band at all times.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The hospital had a comprehensive incident management policy and used an electronic system for reporting and recording them. All staff we spoke with understood their responsibilities to report incidents both internally and externally.
- There were no never events reported for this service from July 2015 to June 2016. A never event is described as a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- There were no serious incidents reported for this service from July 2015 to June 2016, as described in the NHS England Serious Incident Framework (March 2015).
- From July 2015 to June 2016, there were 48 clinical incidents and 12 non-clinical incidents reported in outpatients and radiology department.
- All incidents were graded in severity from 'no harm' to 'severe' or 'death'. The heads of departments automatically undertook an investigation of any incident graded as moderate or above. A root cause analysis was conducted to identify learning opportunities.
- Incidents were discussed at hospital wide governance meetings and departmental meetings to identify trends and opportunities for shared learning.
- Staff were able to tell us about changes made as a result of incidents. For example, staff in radiology told us that changes had been made to the way images were stored on the electronic system as the result of incidents. Images had been stored in an incorrect folder on the electronic system, which meant that it appeared that the images were missing. The action plan included training for staff, daily monitoring and exploring new IT systems.
- The Ionising Radiation (Medical Exposure) Regulations, or IR(ME)R, is a framework that deals with the safe and effective use of ionising radiation when exposing patients and designed to minimise the risk of unintended, excessive or incorrect medical exposure. The hospital had a robust process in place to report radiology errors to Care Quality Commission in line with regulations, for example, for incidents where radiation levels were 'much greater than intended' (MGTI). From July 2015 to June 2016, there were no radiation incidents reported for this service.
- The Ionising Radiation Regulations 1999 (IRR99) aims to protect staff who work with ionising radiation. This legislation requires radiology services to produce 'local rules', which are a set of rules describing the systems

and processes in place to protect staff in individual services. The radiology department had developed their 'local rules', which were displayed in all relevant areas and reviewed when necessary.

- All staff were aware of the duty of candour regulation and the hospital's policy related to the regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For independent providers, the duty came into force on 1 April 2015 and for NHS bodies on 27 November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- There were processes, systems and policies in place to maintain hygiene standards and ensure that infection control practices were carried out in line with hospital policy and national guidance.
- The outpatient and diagnostic imaging departments were visibly clean and there were signs in all areas encouraging staff and visitors to use the sanitising hand gels, which were available throughout the department.
- There were posters above all handwashing basins that encouraged staff and visitors to wash their hands in line with the World Health Organisation (WHO) guidelines ('Five moments for hand hygiene', 2006).
- There were daily cleaning schedules in place. We observed housekeeping and nursing staff cleaning areas regularly throughout the day, including treatment and consultation rooms between appointments.
- There were processes in place to ensure that effective infection control practices were observed. Monthly infection control audits were conducted, which included hand hygiene audits and action plans were developed to address any areas for improvement. For example in July 2016, outpatient department conducted a hand hygiene audit and found that consultant practice was not meeting the hospital's standard of 80% compliance. An action plan had been developed, which included regular audits and training sessions for consultants.
- All staff we observed adhered to the 'arms bare below the elbows' policy and used appropriate personal protective equipment (PPE), such as disposable gloves and aprons, when required. PPE including specialised equipment in diagnostic imaging such as lead aprons and throat shields were available in all appropriate areas.
- In outpatients and radiology departments, there were rooms that could be used for isolation of a patient with a suspected communicable disease, such as chickenpox or measles. Staff we spoke with were able to describe the process.
- The sluice area in outpatients was used to clean dirty equipment post procedures. The room was accessed with a key code by authorised personnel only. We saw that the room was well organised and tidy.
- There were processes in place to ensure that reusable medical devices, such as nasal endoscopes, were decontaminated in line with national guidelines (Health Technical Memorandum 01-06: Decontamination of flexible endoscopes, 2016). The outpatient sister kept a record of staff that were trained and competent in carrying out the three staged decontamination process in line with guidance.
- In outpatients, a member of staff was given the responsibility of ensuring that all infection control audits were carried out monthly. From July to October 2016, compliance was varied and ranged from 66% to 96%. The department had developed an action plan, which was reviewed on a monthly basis at the departmental meeting. Actions included bespoke training and continued monitoring.
- From July 2015 to June 2016, there were no cases of Meticillin Resistant Staphylococcus Aureus (MRSA), or, Meticillin Sensitive Staphylococcus Aureus (MSSA) or Clostridium difficile

Environment and equipment

- There was sufficient equipment to maintain safe and effective care. This included equipment such as resuscitation equipment and blood pressure monitors. There were processes in place to ensure that the equipment was maintained and staff knew how to use it.

Good

Outpatients and diagnostic imaging

- The outpatients department was located on the ground floor and consisted of an adequate sized reception area, 13 consultation rooms, two treatment rooms and an appointments office.
- The imaging department was on the first floor and had a separate reception and waiting area, one x-ray room, one ultrasound room, one digital mammography room, computerised tomography (CT) and magnetic resonance imaging (MRI) room (the MRI was provided by an external provider which was not inspected as part of this inspection).
- Resuscitation equipment was available in outpatients and diagnostic imaging areas. We saw that daily and weekly checks were conducted. All staff had received training in basic life support and the use of the equipment. The hospital conducted regular exercises with the equipment so that staff were familiar with the equipment and process.
- The imaging department carried out risk assessments for all new or modified use of radiation in line with national guidance. The risk assessments addressed occupational safety, as well as risks to patients and the public. For example, we saw all equipment used in radiology such as x-ray machines and CT scanners, had undergone scheduled risk assessments to ensure that levels of radiation were as low as reasonably practicable.
- There were clear signs in areas where ionising radiation was used, including lights and warning notices. In areas where non-ionising radiation was used, such as ophthalmology and dermatology clinics, where staff used high power lasers and intense pulsed light therapy. We saw that there were working instructions for these areas and access was restricted to staff authorised to use the area. The department had had an external audit in December 2015 in regards to the usage and safety of the laser equipment, which highlighted no areas for improvement.
- The imaging department had clear guidelines for which specialised PPE should be used for specific procedures, such as lead aprons and thyroid shields. All specialised equipment was checked twice annually, which was in line with Royal College of Radiologists best practice guidelines.
- Estates department and manufacturers managed the maintenance of all equipment. The hospital had processes in place to ensure that all equipment was serviced in line with manufacturer's guidance. For example, in outpatients there was a designated area to store any faulty equipment. These were clearly marked as not for use and a record was sent to the estates department.
- The healthcare assistants conducted a daily 'fire walk' through the outpatient department. The checklist included checking that fire escape routes were clearly signposted, extinguishers were serviced and secured appropriately and that doors were free from any obstacles or hazards that may prevent access or exit.
- In diagnostic imaging, a radiographer daily checklist was completed at the end of the day to ensure that all equipment was switched off correctly and that images were stored appropriately on the electronic system.
- Staff working with ionising radiation at the hospital were required to wear a dosimeter in line with the regulations. Regular audits were conducted and an annual report published to ensure that effective measurements were in place to protect staff.

Medicines

- There were processes and systems in place to ensure that medicines were managed correctly in outpatients and diagnostics, including recording, handling, storage and safe administration.
- The hospital had an organisational medicines management policy, which defined the roles and responsibilities of all members of staff and gave clear guidance on prescribing medications. All staff were aware of it and there was a process in place to ensure that staff received all updated guidance and reviews of the policy.
- There were some medications, such as topical and anaesthetic creams, held in the outpatients department and no controlled drugs. All medications were stored in locked cupboards and fridges, in a restricted access room.
- The pharmacy provided on-site support to the outpatients and diagnostic imaging departments. This included regular medication audits, advice and guidance on storage.

- Daily checks of fridge and ambient room temperatures were completed daily to ensure that medications were stored at the recommended temperature. If it was identified that there were variations in temperature recordings, the pharmacy department was responsible for ensuring that appropriate actions were carried out to address the issue. For example, we saw that one of the medicine cupboards was kept in a room with no natural ventilation or air-conditioning. At the time of our inspection, the ambient room temperature recorded for this area had been recorded as above the recommended 25 degrees Celsius. The immediate actions taken by the hospital were to introduce temporary air-cooling systems, such as electric fans, and ensure that stock was rotated regularly. The hospital planned to introduce an air-conditioning system in January 2017. This was not highlighted as a risk on the hospital or departmental risk register.
- Sometimes when diagnostic scans were carried out the patient was injected with a chemical contrast agent to improve the clarity and diagnostic accuracy of the scan.The Royal College of Radiographers (RCR) provided updated guidance on how administration of these agents should be managed in February 2015. The diagnostic imaging department had clear guidance on how contrast agents should be prescribed by consultant radiologists using patient group directives (PGDs – a PGD allows authorised staff to give medicines to patients in certain circumstances without the need for a prescription). Specifically trained radiographers, in line with guidance, could then administer the contrast agent.
- Medications were prescribed for patients using the organisation's prescription pads. These were kept locked in the sister's office (the outpatient sister was the only key holder) and a tracking system was used when they were distributed to consultants for clinics.

Records

- Patients' records were managed and stored in line with the hospital's policy. Our review of five patients' care records, discussions with staff and observations of practice confirmed that records were managed in a way that kept patients safe.
- All patients that had previously attended the hospital as an in-patient or had undergone a procedure in the outpatients and radiology department had a Nuffield Health care record. All NHS patient records were integrated with the hospital's own records. Consultants with practising privileges saw their patients at various locations and kept their own separate patient notes. Staff told us that the consultants' medical secretaries arranged for notes to be available for appointments and no patients were seen without appropriate records.
- The medical records department at the hospital ensured that patient notes were available for clinics. The hospital stored all patient records on-site for a specified period and they were then stored in a secure off-site facility. Staff were able to access the records held off-site within 24 hours of a patient's appointment time and if necessary within three hours' notice.

Safeguarding

- The processes and systems in place to keep people in vulnerable circumstances safe from abuse was communicated to staff through mandatory training courses and staff information displays.
- There were no safeguarding concerns reported to CQC from July 2015 to June 2016.
- Staff we spoke with were aware of the process to make a safeguarding referral for adults and children and gave examples of when they would do this.
- All staff in outpatients had received training in adult and children's safeguarding levels one (detailed findings on children's safeguarding in outpatients and diagnostics is reported in the 'Children and Young People' section of this report) and two in line with national guidance.
- All staff in the radiology department had received safeguarding level one training for adults and children.
- The radiology department had 'pause and check' posters in all treatment rooms to remind staff to check that they had the right patient for the correct radiological scan.
- There was information displayed in staff areas relating to female genital mutilation (FGM) and how to report it if it was suspected. Staff had access to a flow chart on the hospital intranet and the hospital's safeguarding policy described how to report FGM.

Mandatory training

Good

Outpatients and diagnostic imaging

- Mandatory training included basic life support, information governance, health and safety, fire safety, manual handling and infection prevention and control. Training was delivered via e-learning modules and face to face sessions. At the time of our inspection, 93% of staff in outpatients had completed their mandatory training and 98% of staff in radiology department. This exceeded the hospital's target of 85%.
- Our review of staff records and discussions with staff confirmed that senior staff in outpatients and diagnostics kept a record of each individual member of staff's training records and sent them reminders when they were due to complete specific modules.
- Staff in reception had received conflict resolution training.

Assessing and responding to patient risk

- There were processes in place in outpatient and diagnostic imaging to assess risks to patients and to monitor and maintain patients' safety.
- The outpatient and diagnostic imaging departments used a modified early warning system (MEWS) in line with the National Institute for Health and Care Excellence (NICE) guidelines (CG50 Acute, illness recognising and responding to the deteriorating patient). This was a colour-coded system staff used to record routine physiological observations such as blood pressure, temperature and heart rate with clear procedures for escalation if a patient's condition deteriorated. Nursing staff that we spoke with were able to describe the process and explained who they would contact in an emergency.
- The diagnostic imaging department had access to a radiation protection advisor (RPA) in line with IRR99 regulations. The RPA was able to provide radiation advice and assist with risk assessments. The contact details for the RPA were in policies and protocols and on display in diagnostic areas.
- At the time of our inspection, the diagnostic imaging department had one radiation protection supervisor and another member of staff completing the training. The role of the radiation protection supervisor was to ensure that staff complied with the requirements of IRR99 and the guidance in the local rules.
- Diagnostic reference levels (DRLs) should be set in line with IR(ME)R guidelines to ensure that patients receive the minimum radiation exposure as is clinically necessary; the level should be based on specific patient groups. The imaging manager and radiation protection supervisor was responsible for ensuring that DRLs were displayed in each appropriate area and regular audits were carried out with changes made when necessary. We saw evidence that DRLs were regularly checked and reviewed.
- There was clear guidance for staff on who could make referrals or requests for diagnostic imaging in line with IR(ME)R guidelines.
- There were clear signs displayed throughout the diagnostic imaging department informing people about areas where radiation exposure was taking place. Access to treatment rooms were restricted by key code access whilst diagnostic imaging was being conducted.
- The diagnostic imaging department had clear processes in place to ensure that female patients of childbearing age were able to inform staff if they were or may be pregnant. There was clear guidance in reception and waiting areas. Staff asked patients prior to carrying out examinations and there was section in the radiology integrated care record for staff to document the information.
- Contrast induced nephropathy occurs when patients display symptoms of acute kidney injury (AKI) after receiving intravascular contrast agents (sometimes used in urology and other specialities to enhance imaging results) and there is no other reasonable explanation for the suspected injury. The diagnostic imaging department had comprehensive guidance on how to manage patients suspected of AKI, which followed RCR guidelines. Appropriate risk assessments were included in the radiology integrated care records. We spoke with radiology staff who were able to describe the process and what their actions would be.
- All staff we spoke with were aware of the process to follow if a patient became acutely unwell in the outpatients or diagnostics imaging department and required transfer to an emergency facility. If a patient required emergency resuscitation that would be carried out by a trained member of staff and patient would be transferred by an emergency 999 ambulance if required.

Good

Outpatients and diagnostic imaging

- The hospital had service level agreements with other local providers, detailed findings can be found in the main surgery report.
- The radiology department conducted quarterly audits of their integrated care records, which incorporated the World Health Organisation's 'five steps to safer surgery' checklist for use in ultrasound. The audit included the correct storage of care records on the computerised system. In September 2016, the audit showed 89% compliance to protocol. That was based on a sample of 28 records, 24 had been completed correctly, one was partially compliant and three had not been stored on the electronic system as per protocol, so were marked as non-compliant. The action rising from the audit was to discuss the correct storage on the electronic system at the next departmental meeting and re-audit.

Nursing and radiology staffing

- There is no national baseline acuity tool used for staffing in outpatients. The outpatient sister planned staffing levels based on demand. During our inspection, staffing levels were adequate and there was an appropriate mix of registered nurses (RNs) and healthcare assistants (HCAs).
- Staff we spoke with told us that staffing was generally good; however, it was sometimes challenging to cover annual leave and sickness due to RN staff vacancies. This was highlighted on the hospital risk register.
- At the time of our inspection, the vacancy rate for RNs was 37%, which equated to 1.32 full time equivalent posts. The vacancy rate for HCAs was 15%, which equated to 0.6 full time equivalent posts. These vacancy rates were higher (worse) than similar providers we hold this data for.
- The outpatients department covered unfilled shifts using permanent bank staff and overtime for substantiated staff; no agency staff were used. From June 2015 to July 2016, the rate of use of bank staff was higher than the average of 13% to 16% for similar providers and ranged between 14% and 26%.
- There was an induction policy for bank staff and records showed that bank staff received appropriate training and received regular updates in regards to hospital policies and guidelines.
- Rotas showed that the actual staffing levels met planned staffing requirements from April to June 2016.
- In radiology, there was a minimum of two radiographers and an HCA on duty each day. The imaging manager planned a 12-week rolling rota that could be adjusted to meet the activity levels.
- There were no vacancies in radiology and rotas were planned to cover annual leave. Agency staff were not used in radiology. Staff told us that if a member of the team had to take short notice leave or was sick, they would generally cover the shifts within the department.

Medical staffing

- For detailed findings on medical staffing and practising privileges, please refer to main surgery report.
- Consultants and radiologists attended the outpatients and radiology department on set days at set times. This meant that department leads were able to plan staffing accordingly.

Emergency awareness and training

- The hospital had a business continuity plan; detailed findings can be found in the main surgery report.
- In the radiology department, there were systems in place to manage incidents relating to the radiological equipment. There were instructions in each area detailing staff actions in the event of an emergency. All staff we spoke with described the processes and their actions.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate effective for outpatients and diagnostics imaging.

Evidence-based care and treatment

- Care and treatment was assessed and delivered in line with evidence-based guidance. This included pathways and protocols based on National Institute for Health and Care Excellence (NICE) guidelines, such as, NICE QS81: inflammatory bowel disease (2015), NICE NG19: prevention and management of diabetic foot problems

(2015) and NICE QS97: diagnosis and management of drug allergies. Evidence based guidelines were discussed at monthly departmental meetings and reviewed annually.

- There were clear policies and protocols in place to ensure that people did not experience discrimination on the grounds of disability, gender, age, pregnancy and maternity status, religious or cultural beliefs. For example, the organisational policy relating to privacy and dignity included reference to equality and diversity.
- The diagnostics imaging department used diagnostic reference levels (DRLs) in line with national guidance to inform the way that levels of radiation could be kept to a minimum without compromising the quality of images. DRLs were audited regularly to ensure that they were in line with national guidance.
- The Medicines and Healthcare products Regulatory Agency (MHRA) is a government body whose function includes the regulation of medicines and equipment used in healthcare. MHRA guidelines are that professionals in health care are required to demonstrate that they have appropriate training in the use of medical devices. In outpatients, all staff had received medical device training appropriate to their roles.
- The hospital had a structured clinical audit programme to monitor compliance to protocols and guidelines.

Pain relief

- Patients we spoke with did not require pain relief during their attendance at the outpatients department.
- Pain relief was not routinely administered during outpatient appointments and pain scores were not recorded.
- Staff told us that if a patient was in severe or moderate pain post procedure, they would liaise with the consultant and obtain a prescription for pain relief.

Patient outcomes

- Staff in outpatients and diagnostics conducted a number of local audits in relation to practice and compliance to protocols. For example, the imaging manager had conducted local audits of waiting times for different modalities.
- In the outpatients department, care record audits were conducted. These covered areas including care records completed in line with national guidance in regards to legibility and consent to treatment. In November 2016, outpatients achieved an overall score of 98% compliance. In response to the audit, staff were reminded to offer patients a copy of their consent forms.
- Outpatients and diagnostics departments did not formally participate in national audits related to patient outcomes.

Competent staff

- For detailed findings on medical staff with practising privileges, please see main surgery report.
- At the time of our inspection, all staff in outpatients and diagnostics had received an annual appraisal. Staff told us that it was an opportunity for them to identify their training needs and areas for development.
- The hospital had developed a bespoke training programme called the 'Nuffield Health HCA quality care programme' for healthcare assistants to acquire new skills in areas such as wound dressing and minor dermatological procedures. All training was supervised and a record was kept of staff competencies. Staff we spoke with said that they were given time to undertake some of this learning.
- The outpatient sister had developed a programme of training for nursing staff that allowed them to acquire new skills, such as decontamination of scopes in line with national guidelines.
- Our review of records and protocols confirmed that staff administering radiation were appropriately trained to do so. All radiographers had clear documentation in line with IR(ME)R guidelines, which highlighted the types of procedures they were entitled to perform.

Multidisciplinary working

- Our observations of staff interactions and discussions with staff confirmed that outpatients and diagnostics staff had good working relationships with consultants and radiologists. The reception and administration staff reported good working relationships with the departments.

Good

Outpatients and diagnostic imaging

- Staff in outpatients kept records of consultants' preferences, in terms of room and equipment layout, and prepared their rooms accordingly.
- The imaging department had a positive working relationship with theatres and provided cover for evening and weekend surgery.
- As part of the justification process to expose patients to radiation, staff in radiology were able to access previous images from other providers through a shared electronic system. External providers could also request previous images from the department if required.
- The radiology and outpatient departments had good working relationships with both the physiotherapy team and magnetic resonance imaging (MRI) teams (both specialities were delivered by external providers and were not inspected as part of this inspection). Teams worked together to provide co-ordinated care for patients.

Access to information

- All staff had access to the hospital's internal website, which allowed them to find hospital policies and evidence based guidance on practice. All staff we spoke with knew how to access the system and told us that they assisted the consultants with accessing information when required.
- Patients' notes included all relevant information relating to assessments, care pathways and treatment plans.
- There were systems in place to flag up urgent unexpected findings to GPs and medical staff. This was in accordance with the Royal College of Radiologist guidelines.
- Clinic information was shared with patients' GPs in letter format. The consultant's and radiologists medical secretaries generally produced these letters following the appointment and sent copies to patients and GPs. Administrative and reception staff in diagnostic imaging sent results from diagnostic tests to GPs and referrers on behalf of radiology consultants.
- Consultants and radiologists with practising privileges were required to ensure that private notes for patients were available for appointments. The hospital told us that from July to September 2016, no outpatients were seen without all relevant medical records available.
- All relevant staff were able to access the electronic system for diagnostic results in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with were aware of the processes involved to obtain consent for care and treatment. Consent practices were audited on a monthly basis and action plans developed for areas of improvement. For example, in October 2016, the audit showed 97% compliance and the action plan was to remind staff to give patients a copy of their signed consent in line with the organisation's policy.
- Staff received training regarding Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) as part of their mandatory training.
- Staff told us that in the outpatients and radiology environments they rarely dealt with patients who required decisions to be made in their best interest or authorisation for DoLS. Staff we spoke with told us that if a 'best interest decision' was required in line with legislation, that would be completed by the consultant treating the patient and if they required support they would liaise with the outpatient sister or matron.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- Staff treated patients with compassion, kindness, dignity and respect. We observed staff taking time to interact with patients in a respectful manner.
- We spoke with four patients and a relative in the outpatients department. They told us that staff were '…always friendly and respectful' and they felt 'safe and cared for'.
- All staff introduced themselves to patients and asked how they would like to be addressed.

Good

Outpatients and diagnostic imaging

- Patients in imaging were given hospital scrubs to wear (when appropriate); staff told us that this meant that patients did not always have to wear gowns, which could potentially impact on maintaining dignity.
- Privacy and confidentiality was maintained in the reception area. Receptionists spoke discreetly when necessary and moved to other areas of the desk if necessary.
- Chaperones were made available to accompany all patients; there were signs on display in reception area advising patients that they could request a chaperone.
- Staff generally respected peoples' individual preferences, habits, culture, faith and background.
- The outpatient sister was developing an outpatient specific survey to gather feedback from patients and those close to them.

Understanding and involvement of patients and those close to them

- Our observations of interactions between staff and patients confirmed that staff communicated with patients in a manner that helped them to understand their care and treatment.
- Patients who were waiting in outpatients and diagnostic reception areas were advised to alert staff if they were waiting in excess of 20 minutes past their appointment time. During our inspection, patients we spoke with told us that their appointments were always on time.
- Patients told us that they felt well informed about their care and treatment and knew when they would receive test results or if a follow-up appointment was required.
- Patients were given information about who to contact if they had any concerns or questions after their appointment.

Emotional support

- Staff we spoke with were aware of the impact that a patient's condition could have on them socially and emotionally.
- Staff told us that they would take some time to explain treatments and written information with patients if they needed extra support to understand their condition.
- The hospital held regular open events to give patients and their loved ones the opportunity to discuss specific conditions and receive support and counselling advice.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. For example, the hospital delivered services for NHS and self-funding patients. The hospital considered the activity levels in specific specialities in the NHS when planning resources for service delivery.
- The hospital had plans to work with local commissioners and other providers to assist with specific waiting list issues in the local area. This involved the hospital liaising with local clinical commissioning groups and other providers to determine if they were able to accommodate specific NHS referrals for certain specialities, such as orthopaedics.
- The outpatients and diagnostic imaging departments had adequate seating in reception and waiting areas. The outpatients waiting area was open planned and spacious.
- There was clear signage at the front of the hospital directing people to the main reception area to book in for their appointments.
- Patients told us that their appointments were made at a time that suited them. Outpatient clinics were regularly held evenings and weekends to meet patients' needs.
- Patients that we spoke with said that information relating to their treatment had been provided to them by letter prior to their appointment. Patients were sent information about dietary requirements such as fasting times and contact details. Patients were told who their consultant would be and advised that they could have a chaperone attend with them if they wished.

Good

Outpatients and diagnostic imaging

- Outpatient appointments were available in the evenings until 9pm.
- Diagnostic imaging was available Monday to Friday 8:30am to 6pm and there were arrangements for an emergency on call service outside of these hours. Radiology staff provided regular evening and weekend support for theatres. Staff told us that they had conducted a three-month trial of opening diagnostic imaging services for referrals and outpatients; however, they had found it was not practical or cost effective.
- The hospital had adequate car parking facilities for patients.
- There were hot and cold refreshments available for patients and those accompanying them.

Access and flow

- Patients had timely access to initial assessment, diagnosis or urgent treatment and could access services at a time to suit them.
- Referral to treatment time (RTT) is the term used to describe the period between when an appropriate referral for treatment is made and the date of the initial consultation or treatment.
- The Department of Health stated that as of June 2015, 92% of all patients waiting to receive treatment on 'incomplete pathways' (at the end of the reporting month) should be seen within 18 weeks. This figure represents both patients who are 'admitted' and 'non-admitted' for treatment. The indicator for 'non-admitted' patients was that 95% should receive treatment within 18 weeks of referral.
- From July 2015 to June 2016, the hospital consistently exceeded the target of 92% of patients on incomplete pathways, except for February 2016 when it was 91%. In the same period, the indicator for 'non-admitted' pathways was exceeded, except for four months when it fell to between 88% and 93%.
- Consultants and radiologists advised the hospital of their availability in advance to assist in the planning for outpatient clinics and diagnostic referrals.
- Booking staff offered patients an appointment time that suited them, unless the patient requested a consultation with a specific consultant. Staff told us that in these instances they would do their best to offer the patient a time to suit them based on consultants' availability.
- Patients who attended an outpatient appointment and were told they needed diagnostic imaging could attend the department on the same day of their appointment as 'walk in patients' if it was convenient for them. The diagnostic imaging department conducted monthly audits of waiting times for all patients. At the time of our inspection, there was an average waiting time of four minutes for all patients including 'walk-ins'.
- Staff told us those patients who 'did not attend' for their appointments were mostly referred back to their GPs or consultants. In some instances, staff would try to contact the patient if they felt that they were potentially vulnerable, for example, if the appointment was for a patient with cancer on a chemotherapy regime and then highlight this to the referrer.
- From June 2015 to July 2016, there were no outpatient clinics or diagnostics imaging cancellations. Staff told us that if they did have to cancel a patient's appointment they would re-arrange an alternative appointment to suit the patient, and as close to the original appointment date as possible.
- From July to November 2016, no patients waited longer than six weeks from referral for diagnostic imaging.

Meeting people's individual needs

- Services were generally planned to take into account the needs of different people. Staff told us that there was no formal process for patients with complex needs, such as a learning disability or patients living with dementia. Staff we spoke with told us that they had not received any specific training related to dementia or learning disability awareness.
- Booking staff told us that if patients needed extra support such as a translator, chaperone or carer for their appointments this was usually highlighted in the referral, discussed with the consultant and added to patient's notes.
- Staff in diagnostics gave us examples of when they would adjust practice to meet individual needs. For example, patients who were anxious about having

specific diagnostic procedures carried out were invited to the department prior to their appointment to meet staff, view the equipment and have an opportunity to discuss the process.

- Nursing staff told us that if patients needed extra time for their appointments due to communication needs, they would organise the room bookings accordingly to avoid them being interrupted.
- The hospital had access to translators using the telephone and interpreters could be arranged in advance for appointments.
- The hospital was wheelchair accessible and had lifts available for all patients to use.
- Patients were provided with documentation regarding charges for planned treatments prior to their appointments. Staff told us that it was important that any additional costs that may be incurred were explained to patients in a clear and sensitive manner.

Learning from complaints and concerns

- The hospital had a complaints management policy, for detailed findings about complaints please see main surgery report.
- There was clear information on display in outpatient and radiology department waiting areas advising patients and those accompanying them how to make a complaint.
- Staff told us about changes made as a result of learning from complaints. For example, staff told us about a complaint made when a patient arrived for a procedure and was seen by a male technician. There was no record that the patient had been offered a chaperone or advised that the technician may have been a male. As a result of this, the hospital updated their chaperone process and added a stamp to patient records to denote that a chaperone had been present. The information that was sent to patients prior to their appointments was updated to say that specific procedures may be conducted by a male technician and patients could have a chaperone present.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- The outpatients department was led by the outpatient sister and the diagnostics imaging department was led by an imaging manager. All staff that we spoke with told us that their leaders were visible and approachable.
- Both the outpatient sister and diagnostic imaging managers were established members of staff and had experience in the NHS and independent care environments.
- Staff told us that they saw the hospital manager on a daily basis and felt that they could voice their concerns and they would be listened to at all levels.
- Staff at all levels told us that they felt that they delivered good quality patient care because they had the capacity and time to plan and support patients and those accompanying them.
- The diagnostic imaging manager had developed clear systems to monitor performance and safety. Some staff felt that the amount of paperwork and forms could be challenging; however, they understood the importance of recording data to improve safety and performance. Staff told us that they felt the situation with paperwork would improve with advances in technology.
- The diagnostic imaging department had an integrated care record that incorporated the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for interventional radiology. There were processes in place to regularly audit the practice to identify best practice and areas for improvement (please see main surgery report for detailed findings of WHO surgery safety checklist audit results).
- There was an organisational 'being open' policy related to duty of candour. In the outpatients department, all staff had been issued with a copy of the guidance and staff in diagnostic imaging were aware of the regulation. All staff told us that if they needed support with duty of candour conversations or advice they would speak with the hospital manager.

Good

Outpatients and diagnostic imaging

- Patients told us that they had received information about the terms and conditions of their treatment, including fees if they were self-funding. There was clear guidance in treatment rooms explaining the fees for extra tests or medicines that were additional to the original quote. Nursing staff told us that it was imperative to ensure that patients were kept informed of fees to manage expectations and be open and transparent.
- Staff we spoke with told us that they felt respected and valued by their peers, teams, organisation and patients.
- There was a strong emphasis on promoting the safety and wellbeing of staff. The organisation had developed a wellbeing strategy, which some staff told us about, that was designed to ensure staff had a good work like balance and access to support if needed.

Vision and strategy for this core service

- All staff we spoke with were aware of the corporate values, which were 'Enterprising, Passionate, Independent, Caring – EPIC'. The organisational strategic intent was to '…help individuals achieve, maintain and recover to the level of health and wellbeing they aspire to, by being a trusted provider and partner'.
- Staff in outpatients and diagnostic imaging were aware of plans for improvements in areas such as improving the electronic records system.
- The hospital had a clear plan on how they were going to expand provision of services through marketing and working with other local providers and commissioning bodies.

Governance, risk management and quality measurement

- The governance processes were hospital wide; for more detailed findings on hospital governance processes, please see main surgery report.
- There were effective governance arrangements in place for the outpatient and diagnostic imaging departments. Each head of department attended hospital wide governance, infection prevention control and medicines management meetings.
- There were processes in place to monitor quality and compliance to protocols in outpatients and diagnostics. For example, the diagnostics department had a structured audit programme to monitor compliance to IR(ME)R requirements. There were processes in place to ensure that equipment and protocols related to ionising radiation were regularly reviewed and staff received support from an appropriate external radiation protection advisor. For example, there was an annual radiation protection report conducted by an external auditor and regular national meetings to discuss radiation protection requirements and protocols.
- The departments both attended monthly departmental and hospital wide governance meetings to discuss incidents, performance, workforce issues and clinical guidance.
- Outpatients and diagnostic imaging had departmental risk registers, which highlighted the main risks for each area. The departmental risk registers were incorporated into the hospital risk register to allow oversight at all levels. Risk registers were reviewed regularly and updated quarterly.

Public and staff engagement

- The hospital conducted an annual staff survey to receive feedback from staff. In the 2016 annual staff survey 100% of staff in outpatients and diagnostics imaging said they would recommend the hospital to friends and family. The survey showed that 94% of staff said they understood and championed the mission and purpose of the organisation, 89% of staff said that they had regular conversations with their line manager about their development and performance and 89% of staff felt that they had the right tools to do their job well. There were also monthly newsletters and staff briefings held to encourage staff to give feedback.
- Staff in outpatients told us that they were developing a tool to collect patient feedback. There was no timescale for when this would be implemented.
- Patients were encouraged to leave feedback and testimonials on the hospital's public website.

Innovation, improvement and sustainability

- There were hospital wide plans to improve the services in all areas, please see main surgery report for detailed findings.

Good

Outpatients and diagnostic imaging

- Some staff told us about different initiatives that the organisation was exploring and planning to implement such as, the integrated electronic patient record and new staffing models to ensure the right person was in the right place at the right time.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital held regular open events for the public, whereby, they could visit the hospital and attend sessions about a variety of procedures or conditions, such as varicose veins.
- A consultant surgeon would hold 'lunch and learn' sessions with the local GPs, to discuss what procedures they carried out at the hospital.
- A large toy car was stored in the play area for children who wanted to drive themselves to theatre for their operation rather than walking or being transported on a hospital bed.
- A children and young people (CYP) satisfaction survey had been developed to capture service user feedback from children, young people of all ages and their parents. The survey responses were small (six) as this was a pilot of a small service. All responses were positive and praised the care and support of all the staff the child and their parent had come in contact with throughout their care episode. The survey encouraged younger children to draw their experiences on the form. For example, a child had depicted themselves as having 'new super powers' following their surgery. The survey had been piloted, and following a review would be circulated to all CYP attending the hospital in early 2017.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should ensure that medical services audit results from the hospital's local audit programme are available to ensure the effectiveness of care and treatment provided is evaluated.
- The hospital should ensure that the oncology service is routinely collecting and monitoring information about the outcomes of patient's care and treatment to ensure that the intended outcomes are achieved.
- The hospital should ensure that medicines are always stored at an appropriate temperature.
- The hospital should ensure that the World Health Organisation safer surgery checklist is followed, including its accurate documentation, particularly in endoscopy.
- The hospital should ensure that all risks are identified, assessed and mitigating actions taken in a timely manner.
- The hospital should ensure that risk assessments to keep patients safe are reviewed regularly, particularly in services for children and young people.