Nuffield Health Woking Hospital

Quality Report

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

Nuffield Health Woking Hospital is operated by Nuffield Health. The hospital has 26 beds. Facilities include two operating theatres, a ward that provides level one care, and X-ray, outpatient and diagnostic facilities.

The Nuffield Health Woking Hospital provides surgery and outpatients and diagnostic imaging. We inspected both of these core services.

We inspected this service using our comprehensive inspection methodology. We carried out announced inspection on the 8 and 9 November 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 outpatient and surgical care:

- There were arrangements to report and investigate any critical incidents and to learn from these.
- Risks were identified and managed to minimise the risk of harm to patients and others.
- Patients were cared for in a clean and hygienic environment and there were systems to prevent and control the risk of infection. The environment was safe and generally fit for purpose. There was adequate equipment available which was well maintained.
- There were adequate numbers of staff with the skills experience and qualifications to meet patients' needs. They were competent to do their jobs and were supported in developing their skills.
- Care was delivered in line with national guidelines and patients experienced good clinical outcomes.
- Patients' pain was well managed.
- Patients received adequate food and drink that met their needs and were not fasted for longer than necessary.
- Patients were treated with dignity and respect, and were involved in planning their care. There were arrangements to ensure that individual's needs were met.
- Patients could access care and treatment when they needed it without undue. They could access treatment by a full range of health professionals and there were arrangements to ensure safe care both in and out of hours. Discharge procedures ensured continuity of care with patients GP's or other health care professionals.
- Complaints were well managed and comments were used to improve the service.
- There was a well understood vision, values and strategy for the service which prioritised safe care.
- There were robust governance systems that ensured the leadership team were assured of the quality and safety of the service.
- Staff felt well supported by the leadership team who were approachable and highly visible. They felt involved in the ongoing development of the hospital.

Summary of findings

However, in out-patients we also found the following issues that the service provider needs to improve:

- The keeping of an accurate, complete and contemporaneous record in respect of each patient.

Following this inspection, we told the provider that it must take one action to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected outpatient and diagnostic services. Details are at the end of the report.

Professor Edward Baker

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. There were systems to keep people safe, these included systems to manage medicines, the risk of infection and the identification and management of risk. Staff understood their responsibilities in relation to reporting incidents and safeguarding those in vulnerable circumstances. There were adequate number of staff at all times to meet the needs of patients who were competent and supported to do their jobs. Care was delivered in line with national guidance and patient outcomes were good when benchmarked. Patients were satisfied with their experience and were treated with dignity and respect. They were involved in their care and treatment. Patients could access care when they needed it and there were arrangements to ensure their individual needs were met and patients consented to their treatment. Complaints were well managed and lessons learnt to improve the service. Staff understood the vision, values and strategy of the hospital and demonstrated this in their work. There were robust governance arrangements which meant the leadership team could be assured of the quality and safety of the service. Staff felt supported by their leaders who were approachable and visible in the clinical areas.
Outpatients and diagnostic imaging	Good	Staff reported safety incidents which were appropriately investigated. Lessons were learnt and staff received feedback when they reported incidents. The environment was visibly clean and fit for purpose. There were arrangements to control the risk of infection. All equipment used was well maintained. Medicines and prescriptions were managed in line with relevant legislation.

Summary of findings

In the diagnostic imaging department there were systems to control and manage risks associated with ionising radiation.
There was sufficient numbers of appropriately skilled staff to meet patients' needs.
Patients reported they were treated with compassion and their privacy was maintained.
Patients could access care when they needed it and the hospital met national and local waiting time standards.
However, we found that the hospital did not always maintain a complete and contemporaneous record of care and treatment in the outpatient department.

Summary of findings

Contents

Good

Nuffield Health Woking Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Woking Hospital

Nuffield Health Woking Hospital provides private surgical and outpatient and diagnostic services to residents of the Woking area in Surrey and opened in 1962. The hospital primarily serves the communities of the Woking area. It also accepts patient referrals from outside this area The hospital is situated in a residential area in the second most affluent area in the UK (outside of London) where private medical insurance levels are significantly higher than the national average.

The hospital does not offer surgical services or invasive procedures undertaken on an outpatient basis to anyone under the age of 16 years, although 16 and 17 years olds are accepted. The hospital provides some out-patient services to children three to 16 years of age.

The hospital also offers assisted conception services in a dedicated unit, the Victoria wing. As these services are licenced and regulated by the Human Fertilisation and Embryology Authority (HFEA) we did not inspect them as part of this inspection. HFEA Last inspected in July 2015 and granted a licence which expires in September 2019.

The hospital has been registered with the CQC to carry out the following regulated activities since 2010:

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

Additionally, it has been registered for the regulated activity of family planning since 2012.

The hospital has had a registered manager in post since 2010. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in September 2016.

The hospital has been inspected twice in and the most recent inspection took place in October 2013 which found that the hospital was meeting all standards of quality and safety it was inspected against. This is the first inspection of this service using our new methodology. There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

We carried out an announced inspection visit on the 8 and 9 November 2016.

Our inspection team

The team that inspected the service was led by Shaun Marten, CQC inspection manager. It comprised two CQC inspectors, and three specialist advisors with expertise in surgery, surgical nursing and radiography. The team also included and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them. The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Information about Nuffield Health Woking Hospital

The hospital has one ward with 26 beds and six chair recovery spaces. There are two operating theatres. Patients are cared for in single, en-suite rooms which means there is no mixed sex accommodation.

There is a separate outpatient department which includes physiotherapy services. The main service provided is in-patient and day surgery, and out-patient services. These services are supported by a pathology department which provides on-site testing for haematology and biochemistry and an imaging department which provides ultrasound, digital mammography, fluoroscopy and general X-ray. There is also an-on-site pharmacy.

Summary of this inspection

Nursing and therapy staff work in their departments and generally do not work in other departments in the hospital. The resident medical officer is available to all clinical areas.

During this inspection, we visited the ward, theatres and out-patients departments. We also visited the clinical support services. We spoke with 34 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners and senior managers. We spoke with 19 patients and one relative. We also received 19 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 16 sets of patient records.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 3,971 inpatient and day case episodes of care recorded at the hospital; of these 43% were NHS-funded and 57% other funded.
- Seven per cent of all NHS-funded patients and 21% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 12,984 outpatient total attendances in the reporting period; of these 21% were other funded and 79% were NHS-funded.

Staffing

There are 136 medical staff with practising privileges including surgeons, anaesthetists, physicians and radiologists. Two regular resident medical officers (RMO), employed under a Nuffield Health Group contract with an external agency work a seven days on duty, seven days off rota.

The hospital employed 21.9 full-time equivalent (FTE) registered nurses, x8.4 FTE care assistants and operating department practitioners, and 70.3 FTE other staff as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager of another Nuffield hospital, but the registered manager of this hospital had submitted an application to become the accountable officer, which was being progressed at the time of our inspection.

Track record on safety (July 2015 to June 2016)

- One never event reported
- There were 256 clinical incidents reported.Of these 200 were graded as causing no harm, 49 as low harm, seven and as moderate harm. None resulted in severe harm or death
- Four serious injuries were reported
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) reported
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA) reported
- No incidences of hospital acquired Clostridium difficile (C.diff) reported
- No incidences of hospital acquired E-Coli reported
- No incidents of hospital acquired venous-thrombo embolism (VTE) or pulmonary embolism (PE) reported
- Twenty complaints were received by the hospital, but none were received by the CQC

Services accredited by a national body:

- BUPA Breast service accredited (2013)
- Clinical Pathology Accreditation (UK) Ltd May (2014)

Services provided at the hospital under service level agreement:

- Catering
- Clinical equipment maintenance
- MRI/CT scanning
- Electromyogram (EMG)
- Facilities management
- Resident Medical Officer
- Scope processing
- Vascular imaging

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:

- There was an emphasis on safety with a good reporting and learning culture for incidents. There were arrangements to manage medicines safely, to minimise the risk of infection and to safeguard those in vulnerable circumstances.
- Equipment and the environment were well maintained. There were systems to ensure that the risks of ionising radiation in the imaging department were appropriately managed.
- Patients were appropriately risk assessed and monitored throughout their stay and there were low levels of hospital acquired harms.
- There were appropriate levels of both consultant nursing and other staff to meet the needs of patients at all times, including weekends. Staff underwent a programme of mandatory training to maintain key skills.
- There were robust plans to ensure business continuity. These had been tested and were effective.
- Records were generally securely stored, were accurate, contemporaneous and comprehensive. However, we also found the following issue that the service provider needs to improve. In out-patients the hospital did not always keep a complete record which was a breach in regulation. You can read more about it at the end of this report.

Are services effective?

Good

We rated effective as good because:

- Care and treatment was based upon recognised best practice and national guidelines. Patient outcomes were monitored. These demonstrated patients experienced good outcomes of their care and treatment when benchmarked.
- Patients' pain was well managed.Their needs for and fluids were assessed and they received sufficient food and drink to meet their needs. They were fasted for minimum periods of time.

Summary of this inspection

- Patients could access care from the full range of health professions who worked as an effective team. There were arrangements to ensure services were available seven days a week. Staff were able to access clinical information that enabled them to care for patients.
- Staff were supported to develop their skills and gain further qualifications. There was an appraisal process which identified their learning and other development needs.
- Patients consented to their treatment and were given adequate information and time to make informed decisions. Generally, people understood their responsibilities when patients lacked the capacity to make decisions. However, we found an example where capacity issues had not been fully considered which the management team acknowledged this demonstrated a need for further training.

Are services caring?

Good

We rated caring as good because:

- Patients consistently gave positive feedback about the care they had received. We observed staff providing people with treatment in a kind and considerate way that protected privacy and upheld their dignity.
- The results patients surveys and were positive. Friends and Family Test results were better than national averages. Patient Led Assessments of the Care Environment exceeded national averages for assessments of dignity.
- Patients were given appropriate information about their care and treatment and told us they felt involved in decisions about it.
- There were arrangement to meet the emotional needs of patients and those close to them.

Are services responsive?

Good

We rated responsive as good because:

- The hospital worked with other stakeholders to meet the needs of the local population. Regular contact with external stakeholders and the provider's corporate marketing function meant that these needs were identified and addressed.
- Patients could access care when the needed it. Waiting lists were minimal and national waiting time standards were consistently achieved.

Summary of this inspection

- The needs of individual patients were assessed and plans made to meet them. There were arrangements to meet the needs of those with a learning disability or living with dementia. The cultural needs of patients could be catered for, although the local population was not particularly diverse.
- Complaints were taken seriously. They were investigated and responded to in line with the provider's policy. There was learning from complaints and concerns with changes made to improve the service as a result of them.

Are services well-led?

Good

We rated well-led as good because:

- The hospital had a clear vision strategy underpinned by explicit values. These were well understood by all staff. Staff felt involved in development at the hospital.
- The leadership team were focussed on safety and quality and were changing the range of services, and the way in which they were delivered to further improve safety and to ensure sustainability. The leadership team showed an awareness of the current challenges and risks to the hospital; and how these could be addressed.
- There was a robust governance and risk management structure. This was well understood by staff and gave the leadership team appropriate assurance about the quality and safety of the service.
- Staff felt supported by the leadership team, and their local managers. Leaders were visible, approachable and credible. Staff felt involved in the running of the hospital and in its future strategic direction. They felt engaged in the change process and received sufficient information.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Although one element of safety requires improvement, the overall standard of service provided outweighs those concerns. We have deviated from our usual aggregation of key question ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure that incidents were identified, reported, investigated, and learned from to prevent recurrence.
- Staff reported incidents on an electronic reporting system. Documents we saw showed the investigation process and learning outcomes. Meeting minutes confirmed lessons learned were communicated with staff. The staff we talked with was able to tell us of the learning outcomes from such events.
- Documentary evidence showed us that trends and themes from incidents were reviewed at a local, regional, and national level. This meant that extensive learning from incidents took place and helped prevent recurrence.
- The provider reported four serious injuries in the period (July 2015 to June 2016). This number of serious injuries was not high when compared to a group of independent acute hospitals, which submitted performance data to CQC.
- There were a total of 256 clinical incidents in the reporting period (July 2015 to June 2016). Out of the 256 clinical incidents, 77% occurred in surgery or inpatients. Whilst the actual number of reported incidents was noted as high, the large majority of the incidents reported were 'no or low' risk incidents and did not relate to clinical care. This suggested there was a good reporting culture at the hospital
- The provider reported four serious incidents (SI's) in the period July 2015 – June 2016. We saw the SI's were subject to in-depth investigation and review through the various governance processes to help prevent recurrence. Staff were able to tell inspectors about the learning from these incidents.
- Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The Nuffield Health Woking Hospital reported one never event between June 2015 and June 2016. This related to an incorrect lens insertion. A full investigation was completed and there was we saw evidence the provider applied the duty of candour. The investigation led to changes in practice across ophthalmology. Staff were able to tell inspectors about the incident and the changes to practice as a result. This demonstrated embedded learning from this incident.
- 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 understood their responsibilities with regard to the duty of candour legislation.

- Mortality and morbidity was routinely monitored through the quality and governance structure as well as the regular Medical Advisory Committee (MAC) Meetings. This was recorded in the meeting minutes we reviewed.
- Medicine errors were reported via the electronic reporting system. These were investigated by the incident reviewer and had pharmacy input.

Clinical Quality Dashboard

- There were systems and processes to measure the quality of care delivered at the Nuffield Hospital. Data provided to CQC showed us harm free care was delivered to patients.
- Falls, venous thromboembolism (VTE) and urinary catheter care were assessed by the service. These assessments were regularly audited to ensure safe care.
- VTE, for the period July 2015 to June2016 showed no incidents of hospital acquired VTE or Pulmonary Embolism (PE) were identified in the reporting period. Audit data showed that VTE and falls assessments were completed in 95% of cases.
- Documents we viewed demonstrated that patient safety information was reported and measured through the hospital's own quality and safety dashboard. Outcomes were reviewed and compared at local and national levels.

Cleanliness, infection control and hygiene

- There were systems to ensure the patients were protected from the risk of health-acquired infections. There were appropriate policies and guidance in place that reflected national guidance and best practice. Staff were aware of the contents of these policies and able to apply them in practice.
- The hospital had an infection prevention and control (IPC) team with input from the local consultant microbiologist. The team fed into the integrated governance group and medical advisory committee (MAC). The infection prevention and control (IPC) committee met monthly and discussed all items to do with IPC including the overview of infections reported. We saw the minutes of meetings for July and August 2016. IPC for the hospital had a quality improvement programme of audits for 2016, made up of five audits carried out at different timescales. These included cleanliness and the environment (quarterly), hand hygiene observations (quarterly), standard precautions (annual), hand hygiene facilities (annual) and hand hygiene competency assessment (annual).
- No episodes of Meticillin-Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C Diff) or Escherichia coli (E-Coli) were reported between June 2015 and July 2016.
- A recent Patient Led Assessment of the Care Environment (PLACE) scored cleanliness throughout the hospital as 100%. This was higher than the England average of 98%.
- All the areas we visited were visibly clean. We saw cleaning records that showed us areas were cleared regularly in line with best practice guidelines. Records also showed us that regular curtain changes occurred in the recovery area as well as deep clean in theatre suite.
- We saw evidence of continuous audit processes to monitor the standard of cleanliness across the department.
- We observed clinical waste was handled, stored, and removed in line with national guidance, HTM 07-01, Control of Substances Hazardous to Health and the Health and Safety at work regulations.
- Sharps bins were labelled dated and not over filled in all the clinical areas we visited. This was in line with the Royal College of Nursing Guidance to support the implementation of The Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.
- Reusable devices were routinely cleaned, labelled, and dated by staff. This provided assurance that items were cleaned before use.
- Staff had access to an ample supply of personal protective equipment (PPE). We saw staff using PPE appropriately when interacting with patients and were observed washing their hands in between patient contacts the World Health Organisation (WHO) 'Five moments for hand hygiene'.
- Staff in theatres adhered to the strict theatre dress code to minimise the risk of infection.
- As the ward area comprised of individual rooms, the provider was able to meet the care needs of patients who required isolation.

Good

Surgery

- We reviewed documentation which demonstrated Nuffield Healthcare routinely tested water quality and theatre air flow in theatres. Results showed compliance with the Health and safety Executive: The control of legionella bacteria in hot and cold water systems HSG274 (2014) and Facilities for surgical procedures and the Department of Health (DOH) guidance for airflow HBN 26 2004.
- We observed theatre staffs scrub technique (the process by which staff prepare for surgery) and found it reflected national guidance.
- Seven surgical site infections were reported between June 2015 and June 2016. The rate of infections during primary hip arthroplasty, primary knee arthroplasty, other orthopaedic and trauma, breast and urological procedures was above the rate of other independent acute hospitals that CQC hold data for. The rate of infections during primary hip arthroplasty, primary knee arthroplasty, other orthopaedic and trauma, breast, and urological procedures were above the rate of other independent acute hospitals that CQC hold data. There was no surgical site infections reported resulting from revision hip arthroplasty, revision knee arthroplasty, spinal, gynaecology, upper Gastro Intestinal (GI) and colorectal or vascular procedures.
- There was a service level agreement (SLA) in place with an accredited provider to manage the decontamination of reusable medical devices. We saw equipment was transferred between sites daily and operating sets were checked before use to ensure sterility. This was in line with the Health Technical Memorandum 01-01: Management and decontamination of surgical instruments.
- There were robust systems to ensure the traceability of reusable medical devices and prosthesis. This was demonstrated in the surgical care pathways and the theatre registers we viewed.
- We noted that there was carpet on one side of the ward and in the side rooms. This did not comply with national guidance. HBN 00-09 for flooring section 3.108 states 'the quality of finishes in all clinical areas should be readily cleaned and resilient' and section 3.109 'flooring should be seamless and smooth, slip-resistant and be easily cleaned'. HBN 00-09 section 3.115 for carpets states 'carpets should not be used in clinical areas. Included in this are all areas where frequent spillage is anticipated. However, renovations had already been completed on one side of the ward and the second phase of floor replacement was due to start after the inspection. This meant the senior management team had taken the appropriate action to manage the risk of health acquired infections and to address the noncompliance with national infection control guidance.

Environment and equipment

- Patients were protected from the risk of foreseeable emergencies because suitable equipment and competent staff were made available.
- Resuscitation equipment was available in clinical areas. This equipment was easily accessible and regularly checked in line with best practice guidance.
- Theatres equipment including anaesthetic machines and difficult intubation airway trolley was available. Records we viewed showed regularly checks of this equipment were carried out daily.
- The hoist, lifts, theatre tables and beds were designed to take in excess of 200 Lbs. This meant that they were safe to use when providing care to bariatric patients. Bariatrics can be defined as a branch of medicine that deals with the causes, prevention, and treatment of obesity.
- We found robust systems to aid the traceability of surgical implants and prosthesis.
- Staff demonstrated regular safety and temperature checks for the blood storage fridge in theatres. This was confirmed by records we viewed.
- The hospital had a Patient Led Assessment of the Care Environment (PLACE) and performance was noted as good. The PLACE scores were the same or higher than the England average for the Hospitals condition appearance and maintenance was reported as 96%, higher than the England average.
- We found there were appropriate SLA's for the maintenance of equipment and clinical waste management.

Medicines

- The provider ensured medications were stored and handled appropriately in line with national guidance.
- Controlled drugs can be defined as a set of drugs that have some potential for abuse or dependence. We reviewed the Controlled Drug (CD) registers on the ward and theatre areas. CD's were tracked and signed out by two members of staff at all times. The records seen showed us that staff were checking the stock levels of CD's in line with the hospital policy.
- The temperature of fridges where medicines were stored were recorded daily, in line with best practice. This provided assurance the unit stored refrigerated medicines within the correct temperature range to maintain their function and safety.
- Medication was administered at the prescribed time. This was reflected on the medication administration charts (MAR) that we reviewed and in the conversations we had with patients.
- There were appropriate systems for ordering and returning medication to the pharmacy department.
- Tablets to Take Away (TTA's) were provided to patients upon discharge. The pharmacists dispensed the medication during working hours and ward nurses dispensed medication outside of normal working hours. Patients we talked with confirmed that they had received adequate information about their medication before they were discharged.
- We found patients had "as required" medicines routinely prescribed on their MAR charts. This meant that the patient could have these medicines without delay.
- Staff had their competency in administrating medications continuously assessed through a competency based framework. This was evidenced by the training documents we viewed and the conversations we had with staff.
- The pharmacy team had auditing systems and processes to ensure the safe medication practices. This included a robust competency based teaching programme for nurses that was delivered on a one to one basis from the lead pharmacist.
- We observed the hospital had secure stores for medical gas cylinders.

Records

- The records we viewed were generally found to be accurate, fit for purpose, and stored securely. However, it was noted that the handwritten surgical operation notes were difficult to read.
- The patient records we viewed were generally found to be signed, dated, legible, complete, and contemporaneous.
- Patient care records were routinely audited and identified areas of non-compliance was addressed.
- Medical records were stored onsite in the hospital. This meant there was easy access to patient's records for staff. However, records were predominantly paper based which had been identified as a potential risk to the organisation by the hospital .The management of the Nuffield Woking were already aware of this and were in the process of making the necessary changes to infrastructure to change to electronic records in 2017.
- We noted that none of the notes we viewed had a GP referral record, with one exception. We discussed this with senior management and were told that these concerns had already been identified as a risk and was being addressed. We saw there an appropriate plan was to address this.

Safeguarding

- The Nuffield Health Hospital Woking had systems to safeguard adult patients who may be identified as at risk of abuse.
- No safeguarding concerns reported to CQC in the period July 2015 to June 2016.
- Staff we spoke with described safeguarding training as part of their mandatory training andtold us that safeguarding was part of staff induction. The staff we talked with were able to tell us about how to recognise a safeguarding and how to report it. This included the identification and reporting of patients who may have been subjected to female genital mutilation (FGM). This meant that staff had the knowledge necessary to safeguard adult patients in vulnerable circumstances.
- Ninety two per cent of all staff had attended safeguarding children level 1 and 90% safeguarding

adult's level 1. Level two safeguarding children and young adults were relevant to seven members of staff and 100% had attended. Three members of staff had received level three safeguarding for children

- Records showed us that that all hospital staff had received level 1 training for adults and only those identified by the hospital were to be trained to level two.
- The hospital had an identified clinical lead for both adult and child safeguarding.
- However the Safeguarding children and young people (2014) – Intercollegiate guidance

  states that the lead professional for children should have received level 4 safeguarding training. The nominated lead professional had not received this training.
- The management team had identified that the hospital was not able to meet the care need of children and young people according to current guidance. Therefore, the hospital director had given three months' notice to all departments, consultants, and external stakeholders that the Nuffield Health Woking Hospital would cease to provide children's and young peoples' services. We saw emails confirming this and our conversations with departmental staff showed they were aware of this change in service. No children were booked to have surgery for December or January and the small numbers who were due to attend for a surgical outpatient appointments were at the end of their care journey at the hospital.

Mandatory training

- There was a programme of mandatory training that enabled staff to undertake their jobs in a safe way. Training modules provided included incident reporting, fire safety, health, safety and welfare, managing stress and whistleblowing. Mandatory training was provided through online or face to face teaching sessions
- The hospital's target for mandatory training compliance was 90%. The records we viewed demonstrated that staff had achieved a compliance rate of 89%.
- Training records were held centrally by the Human Resources, (HR) team. We found good local oversight in the clinical areas.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Nuffield Health Woking Hospital had written admission criteria to ensure it could meet the need of patients who used the service. Patients who used the service had their care risks assessed to ensure their needs could be met before they came into hospital.
- All patients had an appointment with the pre assessment nurse to have their care needs assessed before admission. This was an important process as the hospital offered level one care only. The documents we viewed demonstrated that this process reflected the Nuffield admission criteria
- We saw records that showed patients were assessed against the American Society of Anaesthesiologists (ASA) criteria before admission. The ASA score is a subjective assessment of a patient's overall health that is based on five classes (I to V). Patient is a completely healthy fit patient. Patient has mild systemic disease. Patient has severe systemic disease that is not incapacitating.
- The department had a National Early Warning Scoring tool (NEWS) in place. An early warning system can be defined as a guide used by medical services to quickly determine the degree of illness of a patient. The records we viewed showed that patients had these assessments undertaken regularly. If a concern were noted then a medical review was be carried out. On the rare occasions, when a serious risk to a patient was identified, the patent was transferred to a local NHS organisation. We saw there was appropriate SLA's with a local NHS provider to ensure the safe transfer of patients who deteriorated and required an increased level of care.
- Patients received resident medical officer (RMO) reviews in a timely manner. This was evidenced in the medical records we viewed and in the conversations we had with patients.
- The theatre department had implemented the World Health Organisation (WHO) five steps to safer surgery. We observed the theatre team undertaking the briefing, sign in, time out, sign out and debriefing stages. There was an established audit process to test compliance with the demonstrated 100% compliance for the month of September 2016.

Good

Surgery

- Staff were able to provide inspectors with examples of when the WHO checklist had prevented wrong site surgery in the department.
- We saw a briefing undertaken, in theatre, by all staff before a procedure began. This meant there was a high standard of pre-operative checking and an embedded culture of patient safety in theatres.
- We were provided with verbal and written assurances that there were systems to refer patients who wanted cosmetic surgery for a psychological assessment if necessary.
- We saw one patient whose BMI (Body Mass Index) exceeded the admission criteria. The CQC Consultant specialist advisor reviewed the medical records for this patient. The records showed us that this patient had gone through an extensive pre assessment with medical oversight, to ensure the hospital could manage this persons care needs safely.
- Patient allergies had been clearly noted on their paper notes, medication chart and on their identity band, which alerted staff to their allergy.
- Medicines were readily available for the emergency treatment of malignant hyperthermia (MH). MH can be defined, as is a rare condition that causes a fast rise in body temperature and severe muscle contractions when someone with the disease gets general anaesthesia.

Nursing and support staffing

- The Nuffield Health Woking Hospital was not using a staffing tool at the time of the inspection. The senior management team told us that they had tried various staffing tools but they felt that they did not provide optimal staff numbers for their department. The use of these tools was discussed though governance and MAC processes. It was agreed that the department would not use a staffing tool but that the matron reviewed the staffing levels on a daily basis.
- These reviews looked at patient numbers, dependencies and staff competency. This allowed the department to achieve optimal competent staffing levels that reflected the needs of the service. Evidence of continuous staffing reviews was documented. Staffing was also a standing agenda item at the weekly planning meeting held each Friday.
- Data provided to CQC showed a high level of qualified staff in the overall skill mix in the surgical department.
- Handovers occurred three times a day on the ward. We observed the lunchtime handover and judged it sufficient at communicating patients individual care needs.
- The ward area did not use agency workers. If additional staff were required they were sought from the internal staff bank. Use of bank and agency nurses in inpatient departments was generally lower than the average of other independent acute hospitals we hold this type of data for. There were no agency nurses working in inpatient departments in the last three months of the year July 2015 to June 2016.
- Use of bank and agency nurses in theatre departments was lower than the average of other independent acute hospitals that CQC hold this type of data for. The use of agency operating department assistants and health care assistants was zero. There was some use of these staff from the hospital's own bank.
- There were no vacancies for inpatient nurses, inpatient health care assistants or other staff as at 1 July 2016.
- Sickness rates for nurses working in the theatre department was also generally lower than the average when compared to other independent hospitals.

Medical staffing

- A Resident Medical Officer (RMO) provided medical cover twenty four hours a day. The Hospital had a regular rotation of two RMOs, who were provided by an agency. Each RMO had worked at the hospital for over a year. We reviewed the SLA between the hospital and the agency and human resources files to ensure that all the necessary recruitment checks had been carried out.
- Staff told us they had sufficient and prompt medical doctor cover that was available to meet patient's needs.
- The surgical department had 24 hour consultant led care with each consultant taking responsibility for their own patients. Consultants remained on call whenever they had patients in the hospital. Staff told us that the on call system worked well and that consultants came to the hospital when called.

Good

Surgery

- The hospital's consultant anaesthetists were part of a consortium based within the hospital. This meant that there was a group of consultant anaesthetics who provided continuous anaesthetic cover to the hospital twenty four hours a day.
- Evidence of both anaesthetic and surgical consultant cover was available and the cover list was readily available for staff should they need to make contact.
- The consultants worked under practising privileges agreements. The granting of practising privileges is a well-established process within independent l healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice. We saw the evidence that the provider had complied with legal duty to ensure regulation 19 in respect of staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw these agreements were in place for all medical staff with practising privileges.
- The hospital had 136 consultants working with agreed practising privileges. This related to consultants in post 1 April 2016 with more than 12 months service. The hospital confirmed all medical staff had been fully trained to perform a procedure which they regularly performed within their NHS practice.

Out of Hours cover

- The RMO worked weekly shifts. They were resident in the hospital for seven days at a time. RMO to RMO handovers occurred on a Monday morning. Consultants handed over the care of their patients to the RMO on an individual basis.
- The Nuffield Health Woking Hospital provided 24 hour consultant-led care. There was a 30 minute attendance timeframe. Each consultant had their journey checked before obtaining practising privileges. We saw evidence of this when we reviewed a sample of personnel files. This meant that consultants were able to make it to the hospital within 30 minutes of being called in which avoided unnecessary delays to patient care.
- Consultant anaesthetists provided continuous medical cover and consultant surgeons provided cover for their own patients. There were systems in place to ensure adequate cover should the surgeon take leave.
- A radiographer, physiotherapist, pharmacist, and biochemist also provided an on call service out of hours. We viewed the on call rotas which provided evidence of cover.
- The hospital had an SLA with a local NHS healthcare provider to ensure the patients had access to an emergency imaging and image reporting services which we reviewed.

Emergency awareness and training

- There was an emergency incident plan for staff to access and follow. This plan had been tested with a recent ingress of water and was found to be robust.
- Management told us that staff took part in regular life support and emergency scenarios training. The RMO's also participated in these sessions in order to ensure familiarity with local processes. Staff confirmed this during our inspection.
- Records showed that fire alarm testing occurred regularly. Staff were able to tell inspectors where their various assembly points were. This meant they were aware of their individual roles and responsibilities should a fire occur.
- We saw the records to show the hospital's cardiac alarm system was tested in the morning everyday Monday to Friday and the fire alarm was tested each week on a Tuesday.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Policies and procedures used within the surgical department and the hospital as whole, followed evidence based practice.
- We saw national initiatives were enacted. For example, "Sepsis Six" guidance is the name given to a bundle of

medical therapies designed to reduce the mortality of patients with sepsis. We saw posters in clinical areas reminding staff about the importance of recognising sepsis. Staff were able to tell inspectors what interventions were necessary to treat a septic patient.

- Venous Thromboembolism (VTE) assessments and prophylaxis were embedded in pre-operative care planning. This was routinely audited to measure quality and risk. The audit data and the medical records we viewed demonstrated compliance during the inspection.
- The Nuffield Health Woking Hospital had a comprehensive audit programme and monitored the care provided against its own policies and standard operating procedures. This audit programme reflected local and national audit requirements and results were used to influence change. This demonstrated the care delivered was evidence based and regularly monitored to ensure it was meeting national guidelines and recommendations.
- There was a monthly review of National Institute for Health and Care Excellence (NICE) Guidelines and technical appraisals. All new procedures were subject to Medical Advisory Committee MAC review and authorisation.
- The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. Data submissions were also made for those patients admitted for joint replacements. This meant that that surgeon and implant performance, as well as implant failure, and patient-reported outcomes can be measured effectively at national level.
- All new procedures were subject to MAC review and authorisation. The process of granting of practising privileges reflected NHS Scope of Practice
- We noted that women of childbearing age were not routinely offered a pregnancy test. This was not in line with the Pregnancy Testing – Standard Operating Procedures Nuffield Health Glasgow policy. New guidance form NICE (preoperative tests for elective surgery CG2) has been published in April 2016 which states the necessary steps need to manage the risk to patients who may be pregnant. This meant that the local policy no longer reflected national guidance and all though the hospital was not fully following the local policy practice was in line with the most recent guidance.

Pain relief

- Patients and had their pain needs met during their admission to the Nuffield Health Woking Hospital. A pain scoring tool was in use. We viewed records which demonstrated patients' pain was regularly assessed and addressed by staff. Baseline pain scores were recorded at patient's pre-operative assessments. This meant that there was a recorded a pre-operative pain score in place to aid post-operative pain assessment. We observed ward and theatre staff routinely audited the effectiveness of pain relief using a (Nuffield Health) scoring tool of 1 -10 which was well understood by patients.
- We saw patients had regular analgesia prescribed on their Medical Administration Record (MAR), as well as "as required" (PRN) medication for breakthrough pain.
- During the inspection we saw one patient whose pain needs were greater than expected post operatively. They had received a medical review and had additional analgesia prescribed and advised to stay in hospital until their pain was well controlled. This demonstrated that patients had their care needs assessed and their care plan adjusted to reflect their individual needs.
- The patients we talked with told us their pain was well controlled and that they received their medication in a timely manner.
- The consultant anaesthetists and the resident medical officer (RMO) initially prescribed pain relief thereafter. Specialist pharmacy advice was also available from the pharmacist team including via the on-call pharmacist out of hours.
- The hospital satisfaction questionnaires routinely asked patients how satisfied they were with the way their pain was controlled. The Nuffield Health Woking Hospital scored consistently better than many other hospitals

within Nuffield Health Group. The administration of analgesia was subjected to routine audit and the results showed high levels of patient satisfaction when asked for feedback on the way their pain was managed.

Nutrition and hydration

- There were effective systems to ensure the risk of poor nutrition or dehydration was identified and managed on admission to the ward. A series of risk assessments were undertaken for all patients admitted for surgery. This meant that risks were identified and addressed by staff.
- Staff followed national guidance to ensure that patients were not left for long periods without adequate nutrition and or hydration. Fasting times were in line with national recommendations.
- We observed all the patients on the unit receiving suitable nutrition for their individual conditions.
- Nursing documentation demonstrated that patients had their fluid intake and output monitored continuously, if required, and actions taken if an intervention was necessary.
- All patients had access to a dietician and speech and language therapist review should they require multidisciplinary team (MDT) input. There was an SLA in place with a local NHS provider to ensure that patients nutritional and hydration needs were met.
- The unit used a malnutrition universal scoring tool (MUST) to ensure it assessed patient's nutritional risks. However, we did not see any completed MUST assessments because of the type of short stay patients in the department during the inspection.

Patient outcomes

- The Nuffield Health Woking Hospital was not identified as a CQC outlier in any areas. The term 'outlier' can be used to describe a service that lies outside the expected range of performance.
- There were audits which measured patient waiting times, bed utilisation and late changes to the order of theatre lists. These audits had the overall objective of improving efficiency and effectiveness. However, they were at a relatively early stage in their implementation, but actions taken as a result of their recommendations included: the staggering of admission times for local anaesthetic procedures to reduce the length of time from admission to procedure.
- The department submitted data to Patient Reported Outcome Measures (PROMS). However, Primary Knee Replacement, Hip Replacements and Groin Hernias could not be calculated as there were less than 30 modelled records.
- Local key performance indicators (KPIs) for readmissions, healthcare acquired Infections (HCAI's), returns to theatre and unplanned transfers scored better than the Nuffield Health average.
- The provider reported no deaths at the hospital in the period July 2015 to June 2016.
- Data showed three cases of unplanned readmission within 28 days of discharge in the same period) and six cases of unplanned transfer of an inpatient to another hospital in for the same reporting period. This indicated low levels of transfers to NHS organisations.
- The hospital provided data to the Private Healthcare Information Network (PHIN) and the Competition Markets Authority (CMA). Data from the January – August submission showed a 100% compliance rate.
- The hospital was due to start submitting to the National Breast Implant Register. The registry was designed to record the details of any individual, who has breast implant surgery for any reason, so that they can be traced in the event of a product recall or other safety concern relating to a specific type of implant. We saw the plans and preparations that had been made so this process could begin in the very near future.
- The hospital's performance was benchmarked against a range of other healthcare providers and other Nuffield Health providers and generally compared favourably.

Competent staff

- Patients were cared for by staff with the right knowledge, experience and qualifications to support their needs. Staff were encouraged to acquire additional skills and qualifications relevant to their positions.

Good

Surgery

- Surgical staff competence was scrutinised by the medical advisory committee before practicing privileges were granted. Practising privileges were routinely reviewed at the MAC meetings and this was evidence in the meeting minutes we viewed.
- We saw at least two staff a month had their practicing privileges revoked because they did either do not use the hospital or used it infrequently. This was in line with the Nuffield Health's Practising Privileges Policy and ensured that patients were only treated by staff who maintained their clinical competencies.
- In theatre, two nurses had been trained to be a first assistant and another was about to start their training. Any other staff coming to the hospital to assist consultants had to submit relevant information in line with policy before they could work within the theatre. We were showed documents that the competency of first assistants was regularly monitored.
- Staff appraisal rates were 96% for the ward and 100% in the theatre area. The overall hospital appraisal rate was 85%.
- Nursing and ancillary staff competency assessments were in place across all departments. We saw competency being monitored during our inspection.
- Staff told us they had access to sufficient levels of training to be able to undertake their roles. Inspectors were provided with several examples where staff were supported and encouraged to develop their skills and knowledge base beyond the mandatory requirements.
- We found a robust system in place to ensure that medical, nursing, and allied health professionals held a current registration with their governing bodies. This was evidenced in the human resources files we reviewed. Data demonstrated100% completion rate of validation of professional registration for doctors and dentists working under practising privileges.
- Between July 2015 and June 2016, 28 consultants had their practising privileges removed. This was in accordance with Nuffield Health's Practising Privileges Policy. Medical practitioners who do not use the hospital (or use it infrequently) in a six month period may have their practising privileges withdrawn at the discretion of the hospital director. This ensured consultant staff were familiar with the clinical environment, current polices and systems of work.

Multidisciplinary working

- Staff told us about multidisciplinary team (MDT) working during the inspection. The medical records we viewed demonstrated that patients were treated by physiotherapists (physio). Other MDT input such as occupational therapy, was available via a referral process to the local NHS trust. We saw there was an appropriate SLA that supported this.
- Orthopaedic patients had a physio review prior to discharge. We saw this in operation during the inspection.
- All cancer patients were referred into the local MDT of which the hospital's breast care nurse Specialist was a member.
- Staff told us there was a good working relationship between other departments in the hospital.

Seven-day services

- The Nuffield Health Woking Hospital provided a seven-day service. We viewed document s that showed there was appropriate cover to ensure patients had access to services seven days a week.
- The RMO was resident at the hospital and was supported by patients' individual consultants.
- A radiographer that provided the service outside of normal working hours. This ensured that patents had access to routine diagnostic screening at all times.
- There was a physiotherapist on call for inpatients out of hours. This ensured that patients who required physiotherapy at the weekend had access to the service.
- There was also an on call pharmacist providing out of hour cover. This meant that staff had access to a pharmacist for medicines advice and the ability to have non-routine prescriptions dispensed out of hours.
- A biochemist was on call for the pathology department out of hours including at weekends. This meant that patients had access to pathology services seven days a week.

Good

Surgery

Access to information

- Staff had easy access to necessary information about individual patients, hospital policies, and professional guidance. This was available in the reference folders in clinical areas and accessible online.
- Staff were also able to easily access patients' medical records, pathology and imaging results.
- The RMO also attended the ward hand over. This promoted care continuity and effective communication.
- There were systems and processes in place to ensure care continuity. NHS patients had records regarding their treatment and care referred back the NHS. This meant that follow up appointments and patients outcomes could be monitored back in the NHS.
- Discharge letters were sent to patients General Practitioners (GP's) when patients were discharged or after consultations. We reviewed a sample of discharge letters and found they contained information, to ensure care continuity and appropriate follow up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nuffield Health had a policy for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policy set out procedures staff should follow if a person lacked capacity. Staff had access to flowcharts to prompt them of the process.
- MCA and DoLS were part of the mandatory training programme staff attended. Data provided by the hospital showed 87% had completed DoLS training and 100% had completed MCA training up to August 2016.
- Two consultants held practising privileges for cosmetic surgery at the time of the inspection. Patients who required cosmetic surgery were given the statutory 'cool off' period. This gave patients time to reflect on the information they received at consultation and the opportunity to change their minds about having the procedure.
- We reviewed consent forms in seven sets of medical records. Consent forms were all completed with the proposed surgery, intended benefits, risks, consultant signatures, patient information given and patient signatures.
- We found staff had a knowledge and awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards when questioned.
- We identified one patient who was due to have a procedure on the evening of the inspection whose notes indicated a diagnosis of dementia. We viewed three previous surgical consent forms, all within the inspection time frame. All three had been signed that by this patient despite having been identified as potentially lacking capacity. There was no documentation that would indicate a capacity assessment had been performed. We brought this to the attention of the senior management team who acted immediately to ensure the appropriate processes were followed before further surgery was considered. The senior team acknowledged that more training was required to ensure the service could safeguard patients who lacked mental capacity.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- The patients we talked with during the inspection were very complimentary. They told us staff were "kind, caring, and attentive". Another comment received was, "Staff were caring and respectful. I did have several questions throughout my procedures and always found staff nurses very patient and thorough and helpful. Environment clean and hygienic. I feel in very safe hands". Patients felt the care they received reflected their personal beliefs and said staff respected their wishes.
- The interactions we observed between staff and patients were professional and compassionate.
- The department had embraced the 'hello my names is' campaign. This encouraged and reminds healthcare staff about the importance of introductions in healthcare. We saw staff greeting patients in this way.
- All staff wore name badges and introduced themselves by name. We noted patients were routinely asked how they would like to be addressed.

Good

Surgery

- Patient satisfaction and "Friends & Family" ratings often were better than the Nuffield Health average. Scores ranged between 97% and 100% for the period January to June 2016. There was no differentiation of service between NHS and privately funded patients. FFT scores were similar to the England average of NHS patients across the period January 2016 to June 2016.
- However, response rates had dropped. The senior management team told us that this may be because the system for gathering feedback was changed after a public engagement sessions that suggested the feedback be gathered at home instead of on discharge. This method was implemented but had a negative effect on the response rates. The management team were in the process of reverting to the old method of gathering the feedback on discharge.

Understanding and involvement of patients and those close to them

- There was a named nurse system in place in ward areas. A named nurse can be defined as a designated individual who is responsible for a patient's nursing care during their hospital stay. The patients we talked with knew who their allocated named nurse was.
- Patients told us they felt involved in planning their care. We observed during the inspection.
- Relatives we talked with were very happy with the way their needs were met during their loved ones hospital stay.
- The patients' we talked with told us they were provided with enough information and access to clinicians to ensure they were able to make informed choices about their care and treatment.
- Private patients were provided with detailed information about the fees at their consultant appointments. They also had their fees discussed and agreed with the finance department prior to having surgery.

Emotional support

- The provider was able to meet the emotional needs of patients. Clinical staff provided immediate emotional support to patients and their loved ones. This included reassurance from nursing, ancillary, and medical staff.
- Whilst the hospital did not directly provide counselling services, there was a system in place to make a referral, if, and when it was needed.
- Immediate advice was available from the psychologist who worked in the co-located assisted conception service if this was necessary.
- Staff told us that patients received psychological review prior to surgery, where appropriate. However, given the type of surgery undertaken on the day of the inspection, we could not test this.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The hospital responded to market forces and planned services that local people wanted.
- We found there was active collaboration with local (Clinical Commissioning Groups (CCG's) to respond to requirements for NHS funded patient services.
- The hospital was to act as a "Spoke" in the Musculoskeletal (MSK) Triage service to be launched by the local NHS Trust in October 2016. MSK National Advice and Triage Service(MATS) is a new non-emergency service for adults with muscle and joint problems.
- Day case patients who required admission had immediate access to overnight facilities, should they require them.

Access and flow

- Patient access and flow was found to be good at this hospital.
- Theatre capacity was noted to be 55%, which is a significant underuse of the department and its resources.

Good

Surgery

- The hospital could demonstrate compliance with the 18 week pathway for NHS funded referrals. Above 90% of patients were admitted for treatment within 18 weeks of referral in the reporting period July 2015 to June 2016.
- All other (non NHS funded referrals) access services were subject only to consultant availability.
- Patients could be admitted at a time that suited them. On the day of surgery, they moved smoothly through the department and were either discharged following day surgery or accommodated on the ward for an overnight stay. There were no delays noted during our visit.
- Admissions to the surgical ward were staggered according to each patient's position on the morning or afternoon theatre list. This meant that patients were not admitted to the ward for excessive period of time before their surgeries.
- Nuffield Health Woking Hospital reported they have cancelled 24 procedures for a non-clinical reason in the last 12 months; of these 100% (24 patients) were offered another appointment within 28 days of the cancelled appointment. Staff reported patient cancellations on the internal electronic reporting tool to ensure a robust audit trail for review. We saw evidence of this during the inspection when reviewing the incident reporting log.
- We observed the ward discharge pathway. The patient was provided with appropriate verbal post-operative and written instructions. Patients were also given a card with a contact phone number should they require further information or advice. However, nurses had to hand write patient specific post-operative instructions onto the discharge. There was no process of providing this information electrically which raises a concern about legibility of the instructions.
- We observed two patients being discharged during the inspection. Discharge booklets were given to patients with advice on post-operative care, venous thromboembolism, care of the skin post cannula removal, and ward contact information. They were also provided with wound advice and if required, wound dressings.
- Discharged patients were provided with a contact telephone number to call for assistance or advice in the first 48 hours of surgery.
- Patients who had undergone larger surgical procedures received a telephone follow up call the day after discharge. Patients who had undergone hip and knee surgeries were followed up on day three and thirty post procedure. This was to check on patient's recovery progress and ensured that follow up appointments were in place to aid care continuity. Occasionally, this process identified surgical site infections that were fed back into the hospital reporting systems.
- Staffing was proactively planned in advance of theatre lists. This meant that the ward was more likely to manage the change in demand on the ward well.

Meeting people's individual needs

- A detailed assessment of the patients' needs (including any requirements on discharge) was made prior to admission. We saw evidence of these reviewed in the records we viewed during the inspection.
- These needs were identified at the initial pre assessment stage of care. If specific needs were identified, they were communicated to the ward and theatre staff to ensure appropriate planning before admission.
- All patients had a comprehensive risk assessments carried out at their pre-assessment appointments and on the day of admission.
- Patient information was shared appropriately with theatre and ward teams to ensure each area would prepare in advance for planned admissions this meant that the hospital took the necessary steps to ensure it could meet the individual needs of its patients before they were admitted. For example, we saw the arrangements made for the care of a bariatric patient which ensured their needs were met.
- Patients were provided with verbal and written, procedure specific information to help them make informed choices about their care and treatment they wished to receive.
- Patients were cared for in private on suite rooms that promoted privacy and dignity. They were provided with free Wi Fi and a dedicated phone line, daily newspaper and digital TV.
- Staff told us they provided refreshments for relatives and loved ones.

Good

Surgery

- It was widely accepted that patients with dementia experience difficulties with their sight and perception, which may cause them to misinterpret the world around them. Colour and contrasting colour in particular, can help. The hospital had a wheelchair accessible toilet that had recently been fitted with blue handrails. There was a equipment resource box on the ward with coloured resources, which included a red raised toilet and pictorial toilet seat, day light clock, telephone with large buttons, sensory kit, coloured crockery and cutlery which was made available when a patient living with dementia was admitted. There was also a resource file containing helpful information on caring for patients living with dementia for staff to reference. We spoke with a member of the housekeeping team who showed us the resource box and explained how it was used in practice.
- Staff told us that patients with a learning disability were identified at the pre-assessment. This allowed nursing staff to assess the individual care needs of this patient group. One nurse we talked with provided an example of caring for a patient with learning difficulties, which included liaising with carers, minimising disruptions, and using a tool called a care passport to ensure continuity whilst in hospital.
- Translation services were available, if required, and staff were able to tell us how they would arrange this. There were systems to provide literature in other languages using a commercial company employed by Nuffield Health.
- During our inspection, we observed call bells were answered immediately and staff were attentive to patient needs.
- All patient telephone calls for advice to the ward were recorded in triplicate, for follow up and audit purposes.
- A wide range of food was available to patients so their individual dietary and religious needs or preferences could be met.
- The patients we talked with told us they were very happy with the quality and choice of the food provided to them.

Learning from complaints and concerns

- There were systems to ensure patients comments and complaints were listened to and acted upon effectively. Patients could raise a concern and have it investigated and responded to within a realistic time frame.
- Comments and complaints used were used by management to improve the quality of the service provided.
- Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure. The hospital manager was responsible for the management of complaints. The personal assistant to the hospital's director was responsible for the day to day administration of the complaint management process.
- Information on how to make a complaint was available in leaflet form or on the website. Staff were aware of how to direct patients who would like to raise a complaint or concern. Complaints could be made verbally or in writing directly to the organisation, via the website or by NHS Choices. We observed all the public areas displayed information on how patients could raise a concern or complaints. We saw information was also in patient literature in rooms.
- The Nuffield Health standard operating procedure for complaints set out the relevant timeframes associated with the various parts of the complaint response process. The procedure stipulated the timescales for each stage of the complaints process, how response times were monitored and how complaints could be escalated if the complainant was not satisfied with the response. For all the complaints we reviewed, the provider met the target response times. All complainants received a final response letter which encouraged them to contact the hospital if they were not satisfied with the outcome. All complaints information was retained within a paper file, with copies retained electronically and also stored in the hospital information management system.
- The hospital had 20 complaints in the reporting period July 2015 to June 2016. No complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), an independent adjudicator.

Good

Surgery

- The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the rate of other independent acute hospitals CQC hold data for. The actual number of patient complaints was low, typically fewer than 20 in any 12 month period. CQC directly received no complaints in the reporting period.
- All complaints were recorded in the incident reporting system and were discussed at the monthly clinical governance meetings and included in the clinical governance report. We saw minutes of meetings which confirmed the nature, response and outcome of the complaint were reviewed. The reporting of complaints also formed part of the compliance agenda at the medical advisory committee (MAC) meetings. A summary of the clinical governance report was also made at each individual head of department meetings to support learning. Complaint data was regularly reviewed to help identify trends and themes in the service. This was evidenced by the MAC meeting minutes we reviewed
- We reviewed a random sample of four complaint investigation records for inpatients and found that the Nuffield Health Woking Hospital had acted in a fair, open, and balanced.
- Complaints expressing concern with a medical practitioner or with the clinical outcome of treatment were reviewed by the Medical Advisory Committee (MAC) chairman.
- Staff were able to give inspectors examples of changes to practice from concerns and complaint investigations. This meant that complaints was discussed with staff and in reality, led to changes in practice. We saw ward meeting minutes that also demonstrated 'learning form complaints' was a regular agenda item.

Are surgery services well-led?

Good

We rated well-led as good.

Vision and strategy for this hospital

- The Nuffield Health Woking Hospital had a clear and robust vision and strategy for the service. This was understood and supported by the staff working in the service. The focus of the strategy was in identifying key organisation strengths in order to provide a niche range of services. Refining the service delivered improved patient pathways and experience, and promoted quality and safety of the care. This meant improved productivity with good clinical outcomes for patients who wold be cared for by a skilled and competent work force.
- The strategy at the hospital was driven predominantly by a safety agenda. An example of this was the decision to stop offering paediatric services endoscopy procedures other than those undertaken within theatres in conjunction with other procedures. The management had clearly recognised the dangers and difficulties in providing services where caseloads were too low to maintain staff competencies and the possible safety implications for patients and care pathways. This demonstrated a focused and rational management strategy that reflected the local ethos of the 'patient first – profit second' philosophy.
- The strategy also included the corporate Nuffield Health values and beliefs systems. These values empowered staff to be enterprising, passionate, independent and caring. Staff we talked to and observed during the inspection lived these values when carrying out their daily duties.
- The organisational strategy was directly aligned with the surgical department. This was evident in the planned approach to offering a smaller range of surgical specialities that was driven by quality and safety and staff competency.
- Staff told us that they were consulted and kept felt informed about the proposed changes to the service and the renovations which were underway. They also told us that they felt encouraged to bring their ideas for service improvement to senior management and told us they felt involved in developing the services they worked in.
- We reviewed the Hospital Improvement Plan (HIP). It included the following: substantial investment in the fabric of the building, and operational capacity and services, in order to improve upon the quality of the patient experience. It also mentioned having an improved management meeting structure and flow of information to improve communication between staff

groups and patient safety and quality through re-introduction of staff forums to improve communication between staff groups and reduce the incidence of "silo" working.

- We noted there was an emphasis in the HIP on closer collaboration between hospital staff and external medical secretaries to reduce the number of fragmented patient journeys.
- The plan articulated the rationalisation in service provision to focus on a smaller number of specialities and lower complexity and therefore improve patient safety. It also addressed the need for an improved patient journey for many procedures undertaken under Local Anaesthetic (LA) by increasing the volume and range of accommodation for patient recovery. Further consideration was given to the proposal to move to five day or day case operation.
- There was a commitment to improved collaboration (and more proactive collaboration) with local commissioning groups to ensure the clinical appropriateness of NHS funded referrals.
- The HIP included arrangements for a closer involvement in Nuffield Health initiatives on improving staff recruitment and skill mix.

Governance, risk management and quality measurement

- There was a corporate integrated governance committee that monitored the effective operation of clinical governance throughout the Nuffield group and considered clinical and health and safety matters. These meetings were attended by the group medical director and senior members of staff with clinical responsibilities.
- The hospital has an active Medical Advisory Committee (MAC) which met quarterly. We reviewed the meeting minutes of meetings held in January and April 2016. These were detailed, comprehensive and covered all services within the hospital. Topics discussed included risk, practicing privileges, quality dashboards, and the visions and strategy for the future. At the time of the inspection, the integrated governance committee was in the process of changing its name to the Quality and Safety Committee.
- We met with the chair of the MAC during the inspection and found they had a good oversight of the organisation, its strengths, and areas for development. The MAC was engaged and supportive of the hospitals senior management. The feedback we received about the MAC's leadership from senior staff was very complementary.
- There were various and vigorous audit and quality measurement tools embedded into practice. This meant that corporate and local managed had oversight of the quality of the service it delivered.
- We identified a very healthy and proactive incident reporting culture in the organisation. This meant that staff had confidence in the value of reporting and learning from these incidents.
- Risk registers were kept at service, organisation and corporate levels. Staff in each area could tell inspectors what the top three risks for their areas, action plans and proposed resolution time frames. The risk register was a standard agenda item on the MAC meeting agenda. We saw minutes of these meetings, which demonstrated continuous oversight and involvement in risk management.
- We saw documentary evidence that all complaints and concerns were recorded in the monthly clinical governance report and escalated to the Quality and Safety Committee which demonstrated senior management oversight.

Leadership / culture of service

- There was evidence of strong hospital leadership at the hospital. We also saw effective leadership throughout the surgical department during our inspection. This was evident from the various documents we reviewed, but also the conversations we had with staff and patients during the inspection.
- The hospital was managed by a dedicated and proactive leadership team. Staff told us the hospital director and matron was very visible and accessible. The senior leadership team at the Woking site comprised of the MAC, hospital director and matron. They were supported by the Nuffield's medical director, chief nurse and regional director for the south as well as by the line managers in each clinical area.

- The staff we talked with also told us they felt very support by their immediate line managers, as well as the matron and the hospital director. They felt confident that they could always provide honest feedback to the management when their views were sought.
- There was an 'open door' policy for staff. Some of the staff we talked with told us they had raised concerns and had immediate action taken by the matron. They also told us that they felt confident they could raise a concern with the new hospital director whom they saw as a positive presence in the organisation.
- Staff also told us that matron was happy to help 'roll up her sleeves' on the ward when needed, which promoted the cohesive feeling of 'being in it together'.
- There was an open and 'no blame' culture. The teams felt valued, supported, committed to their patients and each other. The majority of staff we talked with told us about the family feel to the hospital and the impact that had on their individual job satisfaction. This culture also had an impact on patients with one that we talked to, explaining that they choose to use the hospital because of that very caring family approach to care.
- The Nuffield Health Woking Hospital had good levels of staff retention. Many of the staff we talked with had in excess of ten years' service and one with a maximum of thirty.
- A leadership "MOT" was undertaken annually. This tool was used to monitor and improve the quality of the leadership of the organisation. Comments reviewed from the 2015 data were largely positive for the hospital.
- Sickness rates for ODPs and health care assistants working in theatre departments were varied when compared to other independent acute hospitals we hold this type of data for.
- However, sickness rates for nurses working in theatre departments were lower than the average of other independent acute hospitals.
- The Nuffield Health Academy provided tools to support a culture of learning and innovation.
- The Nuffield Leadership and Appraisal system was based on six "key beliefs" (including "Commercial Gain not coming before Clinical Need, Being Straight with People and Taking Care of the Small Stuff".
- Patient satisfaction scores and feedback was recorded into the Clinical Governance Report and to the Quality and Safety Committee for review and or action.
- From the evidence we viewed and the conversations with staff it was evidence that there was a positive audit culture which ensured the provision of safe and effective care. We saw ample examples where the results of these audits were shared with staff. Audit outcomes were shared in a clear and concise way in verbal and written from. There updates contained a thank you note to staff for their continuous efforts to ensuring good standards of clinical care. The staff we talked with told us they took great pride in doing well in these audits.

Public and staff engagement (local and service level)

- Staff were kept well informed by senior management. Methods of communication used included newsletters, meetings, department email chat, and notice boards. There was also a lot of one to one personal contact between staff, which was made possible by the size of the hospital. A staff forum was introduced in October 2016 as a support mechanism and communication aid.
- The Nuffield also undertook an annual leadership MOT to assess staff satisfaction. Questions were scored on a scale of 0 to 10 (10 being the highest score) and 50 staff responded.
- Seventy four per cent of staff said they would recommend Nuffield Health Woking as a good place to work. One hundred per cent of staff said they would recommend the service to their friends and family.
- Eighty six per cent of staff said they were treated fairly and with respect, without discrimination of any form.
- Mindfulness training, healthy eating support, and gym memberships were offered to staff as part of a staff wellbeing programme.
- The organisation took in to account the views of its patients and use the feedback to improve people's experience and the service provided. Their views were sought regularly through informal feedback, as well as formally, through various surveys. We saw ample evidence that demonstrated the data was reviewed and used to implement changes at the hospital.

Good

Surgery

- There was evidence of continuous engagement with external stakeholders. This included the local CCG's, GP services and NHS providers.
- The hospital website had an events tab that provided details of forthcoming events the public could attend. For example at the time of the inspection, there was a public invite to patients considering cosmetic surgery to attend an event.

Innovation, improvement and sustainability (local and service level)

- The sustainability of the service at the Nuffield Health Woking Hospital was underpinned by the management decision to put patients' safety first, and only provide services that it could deliver well, without compromising care quality.
- The pharmacy team had taken the initiative to design and deliver a jargon free medication management competency based teaching tool for staff. This tool has been accepted at national level and had been adapted for use at other Nuffield Hospitals.
- Nuffield Health produced a booklet describing the Nuffield beliefs, and outlining what is important to the organisation. The booklet, called LIFE – a love story, provides useful bite size health related information for patients. It also has a focus on wellbeing, living and loving life, as well as some picture postcards that had poignant quotes from the likes of John Lennon and Hans Christian Anderson etc.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

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 requires improvement.

Although there were many good things about safety in the service, it breached a regulation relating to recording keeping, which means we cannot give a rating higher than requires improvement.

Incidents

- No "never events" related to the outpatients or diagnostic imaging departments were reported by the hospital in the period July 2015 to June 2016 as none had occurred. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital had an incident report writing policy dated 2016 and staff used an electronic incident reporting system. Staff demonstrated a good understanding of how to use the system. Staff told us feedback from incidents were discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn. Staff were able to give us examples of incidents that had been reported in the past. For example a nurse warned a patient of the step when entering the audiology department, who consequently tripped and sustained a wound to their knee. This resulted in a written sign being placed on the department's door as an additional warning for patients of the trip hazard.
- There were 24 clinical incidents reported between July 2015 and June 2016 in the outpatients and diagnostic imaging departments. The rate of incidents was higher than the other independent acute hospitals the Care Quality Commission (CQC) holds data for. Three non-clinical incidents were reported in the same period which is similar to other independent acute hospitals CQC holds data for. However, we saw reported incidents were graded according to severity and all incidents reported were rated as either no or low harm. This is suggestive of a strong reporting culture.
- Incidents were investigated by the management team to establish the cause. The majority of incidents either related to issues with communication or post-surgical wound infections. These were then reported locally to departmental teams, the management board, the medical advisory committee (MAC), the local clinical commissioning group and other relevant organisations as required.
- Staff in the diagnostic imaging department had a clear understanding of what was a reportable incident. A Radiation protection Advisor (RPA) was available for advice, by telephone if required. Staff showed us the incident reporting policy they followed for incidents where patients had received an unintended dose of radiation. Section 15 of the departments IR(ME)R 2000 medical exposures manual and standard operating

procedures states: Clinical Incidents reportable under IRMER 200: Exposures much greater than intended or unintended exposure to radiation not caused by equipment failure. It stated if a patient received a radiation dose much greater than intended or a patient is x-rayed by mistake, a report must be made to CQC.

- Information received before the inspection told us the hospital had one ionising radiation (medical exposure) regulations IRMER incident in the last year. The hospital did not report this to the health and safety executive or to CQC. During the inspection we saw the outcome of this incident which was investigated by the RPA. The RPA stated the procedure was performed appropriately, not categorised as an ionising incident and therefore was not required to be reported further.
- Staff said the dissemination of information regarding incidents and lessons learned was through electronic communications and their attendance at staff meetings. We also reviewed a sample of hospital wide clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This 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. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken. We saw operational staff understood their responsibilities with regard to the duty of candour legislation and we found the responsible manager ensured that the duty was considered and met when investigating safety incidents.

Cleanliness, infection control and hygiene

- The most recent patient led assessment of the care environment (PLACE) score, completed May 2016, was 100% for cleanliness which was better than the national average.
- The outpatients department had an infection control champion known as a 'link person'. The link person was central to disseminating infection control education and support to their local multidisciplinary team. We saw, in the minutes, the link person attended the Infection Prevention and Control (IPC) meetings. They were able to describe how they informed staff of updates through the departments email system and verbally.
- We saw the quarterly hand hygiene observation audit July 2016. Ten members of staff across the hospital were observed and scored 100%. The hospital wide compliance for IPC, with hand hygiene, training was 92% by August 2016.
- We saw the cleaning audit for the pathology department. In July 2016, the department scored 92% and was non-compliant because of insufficient cleaning of the sinks. The audit for August 2016 was worse with a score of 83%. This was due again to the sinks and also the shelving and high surfaces. We saw communication between the management and the cleaners to highlight this. However, all the areas we visited in the outpatients and diagnostic imaging departments were visibly clean and tidy and we saw there were good infection control practices. We saw the cleaning schedule for the rooms and toilets in the outpatients and diagnostic imaging departments were completed on a daily basis when the department was open.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information was displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks. Sanitising hand gel was readily available throughout the department.
- We saw personal protective equipment was available for all staff and observed staff use it appropriately.
- We saw disinfectant wipes were available in each room. Equipment was cleaned with these between each patient use and a green sticker placed on it to show it was. We saw equipment with green stickers on; this meant the equipment was clean and ready for use.

- We saw disposable curtains used in the treatment and consultation rooms. The dates on them indicated they had been changed within six months in line with manufacturer's guidance.
- Waste in the clinic rooms was separated and placed in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1)d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.
- HBN 00-09 for flooring section 3.108 states 'the quality of finishes in all clinical areas should be readily cleaned and resilient' and section 3.109 'flooring should be seamless and smooth, slip-resistant and be easily cleaned'. HBN 00-09 section 3.115 for carpets states 'carpets should not be used in clinical areas. Included in this are all areas where frequent spillage is anticipated. Spillage can occur in all clinical areas, corridors and entrances'. We saw all rooms in the outpatients and diagnostic imaging departments were carpeted except the two treatment rooms, utility, pre assessment room and the diagnostic imaging department examination rooms.
- However, the management of the hospital acknowledged the flooring was not appropriate in these areas and identified this on the department and hospitals risk register. The hospital had an agreed business plan and we saw there was a date for the carpets to be removed and replaced with appropriate flooring.
- Managers told us the carpets were deep cleaned every six months or sooner, if required. We saw records which indicated the carpets in all areas had been cleaned recently. Fabric chairs were cleaned every six months and we saw a cleaning schedule which indicated this had been done.
- We saw the majority of the seating in the outpatients department was covered with a wipeable fabric. HBN 00-09 section 3.133 for furnishings states all seating should be covered in a material that is impermeable, easy to clean and compatible with detergents and disinfectants. We saw there was on ongoing programme of replacement for the fabric chairs, when damaged, with a suitable material in line with the HBN recommendation.

Environment and equipment

- The PLACE scores were 96% for condition, appearance and maintenance of the hospital which was better than the England average.
- The consultation rooms were equipped with a treatment couch and trolley for carrying the clinical equipment required. The room had equipment in it to provide physical measurements (blood pressure, weight and height). This was in line with HBN 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.
- We saw equipment service records which indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw electrical testing stickers on equipment, which indicated the equipment was safe to use.
- We saw certificates to indicate staff were competent to use equipment which was in line with the hospital's medical devices policy.
- We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this a radiation protection committee reported annually on the quality of radiology equipment, which we saw. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000).
- Lead aprons were available in the diagnostic imaging department. We saw evidence which showed checks of the effectiveness of their protection occurred regularly and equipment provided adequate protection as per regulations.
- The ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000) state

medical facilities operating x-ray machines are required to post 'in use' warning signs outside room doors. The diagnostic imaging department had warning signs in place to ensure patients and staff were safe.

- The hospital had facilities for some treatments which used light amplification by stimulated emission of radiation (LASER) therapy. We saw the records which showed the calibration of the laser was checked and recorded before each session. The laser was used in a designated room and the warning sign on the door was illuminated when the laser was in use. The key for the laser was kept securely away from the machine. This was in line with LASER safety guidelines (BS EN 60825-1:2007, safety of laser products: Part 1, equipment classification and requirements).
- The pathology department had access to two analysers for specific tests for bloods. The machines had inbuilt decontamination processes. We saw the maintenance and service records for the machines and these had been done within the last six months.
- We saw confidential waste was managed in accordance with national regulations. Confidential waste areas were available in administration areas and we saw the certificates of destruction supplied by the outsourced shredded waste company.
- Emergency equipment consisted of a resuscitation trolley, two defibrillators and a paediatric emergency bag. One defibrillator was located by the nurses' station and the rest of the emergency equipment was stored in the pre assessment room of the outpatients department. The equipment was in a secure position but not visible or easily accessible as it was behind a door. The management had acknowledged this was not the best location for the equipment and we saw this had been identified on the departments risk register.
- The cardiology technician checked the contents and expiry dates of the emergency equipment weekly. We saw the records of checks. All equipment needed was available, as indicated by an equipment list. All consumables were in date.
- A nurse checked the seals of the resuscitation trolley daily, when the department was open, and recorded 'not in use' on the days the department was not open. The allocation of the nurse was determined by a red dot placed next to the name on the off duty. We saw the majority of the records had been completed to show the equipment had been checked, however, there were gaps evident. The manager of the department was aware of this inconsistency and we saw this was discussed at team meetings. The manager told us they were in the process of determining a method to ensure the checks were completed as required.
- Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.
- The medical devices in the outpatients department were audited in June 2016. The audit showed all devices were fit for purpose; however, the overall score of the audit was 63%. This was because the heads of department did not have access to an up-to-date inventory for devices in the department; there was no access to, or there was no knowledge how to use or export inventory from computer database; a faulty ECG machine which did not display a faulty equipment label; no competency documents in place for department staff; staff were not aware of an indemnity certificate and one was not located in the department; and there was not a statement of purpose (SOP) for medical devices. The audit showed actions to follow up to remedy this.
- The hospital had responded to the audit and had recruited link persons for medical devices and the cardiology technician was the lead for the hospital. The link person for the outpatients department maintained a list of medical devices in the department and liaised with the relevant companies to ensure the devices were serviced.

Medicines

- The hospital had a medicines management policy dated 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.
- No controlled drugs (CD's are medicines liable for misuse that require special management) were kept or administered in the outpatient department.

Good

Outpatients and diagnostic imaging

- Consultants administered medicines in the department and these were accessed by the nurses who held keys. Medications were kept in a lockable cupboard which was secured to the wall. Only authorised staff had access to keys to the cupboard.
- Medications, for example eye drops, were checked weekly for expiry dates and stock levels. We saw the completed forms. The checks were completed by the medicines management link nurse who attended the monthly medicines management meeting.
- We saw the audit schedule for medicine security was completed every three months. The outpatient department was audited in July 2016 and this showed it was compliant in all areas.
- Staff stored prescription pads in a locked cupboard and a registered nurse held the key. We saw the register for recording of prescription pads; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, security of prescription forms, 2013.
- In the diagnostic imaging department, medicines used to perform scans were stored in a locked cupboard with key pad access in a locked room with key pad access. Only authorised, registered professionals had access to the medicine cupboard.
- Staff monitored and recorded the minimum and maximum of the medicine refrigerator and room temperatures where medications and products were stored in the outpatients and pathology departments. We saw records which indicated this was done daily and clearly marked when the department was not open.

Records

- We saw the available paper records of patients being seen in the outpatients department were kept and stored appropriately in the department. These were sent to the medical records department when no longer required.
- The hospital's paper records were stored in the medical records department which could be accessed by authorised personnel only. A register was completed to indicate if a record had been removed and where it had gone to.
- The provider told us that in the three months before the inspection only 55% of patients were seen in outpatients with all relevant medical records being available.
- Additionally the hospital audited the availability of medical records for 20 adult patients and four children patients between April and June 2016. The audit showed only seven adult patients had their medical records available and none of the children.
- We saw the referrals and patients records for the physiotherapy department were received and stored electronically.
- We saw a copy of consultation notes for NHS patients was kept by the hospital. However, copies of the consultant's individual notes for private patients in the outpatient department were not kept by the hospital; these were kept by the individual consultants. The hospital had a record of the original referral and copies of diagnostic treatments performed only. This does not meet the requirements of regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This states providers must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The consultants worked under practising privileges agreements. The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. The practising privileges agreement requires consultants to abide by the rules of the hospital. One rule was the consultant complied with data protection laws and maintains complete and contemporaneous records in the outpatient department.
- The hospital acknowledged the provision of individual medical records for outpatients was not robust and did not follow legislation. The hospital was working towards having a copy of the patient's outpatient record at the hospital. We saw minutes of meetings which detailed how this was to be achieved and was discussed

regularly. A process was piloted in August 2016 for two consultants. A paper record was created for each new patient and the consultant documented in the notes. The record remained the property of the hospital and was stored on site. We were told the process would be audited in February 2017 with an aim to disseminate for all patients in the department. The long term goal was the introduction of an electronic record system where patient's medical notes could only be viewed within the hospital in accordance with data protection legislation.

- The hospital audited information security by using a site risk assessment tool for identifying and recording risks to information within the department. The process was supported by two policies, the information risk policy and the information governance policy which were located on the hospital's computer system. Completing the assessment enabled the hospital to identify areas that were at risk to the confidentiality, availability and integrity of information and which in turn may lead to a breach of the Data Protection Act.
- The tool consisted of 20 questions with RAG (red, amber, green) status and actions required. For actions identified an updated assessment was completed each month until all areas were fully compliant.
- We saw the audits for June and July 2016. The hospital had six key risks identified where improvement was required to obtain compliance. These were: department meetings to review risks; computer screens not periodically locked when unattended; not all emails being sent securely; staff not consistent in undertaking security checks before releasing confidential information; and staff awareness of local business continuity and disaster recovery policies should the computer system not be available.

Safeguarding

- See the Surgery section for main findings. In this section we cover the hospital's arrangements for safeguarding children and adults in vulnerable circumstances
- At the time of inspection the hospital offered a full service for young people of 16 and 17 years of age. It did not offer any invasive procedure undertaken on an outpatient basis to anyone under the age of 16 years. The hospital offered outpatient services for phlebotomy, audiology, ENT, dermatology, radiography and ophthalmology to children between the ages of three to 15 years. The services were provided on a planned basis, so the senior clinical team would be aware when children were scheduled.
- However, the hospital had acknowledged the service provided for children and young persons was not viable and was identified on the departments risk register. All services for children and young persons in the hospital would stop in January 2017. We saw the email correspondence to confirm this.

Mandatory training

- Staff were required to undertake mandatory training courses which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk. Staff told us they were given protected time to complete mandatory courses.
- We saw the training records for staff (excluding medical staff) for mandatory training. The training year for staff was from the month they started work for the hospital. Overall all staff in the hospital had achieved 89% compliance by August 2016. The target set by Nuffield Health was 90%.

Assessing and responding to risk

- Medical cover was provided by the resident medical officer (RMO) who would attend to any unwell patients in the outpatient or diagnostic imaging department if required. All RMO's held a current advance life support (ALS) certificate.
- We saw records showed all nursing staff in the outpatient and diagnostic imaging departments received basic life support training. Additionally we saw relevant staff had attended paediatric basic life support training.
- In the event of an emergency occurring with a paediatric patient, the hospital's policy was to first stabilise and then transfer the patient to the local trust, under the paediatric support service level agreement.

Good

Outpatients and diagnostic imaging

- We saw there was adequate resuscitation equipment, it was accessible and staff knew where it was located. A panel by the nurse's station showed when a cardiac emergency had happened and all available staff attended.
- Signs were displayed throughout the department with the nominated first aiders and fire wardens identified.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor (RPA) was contactable if required. This was in line with ionising regulations 1999 and regulations (IR (ME) R 2000). The RPA service for the diagnostic imaging department was provided by the local NHS acute trust. The hospital had annual radiation protection meetings at the hospital.
- The diagnostic imaging department had a stop buttons on the walls of the examination rooms to stop the radiation examination in an emergency. We saw the records demonstrating these were tested at the annual service.
- We saw local rules available in the diagnostic imaging room which were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff had signed them to indicate they had read them.
- We saw patients for the diagnostic imaging department had their identity confirmed by asking name, address and date of birth. This followed IRMER requirements. We saw the request forms and signatures of staff to identify that identities had been checked.
- A laser protection supervisor was on site for each use of the laser for the ophthalmic service and a radiation protection advisor for lasers specific to Nuffield Health was contactable if required. This was in line with LASER safety guidelines.
- Staff told us the department did scenario training for resuscitation emergencies. This happened every month and tested the staff's response and skills to the situation. Staff gave us examples of managing a patient in an emergency and they felt the response from the rest of the hospital was immediate. We witnessed a quick and appropriate response to an emergency during our inspection.

Nursing and diagnostic staffing

- There were sufficient staff with the qualifications, skills and experience to meet the needs of patients in the outpatient and diagnostic imaging department.
- The department employed nine registered nurses equal to 3.4 whole time equivalent (WTE) and no health care assistants (HCA's). However, one HCA was a regular member of bank staff. We saw the staffing rotas which indicated there was always registered staff available in each department.
- The outpatients and diagnostic imaging department did not use agency staff as the hospitals own staff worked as bank staff when required. Use of bank nurses in the outpatient department was varied compared to other independent acute hospitals CQC hold this type of data for in the reporting period (July 2015 to June 2016). The use of bank was higher than the average of other independent acute hospitals in July 2015 to September 2015, December 2015, February 2016 and March 2016.
- •The diagnostic imaging department had one WTE administration staff and one WTE radiographer. There were two WTE vacancies for radiographers and the hospital was in the process of recruiting. The department had access to two regular agency radiographers to ensure adequate staffing levels for the service.
- The pathology department employed one medical laboratory assistant and two bio medical scientists. There were no vacancies in the department.
- The physiotherapy department employed five therapists who were contracted for a mixture of full and part time hours. There were no vacancies in the department and staff told us there was sufficient staff to provide the service.
- The Nuffield Health policy for children's services specified a trained children's nurse needed to be in attendance for a procedure on a child. We saw off duties which showed the service ensured a children and young person's nurse was available at the time that the service was offered. The child or young person received care in a private room with a parent or carer in attendance.

Medical staffing

- The consultants worked under practising privileges agreements. The granting of practising privileges is a well-established process within independent l

healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice. We saw the evidence that the provider had complied with legal duty to ensure regulation 19 in respect of staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We saw these agreements were in place for all medical staff with practising privileges.

- The hospital had 136 consultants working with agreed practising privileges. This related to consultants in post 1 April 2016 with more than 12 months service. The hospital confirmed all medical staff had been fully trained to perform procedures which they regularly performed within their NHS practice.
- The RMO was on duty 24 hours a day and was based on site for seven days at a time. All RMO's who worked at the hospital were registered with the General Medical Council (GMC). The RMO was provided to the hospital by an agency and we saw the hospital received assurance that all appropriate training had been undertaken.
- Guidelines state a named consultant should have access to the hospital within 30 minutes for paediatric support. The hospital had a service level agreement (SLA) for paediatric support in place with the local NHS Trust which linked into the trust's own paediatrician on call arrangements. The hospital acknowledged their system did not provide access to a named consultant. They considered their system to be a more robust arrangement than a contract with an individual consultant, where absences may adversely impact the continuity of the service provided.

Emergency awareness and training

- We saw the hospital's major incident plan dated 2016. This was to ensure all staff understood their response and action to be taken in the event of an incident. The policy provided contingency plans to ensure the comfort and safety of patients, staff, contractors and visitors under disruptive circumstances. These could be caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage or due to external circumstances beyond the control of the hospital such as a bomb threat. Staff we spoke with were aware of the major incident plan which could be accessed on the hospital's internal computer system.

Are outpatients and diagnostic imaging services effective?

We did not rate effective.

Evidence-based care and treatment

- The hospital had a robust audit programme throughout all clinical departments. Regular audits included patient waiting times upon arrival for outpatient appointment, chaperone audit, consent, medical devices, hand hygiene and infection, prevention and control. We saw copies of these audits and the overall results were positive. Findings were reported to the departments and through to the management board meetings. Trends were identified and action plans created to improve the service to patients which was communicated back to the clinical departments for their action.
- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example, the National Institute for Health and Care Excellence (NICE) guidelines, The Royal Marsden Manual of Clinical Nursing Procedures and the Royal College of Radiologists.
- In the outpatient and diagnostic imaging department staff demonstrated how they could access NICE guidelines, the Royal Marsden and relevant policies on the hospital's computer system.
- The diagnostic imaging department had policies and procedures in place. They were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000) and in accordance with the Royal College of Radiologist's standards.
- The Radiation Protection Advisor (RPA) undertook regular radiation audits and an annual review of dose reference levels. We saw the minutes of the meetings for the last three years and results of audits which showed the hospital was in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000).

- We saw the results of the annual laser equipment and safety audit dated December 2015, which was undertaken by the laser protection advisor. Areas included equipment, control measures, safety management, training and local rules, protocols and policies. The audit showed the hospital was fully compliant with no improvements required.

Pain relief

- In the outpatient and diagnostic imaging department doctors could prescribe pain relieving medicines if required. We saw these were readily available so nurses could give promptly.
- In the diagnostic imaging department, there were a variety of pads and supports available to enable

Patient outcomes

- We saw the hospital audited patient outcomes by participating in national and local audit programmes. The hospital was committed to partaking in the patient led assessment of the care environment (PLACE) and learning from this audit formed part of an ongoing action plan for the hospital.
- The hospital measured performance against key indicators, including healthcare associated infections, which were benchmarked against other healthcare providers and other Nuffield Health providers. We saw the Woking Hospital compared favourably. The hospital had regular review meetings where results were discussed with reference to how they could develop practices to improve upon services delivered.
- We saw the clinical governance report was considered in detail at the integrated governance meeting each month and a summary was discussed at the medical advisory committee (MAC) meetings on a quarterly basis. The report included the results of any improvement initiatives undertaken at department or subcommittee level. The format of the clinical governance report formed the template for individual departmental and subcommittee agendas

Competent staff

- All staff had an induction programme devised by their departmental manager. This included a tour of the facilities and teams, supervised work sessions and protected time for reading the relevant policies and protocols. The induction course was written using a standard template, signed off on completion by the responsible manager and filed in the employee's personnel record. Staff showed us these records.
- We saw competency certificates for staff including nurses, radiographers, physiotherapists and pathology staff, all of whom had the relevant qualifications and memberships appropriate to their position. There were systems which alerted managers when staff professional registrations were due and to ensure they were renewed. These were demonstrated to us.
- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- In compliance with ionising regulations 1999 and regulations (IR (ME) R 2000), we saw certificates were held for staff who were able to refer patients for diagnostic imaging tests. This gave assurance that only those qualified to request a diagnostic examination were able to do so.
- The Nuffield Health leadership and appraisal system was based on six key beliefs (including 'commercial gain not coming before clinical need, being straight with people and taking care of the small stuff'). All the staff we spoke with had received an annual appraisal. We saw their records which showed during the annual review individual responsibilities were outlined. Staff told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with their regulatory bodies. We saw the records to show 86% of outpatient staff had received an appraisal by November 2016. This related to seven applicable staff (six nurses and one cardiologist). The one applicable radiographer had also received their appraisal.
- We saw the hospital received assurances from the agency used for radiography staff. This included training, qualifications, disclosure and barring service (DBS) check, immigration status, professional registration and details of induction.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff working in outpatients and for radiologists. The hospital undertook robust procedures which

ensured consultants who worked under practising privileges had the necessary skills and competencies. The consultants received supervision and appraisals. Senior managers ensured the relevant checks against professional registers and information from the DBS were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the MAC notes.

Multidisciplinary working

- Staff told us they worked well as a team in their departments and all other areas of the hospital. We saw a strong multi-disciplinary approach across all the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the departments.
- We were told the medical staff liaised with colleagues in the NHS if the findings following diagnostic procedures indicated further medical support might be required.
- The physiotherapists told us they had a good working relationship with consultants. They would access further

Access to information

- We saw in the diagnostic imaging department staff were provided with the protocols of examinations undertaken. A folder was kept in the department to guide radiographers explaining how to perform a procedure, the reason for the procedure and to what level the exposure to be set.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). This is medical imaging technology which provides economical storage and convenient access to images from multiple machine types. Theatres, operating rooms and wards could access PACS on a computer. Authorised access was permitted by means of a password.
- Results of pathology tests were recorded on the computer system and we saw authorised clinical staff had access to them.
- Staff from both departments could access a shared drive on the computer where policies and hospital wide information was stored. Staff demonstrated this to us.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nuffield Health had a policy for consent to examination or treatment, dated 2015. The policy demonstrated the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits.
- We saw signed consent forms in five medical records which showed patients had consented to treatment in line with the hospital's policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- Data was submitted to the Friends and Family Test (FFT) for NHS patients only. The hospitals FTT score was 99% between January and June 2016. The FFT scores were similar to the England average of NHS patients. However, response rates were below the England average of NHS patients at 21%.
- The most recent patient led assessment of the care environment (PLACE) score, completed May 2016, for privacy, dignity and wellbeing were 93% which was better than the England average. We saw all treatment and consultation rooms had curtains to ensure patients dignity was respected if the door was opened.
- We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.
- Nuffield Health had a privacy and dignity policy (including chaperoning) dated 2015. We saw signs in the patient waiting areas informing patients they could have a chaperone, if required. We saw certificates which indicated staff had chaperone training. Staff would

Good

Outpatients and diagnostic imaging

record if a chaperone had been offered and document if a patient agreed or declined. In a separate register it was recorded who had been a chaperone, the patient concerned and the day it occurred. We saw the chaperone register which indicated this was occurring. This was in line with the hospital's chaperone policy.

- We saw there were two individual changing cubicles attached to the diagnostic imaging department which ensured patients privacy and dignity were maintained.
- We spoke with eight patients during our visit. Patients told us "the staff are totally interested in me as a person", "they are courteous and respectful" and "they are all very helpful and smiling".

Understanding and involvement of patients and those close to them

- We observed staff discussed treatments with patients in a kind and considerate manner.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.

Emotional support

- Staff showed us the system for them to access counselling services and other psychological support for a patient if it was needed.
- We saw staff interacting with patients in a supportive manner and provide sympathy and reassurance.
- Nurses gave us examples of when they would attend clinic appointments with patients to provide emotional support if required. Staff told us they were able to provide patients and their families extra time if necessary.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The provider told us the hospital predominantly depended on patient choice for its livelihood and therefore focused the hospital to be responsive to patients needs and ensure this was at the forefront of planning and delivering care. The hospital had arrangements and collaboration with CCG's and the local NHS acute trusts. This ensured people had choices about where they received treatment but also that waiting was kept to a minimum. This meant the local population had choice as to where they could receive their care and treatment and the provider was focussed on their needs.
- Services were planned to give patients a choice of convenient times for them to attend for their appointments. The departments were open Monday to Friday. The outpatients department 8am to 8.30pm, diagnostic imaging 8.30am to 7pm, physiotherapy 8am to 8pm and pathology 9am to 5pm.
- Patients told us they had been offered a choice of times and dates for their appointments.

Access and flow

- The majority of patients were privately funded and the remainder NHS funded. There were 12,984 outpatient attendances in the reporting period July 2015 to June 2016 at the hospital. Of these, 21% were NHS funded and 79% other funded. The diagnostics imaging department performed 2,941 examinations in 2015 and 3,166 in 2016.
- A legal requirement by NHS England gives patients the right to access services within a maximum waiting time. This applies to NHS funded patients only. The hospital met the target of 92% of referral to treatment (RTT) waiting times for patients beginning treatment within 18 weeks of referral for each month in the reporting period July 2015 to June 2016.
- The hospital achieved above the national target of 95% for patients beginning treatment within 18 weeks of referral.
- The hospital had no patients waiting six weeks or longer from referral for the ultrasound scan in the same reporting period.
- The waiting times for patients on arrival to the hospital until their admission to the consultation room was audited by the hospital. We saw the audits between

April and June 2016. Twenty adult patients were audited during this period and the average waiting time was 7.6 minutes. Four children, under the age of 16, were audited and the average waiting time was 5.5 minutes. The clinics we observed ran to schedule, we did not see any patients wait more than five minutes.

- Patients told us they were happy with the speed at which they had been notified of their appointments.
- We saw a radiologist provided a report within 48 hours and all reports were checked by a radiographer before they were sent.
- We saw in the pathology department they provided the results of blood tests results within 45 minutes. Certain blood tests, for example full blood count, were available within 15 minutes. The results were available on the computer system.
- The hospital audited dispensing turnaround times of medicines monthly for 15 patients. The aim of the audit was to measure the time a prescription was in the dispensary to ensure that suitable processes and resources were available to facilitate the timely discharge and provision of medicines. We saw the audits for March to July 2016 and the average waiting time was 4.9 minutes.

Meeting people's individual needs

- The waiting areas for the outpatients and diagnostic imaging departments had seating areas with refreshments and magazines available for waiting patients and their supporters. The hospital had several wheelchairs available for patients to use if required.
- Literature was available to help patients understand their care, treatment and general health issues. We saw a variety of health-education literature and leaflets in the reception area. Some of this information was general in nature while some was specific to certain conditions.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in a clear and simple style and language.
- Staff could tell us how they would access translation services for people who needed them. However, we were told these were rarely needed.
- We did not see any leaflets in any other languages apart from English. However, staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database.
- We looked in five sets of patient's records which indicated this was being completed. Reports went to patients and their GP if further investigations were required.
- The physiotherapy department provided a wide range of exercise classes to suit the needs of the patients referred to them. They had a range of equipment to help staff deliver high quality care for patients.
- Patients who were living with a learning disability or dementia were identified by staff when the referral was received. Staff told us if applicable, the appropriate individualised Nuffield Health had a diversity and inclusion strategy to ensure the Equality Act 2010 was embedded in the operations of the unit, and we saw an equality report was submitted to the NHS commissioner. The hospital, under NHS contract, was obliged to accept all qualifying referrals received which met the hospitals referral criteria. This meant they could not discriminate in terms of selection of patients.
- The outpatient department provided a health screening service which provided an appropriate care and support was provided, for example appointments to accommodate individual needs.
- The hospital had a dementia strategy dated 2016 and the hospital's PLACE score, dated May 2016, for dementia was 87% which was better than the national average. This focused on key issues such as flooring, decoration (for example contrasting colours on walls), signage, seating and availability of handrails which can prove helpful to people living with dementia. We saw the toilets in the outpatients department had hand rails in a contrasting colour.
- The hospital had allocated disabled parking bays and disabled toilets signposted in the main reception to accommodate patients living with a mobility disability. Of the eight patients we spoke with, five told us they did not experience any problems with finding a car parking space. However, one patient complained to us there was

only two disabled parking bays and this was not adequate. The hospital director confirmed there were not enough disabled bays and there were plans to extend the parking area.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section. In this section we cover the hospital's arrangements for dealing with complaints and the information applies to all services unless we mention an exception.
- Information on how to make a complaint was available in leaflet form or on the website. Staff were aware of how to direct patients who would like to raise a complaint or concern. Complaints could be made verbally or in writing directly to the organisation, via the website or by NHS Choices.
- We saw copies of four complaints which related the outpatients and diagnostic imaging departments. These related to a blood test, price of treatment, difficulty in making an appointment and an unexpected medical event. We saw the complaint process and outcome completed by the hospital.
- We saw the completed process regarding a complaint received from a patient attending an outpatient and diagnostic imaging department appointment. The complaint was responded to and actioned in a timely manner as per the hospital's policy. The complaint referred to the patient's unsatisfactory experience arranging the initial appointment. Additionally they received the results of tests performed by email from the consultant's secretary, and had no opportunity to ask questions. The feedback received allowed the hospital to review processes to ensure a better experience for future patients. Changes in practice meant a nurse now contacts the patients with results which allow the patient to ask further questions or book a follow up consultation if required.
- Staff received feedback regarding complaints at team departmental meetings as well as on an individual basis.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good

Vision and strategy for this this core service

- See information under this sub-heading in the surgery section. In this section we cover the hospital's ethos and philosophy and its strategic plans,
- There was no specific strategy for the outpatient and diagnostic imaging departments. However, there was a corporate level statement of purpose.
- The managers of the outpatients and diagnostic imaging departments recognised they needed to develop their services to meet the needs of local people and not continue to compete with other providers. This would enable them to focus on a smaller number of specialities with inherently lower levels of complexity in order to assure commercial viability and improve patient safety within national guidelines and legislation, for example the withdrawal of children's services.

Governance, risk management and quality measurement

- See information under this sub-heading in the surgery section. In this section we cover the hospital's systems for assuring the quality and safety of care.
- We saw the risk register for the outpatients and diagnostic imaging department. This had nine items listed with their identified initial and current risk level. The list showed the likelihood, current consequences and review date due. The list was displayed in the manager's office.All staff we spoke with described how they would access the risk register and they were encouraged to report risks to their managers

Leadership and culture of service

- See information under this sub-heading in the surgery section. In this section we cover the hospital's leadership.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities

in all areas of the outpatient and diagnostic imaging services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.

- The managers of the outpatient and diagnostic imaging departments reported to the matron, who reported to the hospital director.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Staff in the focus group told us any changes made were communicated through departmental meetings, newsletters and emails.
- Staff told us the hospital was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.
- Staff told us if they were present when bad news had been given to a patient, their line managers and other members of the team provided support.
- The sickness rate reported for nurses in the outpatient department during the period July 2015 to June 2016 was varied when compared to the average of other independent acute providers CQC holds data for. Sickness rates were higher in July to September 2015, May 2016 and June 2016. The manager of the outpatients department explained to us the reason for the sickness levels was because due to an unfortunate circumstance that affected the whole team and individual members of staff experiencing separate situations. This meant other staff worked extra shifts to assist their colleagues and this ultimately affected their individual health.
- The Nuffield Health leadership and appraisal system was based on six key beliefs (including 'commercial gain not coming before clinical need, being straight with people and taking care of the small stuff'). At the time of inspection all the staff we spoke with had received an annual appraisal. We saw the records which showed during the annual review individual responsibilities were outlined. Staff told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with their regulatory bodies.

Public and staff engagement

- See information under this sub-heading in the surgery section. In this section we cover the hospital's arrangements involving staff and patients.
- The outpatient and diagnostic imaging departments had forums for staff communication. This included departmental meetings, bulletin boards and a monthly company newsletter which was issued following management board meetings.
- We saw managers shared information via email and newsletters. We saw noticeboards displaying information about infection prevention and control, health and safety, safeguarding and lessons learned from incidents and complaints.

Innovation, improvement and sustainability

- The management of the outpatients department had created a conversation tool by email for the department called 'outpatient gossip'. This tool was used for seeking advice, sharing information, introducing new staff to the team and a learning system. It replaced a paper form newsletter. All staff had access to a computer and were encouraged to check their emails on a regular basis. A similar tool had been introduced in the ward areas of the hospital. Staff told us the 'outpatient gossip' chat was beneficial and had improved communication between all staff in the hospital.
- The physiotherapy department had a unique service provided by Nuffield Health called 'Recovery Plus'. A post-surgical patient was seen by the therapists and provided with three months membership for the gymnasium.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The hospital must maintain securely an accurate, complete and contemporaneous record in respect of patients attending the out-patient department

Action the provider SHOULD take to improve

- The hospital should ensure that staff receive adequate training so they can identify those who may lack the capacity to make decisions for themselves and meet the requirements of the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17 (2) (c) The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user attending the outpatient department, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Copies of the consultant's individual notes for private patients in the outpatient department were not kept by the hospital; these were kept by the individual consultants. The hospital had a record of the original referral and copies of diagnostic treatments performed only.