Nuffield Health

Nuffield Health Brighton Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Medical care	Good
Surgery	Good
Services for children and young people	Not sufficient evidence to rate
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection of Nuffield Health Brighton Hospital on the 11, 12 and 22 July 2016 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of medical care (including older people's care), surgery, services for children and young people, outpatients and diagnostic imaging as these incorporated the activity undertaken by the provider, Nuffield Health, at this location.

We did not inspect the magnetic resonance imaging (MRI) or computerised tomography (CT) scanning services, or ophthalmology outpatient services as these are provided and managed by another registered provider.

We rated the hospital overall as good, and rated the core services of surgery, outpatient and diagnostic services and medicine as good. Although we inspected the children's and young peoples service we did not have enough evidence to give this a rating. This was because at the time of the inspection the hospital treated low numbers of children.

Are services safe at this hospital?

We found services were safe at this hospital. This was because:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff.
- Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- Patients were assessed prior to admission to ensure that hospital could safely meet their needs. There were arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and saw that staff used these processes when patients' conditions required this.
- There was suitable medical cover at all times from a resident medical officer and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There were sufficient numbers of nursing and support staff to meet patients' needs.
- There were efficient and effective methods for the handover of care between clinical staff.
- However, medicines management did not always reflect best practice. We identified some concerns in the maintenance of controlled drug registers and the storage and management of medical gases.
- There was no provision for the reporting of emergency imaging out of hours.

Are services effective at this hospital?

- There were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice.
- There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance forums at the hospital.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes and the hospital participated in relevant national audits and benchmarking activities.
- Patient outcomes were good when benchmarked against national standards. There were no concerns regarding rates of unplanned admission, return to theatre or transfer to another hospital.
- Patient's received adequate pain control. They were provided with sufficient food and drink to meet their individual needs although some patients had complained about the quality of food offered.

Summary of findings

- There were systems to grant and review practicing privileges to consultants that ensured they were qualified and competent, and of good character. There were systems to ensure that staff registered with professional bodies retained current registration, including through revalidation.
- Consent procedures followed national guidance and staff acted within the Mental Capacity Act 2005 when patients lacked capacity to make decisions for themselves.

Are services caring at this hospital?

- Patients were treated with dignity and respect and their privacy was maintained. Patients who share their views said they were treated well, with compassion, and that their expectations were met or exceeded.
- Results of the NHS friends and family test and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.
- There were arrangements to ensure patients with complex needs such as those undergoing gender reassignment surgery or chemotherapy had access to appropriate psychological support.

Are services responsive at this hospital?

- Services were planned to meet the needs of patients. We saw some flexibility in the organisation of services that allowed patients convenient access to care and treatment.
- We saw examples of systems to support patients living with dementia and learning difficulties. The environment was appropriate for patients with physical disabilities and was accessible.
- The hospital was exceeding national referral to treatment time standards and waiting lists were minimal.
- There was a robust complaints procedure, which was well publicised and understood by staff. Complaints were investigated, actions taken to resolve issues and there was learning evident from the content of complaints.
- There were arrangements that enabled staff to meet the need of people from diverse ethnic backgrounds. While there were facilities to enable translation, staff did not always follow best practice in this area.

Are services well led at this hospital?

- Nuffield Health has a clear, corporate statement of vision and values which staff at this hospital knew and understood.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams. Staff spoke well of the management team and of each other. The provider was responsible for ensuring that those in director level roles fulfilled the fit and proper person test
- There were arrangements to engage patients through invitations to a patients' forum. Nuffield Health had arrangements for collecting patients views and the hospital's performance was benchmarked against peers
- We noted the management team actively sort out novel ways of working that improved standards of safety and quality. The leadership team also developed new services to meet the needs of patients in the local community and beyond.
- There were governance systems, overseen by Nuffield Health to monitor quality and safety of services. However, these systems had not been effective for ensuring management of medicines met legal requirements. We noted that some corporate policies had passed their review dates and were in the process of being revised.

Our key findings were as follows:

- There were adequate systems to keep people safe and to learn from incidents.

Summary of findings

- The hospital environment was visibly clean and well maintained and there were sufficient measures to prevent the spread of infection.
- There were adequate numbers of suitably qualified, skilled and experienced staff (including doctors and nurses) to meet patients' needs. There were arrangements to ensure staff had and maintained the skills required to do their jobs.
- There were arrangements to ensure people received adequate pain relief and adequate food and drink that met their needs and preferences.
- Care was delivered in line with national guidance and the outcomes for patients were good when benchmarked against national audits and other independent hospitals we hold data for.
- Robust arrangements for obtaining consent ensured legal requirements and national guidance were met.
- The individual needs of patients were met including those in vulnerable circumstances such as those with a learning disability or dementia.
- Patients could access care when they needed it.
- Patients were treated with compassion and their privacy and dignity were maintained.
- The hospital was managed by a team who had the confidence of their teams. Staff felt motivated by the management team.
- Governance systems were not always effective in identifying where services were not meeting legal requirements, or at monitoring the quality and safety of services for children and young people.

We saw several areas of outstanding practice including:

- The hospital worked with the local university to offer a joint Resident Medical Officer (RMO) post. Five RMOs covered the hospital over the 24 hour period and also undertook teaching anatomy and practical subjects to students at the local university. This was an innovative and practical way to attract skilled RMOs to the post and was working well.
- The hospital was a centre of excellence for transgender surgery performing over 300 procedures each year attracting patients from all over the UK and internationally. Feedback received from the gender reassignment service (GRS) was continually positive about the way the staff treated people. Patients thought that staff went the "extra mile" and the care they received exceeded their expectations. Within the GRS there was a proactive approach to understanding the needs of this patient group, which included people who are in vulnerable circumstances or who had complex needs and care was delivered in a way that met patients' needs and promoted equality.
- The hospital had a strong ophthalmology pathway and was a leading independent provider of ophthalmology services in the area. The hospital offered innovative ophthalmic surgery with successful outcomes.
- The hospital had taken steps to become "greener" in its operation and had reduced its carbon footprint by the use of solar panels and light-emitting diode (LED) lights

However, there were also areas of where the provider needs to make improvements.

The provider should:

- Ensure there is a planned preventative maintenance plan for medical gas regulators and that there are suitable safe storage facilities for larger cylinders not required for the medical gas manifolds.
- Consider keeping individual laser registers for each laser in a hard copy format.

Summary of findings

- Review access in the pharmacy dispensary where there was lack of confidentiality and disability access to the dispensary hatch.
- Review the prescription tracking system to minimise the possibility of mis-use.
- Ensure that controlled drugs records are managed in line with legal requirements.
- Make adequate arrangements to report on emergency medical imaging out of hours.
- Take action to address patient feedback on the quality of food.
- Review maintenance and refurbishment plans to ensure the clinical environment meets national guidance.
- Ensure regular risk assessment of oncology patients for venous thrombo-embolism.
- Make arrangements for the transfer out of acutely unwell oncology patients
- Consider how best practice in the interpreting services could be achieved.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Good	We rated medical care services as good overall because: The hospital had systems and processes in place to keep patients free from harm. Infection prevention and control practices were in line with national guidelines. The environment was visibly clean, tidy and fit for purpose. Staff kept medical records accurately and securely. Medicines were stored in locked cupboards and administration was in line relevant legislation. The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. Oncology services demonstrated compliance with National Institute for Health and Care Excellence (NICE) guidelines. Medical care services had an appropriate level of competent staff to meet patients' needs. Staff completed appraisals regularly and mangers encouraged them to develop their skills further. Managers were visible, approachable and effective. Staff overwhelmingly reported the hospital had a 'family feel'. Staff interacted with patients in a kind and caring manner. Patients told us they felt relaxed when having their treatment and were overwhelmingly positive about their experience of care.
Surgery	Good	We rated surgical services as good because: The hospital had effective systems and processes in place to deliver evidenced based care and treatment. This included robust systems for reporting and learning from incidents. Audits were conducted to provide assurance that staff and clinicians worked according to the evidence-based guidance.

Summary of findings

Patients received surgical interventions, care, treatment and support that achieved good outcomes. Their needs were assessed with individual care and treatment planned and delivered appropriately. Patients told us of the excellent care and attention they had received at the hospital.
Leadership was visible and responsive. Staff had confidence in both their immediate team leader and the hospitals senior management team. All staff were fully engaged with the strategic vision and values of the hospital.
There were sufficient numbers of suitably qualified, skilled and experienced staff to care for the patients admitted to the hospital. Staff were appropriately inducted and had the training, learning development and supervision through appraisal to deliver safe care.
There were robust arrangements in place to monitor the competence of consultants with practicing privileges and action was taken where concerns were identified.
There were good infection control systems in place managed and monitored by the infection control team. The general environment was maintained to a high standard.
However;
Medicines management did not always reflect best practice or meet legislative requirements. We identified a number of concerns in the governance of medicine management and the management of medical gases.
There was no provision for the reporting of emergency imaging out of hours.
The hospital kept one laser register for the three lasers currently in use which did not provide a robust method of detailing the use of each individual laser.

Services for children and young people

Not sufficient evidence to rate

We were not able to rate this service due to the low numbers of children being treated at the hospital. However, we found

Summary of findings

Staff understood their responsibilities regarding incident reporting and there was a culture of learning from incidents. There were plans in place to respond to emergencies and major incidents. Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe.
The hospital managed patients' records in accordance with the Data Protection Act 1998.
Appointment times were flexible and offered around school hours. Facilities were suitable for children and young people.
The hospital had clear structures, processes and systems of accountability in place.

Outpatients and diagnostic imaging

Good

We rated the Nuffield Brighton Hospital outpatient and diagnostic imaging service as good because:
Systems were in place for keeping patients safe and staff were aware of how to report incidents and safeguarding issues. Staffing levels were sufficient to meet the needs of patients. The waiting areas and consulting rooms were visibly clean, tidy and free from clutter.
Imaging equipment was appropriately maintained and legislative requirements relating to the safe use of ionising radiation were met. Laboratory facilities were accredited by a nationally recognised external body.
Staff worked as part of multi-disciplinary team and sought consent from patients in accordance with corporate policy and legislation, including the Mental Capacity Act.
Staff were enthusiastic and caring and there were positive interactions between staff and patients who spoke well of their experience.
There were clearly defined local leadership roles in each speciality within the outpatients and diagnostic imaging areas.
Managers and the senior leadership team

Summary of findings

provided visible leadership and motivation to their teams and there was appropriate management of quality and governance at a local level.
However:
There was no effective process for the monitoring of prescription pads and not all members of staff were trained to an appropriate level in safeguarding children.

Nuffield Health Brighton Hospital

Detailed findings

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

Detailed findings

Contents

Background to Nuffield Health Brighton Hospital

Nuffield Health Brighton Hospital, part of the Nuffield Health group, is an independent hospital situated in Woodingdean on the outskirts of Brighton. Woodingdean is residential area which does not have any appreciable levels of social depravation although the city of Brighton and Hove overall has a more mixed population.

The original Nuffield Health Brighton Hospital in Hove was founded in 1976, but the present, larger site in Woodingdean opened in 1995 to meet increased patient demand for services. The hospital was refurbished in 2013 and has 41 patient rooms all with en-suite facilities and 13 consulting rooms, including bespoke oncology, dental and ophthalmic suites.

There are three operating theatres each with an integral anaesthetic room, a dedicated endoscopy suite, and six bay recovery units. The hospital was the regional Nuffield Health hub for physiotherapy and health screening (including exercise tolerance testing) and Nuffield Health pathology services.

There are on-site imaging facilities including X-ray, ultrasound and digital mammography. The hospital hosts CT and MRI scanners which are operated by another provider. Therefore these services did not form part of this inspection.

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. We inspected four core services at the hospital which incorporated all the activity undertaken.

These were medical care (including oncology); surgery; services for children and young people and outpatients & diagnostic imaging.

The registered manager was Mike Evans who was also the controlled Drug Accountable Officer. The matron was Michelle Neal. Both had been at the hospital since November 2105. The provider's nominated individual for this service was Andrew Watkin Jones.

Our inspection team

Our inspection team was led by:

Inspection Lead: Shaun Marten, Inspection Manager, Care Quality Commission

The team consisted CQC inspectors, including a specialist medicines management inspector, and a variety of specialists including:

- A radiographer
- A consultant surgeon
- Three nurses including a children's nurse and one with experience of managing surgical services

Detailed findings

How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We requested information from the local clinical commissioning group. We placed comment boxes at the hospital prior to our inspection which enabled patients to provide us with their views and received 65 comments.

We carried out an announced inspection on the 11 and 12 July and an unannounced inspection visit on the 22 July 2016.

We held two focus groups where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. We spoke with a wide range of staff including nurses, resident medical officer, radiographers and administrative and support staff on 51 occasions.

We also spoke with 20 patients who were using the hospital and telephoned the parents of two children who had used the outpatient service.

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

Facts and data about Nuffield Health Brighton Hospital

During the period April 2015 to March 2016, Nuffield Health Brighton Hospital treated a total of 5,708 patients requiring overnight stays or who were day cases. Day case attendances accounted for 79% of this activity. Overall, there were 3,206 visits to theatre. Of the day case and inpatient stays, 24% were NHS funded. In addition the hospital saw 13,924 outpatient attendances of which 15% were NHS funded.

In the same period, the most common procedures performed were chemotherapy (640), diagnostic colonoscopy (312), diagnostic endoscopic examination of the pharynx/larynx (306) and diagnostic gastroscopy (292). In outpatients, the most active specialities were general surgery (13%), gasto-enterology (12%), cosmetics (9%) and ophthalmic (9%).

There were 197 doctors with practising privileges at the hospital; 10% of these carried out over 100 procedures during April 2015 to March 2016, but 50% did not carry out any procedures during the same period. There were 38.4 full time equivalent (FTE) registered staff employed, including nurses, and about 60 FTE support staff including care assistants and administrative staff. Staff turnover and sickness absence rates for nurses, operating department assistants and health care assistants were below the average when compared to independent acute hospitals for which we hold data. The vacancy rate for nurses working in inpatient departments is higher than the average when compared to other independent acute hospitals for which we hold data.

During the year April 2015 to March 2016 we did not receive any direct complaints or whistle-blowing contacts. The hospital received a total of 23 complaints. None of these complaints were referred to Parliamentary and Health Service Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service.

During the year April 2015 to March 2016 there were no never events at the hospital. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were 190 other clinical incidents reported within this year of which 2% were reported to have caused severe harm or contributed to a patient's death. There were also 49 non-clinical incidents reported.

In the same period there no were no reported cases of MRSA or Clostridium difficile but there was one incidence of E Coli infection. These are serious infections which have the potential to cause harm. There were no safeguarding concerns reported to us in the reporting period.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Medical care

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

Information about the service

Nuffield Health Brighton Hospital provides medical services to patients who are self-paying, are insured, or are NHS patients. Medical services include assessment, diagnosis and treatment of adults by medical intervention rather than surgery.

The medical services provided by Nuffield Health Brighton hospital are oncology and endoscopy. The specialities have their own purpose built areas within the hospital. We inspected both of these areas during our inspection.

Endoscopy involves looking inside the body for medical reasons using anendoscope. An endoscope is an instrument used to examine the interior of a hollow organ or cavity of the body.

Oncology is a branch of medicine that deals with the prevention, diagnosis and treatment of cancer. Treatment of cancer can include the use of chemotherapy, which is the treatment of disease by the use of chemical substances, especially by cytotoxic and other drugs.

The endoscopy unit access is via the ward corridor and consisted of a treatment room, a room for washing equipment used in endoscopy with clean and dirty processing areas and a recovery area. From April 2015 to March 2016, the hospital performed 1,096 endoscopic procedures.

The Kestrel suite is a purpose built chemotherapy suite with four private side rooms, five treatment chairs, and two consulting rooms. The unit holds the Macmillan Quality Environmental Mark (MQEM) which identifies and recognises cancer environments that provide high levels of support and care for people affected by cancer. It been developed in partnership with patients living with cancer and the Department of Health in England. It is a core component of the English Cancer Reform Strategy.

Between April 2015 and March 2016 the suite treated 642 patients. The Kestrel suite did not treat any NHS patients.

We spoke with nine members of staff and four patients. We held two focus groups and had interviews with members of staff. Eight patients completed comment cards regarding the care they received in this service.

Medical care

Summary of findings

We found the medical services to be good. This was because;

- The hospital had systems and processes in place to keep patients free from harm.
- Infection prevention and control practices were in line with national guidelines.
- Areas we visited were clean, tidy and fit for purpose. The environment was light, airy and comfortable. The Kestrel suite was awarded the Macmillan Quality Environmental Mark.
- Staff kept medical records accurately and securely in line with the Data Protection Act 1998.
- Medicines were stored in locked cupboards and administration was in line relevant legislation.
- The endoscopic services demonstrated compliance with British Society of Gastroenterology (BSG) guidelines. Oncology services demonstrated compliance with National Institute of Health and Care Excellence (NICE) guidelines.
- The endoscopy suite was working toward Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation incorporating the endoscopy global rating scale, which is quality improvement and assessment tool for the GI endoscopy service.
- Medical services had an appropriate level of competent staff.
- Staff completed appraisals regularly and mangers encouraged them to develop their skills further.
- Managers were visible, approachable and effective.
- Staff overwhelmingly reported the hospital had a 'family feel' and interacted with each other in a friendly manner.
- Staff interacted with patients in a kind and caring manner. Patients told us they felt relaxed when having their treatment.

Are medical care services safe?

Good

We rated safety in medical services as good. This was because;

- Staff had confidence in reporting incidents and demonstrated learning from incidents. They gave us examples of where change was made a result of an incident.
- The oncology and endoscopy services had good infection control and prevention processes in place.
- The hospital had separate areas for oncology and endoscopy patients, which provided appropriate environments and equipment.
- Medicines were stored, managed and administered safely.
- The services kept complete medical records securely and oncology patients had an individual record of their care which they kept in case they needed to attend an acute hospital.
- Both services had sufficient numbers of appropriately trained staff to provide safe care to patients.

However;

- Staff did not complete risk assessments for venous thromboembolism at regular intervals.
- Staff did not fully document the discussions and decisions made following a root cause analysis.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice. The hospital reported no never events between April 2015 and March 2016.
- Staff told us they reported incidents using the electronic reporting system. They received feedback about incidents at staff meetings and we saw minutes of these meetings which indicated incidents staff

discussed incidents regularly. For example, we saw staff record extended length of stay, cancellations and readmissions as incidents. Staff who did not attend a meeting could access the minutes by computer.

- We saw in the minutes of meetings managers discussed any themes or trends in incidents. There was a review of the quality and content of incidents and any lessons learned were shared among staff.
- In oncology, managers had investigated two incidents of venous thromboembolism (VTE) in the reporting period. The incidents had occurred within three days of one another. The conclusion of the investigations was that the VTE's were unavoidable because of the type of treatment the patients had undergone. We saw documentation of the root cause analysis (RCA) which indicated there were no lessons to be learned. When we discussed these incidents with staff, it was clear a lot more analysis and discussion had occurred than was documented in the RCA.
- The duty of candour is a legal duty on hospitals, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Staff had no examples of where duty of candour had been indicated and demonstrated, but told us the legal obligation was discussed regularly at staff meetings. We saw minutes of these meetings which indicated this had occurred.

Safety thermometer or equivalent

- The hospital used the NHS Safety Thermometer. This is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). However, day case patients' are excluded from the NHS Safety Thermometer. None of the patients undergoing an endoscopic procedure in the reporting period (April 2015 to March 2016) stayed overnight.

Cleanliness, infection control and hygiene

- All the areas we visited looked visibly clean and tidy and there were good infection control practices in place. We observed staff following best practice in line with the Royal College of Nursing essential practice for infection prevention and control, guidance for nursing staff. We observed staff undertaking aseptic techniques such as inserting cannulas and administrating chemotherapy.
- 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. Information was displayed demonstrating 'five moments for hand hygiene' near handwashing sinks.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note 00-09: Infection control in the built environment. Soap and hand towels were available next to the sinks. Sanitising hand gel was readily available.
- There was sufficient space for activities to take place and to avoid cross-contamination between patient seats and beds were in individual rooms. This was in line with Health Building Note 00-09: Infection control in the built environment.
- We saw personal protective equipment was available and staff used it in an appropriate manner.
- We saw there was cleaning schedules in individual treatment rooms which were fully completed.
- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with Health 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 areas where sharps may be used. This demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had been fully completed which ensured traceability of each container.
- At the pre-operative assessment stage, staff screened all patients for MRSA, a type of bacterial infection that is resistant to a number of widely used antibiotics. If a patient was positive, they received treatment for MRSA

and a procedure not performed until the patient was clear of infection. We reviewed five sets of patient records; all five indicated screening was done at the pre-operative assessment stage. The result of the screening test was available in all five records prior to the patient undergoing the procedure.

- The endoscopy suite was separate from other areas. It had separate clean and dirty utility areas and was designed to facilitate flow from dirty to clean areas. This demonstrated adherence to the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope Reprocessing Units, QPSD-D-005-2.2.
- Staff transported dirty endoscopes from the treatment area to the dirty area in a covered, solid walled, leak proof container in line with health and safety executive standards for endoscope reprocessing units'.
- A clear decontamination pathway for endoscopes was demonstrated. There was a pass-through hatch (one way) between the endoscopy room and dirty room. This provided one-way access to washer disinfectors. There was a drying cupboard and a storage cupboard for the endoscopes. Staff kept full scope-tracking and traceability records. They indicated each stage of the decontamination process was occurring. The service audited these records and we saw results of these audits, which indicated all stages of the process were completed. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- We saw water sampling test results, which indicated staff tested the final rinse water from an automatic reprocessor which was tested for its microbiological quality at least weekly. This was in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.
- The most recent Patient Led Assessment of the Care Environment (PLACE) score, completed in 2016 scored 100% for cleanliness, which was better than the national average of 94%.

Environment and equipment

- Oncology and endoscopy services were delivered in surroundings that were appropriate and fit for purpose. We observed that buildings appeared well maintained. The environment in Kestrel suite met recommendations of Health Building Note (HBN) 02-01: Cancer treatment facilities. The endoscopy department environment and equipment was in line with HBN 26: Facilities for surgical procedures: Volume 1.
- We saw equipment service records, which indicated 96% of equipment, had been serviced recently. This was better than the hospitals target of 95%. This indicated equipment was in good working order and checked regularly. Individual pieces of equipment had stickers on to indicate equipment was serviced regularly and ready for use. We saw electrical testing stickers on electrical equipment, which indicated electrical equipment was safe to use.
- Staff reported no problems with equipment and felt they had enough equipment to run the service.
- The most recent PLACE score of the hospital was 98% for condition, appearance and maintenance which was better than the national average of 92%.
- We saw emergency equipment was located close to the Kestrel suite and easily accessible.
- Within the endoscopy suite, resuscitation equipment was available within the endoscopy treatment room, next to the anaesthetic equipment. All equipment needed was available, as indicated by an equipment list. All consumables were in date.
- The theatre manager told us the number and size of endoscopes met the needs of the service. We saw a variety of scopes available to perform a variety of examinations.

Medicines

- A multidisciplinary team discussed a patient's diagnosis and the medicine required at a multidisciplinary team meeting at a local trust. Consultants used local cancer network protocols to prescribe chemotherapy treatment. This is in line with the Cancer Reform Strategy, 2016.
- Chemotherapy medicines were manufactured, aseptically (under sterile conditions), by an external

provider and supplied on a named patient basis. It was checked by pharmacists and pharmacy technicians with specific training in this area before being transferred to the ward area.

- Chemotherapy was delivered in premade bags to minimize the risk of spillage. We saw a risk assessment for a cytotoxic spillage. Staff showed us training certificates to indicate they were competent to deal with this. A spillage kit was available and within date, which meant they were ready for use. This was in line with Hazardous Waste Regulations, 2005.
- Staff gave chemotherapy drugs directly into a patient's vein. A complication of this is a leakage of the drug from the vein into the surrounding tissue. This is called extravasation. Emergency medicines and extravasation kits were available for use. Staff checked them regularly and we saw records of these checks.
- We saw two registered nurses check and document the administration of medicines in Kestrel suite, in line with good medicines management.
- We saw checks occurred to ensure staff had the right drug, right route of administration and the drugs expiry date. Staff recorded the batch number of the drug in the patient record and we saw patient identification checks occurred.
- Medicines were stored securely in a locked cupboard in a locked room. A registered nurse held the keys to the room and the cupboard.
- Staff monitored and recorded the minimum and maximum medicines refrigerators and room temperatures where medicines were stored. Staff took corrective action and recorded when these areas were outside of their recommended temperature ranges.
- In the endoscopy suite, medicines were stored securely in a locked drug cupboard. A registered nurse held the key to the cupboard.

Records

- Patient records were kept securely and unauthorised access was minimised. We saw patient records were stored in locked cabinets in locked rooms in the Kestrel suite.
- Oncology patients carried record books which indicated the chemotherapy type and frequency they had; it also included their most recent blood test results.
- In the endoscopy suite, staff used an electronic records system, which printed out a report of the procedure, immediately after the procedure. This was stored in the patient record and kept in a locked trolley on the ward. Once the patient was discharged, the record was transferred to the medical records department. Authorised personnel only could access this department.
- Staff in all departments had met the health records management training target of 85%.

Safeguarding

- Data supplied to us indicated 95% of staff had attended safeguarding vulnerable adults training, level one. This was in line with corporate policy, but not in line with local authority policy, the Sussex Safeguarding Adults Policy and Procedure Manual.
- Ninety seven percent of staff had attended safeguarding children training, level one and two. This met the Royal College for Paediatrics and Child Health standards in safeguarding children and young people.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. They knew who the safeguarding lead was.

Mandatory training

- The mandatory training programme included; infection prevention and control, health record keeping, safeguarding vulnerable adults and children. Ninety four percent of staff were compliant with mandatory training, which was better than the hospitals target score of 85%. Mandatory training was some on line learning supported with practical sessions.

Assessing and responding to patient risk

- In oncology, a 24 hour telephone line was available for patients to call if they felt unwell. This was in line with the good practice guide for clinical oncologists, The Royal College of Radiologists; 2003. Staff used a recognised triage tool which prompted the user to ask

a standard set of questions and come to a decision about whether the patient needed advice, follow up or assessment. All staff using this were trained to do so during their induction.

- There was not a service level agreement in place which enabled oncology patients to be transferred directly to an oncology department in the local acute hospital. This meant, if a patient became unwell at home or in this hospital, an ambulance would be called to transfer the patient and they would have to wait to be seen in an emergency department. This delayed the time it took for a patient to see a specialist at the acute hospital.
- A modified early warning system (MEWS) was a scoring system that identified patients at risk of deterioration, or needing urgent review. This included observations of vital signs and the patient's health to identify whether they were at risk of deteriorating. Staff at the hospital used a modified early warning score (MEWS) to identify patients whose condition was deteriorating. We reviewed five patient records and saw there was accurate MEWS completion in all five.
- Staff told us that at the start of each endoscopy session they led a team briefing. This included discussion of patient alerts or significant medical history. This was followed by patient checks at the start of the list and a debrief after. This summarised the procedure and medications given, in line with the 'five steps to safer surgery'. In the five sets of records we looked, all stages had been documented in each one.
- Some chemotherapy drugs are harmful to patients and staff. We saw the Kestrel suite had a kit readily available to deal with chemotherapy spills. Staff had received training in how to use the kit and we saw records which indicated staff checked the kit weekly to ensure it was ready for use.
- In oncology, a VTE risk assessment did not occur regularly. We saw a history of VTE was recorded at pre-assessment, but not when patients attended for treatment. There had been two previous incidents involved patients developing a VTE. This indicated there was not a robust system in place to ensure patients were being adequately assessed for their risk of developing a VTE, a known complication of chemotherapy.

Nursing staffing

- The manager of the Kestrel suite told us there were no staffing problems. There was a full time clinical manager and a clinical nurse specialist who supported surgery and oncology specialities. The clinical nurse specialist had increased her hours in line with demand on the service. The service planned to recruit another clinical nurse specialist as the number of patients attending was continuing to increase.
- We saw staff rotas which indicated two members of staff were in the department each day. This was in line with safe staffing for nursing in adult inpatient wards in acute hospitals, NICE staffing guideline, SG1. If a member of staff was off sick, their shift would be covered by another member of staff working overtime.
- The theatre manager told us they flexed staff and the endoscopy list to ensure an appropriate number of suitably trained staff were available for each procedure.

Medical staffing

- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. The hospital confirmed that all medical staff undertaking endoscopies had been fully trained to perform the procedure. These medical staff also regularly performed the procedure within their NHS practice.
- Five resident medical officers (RMO's) worked at the hospital. They worked one 24 hour shift each week and one in every five weekends. In addition to work at the hospital these doctors also worked at the local university, giving anatomy and physiology lectures to medical students.
- The RMO provided a detailed handover in person, to the next RMO at the start of each working day.

Medical care

- Consultants could be contacted if required to discuss their own patients. One RMO we spoke with told us they had never had a problem contacting any of the consultants.

Major incident awareness and training

- The hospital had a major incident and recovery plan which had been reviewed in May 2016. Staff had a good knowledge of this and showed us copies of the document.

Are medical care services effective?

Good

We rated medical services to be good in effective. This was because;

- Standard operating procedures were developed in line with national guidance.
- Staff worked with other health professionals in and out of the hospital to provide services for patients.
- The service took part in peer review to assess their service against others nationally.
- Competent staff provided the service and staff were engaged in developing their skills further.
- Staff had a good understanding of the Mental Capacity Act 2005 and how this applied in practice.

Evidence-based care and treatment

- We saw consultants had reviewed chemotherapy prescriptions for each treatment regime in May 2016. Changes had been made to ensure each regime was in line with current guidance.
- The Kestrel suite took part in a national cancer peer review programme. This involved staff from another hospital looking at a range of quality indicators and we saw the service. The Kestrel suite achieved the standard required.
- The nursing staff formed part of the Sussex nurses group. They benchmarked against other services and had a quarterly meeting with other independent sector nurses and NHS staff.
- We looked at standard operating procedures (SOP) for different aspects of the oncology and endoscopy services. We saw they were in line with national guidance such a British Society of Gastroenterology (BSG) guidelines. Staff had signed them to indicate they had read them.
- Endoscopy staff were aware of National Institute for Health and Care Excellence (NICE) guidance. They did not yet have Joint Advisory Group (JAG) accreditation. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. The hospital was unable to provide us with their self-assessment result. JAG had not yet formally reviewed the hospital. The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation.

Pain relief

- Patients in oncology told us they received excellent help with pain relief.
- During endoscopic procedures, staff used a numbered scoring system for rating a patient's pain. We saw this was recorded in the patient record throughout the procedure.
- A pain relieving gas was available for patients undergoing endoscopic procedures. This enabled them to be discharged home earlier following their procedure as they recovered more quickly.

Nutrition and hydration

- Patients received advice on how to prepare for endoscopic procedures and given general guidance regarding pre-operative dietary and fluid intake. Patients having a procedure which looked into their stomach were advised not to eat or drink anything for at least six hours prior to appointment time, to enable good images of the stomach. We saw information which advised patients of this.

Competent staff

- We saw competency certificates which indicated staff were competent in early detection of the deteriorating patient and MEWS scoring.

- We saw competency certificates in endoscopy which indicated staff were competent in a variety of procedures and in the decontamination of equipment.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies. The surgeons received supervision and appraisals. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the medical advisory committee notes.
- All the staff we spoke with received annual appraisals. The records confirmed this and indicated over 75% for nurses and health care assistants working in inpatient areas in the reporting period (April 2015 to March 2016). Staff told us the appraisal process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with the Nursing and Midwifery Council (NMC).
- There were systems which alerted managers when staff professional registrations were due and to ensure they were renewed. These were demonstrated to us.

Multidisciplinary working

- Staff in oncology told us there was effective multidisciplinary working, with in the hospital and externally. They worked closely with a local hospice to deliver services to patients. Patients told us the liaison between the hospital and hospice was excellent.
- Staff could refer patients to allied health professionals and counselling services if they were required.
- There was effective multidisciplinary working in the endoscopy suite. During our inspection, we saw that the administrative staff, pre-assessment staff, endoscopy staff, medical staff, and ward nursing staff worked well together to ensure the patient pathway was effective.
- We were told that the medical staff liaised with colleagues in the NHS, if the findings following procedures indicated further medical support might be required.

Seven-day services

- The hospital had cover from a resident medical officer (RMO) 24 hours a day, seven days a week.
- Patients receiving chemotherapy had access to telephone advice 24 hours a day, seven days a week. Nursing staff and the RMO provided advice.

Access to information

- Patients receiving chemotherapy treatment carried their own record, which enabled other clinicians to see what treatment they had received. Details of blood test results were kept in this record.
- Records of endoscopic procedures were kept on a computer system, which could be accessed by those with a passcode. A copy was printed out and kept in the patient record, so the doctor could review it in an outpatient clinic.
- Patients received a letter which included the reason for the procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. Staff sent copies of this letter to the GP and placed a copy in the patient's medical records kept at the hospital. In the Kestrel unit, staff sent a copy of the discharge letter to the patients GP on the same day. We looked in five sets of patient records and saw copies of the discharge letter, dated the same day as the procedure. This meant there were effective systems to ensure GP's had up to date information about their patient's treatment and progress.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One hundred percent of oncology staff had attended this training.
- Staff told us capacity was assessed at pre-assessment appointment. They gave us examples of this and had a good understanding of the process.
- Patients received information prior to their endoscopy procedure. This allowed patients to read the

information and, if understood, give informed consent when they came for their procedure. Consent forms appropriately detailed the risks and benefits to the procedures.

- In all the records we looked at, everyone had a signed consent form to indicate a patient had consented to treatment. This was in line with the hospitals policy and Royal College of Surgeons guidelines.

Are medical care services caring?

Good

We rated caring as 'good'. This was because;

- Staff were caring and compassionate.
- Patients commented positively about the care provided from all staff they interacted with. Staff treated patients courteously and respectfully.
- Patients felt well informed and involved in their procedures and care, including their care after discharge from the endoscopy suite.
- Staff supported patients to cope emotionally with their care and treatment as needed.

Compassionate care

- In the hospital's own friends and family test from July 2015 to December 2015, on average 100% of patients would recommend the hospital. Two hundred and fourteen patients took part in the survey.
- The hospital scored 95% in the PLACE assessment for privacy, dignity and well-being, which was better than the national average of 88%.
- The Kestrel Suite was awarded the Macmillan Quality Environment Mark (MQEM) in 2013 which is valid for three years. This stipulates units must be welcoming and accessible to all; they are respectful of people's privacy and dignity; are supportive to users' comfort and well-being and listen to the voice of the user.
- We saw staff treating patients in a kind and considerate manner. Patients told us staff always treated them with dignity and respect.
- We saw staff knock and wait before entering patient's rooms. Patients had the opportunity to have private conversations with staff members in a private room.
- In endoscopy, there was frosted privacy glass on the door to the treatment room. In addition to this staff used a screen to provide extra privacy to patients undergoing a procedure.
- Patients had their own room to change and store their belongings before and during their procedure. There was a recovery room with curtains to protect patient's dignity. Patients returned to their own room following the procedure.

Understanding and involvement of patients and those close to them

- Staff discussed side effects of treatment with patients in a kind and considerate matter.
- Oncology patients received full explanations of what to do if they felt unwell. They carried a record book with details about what to do if they experienced feeling unwell. This was in line with the Manual for Cancer Services: Department of Health; 2004.
- Patients received full explanations and details about the procedures they were to have. We saw information leaflets with this information on.
- Patients undergoing an endoscopic procedure attended the pre-assessment clinic to receive a full explanation about the procedure. Staff gave patients information and medicines necessary for them to have their procedure at this appointment.

Emotional support

- A specialist nurse was available to provide emotional support to patients and another was being recruited. A nurse was available throughout a doctor's clinic to provide additional support.
- Staff could access counselling services and other psychological support for patients if it was needed. A massage therapist was available to provide hand and foot massage to patients whilst they had their chemotherapy treatment.
- We saw staff interacting with patients in a supportive manner and dealt with them with sympathy and reassurance.

Medical care

- Patients told us they could relax when they were having treatment.

Are medical care services responsive?

Good

We rated responsive as good. This was because;

- The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients who met the inclusion criteria, with waiting times of one to four weeks. Care and treatment was coordinated with other providers.
- Information was available for patients in a variety of languages and formats, which met with the needs of the local population.
- Staff dealt with complaint in a timely manner. They were discussed regularly at staff meetings.

However;

- Family members assisted with interpreting which is not considered best practice.

Service planning and delivery to meet the needs of local people

- The hospital provided endoscopy services to both NHS and private patients. The oncology service only provided a service to insured or self-paying patients. The suite was open in the evening on some days which gave patients a choice in the time or day of the week they had their treatment.
- Patients had a choice of receiving their oncology treatment in an area with other patients or an individual room if they wished.
- The Kestrel suite had its own parking spaces, reception and waiting areas which meant that it was easier for patients to attend their appointments and reduced the potential of stress.
- A café was available at the hospital for patients and their families to purchase snacks and drinks. Cold and hot drinks were available in all waiting areas we visited.

Access and flow

- Oncology patients' accessed treatment through their insurance companies or privately. The endoscopy service also included NHS referrals.
- Patients' received a pre-assessment clinic appointment at which the doctor decided on the treatment regime, with a nurse in attendance. This would decide how many days a week the patient would attend for treatment. On the day of the procedure, staff took patient to their own room. Staff prepared patients for their procedure.
- Staff took patients to the endoscopy suite on their own bed, where they had their procedure undertaken. If a patient had sedation during the procedure they would go to a recovery bay, then back to their room. A discharge letter detailing the patients' procedure was sent to the patients GP on the same day. We saw records which indicated this was occurring.
- NHS England publishes Referral to Treatment (RTT) waiting times, of which diagnostic waiting times is a key part. RTT waiting times measure the patient's full waiting time from GP Referral to Treatment, which may include a diagnostic test. Therefore, ensuring patients receive their diagnostic test within six weeks is vital to ensuring the delivery of the RTT waiting times standard of 18 weeks. The hospital had no patients waiting six weeks or longer from referral for a colonoscopy or gastroscopy (two types of endoscopy) from April 2015 to March 2016. In March 2016, one patient waited longer than six weeks for a flexible sigmoidoscopy (a type of endoscopy).

Meeting people's individual needs

- Patients in oncology had access to a range of leaflets explaining their condition and treatment. These included Macmillan Cancer Support research leaflets with clinical information about types of cancers, managing signs and symptoms and other relevant subjects. These were available in large print and available to order in other languages if necessary.
- Staff told us they could access leaflets containing information about endoscopic procedures in other languages if they needed to.

- A complex needs box was available for patients on the ward. It contained a variety of equipment, which could be used for patients living with dementia or those with a learning disability.
- Staff identified patients living with dementia or those with learning disabilities at the pre-assessment appointment. This information was included on an alert form placed in the front of the patient record, which we saw.
- The Patient Led Assessment of the Care Environment (PLACE) undertook an audit. During the period February to June 2015, the food at the hospital was rated at 100%, which was better than the national average 92%. The food on the ward was rated at 98%, which was better than the national average of 94%.
- A patient, following an endoscopic procedure was offered a drink and light snack prior to discharge.
- However, staff sometimes asked family members to assist with interpreting. The use of family members is not considered best practice because staff could not be assured that the patient had given consent for information to be shared. This practice means the patient may have given information to a relative that they may not want to share and is a breach of confidentiality. The provider reported that the use of family members was to balance cultural needs and personal preferences. They felt there were occasions when accommodating the patient's individual preferences around communication and interpretation was appropriate.

Learning from complaints and concerns

- Staff discussed complaints at regular team meetings. We saw minutes of these meetings which indicated this was occurring regularly.
- Staff gave us an example of dealing with a complaint. They had tried to deal with it locally, but had been unsuccessful and escalated it to Matron. The complaint then followed a more formal process in line with the hospitals complaints policy. This meant staff were dealing with patient complaints in an appropriate manner and in line with the hospitals policy.
- There was a complaint leaflet dispenser, collection box and poster on how to complain located at the Kestrel suite entrance.

Are medical care services well-led?

Good

We rated well led as good. This was because;

- Staff spoke highly about their departmental managers, and about the support, they provided to them and to patients. All staff said managers supported them to report concerns. Their managers would then act on them. They said their managers regularly updated them on issues that affected the unit and the whole hospital.
- The senior management team were highly visible across the hospital, and based their offices within the clinical environments to make them more accessible to staff. Staff described open culture and said senior managers were approachable at all times.
- Staff from all departments had a clear ambition for the service and were aware of the vision for their departments.
- Governance processes at department, hospital and corporate level allowed for monitoring of the service and learning from incidents, complaints and results of audits across medical services.
- Staff asked patients to complete satisfaction surveys on the quality of care and service provided. Departments used the results of the survey to improve the service.

Vision and strategy

- The vision for the hospital was to become the private hospital of choice in Brighton and Hove, and regional centre of excellence for patients, by ensuring high quality care, which is safe, effective and personalised.
- Staff from the oncology and endoscopy departments had clear ambitions for the service and were aware of the vision for the department. The vision was to provide the highest standards of care, ensuring a patient's experience was as comfortable as possible.

- The endoscopy team were working toward Joint Advisory Group (JAG) accreditation and on completion of data collection of this meant the unit could proceed to the next part of the process.

Governance, risk management and quality measurement

- There was robust system of governance. Heads of departments met monthly and discussed incidents, complaints and the risk register. They reported to the hospital leadership team. Quality and safety meetings and committees which included infection control, medicines management, information governance, antibiotic stewardship, health safety reported to the hospital quality and safety committee meeting. The hospital leadership team and the hospital quality and safety committee reported to the senior leadership team, which reported to the board
- Quality and safety meetings occurred monthly, we saw copies of the minutes of these meetings. This was in line with the hospitals risk management strategy. The chair of the quality and safety committee was responsible for risk management activities in respect to risks that would potentially affect patient health and safety.
- We saw the risk register for May 2016. The register described the risks involved with their impact, likelihood and risk ratings. Existing risk controls and further actions were listed. Staff signed the register to indicate they had read it. Staff felt they could raise a risk and managers would act on it. Staff discussed this at quality and safety meetings and senior leadership meetings. We saw minutes of these meetings which indicated this was happening.
- The minutes and actions from the clinical governance, Medical Advisory Committee (MAC) health and safety, infection prevention meetings were reported to the management team through the service leads meeting. The information was cascaded to the wider team through departmental meetings and staff briefings. All of these meeting were chaired by the executive director and other members of the executive team. They were designed to be informal to encourage a high level of engagement with the staff.
- The oncology service used the Macmillan Quality Environmental Mark (MQEM) to measure the quality of their service and took part in a peer review programme.
- The endoscopy service had assessed itself in line with JAG accreditation standards.

Leadership/culture of service

- There was a clear management structure which staff were aware of. This meant that leadership and management responsibilities and accountabilities were explicit and clearly understood.
- Staff in oncology reported to the oncology manager. In endoscopy, staff worked with the endoscopy lead, who reported to the theatre manager. The oncology and theatre manager reported to the Matron who reported to the Hospital Director.
- Staff told us they could approach immediate managers and senior managers with any concerns or queries. Staff reported a 'family feel' within the hospital. We observed staff interacted in a friendly way with each other.

Public and staff engagement

- The hospital had set up monthly focus groups, to encourage patients to express their views on the service. Up until our inspection, no patients had attended these meetings. We saw these meetings advertised in the reception area.
- Staff encouraged patients to complete patient satisfaction surveys about the care they received at the hospital. The results of the survey were discussed at quality and safety meetings and included the number of responses the hospital received. We saw minutes of these meetings which confirmed this.
- The hospital had regular departmental and team meetings where staff felt able to contribute and raise issues and concerns. Staff told us they felt able to contribute to meetings and raise concerns if necessary. We saw minutes from team meetings which indicated this was occurring.
- We were told that staff were rewarded throughout the year for going 'Above and beyond'. All staff were invited to attend a Christmas lunch, an external party where they received a gift voucher each.

Medical care

Innovation, improvement and sustainability

- The oncology service benchmarked against other services and reciprocated in peer review with other services. We saw copies of the most recent peer review completed with staff from another hospital. It identified areas of good practice and areas for development in order for the service to make changes or improve services further.

Surgery

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

Information about the service

Nuffield Health Brighton Hospital provides routine, non-urgent elective day surgery and inpatient treatment for adult patients across a range of specialties. The surgical specialities include: orthopaedic and general surgery, gynaecology, urology, gender reassignment surgery, cosmetic, ear, nose and throat (ENT), ophthalmic, colorectal, spinal and minimally invasive surgery.

The hospital does not have facilities to provide care and treatment for patients who are at risk from serious post-operative complications or who require high dependency interventions.

There are 41 inpatient beds which are all single en-suite rooms. The bedrooms are used for both inpatients and day cases. The site has a total of three theatres, two with a specialised air filtration system called laminar flow.

From April 2015 to March 2016, the majority of patients treated were day cases (4,454) opposed to those receiving care as inpatients (1,207). During the same reporting period 24% of inpatients were NHS funded and 76% had other means of funding the treatment.

During our inspection we visited the surgical ward, theatres and the recovery area.

We spoke with six patients and collected the views of 27 patients through feedback comment cards and feedback on our website. We observed care being provided to patients and reviewed eight sets of patient's records both in theatre and on the wards.

We spoke with over 20 staff. This included consultant surgeons, consultant anaesthetists, nurse managers and nurses in a variety of roles. We spoke with allied health professionals including physiotherapists, administrative staff, housekeeping staff and catering staff. We listened to staff in focus groups and took into account staff feedback from our website.

We requested information before the inspection and reviewed the documents the hospital used to monitor its surgical function.

Surgery

Summary of findings

We rated surgical services as good overall because;

- The hospital had effective systems and processes in place to deliver evidenced based care and treatment. This included robust systems for reporting and learning from incidents. Audits were conducted to provide assurance that staff and clinicians worked according to the evidence-based guidance.
- Patients received surgical interventions, care, treatment and support that achieved good outcomes. Their needs were assessed with individual care and treatment planned and delivered appropriately. Patients told us of the excellent care and attention they had received at the hospital. They told us they felt involved in their care and told us that staff listened to them.
- Leadership was visible and responsive. Staff had confidence in both their immediate team leader and the hospitals senior management team. All staff were fully engaged with the strategic vision and values of the hospital.
- There were sufficient numbers of suitably qualified, skilled and experienced staff to care for the patients admitted to the hospital. Staff were appropriately inducted and had the training, learning development and supervision through appraisal to deliver safe care.

However,

- Medicines management did not always reflect best practice . We found that although there were medicine management systems and processes in place, we identified some concerns in the maintenance of controlled registers and the management of medical gases.
- There was not an admissions policy available specific to Nuffield Health Brighton. The hospital's admission policy was a document titled 'Local admissions policy for Nuffield Health Woking Hospital'.
- Although surgical services were able to access support from other health care professionals out of hours through on call rotas for pharmacy, radiology and physiotherapy, there was no provision for a radiologist to report on emergency images out of hours. Patients may need to be transferred out to the local NHS hospital due to lack of out of hours reporting on radiological imaging.
- The hospital kept one laser register for the three lasers currently in use. This was in a loose leaf paper format and did not provide a robust method of detailing the use of each individual laser.

Surgery

Are surgery services safe?

Good

We rated surgical services as good for safety because:

- There were robust systems in place for the reporting and learning from incidents. There was a good reporting culture which engaged all staff across the hospital.
- There were good infection control systems in place managed and monitored by the infection control team. The general environment was maintained to a high standard. The facilities were modern, clean and fit for purpose and provided a safe and efficient working environment and a pleasant setting for patients to undergo investigations and surgical interventions.
- Although not everyone had completed their mandatory training there were systems in place to monitor training compliance and processes to follow this up.
- There were sufficient numbers of suitably qualified, skilled and experienced staff to care for the patients admitted to the hospital.

However;

- Medicines management did not always reflect best practice were medicine management systems and processes in place, we identified some concerns in the maintenance of controlled drug registers
- Although the Nuffield Health Brighton Hospital had well designed medical gas manifolds there were inadequate storage facilities for the medical gas cylinders that did not meet regulatory requirements.
- There was a lack of planned preventative maintenance plan for medical gas regulators and it could not be verified that they had been appropriately serviced and maintained by a competent person
- The hospital kept one laser register for the three lasers currently in use. This was in a loose leaf paper format and did not provide a robust method of detailing the use of each individual laser.
- There was not an admissions policy available specific to Nuffield Health Brighton. The hospital's admission policy was a document titled 'Local admissions policy for Nuffield Health Woking Hospital'.

Incidents

- The hospital had policies and procedures in place for dealing with untoward incidents. The corporate Nuffield Health policies were readily available for staff to access on the hospital's intranet. The electronic reporting system was accessible on every computer on the hospital's intranet. All staff had access to the system including housekeeping and ancillary staff.
- Of the 190 clinical incidents that occurred in the hospital between April 2015 and March 2016, 88% occurred in surgery or inpatients and 12% in other services. However the data suggested that low harm and near miss incidents were not so frequently reported.
- There were no reported never events in the reporting period April 2015 to March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- The hospital reported 2% of all clinical incidents as severe or death. From April 2016 to March 2016 the hospital reported one unexpected death and one serious injury. This number of serious injuries was not high when compared the independent acute hospitals we hold data for.
- Of the 49 non-clinical incidents that occurred between April 2015 and March 2016, 51% occurred in surgery or inpatients with 49% in other services. The assessed rate of non-clinical incidents (per 100 bed days) was below that of the other independent acute hospitals that we hold data for.
- The ward manager was responsible for investigating incidents. The findings were then shared with the hospital matron, the medical advisory committee (MAC) and corporate teams. Regular governance meetings were held where incident feedback was given to managers who then cascaded the findings and any actions to staff at ward meetings. Staff confirmed they received feedback from incidents and there was shared learning during team meetings.

- We saw evidence of root cause analysis (RCA) investigation and the learning points which were disseminated to staff and the organisation as a whole.
- Staff had received training on incident reporting at induction and during mandatory training days. Staff understood their responsibilities to report concerns, record and report safety incidents. The hospital had a no blame culture and all of the staff we spoke with told us they would have no hesitation in reporting an incident or concern. One member of staff told us the hospital encouraged them “Be open and honest, apologise if you make a mistake."
- The ancillary staff we spoke with told us that they would report any incident directly to their line manager. Although they were familiar with the incident reporting system and had computer access, they accessed it infrequently as there were so few reportable incidents. They told us they received feedback on relevant incidents such as slips on floors which were discussed during the housekeeping meetings
- Staff gave examples of reporting incidents and told us the system worked well. Ancillary staff told us about self-reporting a workplace injury. A health care assistant explained how she had reported an incident about a patient with the help of a nurse and received feedback from the manager.
- The hospital had a duty of candour policy available on the intranet. 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.
- The senior staff we spoke with had a basic understanding of the duty of candour, but told us there was no training available. We looked at a recent investigation into a patient’s fall on the ward and noted that the patient and their relatives were contacted within 24 hours of the incident and kept informed. The senior leadership team board meeting minutes reflected the action taken following serious incident or complaints and included contacting relatives.
- Duty of candour was routinely monitored as part of the adverse incident process. The senior management team reviewed all incident logs on a daily basis which included compliance with candour.
- Although the March and April 2016 ward meeting minutes contained reminders for all staff to be familiar with the Duty of Candour, the ward staff we spoke with were not familiar with the term.
- We noted that in May 2016 theatre staff were asked to review the duty of candour flowchart and familiarise with the process in case of any significant harm which occurs to a patient. The flowchart was on the wall in the theatre rest room.

Safety thermometer or equivalent

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism. The hospital submitted monthly data to the NHS as this was part of the information required when treating NHS patients. We noted that the information was kept by the ward manager in a file but was not displayed for patients, staff and visitors.
- The hospital reported 100% screening rates in April 2015 to June 2015 for venous thromboembolism (VTE). There were five incidents of hospital VTE or pulmonary embolism (PE) which had occurred in the reporting period July 2015 to March 2016. The hospital reported 98% VTE screening rates for this period.
- The patient safety data indicated that there were no, falls, pressure ulcers or catheter or urinary tract infections in the past three months.

Cleanliness, infection control and hygiene

- The hospital had corporate Nuffield infection prevention and control policies and procedures that were available to all staff on the hospital’s intranet. The Nuffield Health corporate infection prevention and control lead was available for further support and guidance if required.
- The hospital had arrangements in place to support the management of infection prevention and control. These included an infection prevention team, which included the matron as director of infection, prevention and control, an infection prevention and control co-ordinator and link nurses in each department. Another hospital in the Nuffield Health provided the

hospital's microbiology service. There was a named consultant microbiologist from a nearby NHS trust who provided infection prevention and clinical advice when needed.

- The infection prevention team undertook regular audits and monitored infection prevention and control across the hospital. All results were monitored by the infection prevention committee which met quarterly and fed into the hospital's quarterly quality and safety committee meetings.
- We saw minutes from the infection prevention committee meetings where audit results, policies and training requirements were discussed.
- The infection prevention action log was provided for April to August 2015. The hospital coded areas of concern as red. This meant the impact was likely to be high and action was required as soon as possible to reduce the risk of infection. Examples of red coded areas were hand hygiene and catheter management. These were areas the infection control team flagged as high risk and undertook additional monitoring. We saw from the March and April 2016 ward meeting minutes that the additional monitoring was taking place.
- All areas of the hospital we visited appeared visibly clean and were exceptionally tidy. For example surgical supplies were in date and stored tidily in appropriately labelled drawers and cupboards. This helped to ensure that stocks were used in rotation and a good standard of hygiene was maintained. The sluice and dirty utility areas were kept free from clutter, which made them easier to keep clean.
- Cleaning audits were in place to ensure monitoring of the environment. The hospital undertook patient led assessments of the care environment (PLACE), a national initiative to assess the quality of the patient environment. The assessments apply to hospitals and other locations that provide NHS funded care. The Nuffield Health Brighton Hospital's 2016 Patient Led Assessment of the Care Environment (PLACE) scores were the same or better than the England average for cleanliness (100).
- Patients were cared for in individual rooms which made it easier to isolate individuals if needed. Each room had wash hand basins and personal protective equipment readily available. The bedrooms were cleaned and bed linen was changed daily. The fabric curtains in the bedrooms were steam cleaned three times a year, while the visibly clean disposable shower curtains were changed annually unless soiled which was in line with the manufacturer's guidelines. The housekeepers carried out daily cleaning of the ward areas and emptying of the linen trolleys. Disposable mops and cloths were used for cleaning.
- Cleaning staff undertook daily cleaning of the ward and nursing staff cleaned areas they used in both the ward and theatres. We observed the daily records were completed to identify when staff had completed the cleaning.
- We observed that staff followed the hospital's waste management policies. All waste was segregated and disposed of appropriately. There were instructions for labelling and disposing both clinical and domestic waste on display and evidence of this guidance being followed visible. Disposable sharps were managed and disposed of safely.
- Spillage kits for the safe disposal of body fluids, chemical fluids and cytotoxic waste were provided and were all in date. Staff knew where to locate them, and correctly described the procedure for managing each situation in accordance with the local policy.
- All equipment was stored neatly and as ready to use with 'I am clean' stickers attached. However we noted that although the individual patient rooms and clinical rooms had laminated flooring, the ward corridors were carpeted. This was not so easy to clean if spillages should occur. The corridor flooring was not consistent with Health Building Note 00-09: Infection control in the built environment. However relevant risk assessments together with mitigating actions such as regular deep cleaning were in place.
- We observed good hand hygiene practices throughout the hospital. Hand washing sinks, soap, and alcohol hand rubs were in good supply throughout the wards and theatres. Staff were bare below the elbows and we saw they followed hospital procedures for hand washing between attending patients.
- Personal protective equipment was readily available, correctly stored, and worn by staff in accordance with the hospital's policy. All staff adhered to national dress requirements to minimise the risk of health care

acquired infections. In theatre scrubs and suitable footwear were worn by all staff to minimise the risk of cross contamination of healthcare practitioner's clothing.

- Surgical site infections were monitored and recorded. In the reporting period, April 2015 to March 2016, the rate of surgical site infections (per 100 surgeries performed) was higher than the average for primary knee arthroplasty (one infection out of 11 patients) and breast procedures (five infections out of 354 patients). There were no infections for primary hip arthroplasty, spinal, cranial and vascular surgery. This was based on comparing the results of 12 similar independent hospitals we hold data for. We noted that healthcare-associated infections (HCAI) were monitored by the infection prevention committee who undertook investigations of any HCAI and disseminated any learning required.
- There was no incidence of Clostridium difficile. MRSA or Methicillin sensitive Staphylococcus Aureus (MSSA) from April 2014 to March 2016. There was one incidence of E-Coli in the same period. These are all potential serious infections that could cause harm to patients.
- All identified infections were investigated with a root cause analysis and all infection prevention audits were up to date and cascaded to the teams.
- The hospital had local antibiotic guidelines in place to help control increasing antibiotic resistance by limiting inappropriate and/or prolonged use. Antibiotic use was monitored through the hospital's antibiotic stewardship forum that met quarterly.
- Infection prevention and control was included in the hospital's mandatory training programme. The hospital provided training data which confirmed that the majority of staff had attended infection prevention and control training with included asepsis training for the nurses. Those staff we spoke with all confirmed they had completed this training.
- Feedback from patients during the inspection on the cleanliness of the hospital was consistently good. Comments included "it's very clean and hygienic here"; "the room and bathroom was exceptionally safe and clean"; "I've seen everyone washing and gelling their hands"; "My room was thoroughly cleaned every day including changing the bed linen - even when I was unable to leave my bed."

Environment and equipment

- The hospital had a capital investment programme in place and over the past five years had undertaken major refurbishment and replaced a number of large medical devices.
- The general environment was furnished to a high standard. Patients had individual rooms each with its own dedicated piped oxygen and suction. Each room had shower and en suite toilet, television and Wi-Fi services. The hospital's 2016 PLACE scores were the same or better than the England average for condition appearance and maintenance (98%).
- Patient call bells were available in both the shower area and by the bedside. The call bells were long enough to be accessed in an emergency should the patient be on the floor.
- The theatre environment met national government standards. The hospital had three theatres, two with a specialised air filtration system called laminar flow. The hospital carried out a variety of speciality procedures in the laminar flow theatres which included orthopaedic surgery, general, gynaecology, urology, gender reassignment surgery, cosmetic, ENT, ophthalmics, colorectal, spinal and minimally invasive surgery that required the filtered air system. Each theatre had its own anaesthetic area, scrub facilities, separate male and female changing rooms, rest rooms and administration offices.
- All patients who had a procedure under general anaesthetic or conscious sedation were cared for in a spacious recovery area which was visible from a central communication station. Each recovery bed space had its own oxygen, suction and cardiac monitor.
- The hospital used three class four lasers. There were suitable arrangements in place to ensure that the lasers were maintained used appropriately by suitable trained personnel. This included having a nominated laser protection supervisor and a laser protection advisor who conducted annual reports on the safe use of the lasers.

- We found there was a wide range of equipment available. This included manual handling equipment such as hoists and PAT (patient transfer) slides for patients who required assistance to transfer and medical devices such as blood gas and telemetry equipment. The hospital did not routinely provide bariatric care however specialist bariatric equipment was available if required.
- We saw there were systems in place to monitor, check and maintain equipment. Outside contractors were responsible for ensuring the equipment was appropriately serviced, calibrated and functioning correctly. We noted that each piece of medical equipment was labelled with an asset number and had stickers in place to identify when they had last been serviced, electrically tested and when the next service was due. A library of equipment instruction manuals was kept together with cards detailing who to contact when there were issues with equipment.
- All equipment we inspected within the electrical store had an inventory number and calibration dates attached. However not all equipment stated the date when the next service was due.
- The staff we spoke with confirmed they had access to the necessary equipment they required to meet peoples care needs. They told us the service provided the contractors were "Usually very good depending on the urgency of the situation." We observed staff reporting equipment faults and environment issues and noted the system was easy to use and staff received a prompt response.
- Emergency resuscitation equipment, oxygen and suction equipment was available in the ward area and had been routinely checked to ensure it was ready for immediate use. Theatres had a difficult airway trolley shared between the theatres, which were checked daily by the operating department practitioners.
- Single use equipment such as syringes; needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner.

Medicines

- Although the service had safe medicine management systems and processes in place, we identified a number of concerns relating to governance and performance management.
- Home Office guidance states that controlled drugs (CD) must be securely fitted by internal bolts to a solid wall. The CD cupboards on the ward and in the dispensary did not meet this specification.
- Best practice guidance from the Royal Colleges, national agencies and Department of Health together with legislative requirements under the Medicines Act 1968 and associated regulations require that there is a contemporaneous record of controlled drug administration. In order that all records are traceable and practitioners are accountable for their actions all records must be legible. We found the CD registers in theatre contained gaps and omissions and many of the signatures were illegible. This meant that it was not always possible to confirm which practitioner administered the controlled drug or the time, date and patient who received the drug, which could compromise patient care. The hospital told us that the signatures of all medical practioners who use or have access to controlled drugs in the hospital were securely held on a signature sheet in accordance and this sheet was used to verify signatures in the controlled drugs registers. However, when we discussed the issue of missing signatures with staff, none said they could access this record to resolve queries.
- The medical gas manifolds supply the hospital pipeline system with sufficient quantity of gas by cylinders and/or tanks. Nuffield Health Brighton Hospital' had well designed manifolds. However there were inadequate storage facilities for the larger cylinders not required for the manifolds. We found non-medical gas was stored with medical gases (nitrogen with carbon dioxide). Out of date and corroding fire extinguishers were stored in the cylinder returns store. Empty gas cylinders were stored in an external cage without weather protection. Although there was suitable racking available for small cylinders, three medical gas cylinders were lying on the floor. This did not meet regulatory requirements such as the Department of Health, Health Technical Memorandum (HTM) 02-01: Medical gas pipeline

systems requirements; European Medical Devices Directives 93/42/EC (as amended) or the Medicines and Healthcare products Regulatory Agency (MHRA) recommendations.

- There was a lack of planned preventative maintenance plan for medical gas regulators. The medical gas regulators were not on the hospital's asset database at this location. Although we requested these records they could not be produced. This meant it could not be verified that they had been appropriately serviced and maintained by a competent person.
- There were corporate medicines management policies available that were readily available for staff to access. The hospital had antibiotic guidelines available (Standard Operating Procedure: MM46), which included their use in surgical prophylaxis. The policy was due for review in May 2015.
- Staff had access to relevant resources on medicines management such the British National Formulary 71. Procedures were in place and followed for the management of medicines related controlled stationery (Nuffield Health private prescriptions and controlled drug order books).
- We noted that on the ward CDs were stored in lockable cupboards and their use was recorded and monitored appropriately to ensure safe practice was maintained. CDs throughout the hospital were audited every three months. CD destruction kits were available on the ward for the safe disposal of unused drugs.
- Emergency drug packs for arrest, anaphylaxis and deteriorating patients were available and standardised across the service.
- The hospital had an in-house pharmacy service that operated Monday to Friday 8am to 4pm. The RMO and a nurse had access to the pharmacy out of hours. The pharmacy was an adequate size for quantities of medicines held. Pharmacy provided a clinical service to the ward with pharmacy staff involvement throughout patients' journey. A pharmacy communication book was in use demonstrating effective working relationship between ward and pharmacy staff.
- Medicines were audited on a regular basis. We saw evidence of controlled drugs audit, a medicines storage audit and medical gas cylinder storage audit in theatres undertaken in March 2016.
- Medicine trolleys were used on the wards to store and dispense medicines. We saw they were appropriately secured when not in use. Fridge and room temperatures were recorded daily to ensure that medicines that required cool storage were kept at the right temperature.
- We noted that on the ward, medicines records were clear, well maintained and generally well completed. Allergies were recorded in the patients care record and on patients' individual drug charts.

Records

- The hospital used a mainly paper based system of recording patient care and treatment. Electronic patient care records were not used. At inspection we found that complete sets of medical and nursing records were available for each patient having a surgical intervention.
- The hospital told us they adhered to national Caldicott principles when protecting patient confidentiality. The Caldicott principles are seven recommendations for the management of data in order to safely manage information and ensure patient confidentiality. Matron was the hospital's Caldecott guardian. There was an information governance lead and information governance meetings were held on a quarterly basis. Records were held secure either in the office or with the patient. Staff gave an example of protecting patients who were admitted for transgender surgery through only documenting 'surgery' on any sick certificate.
- We reviewed a sample of eight care records on the ward and in theatre. We found that both nursing and medical records met Nursing and Midwifery Council and General Medical Council guidelines. The records were well completed and provided an accurate personalised record of each patient's care and treatment.
- We found that signatures were in place, complete with staff designation and date. The records were legible with up to date risk assessments and care bundles. The

nursing instructions were appropriately recorded, carried out and then regularly reviewed. The medical and nursing records presented a clear picture of the patient's condition, care and treatment.

- Each three months 30 sets of patient notes were reviewed by the matron and two senior nurses to monitor the quality of documentation and compliance outcomes; compare to previous audits and update the ongoing action plans with potential learning that need to be disseminated to staff members. We noted there were generally no issues identified for action.
- We reviewed the theatre surgical registers and noted all entries were complete, legible, signed and dated appropriately. A separate implant register was kept to provide the basic information needed to evaluate and compare the quality of implants, to enable early detection of serial defects, to assess short- and long-term reactions and complications.
- The hospital kept all the required documentation relating to the safe use of lasers. This included local rules, authorisations, laser risk assessments, record of laser operatives and staff training. We noted that although there were three lasers in use there was only one laser register kept. This was in a loose leaf paper format and did not provide a robust method of detailing the use of each individual laser.

Safeguarding

- The hospital had a safeguarding vulnerable adults and children policy with guidelines readily available to staff on the hospital's intranet.
- Matron was the safeguarding lead for the hospital. She was a member of the Independent Providers Safeguarding Meeting that was chaired by the local clinical commissioning group (CCG). The CCG provided the hospital with a named professional for safeguarding adults.
- The hospital reported there had been little safeguarding activity within the past year. No safeguarding concerns were reported to CQC in the reporting period April 2015 to March 2016.
- All staff undertook basic safeguarding adults training at induction and then yearly as part of the mandatory training requirement. The training was an on-line module that met the criteria for safeguarding level one.
- Although children were not treated as inpatients in the hospital, children did visit the ward area on occasion. Both national guidelines and the corporate safeguarding children policy state that all staff interacting with children should have level two safeguarding children training. Although the hospital told us compliance with the safeguarding training was between 91% (Level one), 96% (level two) and 100% (Level three) this could not be verified at inspection as the safeguarding training records were not available.
- The staff we spoke with were unaware of the level of safeguarding training they had completed. They told us they knew how to access the safeguarding policy. They said they would report their concerns to the nurse in charge or contact matron as the safeguarding lead if needed.
- There were safeguarding flowcharts and posters available which detailed what to do in the event of a safeguarding concern and who the named leads were. There were also flowcharts for what to do if female genital mutilation (FGM) was seen or suspected.
- The gender reassignment team were unable to state what level of safeguarding training they had completed although they thought it was a basic level. They were aware that the matron was the hospital lead for safeguarding told us they would escalate any concerns to her. All patients seen by the gender team were 18 years old and over, it was accepted that any issues related to safeguarding or mental capacity would have been identified and dealt with at the patient's gender identity clinic (GIC) where they would have their psychiatric liaison. However it was accepted that this cohort of patients were vulnerable and they sometimes turned patients away as they were not ready for the surgery. They gave a recent example where surgery was delayed as the patient was not fully committed.
- Although the staff we spoke with had only undertaken basic safeguarding training they were aware of the vulnerabilities of patients undergoing surgery for cancer or cosmetic reasons. They told us it was important to respect patients' views. They gave the example of patients who may prefer alternative medicines and therapies, which could indicate vulnerability and be

open to exploitation. We noted the team had not received female genital mutilation training, although one of the specialist nurses had training at previous employment with an NHS provider.

- We reviewed the minutes from a recent theatre meeting held in May 2016. The minutes stated that new vulnerable adult, safeguarding children and the prevention of terrorist ideals flowcharts were displayed in the staff coffee room. All staff were asked to familiarise themselves with these. This demonstrated that staff were made aware of how to escalate a safeguarding concern.

Mandatory training

- The hospital had a mandatory training policy which specified the type of training each staff group was expected to undertake on an annual basis.
- All mandatory training modules could be accessed from Nuffield Health's learning management system known as Academy Online. Much of the mandatory training was electronically delivered. Staff were automatically informed of the training modules they were expected to undertake and completion was monitored by their line manager. Training levels were monitored and reviewed at ward and theatre meetings, the integrated governance committee and the senior leadership team (SLT) board meetings. Staff and managers told us the system worked well.
- Academy Online was updated daily and reflected any change staff member's job role including additional training requirements.
- A training matrix project was started in April 2016 as mandatory training levels were below the hospital's target of 85%. In order to overcome this staff were to be given three days for mandatory training between Christmas and New Year's Day when the hospital closes. Mandatory training for theatres was 89 to 90% completed for the year to date.
- We were told that training for night staff was challenging because it was difficult to allocate time for training due to the small size of the team. This in addition to other challenges of having separate day and night staff, had resulted in the hospital stating that all new recruits on the wards must agree to work day and night shifts on rotation.
- Practical training such as immediate life support training was run separately, six days each year. This was managed and overseen by the Resuscitation Committee which reported quarterly to the Health and safety Committee. We were told that the training included scenarios where staff would practice emergency first aid in different locations to develop their skills.
- Non-clinical staff were given one day a month training. Although this was not verified ancillary staff we spoke with told us about their monthly training. They said they had completed a booklet with health and safety questions to answer, basic first aid training and infection control training.

Assessing and responding to patient risk

- The hospital's statement of purpose was generic in nature and did not specify that the hospital could not look after patients that required level two critical care such as immediate care following major elective surgery; emergency surgery in unstable or high risk patients or where there was a risk of postoperative complications or a need for enhanced interventions and monitoring.
- The hospital did not have the facilities to manage patients who required level two critical care support. We were told that should a patient's condition deteriorate they were transferred as an emergency to the nearest NHS hospital. This meant that the hospital carefully screened patients during the pre-admission consultation to exclude operating on patients assessed as a surgical risk.
- There was a service level agreement with a local NHS Hospital for the transfer of patients requiring critical care. This was written by the NHS hospital in April 2013. The hospital director told us this was with the NHS hospital for updating. The copy of the SLA that was available did not have a review date included. We were told that this would be requested for the updated document.
- The hospital had a corporate policy for 'The Management of the Risks of the Transfer of Patients'. This had been due for review in October 2014 so was not current. We were told that all corporate policies were currently being revised at national level.

- When asked for the hospital's admission policy we were provided with a document titled 'Local admissions policy for Nuffield Health Woking Hospital'. This policy documented that patients admitted to Nuffield Health Woking Hospital were risk assessed as being clinically safe to be admitted whether through existing co-morbities or due to the complexity of the surgery or procedure being undertaken. The policy gave a list of exclusions to theatre and the need for patients to attend a pre-admission assessment prior to surgery. However the admissions policy was brief and specific to Nuffield Health Woking Hospital. We did not see an admissions policy that set out safe and agreed criteria for the admission of patients for Nuffield Health Brighton Hospital.
- All patients were admitted under the care of a consultant and were assessed on an individual basis to ensure the hospital could meet their needs during the pre-assessment appointment. The patient's previous and current health conditions were assessed at the pre-assessment clinic. Risk assessments were completed and the results documented in the patient's care record. Risk assessments included the risk of venous thromboembolism (VTE), falls, pressure ulcers and malnutrition. Any concerns were documented and any discussions documented. On admission the risk assessments were reviewed and the patient was asked if any changes had occurred.
- The care records included pressure ulcer and falls risk assessments to help identify patients at risk. The tool included the measures needed to reduce the incidence of pressure ulcers or falls such as pressure relieving mattresses or bed rails.
- The hospital used an early warning system to alert them should a patient's condition start to deteriorate. In the sample of records we reviewed the early warning tool had been completed appropriately. The quarterly audit of patients' notes included the completion of the early warning scores. The quarterly audit of thirty sets of patients' notes indicated that MEWS scores were usually completed appropriately.
- An escalation procedure was in place for nursing staff to escalate to the RMO and for the RMO to escalate to the consultant for the patient. If a patient's condition deteriorated and gave cause for concern staff told us both the RMO and consultant were informed. The patient would be taken by ambulance to the local hospital's emergency department. There was no agreement for the patient to be admitted directly to a ward or intensive care.
- The theatre staff followed the five steps to safer surgery. This involved following the World Health Organisation (WHO) checklist before during and after each surgical procedure. We observed staff in theatres following the WHO)surgical safety checklist. For example before the theatre list started there was a team briefing and handover where members of the theatre team were introduced and their roles clarified. This reduced the risk of misunderstanding and errors during the operation. The minutes from theatre meetings confirmed that auditing of the WHO checklist took place and that the results were monitored and acted upon.
- The hospital had a resuscitation committee that met quarterly. Practice resuscitation scenarios took place between each committee meeting to ensure staff maintained their skill level. The scenarios took place in different locations around the hospital. Arrest, anaphylaxis and "deteriorating patient" medicine packs were available and standardised across the service.
- We spoke with the Resident Medical Officer (RMO) on duty during our inspection and they told us that they carried a bleep and were always contactable. They did not have any problems with access to the consultants who were contactable by phone for advice.
- There was a system to review any alerts sent out by the Medicines and Healthcare products Regulatory Agency (MHRA) and ensure that the heads of departments were informed of any national safety alert.

Nursing staffing

- The hospital told us they were currently collecting staffing data using a recognised nursing dependency and skill mix tool. Staffing on the ward was reviewed twice a day by a senior nurse or the ward manager. We looked at samples of staffing duty rotas and noted the hospital was appropriately staffed for the acuity of the patients. The staff we spoke with confirmed that the ward manager did the weekly allocation of staff depending on the expected admissions.
- The ward was usually staffed on patient to nurse ratio of six to one. Patient acuity levels were assessed during

pre-assessment which enabled the forward planning of staff to ensure the number and skill mix was appropriate on any particular day. There was a minimum of two qualified members of staff on duty at all times. This was confirmed in the copies of the staff rotas available on the ward. We noted that from January 2016 to March 2016 there were no unfilled shifts either in theatre or on the ward.

- The inpatient ward provided 1 to 0.19 registered nurse to health care assistant (HCA) ratio with a bank to agency ratio of 4.5 to 1.2. This was similar to the other 12 independent acute hospitals that we hold data for. We spoke with all level and grades of ward staff who told us they felt that nurse staffing was appropriate.
- The theatre departments maintained a ratio of one nurse to almost three operating department practitioners (ODP) and HCA. The hospital used more bank than agency staff over the past year but the use of agency ODPs and HCAs was above the average. This was based on the records of 12 other independent acute hospitals we hold data for. Theatre staff told us there were no problems with staffing and the duty rotas. They said that staff always cover for each other and did on-calls when needed. However there had been much long term sickness of late which had increased the need for agency support.
- The hospital had a small gender team to support patients having gender surgery. We spoke to the gender team who told us they felt that staffing was appropriate with a recent increase in their staffing levels. The team now comprised of two administrators, two specialist nurses, one specialist HCA and two trained staff nurses on the ward.
- The hospital did not have specialist nurses in tissue viability. There were nurses with previous experience but we were told that the local NHS trust would be contacted should advice be required.
- There was no cover for the specialist cancer nurse role on Monday afternoons, although a chemotherapy nurse provided cover on Wednesday afternoons. This meant that it was sometime difficult to facilitate patient support groups and undertake additional training.

Surgical staffing

- The patient's consultant was the person in charge of their care and undertook any post treatment reviews. Out of hours the consultant was called if needed and staff gave examples when this had taken place. The anaesthetists had an on call 24 hour rota and covered their own patients on the first day of surgery. A group of anaesthetists who were based at Nuffield Health Brighton Hospital also provided out of hours cover for the hospital. The hospital employed five Registered Medical Officers (RMO) providing 24-hour medical support.
- The hospital worked with a local university to provide the RMO cover. The RMOs worked a 1:5 rotation at the hospital, covering day or night shifts in accordance with the working time directive. When not working at the hospital the RMOs provided teaching at the university undertaking practical and tutorial sessions.
- When at work RMOs had their own room to use with the ward calling them as necessary. If they became unwell at work or there was any other issue, they provided cover for each other if needed.
- The hospital maintained a Medical Advisory Committee (MAC) whose role included ensuring that any new consultant was only granted practicing privileges if deemed competent and safe to do so. The role of the MAC included periodically reviewing existing practicing privileges and advising the hospital on their continuation. They gave examples where practicing privileges had been suspended or withdrawn as a result of concerns raised. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants working at the hospital.
- There were 197 consultants employed at the hospital under a practicing privileges agreement. The process for granting practicing privileges included an online application, documental evidence, occupational health and disclosure and barring checks. The medical practitioner then attended an interview with the hospital director and matron where practicing privileges were granted or denied. All the information was then submitted to the MAC for the practicing privileges to be ratified. The medical practitioner was required to submit further information and updates on an annual basis.
- The hospital was in the process of reviewing all medical files prior to changing to a digital record system. The

hospital told us the new system was robust and would ensure consultant provided the necessary documents to confirm they had the necessary skills and their fitness to practice. The hospital had completed 160 of the 197 record reviews at the time of the inspection. Those consultants who had missing documentation or who had not practiced in the hospital for some time were contacted to discuss the issues. Ten consultants had received letters to date. This demonstrated that there was good oversight of the practicing privileges process.

- There was a Revalidation and Appraisal policy in place to assist the corporate revalidation team in providing assistance for consultant revalidation. All the consultants practicing at the Nuffield Health Brighton Hospital also worked within the NHS and their records showed they had been through the revalidation process.

Major incident awareness and training

- The hospital had in place a disaster recovery and major incident handling policy which had recently been reviewed. The policy included a flowchart of the procedures and process to follow, scope and individual responsibilities. Also included were contact details of local health care providers, the emergency services, corporate contacts and details of the emergency gas shut off valves.
- The policy was individual to the Nuffield Health Brighton Hospital and detailed the responsibilities of each individual together with the actions they were expected to undertake.
- The staff we spoke with were aware of the policy and knew how to access it in an emergency. They told us that scenario training was undertaken where procedures for major incidents such as fire were tested.

Are surgery services effective?

Good

We rated surgical services as good for effective because;

- The hospital had effective systems and processes in place to deliver evidenced based care and treatment. Audits were conducted to provide assurance that staff and clinicians worked according to the evidence-based guidance.
- Patients received surgical interventions, care, treatment and support that achieved good outcomes. Their needs were assessed with individual care and treatment planned and delivered appropriately.
- Staff worked collaboratively with partner agencies and other providers to promote the health and well-being of the patients.
- Patients were given information at the appropriate time to enable them to make informed decisions and consent to treatment. Where patients were vulnerable or lacked capacity staff had the training and understanding to deal with the situation.
- The hospital provided opportunities for staff induction, learning development and appraisal. Although there was a lack of formal supervisory clinical supervision, staff felt well supported through peer support and formal ward meetings.
- We saw there were robust arrangements in place to monitor the competence of consultants with practicing privileges and action was taken were concerns were identified.

However;

- Although surgical services were able to access support from other health care professionals out of hours through on call rotas for pharmacy, radiology and physiotherapy, there was no provision for a radiologist to report on emergency images out of hours. Patients may need to be transferred out to the local NHS hospital due to lack of out of hours reporting on radiological imaging.

Evidence-based care and treatment

- The hospital had a full range of policies and procedures available which were supplied by the Nuffield Health corporate provider. These policies ensured that care and treatment was provided with in accordance with guidance from the National Institute for Health and Care Excellence (NICE) and other relevant bodies. For example gender reassignment surgery was based on national eligibility criteria based on World Professional Association for Transgender Health guidelines.
- The corporate Nuffield Health policy team undertook continuous review of new legislation, best practice

guidance and advice from the Royal Colleges. We noted that the hospital used NICE medicine management guidance and local medicines formularies and prescribing guidelines.

- We noted that any changes to policies were communicated through the Quality and Clinical Governance Committee. Policy items were a standing agenda item at this meeting.
- The hospital told us that NICE guidance monthly was disseminated to nursing staff and consultant staff as appropriate. All nursing staff had electronic access electronically to a recognised NHS hospital nursing manual and a patient information service which gave procedure specific guidance to patients and nurses. There was online access to current medicines management guidance manuals through the Nuffield Health intranet site.
- The hospital also conducted local audits to provide assurance that staff and clinicians worked according to the evidence-based guidance. Local audit activity included benchmarking their performance against national, local and group outcomes. This included clinical audits which all departments fed into and the monthly safety thermometer audits. The ward staff had a programme of audits in place such as monthly infection control audits, quarterly medical records audits. The records audits demonstrated an improvement in fully completed care records over the past year.
- Clinical audits included gender reassignment surgery which included nursing interventions, consultant interventions and variances to the usual care pathway. The audit identified that there was no problem with pressure ulcers in the gender reassignment patients who may spend a long time in surgery. This was an identified risk for this type of surgery.
- Other audits completed in the past year included a blood transfusion audit and a patient out transfer audit. A clinical sister told us that the transfusion audit resulted in better completion of the fluid balance charts and the patient transfer audit demonstrated that all transfers were completed safely.
- The results from all audits were fed back into the Quality and Clinical Governance Committee where the results were recorded and actions put into place as needed. A quarterly governance report was presented to the MAC for information and discussion. The results were also fed back to staff at the ward and theatre meetings. The hospital gave examples of the outcome of various audits and the actions that were taken. For example theatre staff were good at completing the WHO checklist but were not so good in the observation audits, for example the individual anaesthetists sign in at the beginning of a procedure. This was covered by the team brief each morning but not recorded. A new form for data collection had been developed which should make it easier for staff to complete the forms.

Pain relief

- There were systems in place to effectively manage patients' pain control. The surgical care pathway contained prompts for staff to assess and record if the pain was being managed effectively.
- A baseline pain score was recorded in the pre-assessment clinic and followed through surgery to post discharge when the patients were asked if they had good post discharge pain control. We were told that all patients seen at pre-assessment had the pain scoring system explained and were actively encouraged to discuss their pain or discomfort levels with the nurses.
- On admission the nursing team discussed the current pain or discomfort level with the patient using the 0 to 10 pain score. This gave a baseline for further treatment if needed.
- The hospital also collated patient feedback regarding their pain control in the patient satisfaction surveys. Specific questions were asked in relation to pain management which the hospital reviewed monthly. In the April 2016 patient satisfaction report 98% of patients agreed that staff did everything they could to control their pain. The patients we spoke with confirmed they were comfortable and their pain relief was well managed.

Nutrition and hydration

- The hospital used a nutritional assessment tool to risk assess each patients level of nutrition and hydration. If risks were identified management guidelines were provided for staff to follow. All discussions and outcomes were recorded to ensure the patients nutrition and hydration needs were suitably met.

- On admission the RMO reviewed each inpatient, dependent on their acuity, for their hydration and nutrition status.
- The hospital followed best practice guidance on fasting prior to surgery. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before. Instructions about starve times was given during the patients pre-admission visit. Staff checked as part of pre procedure checks when the patient last ate or drank and this was recorded in the patients care record.
- Following surgery fluid input and output records were kept and the patients' condition monitored until normal urinary functions resumed.
- There was no access to a dietitian at the hospital. Should advice be needed then staff confirmed they would contact the local trust for advice.

Patient outcomes

- As a private hospital Nuffield Health Brighton Hospital did not participate in the majority of national audits undertaken by the NHS. However the data that was available indicated that the hospital was either similar or better than expected when compared with other hospitals offering a similar service. This included readmission rates, returns to theatre and unplanned transfers to other hospitals. This indicated that patients were achieving positive outcomes for their conditions following intervention by the hospital.
- The data submitted confirmed there were 12 cases of unplanned transfer of an inpatient to another hospital in the reporting period and 18 cases of unplanned readmission within 29 days of discharge in the reporting period (April 2015 to March 2016). This number of unplanned transfers and readmissions was not high when compared with the group of 12 independent acute hospitals which we hold data for.
- The hospital participated in national audit programmes where appropriate including quarterly audits as required by NHS England. For example patient reported outcome measures (PROMS), National Joint Registry (NJR), patient assessment of the care environment (PLACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) if applicable.
- PROMS and NJR processes report patient outcomes in a format that allows hospitals to compare their results with other private providers and the NHS. The hospital's adjusted average health gain for PROMS - Primary Knee Replacement could not be calculated as there were less than 30 modelled records. (April 2014 – March 2015).
- Patients who were booked for joint replacement surgery were asked to consider giving consent for registration on the NJR which monitors infection and surgical revision rates. Patients were actively monitored following discharge for surgical site infections. There was no current information available on this audit.
- The hospital gave out PROMS questionnaires for those patients undergoing specific surgeries and then followed up the data by means of a monthly report. Details of healthcare associated infections were reported on a monthly basis.
- As part of PROMS the EQ-VAS asks patients to indicate their overall health on a vertical scale, ranging from "worst possible" to "best possible" health. Out of six records all were reported as improved. The Oxford Knee Score reported 67% improved and 33% as worsened.
- The hospitals adjusted average health gain for PROMS - Primary Hip Replacement were suppressed to protect patient confidentiality. (April 2014 to March 2015).

Competent staff

- The hospital provided opportunities for staff induction, learning development and appraisal. There was a formal induction process supplemented by mandatory training and other training and updates as required. We spoke with a new healthcare assistant who told us they had been allocated a mentor on induction, which they found very helpful.
- We spoke with staff both individually and in groups and they told us that Nuffield Health Brighton Hospital supported them with their learning needs. We heard individual stories of staff undertaking further development with the support of the hospital such as developmental and vocational courses.
- We saw that managers and heads of departments were responsible for ensuring all their staff had completed

the required training. Training issues were picked up and chased where gaps were identified. We heard that training for night staff was a challenge because it was a small team.

- We spoke with staff who told us that since April 2016 a training matrix had been implemented which identified training needs and priorities. It had been identified that there had been insufficient time allocated for training in the past however this was being addressed through an initiative when the hospital closed for three days over the Christmas period this time would be allocated to ensure that all staff were up to date. If staff had completed the training before this they could have the time off.
- Each RMO had an on-line training portal which was monitored by Human Resources and their line manager. They received e-mail reminders to complete training when needed.
- Additional training was provided where there was an identified business need. For example the organisation had identified the need for training on violence and aggression and this was being provided. Previous external trainers had provided training on acute kidney injury and sepsis but this had been poorly attended. A training need was identified for dementia training and basic external training was booked for July 2016. None of the staff we spoke with had undertaken recent training on the Mental Capacity Act 2005.
- Ward and theatre staff told us that they had not undertaken any training specific to caring for patients undergoing transgender surgery. Although specialist nurses were available for support they felt specific training would be helpful in caring for this client group.
- The staff we spoke with told us they received annual appraisals. This was confirmed by the records we saw. Records indicated over 75% for nurses and health care assistants working in inpatient areas in the reporting period (April 2015 to March 2016). Less than 75% of nurses, health care assistants and operating department practitioners working in the theatre departments had received their appraisals in the same reporting period.
- We noted that although there was little opportunity for formal clinical supervision all the staff we spoke with told us they felt well supported. A clinical sister confirmed she had an informal chat with the ward manager every three months with an annual appraisal and six monthly reviews. She told us that appraisals were more useful for newer staff. Healthcare assistants told us about their six monthly appraisals, which they found useful to put forward suggestions for further training. Their manager had suggested areas of development and discussed hospital objectives for the following year.
- We spoke with ancillary and administrative staff and they told us they received the training and supervision necessary for them to do their job in addition to the mandatory training for all staff. We were told that there was a monthly training day for non-clinical staff. The food service assistants confirmed they had annual appraisals but told us that these were more useful for newer staff who were looking for progression.
- The role of the Medical Advisory Committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken.
- Many consultants brought in their own first assistants to support them during surgery. A register of first assistants was kept which detailed their registration with their professional body and Disclosure and Barring Service (DBS) checks. The hospital required them to have their own indemnity insurance. These checks helped to ensure these staff had the skills and qualifications necessary and were of good character. However the training for this group of healthcare professional could not be verified as they kept their own training records.
- The MAC chair confirmed that any concerns or complaints about a consultant's practice were dealt with swiftly and could lead to suspension if necessary. We heard examples of where clinicians practicing privileges had been suspended and saw incidents where practicing privileges were deferred pending further information. This demonstrated that clinicians' skills, competence and experience were monitored by the hospital.
- There were two surgical consultants and two anaesthetic consultants working at the hospital who did not also work in the NHS. There were arrangements in place to ensure that consultants practice was reviewed in line with their governing body's revalidation requirements.

- The gender team told us they were working on formal training package for the RMO; this would include them watching gender reassignment surgery as part of their induction at the hospital.
- The cancer nurse specialist had access to free education and funded courses provided by Macmillan. She also had an external cancer specialist manager and a clinical supervisor at the local university who provided monthly supervision for difficult cases.

Multidisciplinary working

- We found throughout the hospital, staff worked collaboratively to promote the health and well-being of the patients. It was a small hospital and all staff groups knew each other and were fully involved with improving patients' health and recovery both before and after surgery.
- We observed positive interactions and collaborative working between the ward and theatre staff and in theatres between the surgeons and theatre staff.
- Ward staff told us that although the hospital did not employ many specialist nurses, if needed their advice and involvement would be sought from the NHS. They gave examples of the tissue viability nurses who attended the hospital to see patients on request and continued to care for patients following their discharge home.
- Ward staff told us that they liaised with the district nursing and GP services prior to patients returning home to make sure that support mechanisms were in place once the patient returned home. The integrated surgical care pathway included discharge planning and the support services to be arranged early on in the planning and assessment process.
- We looked at the treatment records of treatment for eight patients who had recently had surgery. The records contained details of all the multi-disciplinary input which included the medical, nursing and anaesthetic teams, recovery input and physiotherapy when back on the ward.
- The gender reassignment team described a good working relationship with their consultants and national gender reassignment bodies. An example of this was the formal multidisciplinary meeting held for all gender reassignment patients admitted for surgery to the hospital. This was attended by a specialist nurse, surgeon, and a representative from the patient's gender reassignment clinic and hospital matron. The gender team described a robust process for working with the patient's GP and told us how they liaised with the GP before the patient comes into the clinic. The GPs carried out the routine blood tests for this cohort of patients to avoid them having to travel to the hospital.
- GPs were invited to go to their local Nuffield Health Hospital for training related to caring for gender reassignment patients. On discharge, the ward and the consultant sent the GP a letter, including information to support the GP and information about the ongoing prescriptions required by the patient. The gender team also worked closely with the patients GIC and social services if necessary.
- The physiotherapists and occupational therapists are based at the hospital. Other specialists such as dieticians and stoma nurses based at the local NHS hospital could be contacted if necessary. The food service assistants confirmed that dieticians occasionally visited the wards; however, they did not liaise with the kitchen staff unless there the patient was very ill.
- The hospital had service level agreements (SLA) with other service providers where needed. Such as an SLA for transferring patients to a nearby NHS hospital in an emergency and another with a radiation service to provide radiation protection advice for the theatre lasers.

Seven-day services

- The hospital provided elective surgery Monday to Friday each week from 8am to 8pm. The theatres did not usually operate at weekends with only eight Saturdays utilised in the previous year.
- The type of surgery was dependant on which consultant was booked in for which day. Staff were aware of the patient lists in advance to enable appropriate staffing levels and rooms to be available.
- Nursing staff were available to provide routine or urgent medical and nursing treatment 24 hours a day. A RMO was available on site 24 hours a day, seven days a week and was always available on a bleep system.
- A senior nurse was on duty at all times. There was a clinical on-call rota which supported the ward team out

of core business hours. There was also an on-call manager for theatres and the pathology department. The senior leadership team operated an on call rota and were available via phone outside of day time working hours.

- There was an out of hours on call theatre rota available including the consultant and anaesthetist for that patient should a patient need to return to theatre. This team were available within a 30 minute timescale to enable urgent return to theatre. However, the January MAC minutes identified that the out of hours on call consortium of anaesthetists would only see a patient in an emergency if they had treated that patient. The minutes identified that patients who were not covered would be transferred out to the local NHS hospital.
- The surgical services were able to access support from other health care professionals out of hours with an on call rota for pharmacy, radiology and physiotherapy teams out of hours. The pharmacist was available for telephone advice and there was a service level agreement in place for out of hour's provision of medicines.
- The Royal College of Radiographers standards state that patients should have access to timely radiological services to allow accurate diagnosis and appropriate treatment. Where services cannot be provided throughout the 24 hour period there should be alternative arrangements for providing that service. In December 2015 the MAC raised a concern relating to emergency imaging. It was identified that there wasn't a protocol for having the radiography images reviewed in an emergency and it was usually the consult surgeons' responsibility to do this. In April 2016 the hospital had implemented a standard operating protocol for the validation of radiology results. The protocol confirmed it was the consultant's and RMO's responsibility to review radiography images out of hours and that the unreported images would be reported by a radiologist during their next working session. This meant there was a risk that patients may be transferred out to the local NHS hospital as an emergency due to the lack of out of hours reporting provision for radiological imaging

Access to information

- There were systems in place to ensure that staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included test results, risk assessments and medical and nursing records.
- There were paper-based records for each patient; one for medical notes and one for nursing notes; nursing records including observation charts were accessible in the patient's room. This enabled consistency and continuity of record keeping whilst the patient was on the ward, supporting staff to deliver effective care.
- There were computers available on the wards. These gave staff access to patient and hospital information for example policies and procedures.
- When patients were transferred to other hospitals for further care, transfer letters were completed.
- Staff had access to General Practitioner (GP) referral letters when patients attended pre admissions clinic. We saw good examples of information sharing in the gender team where confidential information was held securely but was available to support the care and treatment of the patients.
- The specialist cancer nurse told us that if there was any information to share with the wider team she would write in the patient's notes. She also kept separate additional records such as the specialist referral form and notes and chemotherapy notes if appropriate. The specialist records were stored locked in the specialist nurses office. The specialist cancer nurse occasionally supported members of staff. She told us she documented these consultations and the records were kept locked in her office in a sealed envelope.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Patient Consent to Examination or Treatment Policy, (Version 5.0) was due for review September 2009 so was not current. We were told that all corporate policies were undergoing review at national level. However we noted that the hospital had in place the Nuffield Health corporate consent policy which met current best practice guidelines issued by the Department of Health.
- The policy was readily available for staff to access and included guidelines for treating adults who were unable

to consent to investigations or treatment. A separate consent form was used in these instances which included the involvement of the patient's family, a capacity assessment and a declaration of best interest.

- Staff we spoke with, both in theatres and on the wards were aware of the policy and the correct procedures to ensure patients gave valid consent prior to any treatment or surgical intervention.
- All staff received training in the requirements of the Mental Capacity Act 2005 (MCA) part of their mandatory training. The gender team told us they relied on the patients local gender identity clinic (GIC) to identify any issues related to the MCA; the team did not have any recent training but felt they had the experience to identify any issues. Gender patients received a psychiatry referral and confirmed second opinion of diagnosis at their local GIC.
- We asked staff how they would manage a patient with limited capacity to make their own choices or decisions and although this rarely happened, they were clear of the process that would be instigated if patients did not have capacity. However we noted that there were no formal capacity assessment tools available should a patient's capacity be questioned.
- We noted that training including MCA and Deprivation of Liberty Safeguards (DoLS) was a standing item for the quality and safety committee which met quarterly. The March 2016 meeting minutes noted 95% compliance with DoLS training.
- Staff confirmed that patients undergoing plastic surgery or gender reassignment were given a consent form at the pre-assessment appointment. They were asked to take this away with them and asked not to sign this on the day but to take it home to consider. The consent form included information about the operation, possible complications and their likelihood and information about cosmetic appearance post-surgery.
- We looked at the recording of consent for those patients undergoing surgery at the time of our inspection. We found that consultants recorded full details of the conversations they had with patients.
- Patients we spoke with confirmed the consultant had detailed the potential risks of their surgery and they were happy to sign the consent form with full knowledge of the surgical risks.
- The hospital had corporate policies available for the resuscitation of patients including 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions. The policy made clear that all patients who had a cardiac arrest would be resuscitated unless a current DNACPR order was in place. No surgical patients had a DNACPR form in place at the time of our inspection.

Are surgery services caring?

Good

We rated surgical services as requires good for caring because;

- The hospital had systems in place to allow patients to feedback their experience of care at the hospital. The results of the surveys indicated that Nuffield Health Brighton Hospital l provided excellent, compassionate care by friendly and approachable staff.
- Patients we spoke with during the inspection confirmed that staff were kind, considerate and respectful. We observed interactions between the staff, doctors, consultants and patients and saw that without exception staff were attentive and caring in their attitude. They provided assurance and support where needed and anticipated when additional care was required.
- The hospital provided services and information to actively involve patients and those close to them. For example patients told us that they had received ample information prior to admission and during their stay and that the staff and consultants took the time to listen to them and their concerns.
- We were told how staff at the pre-assessment clinic took time to counsel patients and allay their fears. Patients and their families were cared for by kind and compassionate staff who went out of their way to support them.

Compassionate care

Surgery

- The NHS 'Friends and Family Test' is a survey measuring patients' satisfaction with the care they have received and asks if they would recommend the service to their friends and family. The scores related only to those patients seen and treated on behalf of the NHS. The results from the NHS Friends and Family test for the period October 2015 to March 2016 indicated high satisfaction scores (above 85%). The response rate was generally moderate (31% to 60%). The most recent response in April 2016 indicated that 99% of NHS patients who responded would recommend the hospital.
- The Nuffield Health Brighton Hospital's 2016 PLACE scores were the better than the England average for privacy, dignity and wellbeing (95%).
- The Nuffield Health group used a patient satisfaction survey where the results were compared monthly against other Nuffield Health hospitals. The results were noted at the Clinical Governance Committee. We noted that the majority of patients rated the overall quality of care as either excellent or very good. In the April 2016 patient feedback report Nuffield Health Brighton Hospital consistently higher than the majority of other Nuffield hospitals for with the exception of the quality of food.
- The hospital was compliant with the Government's requirement to eliminate mixed-sex accommodation. Patients admitted to the hospital were only admitted to single rooms and only shared facilities when clinically necessary such as in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.
- We spoke with eight patients during our inspection and received completed comment cards from 26 surgical patients. Without exception, patients reported staff were polite, friendly and approachable, always caring and respectful. All the patients we spoke with were very happy with the care and treatment provided. We received comments such as "My care has been outstanding"; "The doctors and nurses have all been exceptionally kind"; "They have turned my life around, I can't thank them enough"; "Staff are genuine and sincere – they really care about you."
- We noted that patients receiving treatment and support were treated with dignity and respect, particularly on the wards, where staff always knocked before entering and addressed patients in a professional manner."
- In theatres staff were mindful of patients' privacy and dignity taking care to ensure they were always covered appropriately when they were vulnerable and unable to look after themselves. We observed theatre staff talking gently with patients and holding their hands to reassure them in the anaesthetic room. One patient gave special praise for the nurse who held helped reassure them by holding their hand during the anaesthetic process.
- We saw examples of patients 'going the extra mile' for example facilitating an ex patient who called in on the off chance for a chat with the nurses. We heard how the gender team had identified that patients often required supplies for care before and after surgery. They had put together a box of supplies that patients could pay for or they could make up their own box if they prefer. The box included a waterproof bag, mirror, aqueous cream, wipes, underwear, alcohol gel, disposable small medical devices, scissors and sterile wipes.

Understanding and involvement of patients and those close to them

- Prior to admission for surgery every patient had their individual needs assessed and a plan of care was put in place to address those needs. This included social and psychological wellbeing. Patients were given time to assimilate any information and ask questions.
- Patients told us that the doctors took time to discuss what was happening and their treatment plans were discussed at the ward rounds. One patient told us "It's a five star service everyone from the domestics, receptionist, nurses and consultant have treated me with great respect and dignity.

Emotional support

- During the pre-assessment consultation staff took time to allay patients' fears. We saw that the assessment tool included assessing patient's psychological well-being, maintaining interpersonal relationships and recording any significant life events which may have impacted on their health.

- There was not a separate assessment for anxiety and depression however the documentation included discussing any anxieties about the surgery and confirming that the patient had realistic expectations.
- During our inspection we noted the emotional support available for patients recovering from surgery. For example where surgery was life changing there were support services available such as counselling and specialist NHS nursing support.
- Patients undergoing gender reassignment surgery had access to the specialist nurses to provide emotional and psychological support. Psychological counselling would have taken place by the gender identity clinic prior to surgical referral. The nurses encouraged patients to contact them both before and after the surgery. They told us that if the patients didn't make contact with the following surgery the team would phone them to make sure all was well.
- The Macmillan nurse specialist was available to patients treated by oncologists, including inpatients and chemotherapy patients. Patients could see the nurse before and after surgery. They also contacted them via telephone at home to offer further support if needed.

Are surgery services responsive?

Good

We rated surgical services as good for responsive because;

- The hospital was constantly reviewing the service in order to meet the needs of the local population.
- Patients had timely access to assessment, diagnosis and treatment. There were no delays in accessing surgical intervention and patients told us they had been able to arrange their surgery at a convenient time for them. We saw that plans for safe discharge were considered at the pre-admission clinics where individual patients' needs were discussed.
- The hospital was purpose built and had good disability access throughout. This meant that all patients had equal access to the service.
- Patients were all assessed prior to admission to ensure that the hospital could meet their needs. Where required additional arrangements were put in place to support patients such as extra staff, specialist nurses or family members.
- Patients were encouraged to feedback their experience of the service the received. There was a complaints policy and procedure in place with information available for patients about how to raise concerns. The hospital acted on any concern or complaint and used this information to improve the service it offered.

However;

- Patient feedback indicated that the quality of food serviced did not always meet their expectations. Although some patients said the food was good, others reported poor quality food served at inappropriate times. Although the hospital was aware of these concerns there remained a problem with the quality of food.
- The use of patient's family members as translators was not best practice.

Service planning and delivery to meet the needs of local people

- As an independent hospital treating mainly elective patients the hospital was constantly looking at the services it offered in order to meet the needs of the local population. The service was undertaking less orthopaedic work than planned and so was working proactively with consultants to offer other services relevant to the local population. For example the hospital was one of few in the country which offered gender reassignment surgery.
- From the minutes of the senior leadership team meetings we saw that the hospital was working closely with NHS commissioning groups regarding providing surgical services for NHS patients. During the reporting period (April 2015 to March 2016), 24% of inpatients were NHS funded patients and 76% had other means of funding treatment.
- We saw through minutes of the MAC that practicing privileges were kept under review by the MAC and executive director to ensure that they were only offered practicing privileges at the hospital if there was an identified need.

- The ward and theatre staff told us that they had good teams in place who could work flexibly if circumstances needed. Extra staff could be brought in if the workload was extra busy although this rarely happened as most eventualities were planned for.

Access and flow

- We found that patients had timely access to assessment, diagnosis and urgent treatment. Staff told us that there were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems.
- Following an initial appointment or referral all patients were reviewed in outpatients at a pre-assessment clinic and then normally booked in for surgery within seven working days. This allowed the hospital time to carry out a thorough pre-assessment. Assessments were made for mental capacity, falls risk and manual handling and with any necessary actions started before the patient was admitted. For example ensuring the right equipment was available prior to admission.
- Due to the elective nature of the admissions a planned duration of stay was between one and four days dependant on the type of surgery. Staff told us that it was generally only the gender reassignment patients who stayed over four days. Each type of surgery had an expected care pathway and any variances to this were monitored and investigated.
- The hospital told us that 16 procedures were cancelled in the last 12 months due to a power outage. All patients were offered another appointment within 28 days of the cancelled appointment in line with government guidance.
- The hospital's patient information management system was in the process of being updated. The current system could not produce wait time audit reports for insured and self-pay private patients. The new system was due to be operational in 2017.
- The wait times for e-referral NHS patients were tightly controlled by the NHS referral to treatment time management system. This was reported on a monthly and quarterly basis. The hospital met the target of 90% of admitted NHS patients beginning treatment within 18 weeks of referral for 10 months in the reporting period (April 2015 to March 2016).
- Patients all told us they had been able to arrange their surgery at a convenient time for them. For example one patient told us how their surgery was arranged around work commitments so a member of the patient's family could accompany the patient to hospital.
- The gender team told us that they were one of the busiest gender reassignment surgical units, both nationally and within Europe. They had seen and treated adults from 18 to 80; this included both NHS and private patients. Referrals were received from around the country. All patients undergoing gender reassignment had their pre-surgery assessments, psychological support and evaluations undertaken at their local gender identity clinic before referral to the Nuffield Health Brighton Hospital for surgery.
- We spoke with staff who told us that they liaised with social services and the patient's GP to ensure there was a safe discharge plan in place. This was then documented in the integrated surgical care pathway.
- On discharge patients were given contact details for the hospital and told they could contact by phone or email. Patients were also given a written report which gave recovery advice including eating and drinking, mobility, driving and returning to work. Individual information was given on wound care, healing, pain relief and medication.
- The gender reassignment patients had access to the gender team and could book an emergency appointment at any time. They were seen between eight and ten weeks after surgery for a post-operative follow up appointment.
- Staff explained the discharge procedure where an electronic discharge letter was sent to the patients' GP on the day of discharge. We saw copies of the discharge letters kept in patient's notes. Staff told us that delays in discharge did not happen often and there were very few cancellations.
- Any cancellation was usually due to patient choice, adverse test results or decisions at pre-assessment; for example the need for high dependency care following surgery.

Meeting people's individual needs

- Nuffield Health Brighton Hospital was a modern purpose built hospital with good access throughout. For

example there was level flooring, wet room showers, disabled toilet facilities and extra wide doors and corridors. There were dedicated disabled parking spaces close to the main entrance. This meant that people with a disability had equal access to the facilities.

- The hospital had an equality, diversity and inclusion policy which aimed to create an environment where all individuals were valued. A disability access audit was conducted in January 2016. There were several minor adjustments required that were completed within three months. The Nuffield Health Brighton Hospital's 2016 scored 91% for dementia care and 88% for disability in the 2016 Patient Led Assessment of the Care Environment (PLACE) audits.
- Staff told us there was no discrimination between NHS and private patients, all were treated the same and were admitted to a private room with en suite bathroom facilities, TV and Wi-Fi which promoted dignity and comfort. They told us of simple initiatives to improve patients stay in the hospital such as allocating long stay patients rooms with a sea view.
- We were told that patients' individual needs and requirements were assessed and documented during the pre-assessment clinic appointment. If specialist requirements were identified these would be put in place before admission. Specialist aids included bariatric equipment, specialist moving and handling devices or dietary requirements. Alerts were generated to inform ward, theatre and catering of specific requirements and dietary needs. We saw alerts generated to inform the ward manager of specific requirements for patients being admitted the following week.
- Basic dementia training had been given to all staff. The training described what the condition was and raised awareness amongst staff. However, senior staff acknowledged that it was a first step and further training was needed on how to care for this group of patients. The housekeeping staff told us how following the dementia training the need for specialist equipment had been identified. We saw they now provided a box with dementia friendly cutlery and eating utensils and an easy to access phone.
- The gender team explained how they helped to support patients with a learning difficulty and gave a recent example of working with the patient's gender identity clinic and social services. They adapted the format of all the information provided to include more pictorial information.
- Useful and appropriate information for patients was available in folders in the rooms. This included an introduction to the healthcare team with pictures of different uniforms, room information (television, telephone, nurse call system etc.), menus and medicine storage and administration. There were also information leaflets available on various conditions and health and wellbeing.
- The hospital provided three meals a day for inpatients with snacks available if required. Copies of the food menus were available in each room and included dietary options such as vegetarian, gluten free and vegan. Hospital's 2016 PLACE assessment scores for food ranged between 94% for organisation-wide food to 76% for ward food. The patients we spoke with spoke positively about the quality and quantity of food provided.
- Staff had contact details for religious and cultural leaders if needed for cultural or spiritual support. Staff told us that this service was very rarely needed or asked for.
- The staff supported family and friends to visit with open visiting until 10pm when visiting was by arrangement with the ward staff. Visitors were able to have meals at the hospital which were charged to the patient's account. Patient's told us their visitors were always made to feel welcome with a cup of tea. One patient told us how well their relative had been taken care of while they were waiting.
- A translation service was available for patients. Information about this service was included in the patient information folder kept within the rooms. However on speaking with staff they told us that family members were sometimes used. Using a relative is not good practice, unless the patient specifically requests it, as there are issues of confidentiality. It is not always possible to be certain that the interpretation is correct and unbiased.

- The Nuffield Health website also included information for patients on the services available at the hospital and detailed information about the individual operations, the risks and benefits.
- The care pathway included documenting that suitable arrangements were in place for a safe discharge. This included ensuring that family and carers needs and responsibilities were taken into consideration. For example community services were considered and discussions documented if the person's carer would be able to meet the patient's discharge needs.
- We observed patients being cared for in recovery. They appeared comfortable, relaxed and pain free. The bed area was spacious which meant that auditory and visual privacy were maintained at all times. The nurse kept the patient informed of their treatment plan and gave a verbal handover to the ward nurse who came to transfer the patient back to the ward. The handover included details about the patient's clinical condition, instructions from the surgeon and a safety checklist and was documented in the patient's notes. The comprehensive handovers helped to ensure that patients' individual needs were met and that their surgical care was continuous between theatre and the ward.
- The quality of food received mixed reviews. The hospital was aware this was an area for improvement as this received the lowest score for the hospital's patient satisfaction survey. At 92% satisfaction was the fifth lowest score out of the 31 Nuffield Health hospitals. The patients we spoke with told us the food was "OK" and "adequate." One person told us "You don't come into hospital for the food do you."
- The April 2016 patient feedback report included 10 comments about food. Although four were positive, there were six adverse with comments such as "Catering a very poor experience", "Some of the meat pies and some of the sauces were over salted and difficult to eat.", One patient wrote "Catering very poor - after 17 hours without food I was very hungry after my op but only sandwiches - (very poor) had been offered. Pudding when I had it was solid with overcooking. Breakfast prunes were served with stones! Pancake - main course arrived 35 minutes after everything else - cold tea! Because of such awful catering I was very pleased to go home quickly!"
- The food service assistants told us that if a patient required assistance with eating they would inform a nurse who would support the patient. They told us that this was not often necessary. The food service assistants asked patients' what they thought of their meal after each meal. This information was recorded, discussed at team meetings and used to inform the menu options.

Learning from complaints and concerns

- We found that there were systems in place to listen to patients concerns and take appropriate action if required. The hospital had a complaints policy and procedure available for staff to access if needed. We noted that the hospital director took overall responsibility for the management of complaints. The matron would lead and investigate any clinical complaints involving the relevant head of department where necessary.
- If a complaint involved a consultant with practicing privileges the hospital director and matron met with the individual to discuss the issues raised and notify the MAC if required.
- There was a formal system in place to log each complaint and ensure it was responded to in a timely way in line with the hospital's policy. All complaints were uploaded onto the incident reporting system, which enable the hospital to generate reports and identify trends. Each week the hospital director and matron would meet to review the complaints log and ensure timelines were being met.
- Complaints were discussed at the monthly board meetings, head of department meetings, the quarterly MAC and clinical governance meetings. We reviewed a sample of minutes from these meetings and noted that complaints were reviewed for themes, patterns and lessons learnt.
- We saw evidence of discussions and information sharing regarding incidents, complaints and concerns seen in various ward and theatre meeting minutes provided. The food service assistants confirmed that relevant complaints and concerns were discussed at their team meetings, including patient feedback on the menu.

Surgery

- The hospital had listened to patients concerns and made changes where indicated. These included: clearer billing and the purchase of new equipment for patients that are hard of hearing for use with the ward TV's.
- CQC has received no complaints regarding this hospital in the reporting period (April 2015 to March 2016). Although one complaint was received after April 2016.
- The hospital had received 23 complaints in the reporting period (April 2015 to March 2016). None of the complaints had been referred to Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service). The assessed rate of complaints was below the average of the other 12 independent acute hospitals we hold this type of data for.
- We reviewed five sets of complaints records against the recommendations made jointly by the Parliamentary Health Services Ombudsman, Local Government Organisation and Healthwatch. We found complaints were managed in line with this guidance except that no formal risk assessment was documented on receipt of a complaint.
- We noted that the patient guide and hospital's website did not give information about how to make a complaint or raise concerns although there was a general enquiry form which patients could access. There were complaints leaflets available in the main reception area.
- Staff told us they encouraged patients to raise their concerns with them or their managers in the first instance, where the issue would be addressed without accessing the formal three staged formal complaints process.
- The patient satisfaction questionnaire had a dedicated section for patients to raise any concerns. We saw that the monthly feedback included the patients comments for the departments to take further action on if required.

Are surgery services well-led?

Good

We rated surgical services as good for well-led because;

- Nuffield Health Brighton Hospital had a strategy in place for delivering safe care with plans for developing the service.All staff were engaged with the vision and values of the hospital and told us how proud they were to work at there.
- We found that the hospital had a robust governance framework in place which included policies, procedures and oversight by the senior management team, the clinical governance committee, quality and risk committees and the Medical Advisory Committee. The hospital was supported by the Nuffield Health corporate clinical quality and governance committees. All the staff we spoke with were clear about their roles and responsibilities.
- The matron and the senior management team maintained a visible presence throughout the hospital. Staff reported good leadership within the surgical services and the hospital as a whole. Managers were approachable and staff told us they would have no hesitation in raising issues, confident that they would be listened to and action taken.

However:

- We found some of concerns related to governance. This included the management of medicines and out of date or unavailable policies.

Vision and strategy

- As part of a large independent healthcare provider the Nuffield Health Brighton Hospital had the corporate vision and values of Nuffield Health. The corporate values were displayed throughout the hospital in staff and public areas and staff were aware of them. The hospital's own vision was to become the independent private hospital of choice for people living in and about Brighton and Hove. The hospital told us they aspired to be a regional centre of excellence for patients for cancer, spinal, and transgender procedures.
- At senior management level the hospital had a clear vision and statement of values. Staff in theatres and on the wards told us that the hospital was committed to delivering safe and effective clinical care.
- The vision and strategy of the hospital formed part of the annual business plan set by the senior leadership team. The business plan formed part of staff objectives and was reviewed through the appraisal system.

- We saw that the hospital had a robust and realistic strategy in place for delivering safe care. Minutes from senior leadership meetings and the Medical Advisory Committee (MAC) confirmed that the senior management teams and consultants practicing at the hospital were aware of current the issues and the hospitals plans to address them.
- For 2016 the hospital had developed five goals linked to CQC's five key lines of enquiry. Each goal had specific objectives and actions in place. For example to achieve the well led goal of assuring the delivery of high quality person-centred care, support learning and innovation and promote a fair culture the hospital put in place actions for recruitment training of heads of departments, wellbeing initiatives and encouraging feedback from staff.
- At ward level and in theatres senior managers were aware of the business objectives for core surgical services and were involved at a senior management level in developing the service.

Governance, risk management and quality measurement

- The hospital had a governance framework in place which included policies, procedures and oversight by the senior management team, the clinical governance committee, quality and risk committees and the MAC.
- .We found some of concerns related to governance. This included the management of medicines and out of date or unavailable policies.
- The hospital was supported by the corporate Nuffield Health clinical governance quality committee and the corporate board integrated governance committee. The organisation learns from never events or serious incidents that happened elsewhere. Information was shared via email at a corporate level once the investigation or root cause analysis had been completed.
- Nuffield Health had developed 81 quality performance indicators for each hospital to check performance against best practice. The indicators were a combination of feedback from patients, internal and regulatory standards. The top ten indicators were published on the organisations website. The Nuffield Health Brighton Hospital scored 94% in the March 2016 quality governance sign off against best practice. Areas for improvement included incident reporting, unplanned return to theatre, mandatory training and consultant files updated. The hospital had taken action on these issues at the time of our inspection in July 2016.
- We noted that medicines optimisation met the current needs of the service and was well developed to support patients throughout their inpatient journey. The service has also compared their service provision to a recognised professional standard and developed a strategy and action plan. However we identified a number of issues related to the governance of medicine management that had not been identified or addressed.
- The hospital's clinical governance committee and MAC were responsible for ensuring that the surgical interventions undertaken at the hospital were safe and effective. Both committees monitored the incident reports, complaints and issues that impacted on the surgical activity.
- Each department had developed its own departmental risk register and departmental business continuity plan in accordance with standard operating procedures. The departmental risk registers were combined to form the overarching hospital risk register.
- Each item on the risk register had the risk assessed and an appropriate action plan in place with a lead person responsible. The risks registers were reviewed on a monthly basis. The top 12 risks on the hospital risk register were discussed at the monthly board meeting as a main agenda item. Risks affecting the hospital were also discussed at other governance meets such as the quality and clinical governance, health and safety, security, medicines management and the MAC.
- We reviewed the departmental and hospital risk registers and noted they were up to date and frequently reviewed to ensure the risks were being adequately managed.
- All the staff we spoke with were clear about their roles and responsibilities regarding health and safety and clinical governance.
- We saw that provider visits took place periodically where members of the regional quality and risk management team together with a regional director and

a senior manager from another hospital within the Nuffield Health group undertook quality monitoring visits. Following the visit a report was compiled with actions for the hospital to take.

- The hospital has been subject to a number of checks and reviews from external bodies in the past year. These included a Patient Led Assessment of the Care Environment (PLACE) audit, fire, police controlled drugs and a legionella risk assessment.
- The management team had an understanding of the Workforce Race Equality Standard (WRES) as this will be national requirement from 2017 to produce key data relating to race quality in the workplace. The management team had produced the data for which they currently held, for example the numbers of staff from black and ethnic minority groups. The management team was in the process of implementing reporting processes to capture the data to enable them to fully comply with WRES reporting requirements.

Leadership/culture of service

- The senior leadership team of the hospital had changed since November 2015. The hospital acknowledged that as a result of the changes to the hospital leadership team in 2015 there had been less consultant and staff engagement. This was reflected in the consultant and leadership surveys. Since then, staff reported the new leadership team had worked to improve the rapport between consultants and a new MAC had been elected with over 50% new members. Staff spoke positively about the changes and how the hospital was now moving forward.
- Local leadership for surgery was provided clinically by the MAC chairman and operationally by the theatre manager and ward manager who reported to the matron. The RMO was responsible to matron.
- Each department had a head of department who reported to Matron. There were deputies available should the senior managers be absent for any period.
- Staff throughout the hospital spoke of the visibility of the executive director and senior management team. They told us they felt able to approach the senior managers with any concerns if needed.
- We spoke with all grades of staff across the hospital who told us they felt supported and encouraged to carry out their day to day duties.
- The ward and theatre managers spoke with enthusiasm about their role and the service they offered. They told us they worked closely with the executive team.
- We noted that there had been problems identified with team working in theatres. Minutes from a theatre meeting held in May 2016 discussed unresolved issues and poor behaviours not being corrected. We heard how following a further meeting it was agreed that senior staff would set a better example.
- Staff told us that there was now good leadership within the surgical services and the hospital as a whole. They told us the managers were very approachable and they would have no hesitation in raising issues confident that they would be listened to and action taken.
- The consultants we spoke with told us the hospital was a good place to work and the surgical teams were efficient and competent.
- We heard from staff that the hospital had been through a period of difficult change but they were supported by the matron and hospital director who had an open door policy. They were happy that concerns were now listened to and they knew how to escalate issues.
- All of the staff we spoke with were positive about hospital leadership and felt that communication was good between staff and hospital management. They told us everyone was very friendly and supportive; the consultants were open, honest and open to suggestions. One staff member told us “Matron and the director are fantastic but it’s the staff who are the one constant that maintains continuity.”
- No whistleblowing concerns were reported to CQC in the previous 12 months from April 2015 to March 2016.
- We looked at staff sickness and vacancy rates as this can be an indicator of the culture within the hospital. We found that staff sickness was similar to the other 12 independent acute hospitals we hold data for in the reporting period April 2015 to March 2016. For the registered nurses the sickness rate was below 5% and for healthcare assistants below 10%. The vacancy rates for nurses (10%), operating department technicians (ODPs) and health care assistants (15%) working in

theatre was slightly worse than the average. However the theatre staff turnover rates (under 5%) were better than the average when compared to independent acute hospitals, in the reporting period April 2015 to March 2016. Staff turnover rates for nurses working in inpatient departments and other staff (under 5%) were similar to other independent acute hospitals we hold data for.

Public and staff engagement

- The hospital had a patient feedback system that operated across the Nuffield Health group. The hospital also operated the NHS family and friends test which was a short survey where patients were asked four questions relating to the quality of care and if they would recommend the hospital to family and friends.
- The results for Nuffield Health Brighton Hospital for April 2016 indicated that the 319 patients who completed the questionnaire generally very happy with the care and quality of service they received. The general satisfaction rate across all the questions was between 93 and 100%. Overall, 97% were satisfied with their experience at the hospital.
- The hospital told us that when the surveys are reviewed themes are identified and action put in place to address any dissatisfaction. A patient was usually invited to the meeting to actively participate in giving feedback.
- The hospital also maintained a 'you said we did' patient information board in the foyer which included any monthly theme that may have arisen and the actions taken to address them.
- The hospital held customer focus group meeting where the monthly patient satisfaction surveys were discussed. Although patients were invited to these focus groups they were not always able to attend. The minutes of the last four meetings documented that patient representatives had not attended although invitations to attend were displayed in the hospital's reception area.
- There were no other forums identified where the hospital engaged with the general public. However the hospital did undertake health promotion events and support patients groups following discharge. We noted that an event to discuss back pain and options for spinal treatment was being held at the hospital later in the year.
- We noted that the Nuffield Health website provided much information about the surgical interventions which included information on marketing cosmetic surgery. The information was noted to be honest and gave responsible advice.
- There were no items of rated feedback on the NHS Choices website for Nuffield Health Brighton Hospital in the reporting period April 2015 to March 2016.
- The hospital described good working relationships with local and national NHS bodies together with strong links with the local university.
- The hospital had an established system of departmental meetings where staff felt able to contribute and raise issues and concerns. Team meetings were held on a regular basis and staff told us they felt able to contribute where necessary. We saw minutes from team meetings from both the ward and theatres which included team member discussions about relevant issues such as team behaviour and concerns.
- All the staff we spoke with were proud to work for the hospital and felt fully engaged with the success of the hospital and their role in making it happen. The hospital gathered feedback from consultants through a twice yearly survey.
- We were told that staff were rewarded throughout the year for going 'Above and beyond'. All staff were invited to attend a Christmas lunch, an external party where they received a gift voucher each. We were told that recognising staff as individuals, such as when they had personal issues or special celebrations this was recognised and helped to create a happy workforce.
- Many staff had worked for many years at the hospital and told us how proud they were to work at the hospital. One staff member told us "The hospital allows you to do the job properly as it should be done."

Innovation, improvement and sustainability

- The hospital worked with the local university to offer a joint Resident Medical Officer (RMO) post. Five RMOs covered the hospital over the 24 hour period and also undertook teaching anatomy and practical subjects to students at the local university. This was an innovative and practical way to attract skilled RMOs to the post and was working well.

Surgery

- Staff at ward level and in theatres were proud of the service they offered. They were keen to tell us of successes they had achieved, and the changes that had been made to improve the patient experience. These included consistently high patient satisfaction scores and the work being undertaken by all staff to improve the patients experience such as the dementia friendly initiatives.
- The hospital was a centre of excellence for transgender surgery performing over 300 procedures each year attracting patients from all over the UK and internationally.
- The hospital had a strong ophthalmology pathway and was a leading independent provider of ophthalmology services in the area. The hospital offered innovative ophthalmic surgery with successful outcomes The hospital offered a one-stop approach to eye condition with rapid access, specialist equipment and newly refurbished clinical areas. Ophthalmic procedures were the most common surgical interventions undertaken at the hospital.
- The hospital told us that they were trailing a new system of extending the time from pre-assessment to surgery. This was in consultation with staff in order to ensure that all the necessary arrangements were in place such as adequate staffing, equipment and test results. The staff we spoke with told us that the trial so far was successful and had improved the patient journey and flow through theatres.
- The hospital had taken steps to become “greener” in its operation. The hospital was the first independent hospital in the UK to use extensive utilise solar panels to supplement their energy outlay and reduce its carbon footprint. The hospital was proud of it had reduced its carbon footprint by the use of solar panels and light-emitting diode (LED) lights.

Services for children and young people

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

Information about the service

Nuffield Health Brighton Hospital offers surgery (excluding cosmetic surgery) for children and young people.

Between April 2015 and March 2016, the hospital carried out 643 outpatient attendances for children aged three to 15 years old. These accounted for 3% of general hospital activity for this period. For the same period, there were 11 inpatient discharges, 21-day cases and 102 outpatient attendances for age group 16 to 17 years old. This accounted for 1% of general hospital activity.

The hospital does not offer in-patient surgical and general anaesthetic services to children below the age of 16. Young people aged16 to 18 years are assessed for their suitability for surgery in an adult setting at pre-assessment. Patients and their families were informed that the young person would be looked after by an adult nurse rather than a paediatric nurse.

The outpatients department sees children aged 12 to16 years old for diagnostics and treatment, including ear suctioning and naso-endoscopy, this is a way of looking at the soft palate and throat. It involves using a thin, flexible tube with a very small telescope at the end, which is passed into one of the nostrils. Other services for children and young people offered at this hospital are phlebotomy and physiotherapy.

The radiology department offers services to children and young people aged three to 17 years old, but do not offer interventional examinations, or those requiring medication or contrast medium. The hospital has 2 rooms for general x-ray, with an external imaging provider providing CT and MRI services.

During our inspection, we spoke to fourteen staff including managers, nurses, consultants, allied health professionals, housekeeping staff and administrative staff. We also interviewed two parents of children who recently attended appointments at the hospital by telephone. We viewed information about the service and its performance and reviewed five sets of young person's notes.

Services for children and young people

Summary of findings

- Staff understood their responsibilities regarding incident reporting and there was a culture of learning from incidents.
- Staffing levels and skill mix were planned, implemented and reviewed. Any staff shortages were responded to quickly and adequately.
- There were plans in place to respond to emergencies and major incidents. Staff understood their roles and responsibilities and plans and processes were robustly tested and reviewed.
- The hospital managed patients' records in accordance with the Data Protection Act 1998. Patients' records were easy to find.
- Appointment times were flexible and offered around school hours.
- Facilities were suitable for children and young people. An environmental risk assessment had been completed to ensure the waiting area and consulting rooms were safe for all children.
- The hospital had a clear vision and values, which staff knew and understood.
- The hospital had clear structures, processes and systems of accountability in place. These included robust governance structures that ensured the quality of care and treatment had sufficient coverage at relevant committee meetings. Staff were appropriately informed of any changes within the hospital.

Are services for children and young people safe?

Not sufficient evidence to rate

- Staff understood their responsibilities regarding incident reporting and were fully supported by the senior staff to do so. There was a culture of learning from incidents.
- Staffing levels and skill mix were planned, implemented and reviewed. Any staff shortages were responded to quickly and adequately.
- There were plans in place to respond to emergencies and major incidents. Staff understood their roles and responsibilities and plans and processes were robustly tested and reviewed.

Incidents

- The hospital had policies and procedures in place for dealing with adverse incidents and risks. Policies were readily available for staff to access on the hospital's intranet. Staff showed us these policies and knew how to access and navigate the system.
- There had been no serious incidents, incidents or never events involving children at the hospital between April 2015 and March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- Incidents and safety issues were escalated to the quality and safety committee, which met monthly and was attended by department managers. Staff received regular feedback regarding action plans and changes as a result of these meetings. Staff told us they received feedback from individual incidents, which they found valuable.
- From April 2015 to March 2016 the assessment rates of non-clinical incidents (per 100 bed days) was better than other similarly sized independent hospitals we hold data for.
- When incidents were reported, a full investigation was carried out and steps were taken to ensure lessons were learnt. Action plans were produced following

investigations. For example, child supervision notices advising parents must supervise their children had been put up at regular intervals around waiting areas. This was in response to an incident when a child had been left on their own during their parent's appointment.

Cleanliness, infection control and hygiene

- There was a programme of audit for infection prevention and control and we found that where performance required improvement there were effective remedial actions taken. An infection control audit from April to August 2015 showed a score of 75% for staff use of personal protective equipment, for example gloves and aprons. There was poor apron compliance in all areas. In response to this staff received further training and we noted during the inspection that staff were compliant with using personal protective equipment.
- A staff hand hygiene audit from August 2015 showed 75% compliance, reasons for the low score included staff using incorrect hand washing techniques and too long nails. Since then staff had received training and during the inspection, we observed staff using the World Health Organisation five moments for hand hygiene technique effectively. There were no children and young people on site to observe, but staff advised us children and parents were encouraged to use the available hand sanitisers.
- The audit also showed there was only 53% compliance with bare below the elbows policy, which did not comply with the Journal of Hospital Infection 86S1 (2014). In response to this staff received training on infection control in December 2015 and during the inspection we noted all staff were compliant with the bare below the elbows policy.
- Clinical areas had achieved a patient led assessment of the care environment (PLACE) score of 95% or above which was in line with national standards. A PLACE score is a system for assessing the quality of hospital environment.
- The hospital had no incidences of Clostridium Difficile or MRSA from April 2015 to March 2016.

Environment and equipment

- The environment was appropriate for children and young people, including those with limited mobility. Regular assessments of hazards showed areas of concern and actions taken to minimise the risk. For example, hot drinks machines had been moved away from children's play/waiting areas and warning signs placed over items warning of hot water.
- There was no paediatric resuscitation trolley; instead the hospital had a paediatric airway kit which consisted of three different sized paediatric airway tubing and a paediatric bag valve mask, which was kept with the adult trolley. All equipment was in date and checked daily. We saw evidence that the local ambulance service and the Nuffield paediatric safeguarding lead had signed off the kit to show it met national standards.
- The hospital only accepted children aged 16 and over for surgical procedures. Children this age would require the use of an adult resuscitation trolley. Therefore, the equipment provided by the hospital was appropriate for children of all ages.

Medicines

- Medicines were stored in a way that ensured their efficacy. The minimum and maximum medicines refrigerators and room temperatures were monitored and recorded where medicines were stored. Corrective action had been undertaken and recorded when these areas were outside of their recommended temperature ranges. We saw evidence of this in a medicine storage audit from March 2016.
- The in house pharmacy service was open Monday to Friday, 8am to 4pm. The pharmacy provided a clinical service to the ward, which supported young people who were inpatients. However, there was no pharmacist with paediatric medicine training. Staff told us that only over the counter analgesia and antibiotics were dispensed from the pharmacy. Emergency medicines including oxygen were available for use within a tamper evident trolley with expiry dates checked on a regular basis.
- Medicines were recorded in patient records. We saw five children and young person's patient records which were signed and dated appropriately, indicating what medicines had been administered and evidence that staff had checked on a patient after administering as needed medication.
- Prescription pads were stored securely with tracking systems in place. However, prescription books were only

sent to pharmacy when they were empty. Therefore, a stolen prescription would not be identified in a timely manner. This was not in line with NHS Protect, Security of prescription forms guidance 2013.

- Nuffield Health corporate medicines management policies were available for staff to access on the intranet. Staff showed us these policies and knew how and when to access them.

Records

- Information governance training was mandatory for all staff. There was an information governance lead as well as information governance meetings on a quarterly basis.
- Matron was the hospitals Caldicott guardian and supported staff to adhere to Caldicott principles in order to ensure patient confidentiality. The Caldicott principles are seven recommendations for the management of data in order to safely manage information and ensure patient confidentiality.
- We checked all paediatric records in surgery from February to December 2015 (five in total) and found they were contemporaneous, legible, dated and signed and contained full clinical details in line with the Royal College of Physicians Standards for the clinical structure and content of patient records 2013.
- We looked at pre-assessment information and saw that tests and investigations were clearly documented with the child's medical and social history recorded prior to them being admitted for surgery.

Safeguarding

- Ninety seven per cent of staff had attended safeguarding children training, level one and two. This met the Royal College for Paediatrics and Child Health standards in safeguarding children and young people.
- Staff had a good understanding of what a safeguarding concern might be. They told us they would escalate any concerns to their manager. Staff knew the location lead for safeguarding children was the matron who had training to level three. In addition, Nuffield Health employed a corporate safeguarding lead who was trained to level 4 in paediatric safeguarding. They could be contacted for specialist advice and support where required.
- The hospital had a separate children's safeguarding policy, which referenced all areas required under Working Together to Safeguard Children 2015, such as trafficking.
- The hospital had completed a safeguarding assurance tool for the local commissioning group where nine standards were rated as green, amber or red, depending on compliance. Of the nine standards, Nuffield Health Brighton Hospital met all requirements on two standards, six standards had one or more amber rating and one standard did not have any requirements met. This was related to lack of information regarding female genital mutilation. Since then, action plans had been put in place to improve aspects where the hospital did not meet standards, including completion dates and an accountable person.
- In outpatients there was a procedure process guide showing best practice methods for three to six year olds and six years plus. There were also pathways for female genital mutilation. This demonstrated staff followed best practices, roles and responsibilities in line with national guidelines such as the Female Genital Mutilation Protection Order.
- Two consultants we spoke with provided evidence they had level three paediatric safeguarding training.

Mandatory Training

- Staff we spoke with on the wards and in outpatients confirmed that mandatory training was available and that staff were actively encouraged to complete it with the training monitored through staff appraisals. Staff felt the level and quality of mandatory training was adequate.
- The hospital benchmark for mandatory completion rates was 85%. The total number of nursing staff trained in advanced paediatric life support or equivalent was five, which was the correct ratio of staff to patients. This was in line with the Royal College of Nursing guidance on defining staffing levels for children and young people's services. In outpatients, the majority of training met this standard. However, the practical infection control and intermediate life support were below 85% and were therefore did not meet the target. Paediatric

life support was classed as mandatory training in outpatients from April 2016, completion rates were below 85%. We did not see an action plan to improve this figure.

- Staff received training via e-learning for seven mandatory areas including infection control and fire safety. Each member of staff had a training matrix, which showed the required frequency of each course as well as completion data. Mandatory training formed part of the appraisal process to ensure compliance.
- We spoke with ancillary and administrative staff who confirmed they attended all mandatory training in addition to role specific training such as customer care and computer skills.

Assessing and responding to patient risk

- Nuffield Health Brighton Hospital did not provide surgical services to children under 16 years old. The hospital only operated on young people who were deemed low risk in surgery, for example, they were adult height and weight. In outpatients, the hospital only performed non-invasive procedures on children. Therefore, they did not require the use of tools such as paediatric early warning signs.
- In surgery, staff assessed children for any pre-existing conditions such as diabetes, epilepsy or history of cardiac issues. If a pre-existing condition was found, the child would not be operated on. In these instances, staff referred the patient to another service. We saw a local admissions and exclusion policy, stating triggers and next step in the process for admission or exclusion of patients. This meant staff were able to assess the appropriateness of the service to deliver safe care and treatment to patients.
- In radiology, there were exposure charts that enabled staff to accurately calculate the correct exposure dosage for each child based on age, height and weight. These guidelines were in accordance with the Ionising Radiations Regulations 1999.
- All resident medical officers were trained in emergency paediatric life support or equivalent and worked on rotation to provide 24-hour cover for the hospital. We saw training records, which showed that resident medical officers were trained in emergency paediatric life support or equivalent. We saw Consultants with practicing privileges received training from NHS trusts and were up to date with European paediatric life support training.
- There was a service level agreement between the local NHS children's hospital and Nuffield Health Brighton Hospital. If a child or young person became unwell, the child would immediately be transferred by ambulance. We saw the deteriorating children's policy, which detailed processes staff must follow should a child or young person become unwell.
- Risk assessments checked for diabetes and epilepsy, were available and completed during pre-assessment and then followed up on the ward.

Nursing staffing

- The hospital did not have a registered children's sick nurse. The Nuffield Health paediatric lead nurse based at Epsom and the local clinical commissioning group safeguarding board provided guidance and support to hospital staff. Staff advised us they would request support if during pre-assessment there were any concerns prior to agreeing an admission.
- The outpatient department used an acuity tool to measure required staffing levels based on patient numbers at clinic. These were defined at pre-assessment in order for the forward planning of staff and skill mix to ensure adequate staffing levels were present at clinics.
- In surgery, a data collection tool was used twice a day to ensure appropriate and safe staffing levels. There was a minimum of two trained members of staff on duty at all times, with a nurse to patient ratio of 1:6.
- Use of bank and agency staff was appropriate for the size and type of hospital. In surgery, the use of bank and agency workers was below average. In outpatients, it was average for the size and type of department. In the last three months, outpatients had used bank staff only, not agency. Bank and agency staff provided evidence of competences including paediatric safeguarding and life support training, before being allowed to support child inpatients or children's clinics.

Medical staffing

Services for children and young people

- Consultants and anaesthetists providing services to children were required to confirm their scope of practice based on the age group being treated and the hospital board monitored their competencies. This was in accordance with the Royal College of Surgeon and Anaesthetists guidelines.
- The resident medical officers co-ordinated their own rota with each working a 24 hour shift in the week as well as one in every five weekends. This meant there was continuous cover at the hospital.
- The hospital had three radiographers with paediatric radiography training. A dedicated paediatric radiologist reported on the examinations. The paediatric radiologist was a consultant in a local NHS hospital dedicated to children and young people. A consultant paediatric radiologist performed all ultrasound examinations.
- Anaesthetists were on call 24 hours a day, seven days a week. They covered their own patients on the first day of surgery with an out of hours on call consortium of anaesthetists providing out of hours cover at the hospital. However, the January MAC minutes identified that the would only see a patient in an emergency if they had treated that patient. If they had not, there was a process to transfer the patient to the local NHS children's hospital.
- During our inspection, we were told that physicians and surgeons provided out of hours cover for their own patients following surgery and processes were in place for arranging cover if they were unavailable.

Major incident awareness and training

- The hospital had a disaster recovery plan that consisted of arrangements, procedures and documents for reference in the event of a major incident such as flooding or electricity failure. Included in the plan were systematic instructions, staff responsibilities and accountability. Staff knew the contents of the plan, what to do in the event of a major incident as well as how to access the policy on the internal intranet system.

Are services for children and young people effective?

Not sufficient evidence to rate

Evidence-based care and treatment

- Policies and procedures were available for staff to view on the intranet. Some information was available in folders for quick reference. For example, a children and young person's folder provided information on how to set up consultant's clinic and treatment rooms prior to appointment; this included a checklist of equipment and safeguarding procedures with flow chart.
- The National Institute for Health and Care Excellence guidelines were discussed at quality and safety committee meetings to assess the suitability of being adopted by the hospital. Staff told us any relevant new guidelines would be disseminated at team meetings. During our inspection, we saw evidence of the hospital's standard operation procedures that were in line with national guidelines. For example, paediatric early warning system, cardiopulmonary arrest prevention in hospitals and the management of cardiac, respiratory arrest and anaphylaxis in children.

Pain relief

- No invasive procedures were carried out in the outpatient department that would require pain relief.
- We saw evidence of consultants providing prescription and advice on pain management at home for young persons who had surgical procedures. This was in line with the hospital's pain management policies and procedures.

Nutrition and hydration

- Staff had access to a dietician with specialist expertise in the nutrition of children and young people if they were required via the local NHS trust.

Patient outcomes

- There were no outcome measures for children less than 16 years old seen in the outpatient department following their appointment. We did not see any evidence of audits carried out which were specific to children and young people services.

Competent staff

Services for children and young people

- The hospital employed consultants with practising privileges. The hospital had a robust practising privileges policy, which detailed roles and responsibilities, quality and safety and standards of practice. Before being able to practice at the hospital, consultants had to provide documentary evidence of their disclosure and barring service enhanced check. We checked practising privileges and found that they contained all relevant information. All consultants were registered with the General Medical Council, which was regularly reviewed as part of the appraisal and revalidation process.
- The hospital had arrangements in place to identify and suspend consultants with surgical practising privileges who had not worked in the hospital for 12 months or more. There was also a link with the local NHS hospital to ensure this process was robust. This was in accordance with Independent Healthcare Advisory Services/NHS Employers: guidance for employer on sharing information about a healthcare worker where a risk to the public or patient safety has been identified July 2013.
- Hospital data showed there was 100% completion rate of validation of registration for inpatient nurses but this did not include validation of professional registration for staff in post less than six months. Ninety five per cent of staff we spoke with had an appraisal in the last year.
- We saw training records, which showed all three radiographers, had up to date paediatric radiography training.

Multidisciplinary working

- Consultants referred patients to other services in the hospital when it was appropriate, this included physiotherapy and diagnostic imaging services. This meant that patients had access to continuous care and treatment in a timely manner.
- The hospital did not have a play therapist as children only attended hospital for a short time.

Seven-day services

- The hospital's radiologists did not provide out of hours cover, however, if a patient required access to diagnostic services out of hours, the hospital had an on-call radiographer to provide this service.
- A senior nurse was on duty at all times. A clinical on-call rota supported the ward team out of core hours. There was also an on-call manager for theatres and pathology.

Access to information

- Medical records generated by hospital staff were kept in the hospital's medical records department. The department was secure and had a coded lock to access.
- The consultant's medical secretaries followed up each appointment with the consultant by sending a letter to the patients' GP. We saw these in patients' records.
- Administrative staff in the booking office were trained to use the electronic booking system and had a list of professionals qualified to treat children and young people. Staff referred to this list before booking and confirming any appointments.
- In outpatients, approximately 95% of all patients were seen with all relevant medical records being available. Therefore, staff that had access to accurate, up-to-date information were treating patients.

Consent

- The hospital consent policy included information for obtaining consent from children and young people. This meant staff sought consent for care and treatment in line with department of health legislation and guidance.
- The five records for children in surgery we reviewed showed evidence that consent was sought and recorded. We noted the correct form was completed with the patient's signature prior to and on the day of surgical procedure. This was in accordance with the hospital's policy and Royal College of Nursing: caring for children and young people: Guidance for nurses working in the independent sector.
- Staff had good knowledge of assessing children and young people's ability to consent using Gillick competency guidelines. Gillick competence is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Are services for children and young people caring?

Services for children and young people

Not sufficient evidence to rate

- We were unable to make a judgement for this element of the report, as there were no children or young people attending the hospital for surgery or outpatients during our inspection. We spoke with two parents via telephone interviews, whose children had recently been admitted to the hospital and found; Children and young people were treated with dignity, respect and given privacy at all times.
- Staff took the time to discuss next steps and allay the fears of both parents and children and young people.
- Staff provided emotional support to families in the first instance, but knew when to refer to outside agencies.

Compassionate care

- Parents advised us via telephone that nurses spent time talking with the child and their parents answering questions and allaying fears.
- During our inspection there were no children attending the hospital for surgical interventions or outpatient appointments. We spoke with their parents on the telephone who told us all staff were very approachable. Family members we spoke with said hospital staff were "Lovely," and, "Could not do enough for you."
- We were unable to observe any interactions between staff and children or young people. However, staff told us that children, young people and their parents were treated with dignity and respect. They said they knocked on doors before entering, lowered themselves down to the child's level when talking to them and used age appropriate language. Parents we spoke with on the telephone confirmed this.
- Children and young people were cared for in single en-suite rooms that ensured their privacy and dignity.

Understanding and involvement of patients and those close to them

- Families advised us they were kept informed regarding procedures and next steps and their opinions were considered when making decisions. They said staff were very open regarding the cost of treatment, when payment would be required and the different payment options.
- In radiology, staff described the measures they took to reassure children and their parents, such as allowing parents to sit with the child during procedures and taking time to explain treatments.

Emotional support

- Staff said they would support patients in the first instance and referred to outside agencies if they felt it was required. Families confirmed this had been their experience.
- Staff organised nurse and consultant allocation to give patients as much consistency as possible in both outpatients and surgery. This enabled staff to build a strong relationship with children and their families.

Are services for children and young people responsive?

Not sufficient evidence to rate

Service planning and delivery to meet the needs of local people

- Following a review by Nuffield management, the inpatient paediatric under sixteen's service was suspended in 2014. This decision was based on the low numbers of inpatient paediatric cases that were being treated, the level of nursing expertise required and the skill and knowledge required to keep staff adequately up to date in this area. However, the hospital continued to provide services to under 16's on a purely diagnostic basis in outpatients and a small number of day cases. During our inspection, we were told hospital management was assessing the viability of this service based upon patient demand and would be reviewed at the next Medical Advisory Committee meeting.
- Surgical procedures for 16 to 18 year olds were pre-planned, with pre-assessment arranged to ensure suitability. Young people who required further assessment were referred to the local NHS children's

hospital. Staff advised us the Nuffield Health paediatric lead nurse provided guidance and support if the pre-assessment nurse had any concerns prior to agreeing an admission date.

- The radiology department saw children and young people aged between three and 18. Children and young people did not receive any medication or contrast. The hospital saw on average four referrals a month, including MRI, CT, ultrasound and projection radiography.
- During our inspection, we were told the young person and their family were informed at pre-assessment that an adult nurse would provide care and treatment. Of the five patient's notes we reviewed during our inspection, only one had recorded evidence of this conversation.

Access and flow

- The hospitals booking team arranged appointments as soon as possible, within a few days. The booking team checked the age of any child before allocating an appointment with a consultant with the scope to treat that age group. One member of staff demonstrated this process to us using the electronic booking system during our inspection.
- Children and young people were allocated longer appointment slots to provide flexibility and time for explanation and assurance. Wherever possible appointments for children and young people were booked outside normal school hours.

Meeting people's individual needs

- Before making an appointment, booking staff would check if the child or young person had any special needs in order to assess whether the hospital could meet their requirements.
- There was one waiting area for adults and children. However, adult and children's clinics did not occur at the same time. We were told for children's clinics, the waiting room would be set up with toys and nurses spent time talking with the child and their parents answering questions and allaying fears. We observed here were small tables, chairs and toys in waiting areas for younger children as well as a television.
- Drinks machines were available in the reception area and outpatients waiting area for any patient who required hot or cold drinks.
- We saw a varied food and drinks menu that catered for young people who were inpatients. The hospital Patient Led Assessments of the Care Environment (PLACE) audit results for food scored 99%, this was above the England average of 93%.
- Translation services were available from an external provider if required and staff knew how to access this.

Learning from complaints and concerns

- The hospital had processes in place in order that complaints could be reviewed, themes identified and changes made to practices where appropriate. If a complaint involved a consultant with practicing privileges, the head of department and the matron met with the consultant to discuss and resolve the complaint.
- The hospital director had overall responsibility for the management of complaints in line with the hospital's corporate policy. If a complaint involved any aspect of clinical care, the matron led the investigation and directly responded to the complainant. The matron also liaised with the relevant head of department to ensure they were fully involved with the investigation. A member of the administrative staff managed the formal complaint system and ensured timelines were adhered to.
- Lessons learnt from complaints were disseminated to all staff during team meetings. We saw minutes from the quality and safety meeting dated November 2015 where a complaint and learning related to children and young people were discussed.
- Hospital information leaflets detailing how to make a complaint were available in the waiting areas and staff showed us these are also available in patient's information folder on the ward. This meant the information was accessible to parents of children and young people, if they wanted to make a complaint.

Are services for children and young people well-led?

Services for children and young people

Not sufficient evidence to rate

Vision and strategy

- The hospital had identified the viability of providing the children and young people services as an area that needed to be developed. We were told this would be done by a review of the access to children's services, ensuring compliance as well as being responsive to the needs of the local community. However, at the time of inspection they did not have a children and young person's strategy. Staff knew the hospitals overall vision, values and strategy.

Governance, risk management and quality measurement

- Quality and safety committee meetings were held quarterly and were attended by all heads of department including the hospital director and chaired by the hospital matron. We reviewed meeting minutes; agenda items included complaints, policies, medicine management, infection control and prevention. The outcomes of these meetings were disseminated at all staff meetings. However, we did not see evidence that issues we had identified such as safeguarding training, monitoring of outcomes and lack of audit were discussed at these meetings.
- We saw the hospitals reporting structure, which included a range of meetings to review processes and the hospital's performance. There were monthly senior team leader meetings where safety issues such as incidents, the risk register and governance were discussed. We saw minutes from these meetings from January to April 2016. Where action was required, someone within the senior team was designated as the accountable person and a sign off/completion date included in the minutes, which was followed up at the next meeting.
- The medical advisory committee met quarterly and during our inspection, we were told that the chair of this committee had started the role in June 2016.
- There were monthly senior team leader meetings where safety issues such as incidents, the risk register and governance were discussed. We saw minutes from these meetings from January to April 2016. Where action was required, someone within the senior team was designated as the accountable person and a sign off/completion date included in the minutes, which was followed up at the next meeting.
- An ear, nose and throat paediatric consultant who worked at a local children's hospital sat on the medical advisory committee. Therefore, children and young people had someone representing them at an appropriate level within the hospital.

Leadership/culture of service

- Staff told us the culture of the organisation was to always put the patients first. They knew the hospital's values and vision and advised us they were kept informed of changes by senior management.
- We observed staff being polite and caring towards patients and each other.
- There was a robust whistleblowing policy which detailed systematic explanations of processes, described the different stages of formal resolution, timescales and information regarding reviews and implementation. Staff we spoke with knew the policy and said they felt confident in reporting a colleague, stating higher management would be supportive.

Public and staff engagement

- Staff told us that they felt actively engaged and they were given an opportunity to share their views for future planning and delivery of the organisation.
- The hospital had set up monthly focus groups, to encourage patients to express their views on the service; we saw these meetings advertised in the reception area. However, during our inspection, we were told that patients had not attended these meetings to date.
- Staff told us that they encouraged patients to complete patient satisfaction surveys about the care and treatment they received at the hospital. The results of the survey were discussed at quality and safety meetings and we saw minutes of these meetings to confirm this.
- The hospital had an established system of departmental meetings where staff felt able to contribute and raise

issues and concerns. Staff told us they were encouraged to attend these meetings on the regular basis and acknowledge that these meetings are beneficial to them.

- During our inspection, we could not find evidence of engagement with the public and staff regarding how the services were provided for children and young people. Patient satisfaction surveys were available. However, they were not designed specifically to encourage a child or young person to feedback their views.
- Nuffield Health Brighton Hospital did not have any means of separating feedback from patient satisfaction surveys from children and young people or their parents from the general patient feedback. Patient satisfaction surveys were not age specific and therefore could not be used to improve the children's services.

Innovation, improvement and sustainability

- The hospital was proud of being environmental friendly. For example, a kestrel had nested on the roof of the hospital and a camera had been set up to stream live footage of the kestrel and her nest to patient televisions.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient and diagnostic imaging service at the Nuffield Health Brighton Hospital covers a wide range of specialities including: anaesthetics, cardiology, clinical oncology, cosmetics, dermatology, dietetics, ear, nose and throat (ENT), elderly medicine, gastroenterology, gender reassignment, general surgery, gynaecology, haematology, medical oncology, neurology, neurosurgery, ophthalmic, oral and maxillofacial, orthopaedics, paediatrics, renal, respiratory, rheumatology and urology. There are also audiology clinics held at the hospital, these are commissioned and run by a separate provider and therefore are not included in this inspection.

The diagnostic imaging service carries out ultrasound and x-ray imaging, including procedures such as mammography (imaging to see inside the breast) and fluoroscopy (imaging that can provide live images of a moving internal function, such as swallowing). The service also provides theatre and ward mobile imaging support. Static magnetic resonance imaging (MRI) and computerised tomography (CT) was provided by a third party and was therefore not included as part of this inspection. We did not assess children and young people's outpatient services as part of this core service as these were assessed as part of the children and young people's core service.

The outpatients department is situated on the ground floor and consists of eight general consulting rooms, a dental suite, an ophthalmology room, ENT room, phlebotomy room, three treatment rooms and two pre-assessment rooms. The gender reassignment service is based on the first floor and consists of a consulting room, waiting area and patient lounge.

The physiotherapy is also situated on the ground floor, along the corridor from the outpatient area. The service consists of a waiting area, treatment rooms and a physiotherapy gym.

The pathology service is accredited by the United Kingdom Accreditation Service (UKAS) and was situated within the diagnostic imaging department.

NHS patients can be referred by their GP, self-funding or insured patients can access the services via direct referrals. NHS services are commissioned by local clinical commissioning groups (CCGs). Some services such as breast screening also offer self-referrals.

The majority of activity at the hospital is funded privately (85%), and 15% of activity was NHS funded. Outpatient attendances made up 71% of the overall activity at this hospital (13,924 attendances) for the period from April 2015 to March 2016.

As part of our inspection we spoke with 10 patients, and 9 members of staff including administrative staff, healthcare assistants, managers, nurses, physiotherapists and radiographers. We observed care and looked at 14 sets of patient medical records, four in outpatients and 10 in diagnostic imaging. We received 30 comment cards where patients shared their views of the service with us.

Outpatients and diagnostic imaging

Summary of findings

We rated the Nuffield Health Brighton Hospital outpatient and diagnostic Imaging service as good because;

- Systems were in place for keeping patients safe and staff were aware of how to report incidents and safeguarding issues.
- The outpatient and diagnostic imaging departments were visibly clean, tidy and free from clutter.
- Staffing levels were sufficient to meet the needs of patients.
- We observed multi-disciplinary working and staff sought consent from patients in accordance with corporate policy.
- Staff were enthusiastic and caring. We observed positive interactions between staff and patients. Nearly all of the patients spoke highly of the care they had received regardless of how they were referred or funded.
- Wheelchair access was available throughout the hospital and there was clear signage directing patients to the departments.
- There were clearly defined and visible local leadership roles in each speciality within the outpatients and diagnostic imaging areas. Managers and the senior leadership team provided visible leadership and motivation to their teams.
- There was appropriate management of quality and governance at a local level.

Are outpatient and diagnostic imaging services safe?

Good

We have rated the safety of outpatients and diagnostic imaging services as good because;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses, and learning from incidents was discussed and shared across the department.
- Staffing levels were planned and reviewed to keep ensure patients were kept safe.
- Imaging equipment was appropriately maintained and legislative requirements relating to the safe use of ionising radiation were met. Laboratory facilities were accredited by a nationally recognised external body.
- The waiting areas and consulting rooms were visibly clean, tidy and free from clutter.
- There were plans in place to respond to emergencies and major situations which were understood by staff.

However;

- Some of the consulting rooms had a mix of carpet and vinyl flooring which did not comply with Health Building Note (HBN) 00-10 (Department of Health 2013) although suitable risk assessments and mitigations were in place.
- There was no effective process for the monitoring of prescription pads.
- Not all members of staff were trained to an appropriate level in safeguarding children.

Incidents

- Over the last 12 months there have been no reported never events for the outpatient or diagnostic imaging department. Never events are serious, largely preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- There were no incidents classified as serious reported in the same period. Serious incidents are defined by the

NHS England Serious Incident Framework 2015 as events in healthcare where the potential for learning is so great, or the consequence to patients, families, carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

- There was a corporate level policy on reporting incidents, serious incidents, near misses and never events which we reviewed and noted was in date.
- There was a total of 52 clinical incidents and six non clinical incidents reported in the out-patient and diagnostic Imaging service in the period from April 2015 to March 2016. This number made up for 12% of the incidents reported hospital wide. The rate of reported clinical incidents of incidents of about 0.4 per 100 attendances was slightly above the average for the data from independent hospitals we hold, however the hospital reported only 2% of incidents hospital wide resulted in severe harm or death.
- All staff that we spoke to in outpatients and the imaging department, were able to explain how to report an incident using the electronic reporting system and were able to give examples of previously reported incidents.
- There was learning from incidents. For example, we saw records of an incident where a consultant had requested a drug but had not provided the patient details and had later said the drug was not used and discarded. This was discussed at the monthly outpatient meeting and it was decided that prescriptions must always be completed before any drugs are to be released.

Cleanliness, infection control and hygiene

- There was an infection prevention lead nurse for outpatients and an infection prevention assistant for radiology. The role of these members of staff was to lead on infection prevention and control in their department, and they attended the Infection Control Committee meetings. We saw infection prevention committee minutes which saw representatives from outpatients and pathology, there was however no representative from the imaging department.
- The outpatient and diagnostic imaging departments were visibly clean, tidy and free from clutter. The imaging department had checklists and protocols for all room cleaning which were consistently completed. The toilet in the outpatients department was visibly clean and there was a cleaning checklist on the back of the door which detailed that it had been cleaned on seven of the last eight working days listed.
- The hospital's 2015 Patient Led Assessment of the Care Environment (PLACE) score for cleanliness was 99% which is better than the England average of 98%.
- Over the last 12 months there had been no reported cases of healthcare-associated infections such as MRSA, clostridium difficile (C.difficile) or, Methicillin Sensitive Staphylococcus Aureus (MSSA) for the outpatients and diagnostic imaging department. MRSA, MSSA and C. difficile are all infections that have the capability of causing harm to patients.
- We observed staff using the hand hygiene gel and this was available both at the hospital and department receptions. There were sinks available in each of the consulting rooms with hand soap and paper towels. This meant that staff and patients could ensure effective hand hygiene.
- The hospital carried out hand hygiene audits and identified that the compliance rate had fallen in 2015 to 75%. The rationale for this was that a newer, more comprehensive audit tool list was now being used with more points to observe on.
- The hospital began completing hand hygiene facilities audits in 2015 which looked at sink compliance and availability of hand washing facilities available. The score for 2015 was 99%, and the only issue identified was that one of the sinks did not have moisturiser situated on it.
- We saw an action log following an infection prevention audit which identified that staff had too long nails and not all staff were bare below elbows. All staff we observed in the outpatients department now complied with this which showed that remedial action followed audits.
- We saw an action log following an infection prevention audit which was undertaken in 2015 which identified that not all sharps bins were half closed. We saw three sharps bins on our inspection, and two out of the three were closed appropriately. We saw sharps bins were available in treatment areas where sharps may be used.

This demonstrated compliance with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had been fully completed which ensured traceability of each container.

- Waste in clinic rooms was separated and in different coloured bags to identify the different categories of waste. This was in accordance with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.
- There were disposable gloves and apron dispensers fitted to the wall and these were stocked although we did not see staff use these during our visit, as there were no procedures taking place.
- There was a protocol for the cleaning and decontamination of nasoendoscopes (instruments used to look inside the nose), there was an endoscope washer which could store cleaned equipment for up to seven days. There was also a three stage wipe system which had a log book detailing the asset numbers of those cleaned and by whom to ensure traceability. We saw that all stages of the process had been completed.

Environment and equipment

- The PLACE audit showed a decline from 98% in 2014 to 94% in 2015 but this was still better than the England average of 92%.
- The hospital had a spreadsheet detailing all medical devices and equipment and their planned maintenance dates.
- Flooring in consulting room 8, the ophthalmology assessment room and the room used for decontamination of endoscopes in outpatients were non-compliant with Health Building Note (HBN) 00/10 Part A Flooring (Department of Health 2013). 2.9 states that there should be a continuous return between the floor and the wall, for example coved skirting with a minimum height of 100mm for easy cleaning. The consulting rooms were carpeted and had separate wooden coving, and the endoscope room had separate coving from the floor. This means the surfaces could not be effectively cleaned, however there were relevant risk assessments in place for this.
- In consulting room 8 and the ophthalmology assessment room there was a mix of carpets and vinyl which is contrary to the HBN 00/10 Part A 2.4 which clearly states 'carpets should be avoided in clinical areas', however there were relevant risk assessments in place for this as required by the guidance.
- The room used for cleaning of nasoendoscopes was labelled as a Medical Secretary office. Staff told us this had previously been the use of the room but it had been a nasoendoscope decontamination room for at least a year. The floor did not comply with Health Building Note (HBN) 00/10 Part A Flooring (Department of Health 2013). 2.9, which states that there should be a continuous return between the floor and the wall, and there was separate wooden coving on the wipeable floor, meaning the floor could not be effectively cleaned.
- The outpatient waiting area and adjoining corridor to the consulting rooms were carpeted throughout. We spoke to a member of staff about how a carpet with a spillage would be cleaned and we were shown a spillage kit. There was a risk assessment in place for the cleaning of carpets and control measures were in place for this which was acceptable practice.
- The chairs in the consulting rooms were fully wipeable. However the chairs and sofa in the patient waiting areas were partially upholstered on the outer edges, meaning they could not be effectively cleaned if contaminated. There was a risk assessment in place for this furniture, and the cleaning regime was for them to be steam cleaned six monthly (in addition to daily cleaning of the wipeable sections).
- The curtains in use in the consulting rooms in outpatients and radiology were disposable and were dated. The standard operating procedure for safe management of laundry stated that disposable curtains will be changed twice a year or sooner if contaminated. However, we looked at three consulting rooms, and all of the curtains seen were dated August 2015, indicating that they had not been changed for eleven months.
- There were light boxes situated outside the treatment rooms which could be switched on to indicate when the class four laser equipment contained within it was in use. We did not see this in use at the time of the inspection but normally these would prevent staff or service users entering the room when potentially

harmful lasers were in use. This was in line with the local rules and the local rules been written in accordance with the Medicines and Healthcare products Regulatory Agency's Guidance on the Safe Use of Lasers, Intense Light Source Systems and LEDs in Medical, Surgical, Dental and Aesthetic Practices, DB2008(03).

- All imaging equipment maintenance contracts were held centrally and we saw these. They demonstrated that imaging equipment was appropriately maintained.

Medicines

- We saw that medicines in the outpatient department were stored securely in line with relevant guidance.
- Emergency medicines including oxygen were available for use within a tamper evident trolley. We saw that expiry dates were checked on a regular basis.
- We saw that the minimum and maximum medicines refrigerators and room temperatures were monitored and recorded where medicines were stored. Corrective action had been undertaken and recorded when these areas were outside of their recommended temperature ranges. We reviewed a medicine storage audit undertaken in March 2016 this demonstrated that the diagnostic imaging department checked the room temperature daily, that the room was secure and recorded any variances in temperature. We observed this on site.
- We saw minutes from the Medicines Management Forum undertaken in April 2016 which representatives from the outpatient and diagnostic imaging departments attended. Relevant drug alerts issued from the National Patient Safety Agency (NPSA) were discussed at this meeting.
- Drug prescription pads were stored securely onsite. Prescription tracking systems were in place however, they were not fully effective in monitoring the use of prescriptions. This was because the prescription books were only sent to the pharmacy once empty, meaning that an inappropriate/stolen prescription would not be identified in a timely manner. This was not in line with NHS Protect, Security of prescription forms guidance, 2013.

Records

- The outpatients department did not have an electronic care record. This meant that all patient notes were paper based. Both management and medical records staff were aware of the upcoming project to move to an electronic integrated care record and were positive about this system coming in.
- We viewed 10 sets of patient records in the diagnostic imaging department, these were full, accurate and had the original request form scanned in. There was an identity check procedure to ensure they had the correct patient for the correct procedure whereby the scanned request form was gone through with the patient and ticked as the details matched. We also observed a staff member checking the area due to be x-rayed was correct with the patient.
- In the gender reassignment office, there was a whiteboard detailing all of the patients currently waiting for an appointment or surgery. The office was situated on the first floor, and the door was kept shut and had a key code on it to prevent access from anyone other than staff members. This meant that patients' data was kept safe and secure.
- Information Governance training was mandatory for all staff. All staff in outpatients and diagnostic imaging had completed this.

Safeguarding

- The outpatient and diagnostic imaging department treated adults who could be accompanied by visiting children, and therefore a minimum of level two safeguarding training is required. We saw that six out of ten members of staff in outpatients were level two trained. This was not in line with the corporate safeguarding children policy which states it is mandatory for all staff interacting with children to have level two safeguarding children training. This meant that some staff may not have the skills or knowledge to identify and escalate safeguarding concerns around children. In the diagnostic imaging department, we saw evidence that all clinical members of the department had been level 2 trained and the manager explained that this had not been updated on the electronic record system yet as the system had been not working recently. However, this was not in line with national guidelines which recommends that staff working with children

should be trained to level 2 in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010.

- There was a corporate level Nuffield Health safeguarding policy for children young people and adults which was in date. Staff at a focus group told us they would be confident in identifying and escalating safeguarding concerns and had all received varying levels of safeguarding training since coming to the hospital.
- Staff told us that there were flowcharts and posters throughout the hospital and we saw flowcharts in the outpatient office detailing what to do in the event of a safeguarding and who the named leads were. We also saw flowcharts for what to do if female genital mutilation (FGM) is seen or suspected.
- We observed a member of staff in outpatients identify that there were two unaccompanied children in the waiting area, and quickly sought to reunite them with their parent who had gone into their appointment.
- There were no safeguarding concerns reported to CQC in the reporting period April 2015 to March 2016.

Mandatory training

- The target completion rate for mandatory training for the hospital was 85%. Mandatory training compliance for outpatients was above 85% for most elements. Aseptic technique, Infection control: practical, intermediate life support and paediatric life support had varying compliance below 85% and were therefore were not compliant with the target.
- Staff at a focus group told us that they had 'comprehensive' mandatory training and felt they had the right level of training to carry out their role safely.
- Diagnostic imaging staff were compliant with their mandatory training except for practical manual handling and a date was being sought for this at the time of the inspection. Staff told us that if patient hoists were required, the ward staff came down to use these as they were up to date with the training.

Assessing and responding to patient risk

- There were emergency call buttons in all of the consulting and treatment rooms we saw so help could be summoned in the event of an emergency. Staff told us that if a patient deteriorated, they would use the emergency call buttons or contact the Resident Medical Officer (RMO) for support.
- Staff told us about responding to risks in the outpatients department: one example given was around the placement of the hot drinks machines. This was originally close to the children's toys in the waiting area and was moved away to reduce the likelihood of harm coming to the child.
- There was an emergency trolley available in the physiotherapy department. This could be used in the event of a patient or relative collapsing and needing resuscitation. The trolley was secured and tagged, and had a checklist which we saw was regularly completed.
- Nine members of staff had completed basic life support training in outpatients (90%) and five staff had completed immediate life support training. Six members of staff had completed paediatric basic life support training in outpatients (60%). All members of staff in diagnostic imaging had completed basic life support training and two had completed paediatric basic life support. Due to the small numbers of staff in the department, these percentage compliance rates may suggest a more concerning situation than is actually the case. This means there were staff competent to deal with patients who are unresponsive and may have suffered a cardiac arrest.
- The imaging department displayed clear warning notices, doors were shut during examination and warning lights were illuminated when radiation was occurring.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required. This was in line with ionising regulations 1999 and regulations IR (ME) R 2000).
- Imaging department staff also carried out regular quality assurance checks. This indicated equipment was working as it should. These mandatory checks are in line with ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R 2000). We saw records of these checks, for each machine, was completed each day.

Outpatients and diagnostic imaging

- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited. Diagnostic imaging staff had a clear understanding of protocols and policies. Protocols and policies were stored on a shared computer file which staff had access to. Staff demonstrated their knowledge of where policies were kept.
- Signs advising women, who may be pregnant, to inform staff, were clearly displayed in the diagnostic imaging departments in line with best practice.

Nursing staffing

- The outpatient department had 6.4 full time equivalent (FTE) nursing and midwifery registered staff and 2.8 FTE health care assistants (HCA). This gave a ratio of one nurse to 0.43 HCA. Staff told us they felt they had enough staff to carry out their work safely.
- The outpatients department used bank staff, and occasional agency staff. When compared with other independent hospitals for which we hold data the usage of agency staff was comparable. For nursing staff, the rate of agency use was average throughout the time period, and use of healthcare assistants was average throughout the time period except for the first three months of 2016, where usage was above average.
- We saw an example of an agency staff checklist, which required agency staff to sign off that they had been shown/introduced to all aspects of the service, including orientation to the site and hospital policies. This is then counter signed by the department manager and ensures the staff are competent and have knowledge of all areas before commencing their role.
- The outpatient manager explained that staffing levels were based on clinical need, and explained that Monday was one of their busiest days for clinics and therefore more staff were rotated on than for Fridays where the flow of patients was much less.
- The imaging department had three radiographers and an imaging assistant and staff told us this was sufficient to meet the needs of their patients.

Medical staffing

- Across the hospital there was 197 doctors employed under practicing privileges, this was not broken down by department level so it is not possible to state how many worked for the outpatient and diagnostic imaging service.
- Half of all the consultants with practicing privileges had not carried out any episodes of care in the period from April 2015 to March 2016. We found that the senior management team were carrying out an exercise to contact all consultants who had not worked at the hospital to renew or revoke their practising privileges to ensure that consultants were still familiar with the working practices at the hospital and could practice safely.
- The hospital had Resident Medical Officer (RMO) cover, 24 hours a day, seven days a week. Staff in outpatients told us that the RMO was accessible. We reviewed the arrangements for the recruitment of RMO's and looked at five RMO personnel records. We saw that all necessary checks such as checks on the registration with the General Medical Council and Disclosure and Barring Service checks had been carried out.

Major incident awareness and training

- The outpatient department had a business continuity plan and staff were aware of the location and nature of this.
- The imaging department had a business continuity plan (BCP) and staff were aware of this. There were various flowcharts as part of this and examples such as 'in the event of equipment breakdown'. All staff were given an induction to the BCP and we saw that staff had signed to say they understood it.
- There were visible fire alarms fitted at both ends of the outpatient department. Visible fire alarms work in the same way that standard fire alarms work but have the addition of a red flashing light, meaning that hearing impaired people would be able to see the flashing light. We saw that these were tested routinely.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness as we do not currently collect sufficient evidence to rate this;

- There was a good multidisciplinary team approach to care and treatment involving a range of staff working together to meet the needs of patients using the service.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- There were good levels of appraisal completion across the departments.

Evidence-based care and treatment

- The pathology service was accredited by the United Kingdom Accreditation Service (UKAS) and was situated within the diagnostic imaging department. UKAS accreditation meant that the service had an independent annual audit of the pathology services to ensure it met standards that endured the reliability of results and safe working practices.
- Staff in the outpatient areas reported they followed national or local guidelines and standards to ensure patients receive effective and safe care. An example of this was how the pre-assessment team used National Institute for Health and Care Excellence (NICE) guidance and incorporated this into their practice through the elective surgery pre-assessment tool.
- Radiation exposure and diagnostic reference levels were audited regularly and evidence of this was seen during inspection.
- The provider had an appointed radiation protection supervisor (RPS) and a radiation protection adviser (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. This meant that the hospital had an independent annual audit of the imaging services.
- We saw copies of the 2014 and 2015 independent annual audits (Radiation Protection Adviser audits) of the imaging services, and saw in the 2015 audit that recommended improvements had either been implemented or were due to be implemented with mitigations in place.
- The imaging department saw children from three years of age and there was a paediatric radiologist who reviewed and reported the radiological images produced from these. We saw separate protocols for imaging children. This was in line with the Royal College of Radiologist's guidelines.
- The imaging department followed iRefer, the Royal College of Radiologists radiological investigations guideline tool accredited by NICE and this was also used by anyone who referred patients to the service.

Pain relief

- At the time of the inspection, we did not observe any patients who required pain relief, however staff told us that the resident medical officer (RMO) would be contacted if a patient required pain relief or if they felt a patient's health was deteriorating. Doctors could prescribe pain relieving medication in clinic, if required.

Competent staff

- Staff at a focus group told us that their appraisals were useful and contained a personal development plan (PDP) to work towards. Staff were also able to ask about extra training and conferences at these sessions. One hundred percent of outpatient health care assistants (HCA) and nurses had an appraisal in the period from March 2015 to March 2016.
- Staff had opportunities to develop professionally. This contributed to maintaining their registration with the nursing and midwifery council (NMC). The outpatient manager gave examples of staff progressing through the department including a staff nurse who had worked up to become her deputy, and an HCA who was attending a university course to be able to become a qualified nurse.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured consultants who worked under practising privileges had the necessary skills and

competencies. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service were completed.

- There were systems to alert managers when individual staff member's registration with professional bodies was due to expire, and to ensure that registration was renewed and current. These systems were demonstrated to us.

Multidisciplinary working

- In the imaging department, patients who attend for an arthrogram fluoroscopy (injection of contrast into joint) go to x-ray for this and are then taken straight to the Magnetic Resonance Imaging (MRI) scanner for their scan. The MRI was run by a third party contractor and therefore we are not able to inspect this part of the service but this demonstrated a good working relationship throughout the department.
- We spoke to staff in pre-assessment who spoke of the good working relationship between pre-assessment and theatres and advised there was almost daily contact with theatre staff about upcoming patients and issues.

Seven-day services

- The outpatient department did not offer a seven day service as previous weekend clinics had not been popular with patients and had been underutilised.
- The diagnostic imaging department was open from 9am to 5pm, Monday to Friday, with occasional late clinic in the evening. The department told us there is no demand for the department to be open at the weekend.
- An on-call radiographer was available 24 hours a day, seven days a week for emergency examinations.

Access to information

- There were systems to ensure diagnostic images were accessible to clinicians when required. The electronic picture archiving and communication system (PACS) was used for storing and accessing diagnostic images and corresponding reports was accessible by the outpatients department. The hospital used a software system that was used alongside PACS to manage image archives and record-keeping. Older images or images carried out by another provider were shared onto this system via an online electronic sharing portal.
- However, the PACS system and the hospital information system did not link and therefore all information from the PACS system was written in a day book. This was then sent to administrators to input onto the hospital system which was then checked by both departments for accuracy.
- Radiology reports were not able to be sent electronically to the referring GP and therefore they were printed off each day and sent in hard copy to the GPs. Any incidental or urgent findings on the reports these were be faxed after the department contacting the GP by telephone.
- The hospital reported that approximately 5% of patients had been seen without medical records. We spoke to staff in the medical records department who advised us that they could not say for sure how many patients were seen without their notes in outpatients, but there were very few. In the event of a patient appointment without records, staff contacted the patient's GP in the first instance, and make up a temporary set of notes. Medical records staff would also check that the notes were not stored in a different part of the library; for example if the patient had recently been discharged from surgery and the notes were still in the 'inpatient' section of the library. This would be checked by using the tracer card system, which was a system for tracking the whereabouts of notes in the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an in date policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- All diagnostic imaging staff attended study days regarding MCA and DoLS training and we saw evidence of this.
- At the first clinic appointment with the gender specialist nurse, patients were given a consent form, which they took away with them and could send back in a self-addressed envelope provided, patients were asked not to sign this on the day but to take it home to consider. The consent form included information about the operation, possible complications and their

likelihood and information about cosmetic appearance post-surgery. This showed that patients were encouraged to consider all information available to them and to consider their consent.

- In the diagnostic imaging department, the consent form used was based on the World Health Organisation checklist and consent forms were regularly audited. We saw the audit from June 2016 which demonstrated that all patients who had an interventional procedure had provided consent.
- We saw patient information leaflets in the outpatient waiting areas that explained what consent was and why they may be asked for it and helped them to make an informed decision about their treatment.

Are outpatient and diagnostic imaging services caring?

Good

We have rated outpatients and diagnostic imaging services as good for caring because;

- Feedback from people who use the service, those who are close to them and stakeholders were positive about the way staff treat patients.
- Patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.
- Patients felt supported and told us they felt staff cared about them.
- Patients' privacy and confidentiality was respected at all times.

Compassionate care

- The NHS Friends and Family test (FFT) data provided to us was hospital wide and not able to be broken down by service. The results from July to December 2015 showed a score of 99% or more, but the overall response rate was low, with an average of 38% of patients visiting the hospital completing the test.
- We saw the outpatient survey responses for the past year that had been collated by one of the staff members in outpatients who took responsibility for this. We viewed the responses for the past three months and saw largely positive comments about the service, with several named plaudits for staff members.
- We reviewed 30 feedback cards that had been completed by patients visiting the outpatient department. The majority of these were positive about the staff, environment and care. Consistent comments on the positive feedback cards were the warmth and friendliness of the staff working in the department.
- We spoke to four patients waiting for an outpatient appointment. They all agreed they were greeted warmly and had been treated individually and non-judgmentally. One patient had been informed of a delay to their clinic when they checked in, but had had a positive experience up to that point.
- We saw thank you cards and letters that the gender reassignment team had received. We reviewed approximately ten of these and found that the warmth and friendliness of the staff through their treatment was valued extremely highly and patients were very happy with the treatment they had received.
- We spoke to three patients in the diagnostic imaging department waiting room, all felt that they were greeted well by the diagnostic imaging staff and we observed staff introducing themselves to their patients.

Privacy and Dignity

- The hospital Patient Led Assessment of the Care Environment (PLACE) audit score for privacy and dignity saw an improvement from 92% in 2014, to 100% in 2015, showing a significant improvement. This score was significantly better than the national average of 87%.
- All of the consulting and treatment room doors in outpatients had signs on to indicate whether the room was in use or not. There was also a board at the outpatient reception which had all rooms occupancy listed and by which consultant. This helped to ensure patient dignity was protected from unnecessary interruptions.
- The gender reassignment service was separate from the main outpatients waiting area on the first floor and had a waiting area and a patient lounge. The signage for this department was discrete.

Outpatients and diagnostic imaging

- In the diagnostic imaging department there was a large supply of gowns and dressing gowns for patients to use whilst getting changed and attending their scan.
- We observed a staff member checking the identity of a patient when called for their scan, but this was done away from other patients to ensure confidentiality.
- There were two cubicles in the radiology waiting area, and once patients had changed into their gown they could either re-join the waiting area, or sit in the separate waiting area leading to the imaging rooms. All patients were given dressing gowns as well as hospital gowns for extra comfort and dignity. Patients reported they liked these and the use of a locked cupboard where their clothes and belongings were stored whilst they were having their scan. The patients we spoke to felt their confidentiality was respected at all times.
- All staff we observed were friendly towards patients and colleagues.
- The physiotherapy gym had a curtained area for privacy when patients were using the equipment.
- There was an in date policy on privacy, dignity and the use of chaperones. There were chaperone signs on the desk and staff explained how the consultants could ring reception during the consultation if the patient decided they would like a chaperone, and one of the nurses allocated to that clinic would attend. We saw an audit carried out of chaperone use for the previous three months which showed that patients were consistently offered a chaperone.

Understanding and involvement of patients and those close to them

- We spoke to one patient waiting for an outpatient appointment who told us that they felt treated as an individual and had been given good information about the process and what was going to happen. They thought the staff were professional and caring.
- Three patients we spoke to said they felt the hospital was very non-judgmental, and found everyone very friendly. They said the consultants gave good advice and they did not feel pushed into anything.

Emotional support

- The gender reassignment service had a dedicated clinical nurse specialist (CNS). After their consultations, patients were given information sheets which included the CNS phone number on which they could contact and leave a message at any time which we saw.
- Staff told us that in the breast clinics, they could ask Macmillan nurses to sit in on appointments if they were breaking bad news or had patients with a cancer diagnosis.

Are outpatient and diagnostic imaging services responsive?

Good

We have rated the outpatients and diagnostic imaging services as good for responsive because;

- Patients' needs were met through the way services were delivered.
- The provider met their referral to treatment (RTT) targets for non-admitted patients beginning treatment within 18 weeks, with the exception of one month during the reporting period.
- Patients could choose appointments that suited them.
- Patients were kept informed of any disruption to their care or treatment.

Service planning and delivery to meet the needs of local people

- The outpatient department held clinics between 8am and 8pm Monday to Friday. The outpatient manager explained how the department had trialled opening for clinics on the last Saturday of every month but that there had been poor uptake on this. They are now trialling holding morning clinics on the second and fourth Saturday of each month. This demonstrates that the service was responding to the needs of patients to ensure they had access to services at a time that suited them.
- The physiotherapy department did not offer seven day working but the department did offer extended hours on four days Monday to Friday. This meant patients had a choice of appointment times and days most convenient to them.

Outpatients and diagnostic imaging

- The imaging department offered non-symptomatic breast screening. This clinic was run by two mammographers (a radiographer who was trained to carry out imaging of the breast) and had a specific protocol which was followed. Patients could self-refer and if any anomalies were found, the patient could either request to be seen by a breast surgeon at the hospital or be referred back to their GP.
- Patients for the gender reassignment service were referred from Gender Identity Clinics (GIC) from across the United Kingdom (UK). Patients for this service travelled from all over the UK and often had long journeys to their appointment. Staff explained that because of this, they offered these patients appointments around midday and early afternoon to allow them sufficient time to travel.
- The gender team described a robust process for working with the patient's GP. The team liaised with the GP before the patient comes into the clinic and the GPs carry out routine blood tests and MRSA screen to avoid the patient having to travel to the hospital.

Access and flow

- Non-admitted pathways are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital. The provider met the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period from April 2015 to March 2016 except for October 2015 where the hospital reported only 67%. The hospital told us that there were inaccuracies in the data submitted in October 2015 due to staff changes in the team responsible for reporting this data. Once the issue was identified, steps were taken to ensure adequate training and guidance was given to the staff members in this department to ensure consistent future reporting.
- Patients accessed NHS services via a GP referral through the Choose and Book system by direct referral for self-funding patients or via their health care insurer.
- All physiotherapy patients were appointed and seen within 24 hours and therefore there were no waiting lists for physiotherapy appointments. Which meant patients received their treatment in a timely manner. We observed a receptionist informing patients on their arrival that the clinic was running behind and apologised for this.
- We spoke with one patient who told us they got an appointment in under a week with their preferred consultant and were very happy with this.
- Staff we spoke with reported timely access to diagnostic imaging results.
- We saw minutes from an outpatient meeting where it was agreed that NHS or Choose and Book patients would be asked to come back for their stage one pre assessment clinics during quieter times rather than on the day of their consultation to make room for private patients. This indicated NHS patients may not get the same level of service from the department that private patients get as they did not have the same choice of appointment time and private patients were seen as the priority.

Meeting people's individual needs

- There was a hearing loop induction (a type of sound system that works with hearing aids to enable people to hear clearly) at the reception desk in outpatients. The hospital carried out a disability access audit in 2015, on the action plan it was identified that an additional hearing loop induction was required for the x-ray department and we saw that this had been installed.
- The Patient Led Assessment of the Care Environment (PLACE) score relating to food improved from 98 % in 2014, to 99% in 2015, this is better than the England average of 93%.
- The gender reassignment service waiting area was separate from the main outpatient waiting area. Patients that used this service checked in at the main reception, but were met by a member of staff who introduced themselves and asked for their name. The member of staff then directed them to the waiting area for their appointment.
- Staff told us that they could access taxi drivers that had knowledge of gender dysphoria (condition of feeling one's emotional and psychological identity as male or female to be opposite to one's biological sex) to make gender reassignment patients more at ease when travelling to or from their appointment.

Outpatients and diagnostic imaging

- If a patient with a learning disability attended a gender reassignment appointment, the gender team worked with the patient's GIC and social services. They showed us an example of how they adapted the format of all the information provided, which included more pictorial information to suit the patient's needs.
- The waiting area in outpatients had comfortable chairs, patient leaflets, current newspapers and magazines. There was also a television on, which we observed people watching whilst waiting for their appointment. Two patients we spoke with commented on the ease of being able to make themselves complimentary hot and cold drinks.
- The toilet in the outpatient waiting area was wheelchair accessible and had grab rails and lowered sinks. There were dedicated car parking spaces at the front of the hospital, close to the main entrance for disabled people. The outpatient and diagnostic imaging service was mainly on the ground floor and so easily accessible but there were also lifts available to get to other parts of the hospital, including the gender reassignment service.
- However, he pharmacy hatch where patients could collect medicines prescribed at their clinic appointment lacked privacy as it was in a public area, and did not provide access to a person in a wheelchair due to the height of the hatch.

Learning from complaints and concerns

- There were leaflets available in waiting areas detailing how to make a complaint to the hospital.
- Staff at a focus group gave examples where learning or change had been implemented following a complaint or feedback. An example of learning from complaints came from the gender reassignment service. A patient gave feedback that some written information they had been given had not been clear and that this was adapted following this feedback and we saw that the information pack was a working document that had been adapted and updated to suit patients' needs.
- Radiology staff reported that they had received no formal complaints in the last two years and were proud of the plaudits they had received from patients.

Are outpatient and diagnostic imaging services well-led?

Good

We judged the outpatient and diagnostic imaging service as good for well led because;

- The leadership, governance and culture promoted the delivery of high quality person centred care.
- The leadership was knowledgeable about quality issues and priorities, understood what the challenges were and takes action to address them.
- The senior management team were visible across the hospital. Staff described an open culture and said senior managers were approachable at all times.

Vision and strategy

- The vision for the hospital was to become the private hospital of choice in Brighton and Hove, and regional centre of excellence for patients, by ensuring high quality care, which was safe, effective and personalised.
- We saw minutes from an outpatient department meeting in February 2016, which indicated the performance of the hospital for the previous year was discussed and the business objectives going forwards.

Governance, risk management and quality measurement

- Monthly meetings were held at department level, and issues identified from these meetings were discussed at the hospital leadership team (HLT) meetings. These meetings then fed into the senior leadership team (SLT) meetings which fed into the hospital board.
- We saw minutes of the monthly departmental meetings for outpatients. Incidents, training and feedback from patient surveys were discussed.
- We saw minutes of the departmental meetings for diagnostic imaging, these were not held monthly as described on the hospital committee structure. Minutes from January and June 2016 were seen and incidents, audits, policies and training were discussed.

- We saw minutes of SLT meetings that showed that incidents, complaints and mandatory training compliance were discussed at board level.
- The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) procedures and protocols were issued in February 2016 and these were discussed at the Quality and Safety Meeting.
- The hospital was subject to annual Radiation Protection Advisor audits, and we saw the 2014 and 2015 reports. The audit for 2016 had taken place in May and staff told us they were still waiting for this report.
- Both departments in this core service had their own risk registers and staff were proud of this. Risk registers were discussed at the senior leadership team meetings, the hospitals governance committee meetings and we saw minutes of these meetings which indicated this was occurring.

Leadership/culture of service

- Staff demonstrated knowledge of the management structure and new appointments at a corporate level in the organisation, an example of this was the appointment of a new pre-assessment lead for the organisation and a member of staff had made contact and interacted with them.
- Outpatient staff reported to the outpatients' manager, who reported to the hospital matron. Diagnostic imaging staff reported to the diagnostic imaging manager, who reported directly to the matron.
- Every member of staff we spoke to spoke highly of the matron. They told us she was visible and approachable on a daily basis, and had a genuine open door policy.
- Staff told us about a recent period of change following a new hospital director and matron, but were positive with the changes that had been made and going forward.
- We spoke to managers who were proud of their staff and the contribution they make.
- There was a culture of transparency and honesty amongst staff. Staff told us managers encouraged and supported them to report incidents.
- Staff turnover rates for nurses and healthcare assistants (HCA) within the outpatients department are below the average compared to other independent acute hospitals for whom we hold data.

Public and staff engagement

- The hospital participated in the Patient Led Assessment of the Care Environment audit which enabled patients to audit and score the hospital for the environment and some hotel services such as food.
- We saw minutes from the customer focus group meetings for the last year, which discussed monthly patient satisfaction surveys. There was also discussion of staff behaviours and examples of where staff had gone the extra mile to help colleagues. There were patient satisfaction surveys available to be completed and posted in a locked box on the reception desk. We saw that the main feedback themes were displayed in the hospital reception area.
- Staff at a focus group told us that patients were invited to customer focus group meetings but were not always able to attend. We reviewed the minutes of the last four meetings and noted that patient representatives had not attended. We saw invitations to attend were displayed in the reception area.
- Staff at a focus group told us that they were invited to attend the customer focus group meetings.
- Both outpatients and diagnostic imaging had staff meetings. We reviewed the minutes from the April diagnostic imaging team meeting and saw that all staff (with the exception of the radiologists) attended.

Innovation, improvement and sustainability

- The outpatient manager attended outpatient manager meetings for the whole Nuffield Health, and had the opportunity at these meetings to share best practice with outpatient managers from across the country. An example of a change that came about from these meetings was the role and remit of HCAs. This role had varying remits across the country and it was agreed that these need to be standardised to ensure fairness and consistency.
- The outpatient staff monitored their own patient satisfaction surveys and this was another example of an outcome from the Nuffield outpatient manager

meetings. Responses are collated monthly and where staff are named, they can be used for revalidation purposes and for using in feedback and one to one meetings.

- In pre-assessment, staff felt not all of the corporate pre-assessment documentation was detailed enough for their patients' needs, and therefore they printed additional stickers with tick boxes and added these into to all forms to provide assurance that they were collecting information needed before patients' treatments.
- The outpatient manager told us about the upcoming roll out of the electronic care record and explained that this would be rolled out one speciality at a time to ensure that there was adequate time to ensure effective implementation.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital was a centre of excellence for transgender surgery performing over 300 procedures each year attracting patients from all over the UK and internationally. Feedback received from the gender reassignment service (GRS) was continually positive about the way the staff treated people. Patients thought that staff went the extra mile and the care they received exceeded their expectations. Within the GRS there was a proactive approach to understanding the needs of this patient group, which included people who are in vulnerable circumstances or who had complex needs and care was delivered in a way that met patients' needs and promoted equality.
- The hospital worked with the local university to offer a joint resident medical officer (RMO) post. Five RMOs covered the hospital over the 24 hour period and also undertook teaching anatomy and practical subjects to students at the local university. This was an innovative and practical way to attract skilled RMOs to the post and was working well.
- The hospital had a strong ophthalmology pathway and was a leading independent provider of ophthalmology services.
- The hospital had taken steps to become "greener" in its operation and had reduced its carbon footprint by the use of solar panels and light-emitting diode (LED) lights.

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure there is a planned preventative maintenance plan for medical gas regulators and that there are suitable safe storage facilities for larger cylinders not required for the medical gas manifolds.
- Consider keeping individual laser registers for each laser in a hard copy format.
- Review access in the pharmacy dispensary where there was lack of confidentiality and disability access to the dispensary hatch.
- Review the prescription tracking system to minimise the possibility of mis-use.
- Ensure controlled drugs records are managed in line with legal requirements.
- Make adequate arrangements to report on emergency medical imaging out of hours.
- Take action to address patient feedback on the quality of food.
- Review maintenance and refurbishment plans to ensure the clinical environment meets national guidance.
- Ensure regular risk assessment of oncology patients for venous thrombo-embolism.
- Make arrangements for the transfer out of acutely unwell oncology patients
- Consider how best practice in the interpreting services could be achieved.