Nuffield Health Exeter Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection as part of our programme of independent healthcare inspections under our new methodology. The comprehensive inspection was carried out through announced visits on 10 and 11 May and 9 June 2016. We did not carry out an unannounced inspection.

Our key findings were as follows:

We rated the hospital as good overall, with surgery and children and young people's services rated as good in all domains. Outpatients and diagnostic imaging services were rated as good in responsive, caring and well led domains and requires improvement in the safe domain. We did not rate effective for outpatients and diagnostic services due to insufficient evidence being available.

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff.
- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service.
- Patients were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Patients and their relatives were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Patients spoke highly of the approach and commitment of the staff who provided a service. Staff went above and beyond their usual duties to ensure patients received compassionate care.
- Patients received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with patients and their families.
- Staff understood the individual needs of patients and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to patients and their relatives and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the departments they worked in. They spoke highly of the culture and levels of engagement from managers.
- Staff worked in an open and honest culture with a desire to get things right.

Are services safe at this hospital/service

- The hospital promoted a culture of reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place.
- The management of medicines and infection control was in place with audit tools used to monitor practice.
- Staff were clear about safeguarding practices and knew what actions to take if they had concerns.
- Records were stored securely and audited for compliance with protocols. However in the outpatients department some confidential information was left unattended in unlocked treatment/consultation rooms.
- Nursing and medical records had been completed appropriately and in line with each individual patient's needs.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient.

Summary of findings

- The service had not yet achieved Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) for its endoscopy service.
- The provider had a compliance level of mandatory training target of 90%. Most mandatory training achieved 100%
- Equipment specific to children's needs was available for use.
- Staffing levels met the RCN guidance on defining staff levels for children and young people's services.
- Infection rates were monitored.
- In the outpatients department not all hand wash basins or flooring in clinical areas were compliant with Department of Health 'health building notes' (HBN) which give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities

Are services effective at this hospital/service

- Needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance. Staff were aware of the guidance relevant to their area of work.
- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- Staff were trained to ensure they were competent to provide the care and treatment needed. Staff training and appraisal was ongoing. Consent to care and treatment was discussed and obtained in line with legislation and guidance.
- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Regular audits were carried out to monitor performance against national patient outcomes and to maintain standards.
- Patients were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients.
- Children and young people's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.

Are services caring at this hospital/service

- Patient feedback about the service was positive. Patients said staff were kind, caring and supportive. We saw staff were kind and caring, their focus being excellent patient care. They praised the way the staff really understood their needs and involved their family in their care. Patients were treated as individuals. Staff described occasions when they had been flexible at short notice to ensure patients had their procedures carried out.
- Between July and December 2015 there were high satisfaction scores (85% and above) with the NHS Friends and Family Test
- Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe. Staff went above and beyond their usual duties to ensure patients experienced high quality care.
- Staff were skilled to be able to communicate well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care.

Summary of findings

- Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. They were polite, calm and reassuring. The departments were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about patients compassionately with knowledge of their circumstances and those of their families.
- Paediatric staff used age appropriate distractions for their patients to relieve anxiety.
- Comments from patients and their parents specified the positive effect staff attitude and approach had on their stay.
- Staff responded to parent's and children's emotional needs by recognising and responding to anxieties. They did this by providing information and reassurance appropriate for age and understanding.

Are services responsive at this hospital/service

- Services were planned to meet patients' needs. The flow of patients through the hospital was well organised. Patients felt well informed about the procedure and what to expect during their recovery.
- Services were tailored to meet the needs of individual patients and were delivered in a flexible way.
- Complaints were responded to in a timely manner and any learning was taken forward to develop future practice. Staff actively invited feedback from patients and their relatives and were very open to learning and improvement.
- There was level access into the building and a passenger lift to all floors ensuring patients could move around the building.
- The hospital had reviewed the quality of the service and made reasonable changes where required, to ensure they could provide a safe service in a way that would suit the needs of children and young people.
- Where young people may feel sensitive about a procedure, arrangements were made to provide an advocate who was independent of their family or professionals providing direct care.

Are services well led at this hospital/service

- The hospital had a vision for developing the service and shared this with their patients.
- There were clear governance processes in place to monitor the service provided.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice would be introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible. Staff had confidence in leadership at each level and felt they would be listened to.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the patients in their care, their staff and the unit.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was a high level of staff satisfaction with staff saying they were proud of the departments as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.

Summary of findings

- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary
- Actions were monitored through audit processes and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.

Importantly, the provider MUST take action to:

- Ensure the outpatient department was cleaned effectively.
- Make sure the flooring and clinical hand-wash basins in the outpatient department complied with infection prevention control in accordance with Health Building Note (HBN) 00-09: Infection control in the built environment.

The hospital SHOULD take action to:

- Continue to investigate and monitor the occasional infestation of cluster flies in the roof space above the operating theatre.
- Continue to ensure staff complete mandatory training as required to reach the organisations target of 90% compliance.
- Ensure there was a decontamination policy for laryngoscope handles and blades in line with the Medicines and Healthcare Products Regulatory Agency (MRHA) Alert 2011.
- Gain Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) (recognition granted to organisations which meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service.
- Consider how children are protected from scald injuries wherever possible.
- Consider close monitoring of hygiene standards in all areas children and young people attend.
- Consider close monitoring of staff compliance with hospital protocols including chaperone policies.
- Closely monitor the cleaning of all areas to ensure they are dust free.
- Closely monitor compliance with hand hygiene protocol for all staff including consultants.
- Make sure all confidential records are stored securely.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	• Staff were encouraged to report incidents. Learning was taken from their own incidents and those reported at other Nuffield hospitals. • The systems in place to monitor patient safety including the World Health Organisation (WHO) surgical safety checklist were in place and well managed. • Treatment was provided in line with national guidance and staff were aware of the NICE guidance related to their practice. • Policies and procedures were in place to support staff and were available to all staff at all times. • Staff had mandatory and role specific training to enable them to competently provide the care and support needed by patients. • Feedback from patients and their relatives about the care provided was positive. Staff were seen to be kind and caring and provided individualised care. • Services were planned to meet patient's needs. The flow of patients through the hospital was well organised. • Complaints were responded to in a timely manner and according to Nuffield Health's policy. Learning was taken from complaints to develop good practice. • There were clear governance processes in place to monitor the services the hospital provided. • Managers were visible at each level, approachable and responsive. Staff had confidence in the leadership team.
Services for children and young people	Good	• Investigations of incidents, comments and complaints identified where improvements were needed and these were acted upon wherever possible. • A six monthly audit of the service reviewed safety and quality. National standards such as Royal College of Nursing (RCN) guidelines and National

Summary of findings

Institute for Health and Care Excellence (NICE) guidance were used as benchmarks. Gaps in service were identified and actions taken to develop systems that would meet the guidelines.

- Governance systems monitored standards of care and ensured appropriately trained staff cared for children and young people.
- Plans were being made to further improve the service in safety and responsiveness to children and young people's needs such as using audit to ensure record keeping protocols were followed by staff and engaging patients and the public in assessing the service.
- All hospital staff were aware of when they would need support from registered children's nurses or a paediatrician and how to access them.
- Children and young people had their individual needs assessed and plans were put into place to meet those needs wherever possible. This was to make their hospital stay less traumatic.
- Areas used were not dedicated solely for use by children and young people but were adapted where possible to make them more appropriate for any age of child. For example, beds for children and teenagers had different linen and activities were provided to entertain and distract all ages.
- Staff provided information for parents and for children in suitable formats.
- Parents we spoke with felt informed and that their children were treated as individuals.
- There was representation at leadership meetings and other committees throughout the hospital.
- Consultants were monitored for competency in their field of surgery and were required to provide evidence of their practice before being allowed to practice at this hospital. If consultants performed procedures less frequently at this hospital they had to provide evidence that they had performed these procedures in other settings such as NHS premises, on a more frequent basis.

Outpatients and diagnostic imaging

Good

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff.

Summary of findings

- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service.
- Patients were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Patients and their relatives were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Patients spoke highly of the approach and commitment of the staff who provided a service. Staff went above and beyond their usual duties to ensure patients received compassionate care.
- Patients received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with patients and their families.
- Staff understood the individual needs of patients and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to patients and their relatives and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the department as a place to work. They spoke highly of the culture and levels of engagement from managers.
- Staff worked in an open and honest culture with a desire to get things right.

Summary of findings

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Good

Nuffield Health Exeter Hospital

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

Summary of this inspection

Background to Nuffield Health Exeter Hospital

Nuffield Health Exeter Hospital is an independent hospital, which is part of the Nuffield Health corporate group. It provides outpatient and surgical services to adults, children and young people from birth upwards.

The hospital had two wards with 37 inpatient beds provided in single en-suite rooms. There were a further six single rooms with shared toilet facilities, used mostly for day cases and children.

There were three operating theatres and an endoscopy/ laser room within the theatre suite. There was a six bay recovery (post-anaesthetic) area in the theatre suite, with one being paediatric friendly. The hospital had 11 outpatient consulting rooms, a small pathology laboratory and an on-site pharmacy.

There were 11 consulting rooms, two cardio physiology rooms and three treatment rooms where procedures were performed under local anaesthetics.

The diagnostic imaging service provided a range of general and specialist imaging services including plain x-rays, ultrasound, mammography and Magnetic Resonance Imaging (MRI).

Our inspection team

Our inspection team was led by:

Mandy Norton, Inspector, Care Quality Commission.

The team included four CQC inspectors, a CQC pharmacist and four specialists: a consultant surgeon, a theatre manager, a paediatric nurse and an infection control specialist nurse. .

Why we carried out this inspection

We carried out this comprehensive inspection as part of our scheduled in depth inspections of independent hospitals.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

The inspection team inspected the following three core services at the Nuffield Health Exeter Hospital:

- Surgery.
- Services for children and young people.
- Outpatient and diagnostic imaging services.

Prior to the announced inspection, we reviewed a range of information we held about the service.

Our announced visits which took place on 10 and 11 May and 9 June 2016. During our visit we spent time on the ward and in the outpatient department observing the treatment and care provided. We also spent time in the operating theatres and the recovery area. We made a second visit to observe children being admitted for laser surgery.

Summary of this inspection

We spoke with the management team of the hospital and the chair of the medical advisory committee, a variety of staff, including nurses, healthcare assistants, doctors, therapists, radiographers, department managers and support staff. We also spoke with patients and relatives.

Information about Nuffield Health Exeter Hospital

Nuffield Health Exeter Hospital is an independent hospital, which is part of the Nuffield Health corporate group. It has been providing services in Exeter since 1963. It provides outpatient and surgical services to adults, children and young people from birth upwards.

The Nuffield Health Exeter Hospital was previously inspected by CQC in March 2014 prior to the change to the new fundamental standards. At that inspection all the areas inspected were found to be compliant.

The hospital had two wards with 37 inpatient beds provided in single en-suite rooms. There were a further six single rooms with shared toilet facilities, used mostly for day cases and children.

There were three operating theatres and an endoscopy/ laser room within the theatre suite. There was a six bay recovery (post-anaesthetic) area in the theatre suite, with one being paediatric friendly. The hospital had 11 outpatient consulting rooms, a small pathology laboratory and an on-site pharmacy.

There were 3,829 visits to the theatre between January and December 2015. Of these 547 were NHS funded inpatients that stayed overnight and 723 were NHS inpatient day cases. The remaining patients were self-pay or funded by their insurance companies.

The five most common surgical procedures performed between January and December 2015 were:

- Adult cardiac catheterisation (360)
- Total knee replacement (352)
- Knee arthroscopy (237)
- Total hip replacement (233)
- Diagnostic colonoscopy (169).

There were 11 consulting rooms, two cardio physiology rooms and three treatment rooms where procedures were performed under local anaesthetics.

The diagnostic imaging service provided a range of general and specialist imaging services including plain x-rays, ultrasound, mammography and Magnetic Resonance Imaging (MRI).

There had been 7,783 outpatient appointments for the period from January to December 2015 The data was divided into first attendance and follow-ups for NHS funded patients and those funded by other means. Data showed that for NHS funded patients there were 1,253 first attenders and 1,280 follow-ups; and for other funded there were 3,713 first attenders and 1,517 follow-ups.

The most commonly performed procedures for children and young people between January and December 2015 were laser destruction of skin lesions and surgical excision of lesions of skin or subcutaneous tissue. Other conditions treated included procedures for ear nose and throat, dental extractions, circumcision and orchidopexy (procedure for undescended testes)

Between January and December 2015, 69 children and young people underwent procedures; 11 as inpatients and 58 as day cases. 20 of these were NHS patients and 49 were funded by alternative methods. Within the same period there were 180 outpatient attendances for under 18 year olds. 47 of these were NHS funded patients.

Physiotherapy consultations are offered for children and young people who could be referred by a health professional or on a self-referral basis.

Summary of this inspection

What people who use the service say

Patients and their relatives had high praise about the hospital, the services offered and the staff who worked there. The patient representative group said they had regular meetings with the service and felt staff engaged well with them listening to their concerns and points of view.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- The hospital promoted a culture of reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place.
- The management of medicines and infection control was in place with audit tools used to monitor practice.
- Staff were clear about safeguarding practices and knew what actions to take if they had concerns.
- Records were stored securely and audited for compliance with protocols.
- Nursing and medical records had been completed appropriately and in line with each individual patient's needs.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient.
- The provider had a compliance level of mandatory training target of 90%. Most mandatory training achieved 100%
- Equipment specific to children's needs was available for use.
- Staffing levels met the RCN guidance on defining staff levels for children and young people's services.
- Infection rates were monitored.
- The design of the flooring in treatment and consulting rooms and the use of most clinical wash-hand basins did not facilitate good infection prevention and control practices to enable thorough access, cleaning, disinfection and maintenance to take place.
- Dust was found on high and low levels in particular under all examination couches.
- There was a lack of security of some confidential information.

Are services effective?

Good

- Needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance. Staff were aware of the guidance relevant to their area of work.
- Policies and procedures incorporating national guidance were in place and available to all staff. Staff knew where to access guidance and policies.
- Staff were trained to ensure they were competent to provide the care and treatment needed. Staff training and appraisal was ongoing. Consent to care and treatment was discussed and obtained in line with legislation and guidance.

Summary of this inspection

- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Regular audits were carried out to monitor performance against national patient outcomes and to maintain standards.
- Patients were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients.
- Children and young people's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.

Are services caring?

Good

- Patient feedback about the service was positive. Patients said staff were kind, caring and supportive. We saw staff were kind and caring, their focus being excellent patient care. They praised the way the staff really understood their needs and involved their family in their care. Patients were treated as individuals. Staff described occasions when they had been flexible at short notice to ensure patients had their procedures carried out.
- Between July and December 2015 there were high satisfaction scores (85% and above) with the NHS Friends and Family Test
- Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe. Staff went above and beyond their usual duties to ensure patients experienced high quality care.
- Staff were skilled to be able to communicate well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. They were polite, calm and reassuring. The departments were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about patients compassionately with knowledge of their circumstances and those of their families.
- Paediatric staff used age appropriate distractions for their patients to relieve anxiety.

Summary of this inspection

- Comments from patients and their parents specified the positive effect staff attitude and approach had on their stay.
- Staff responded to parent's and children's emotional needs by recognising and responding to anxieties. They did this by providing information and reassurance appropriate for age and understanding.

Are services responsive?

Good

- Services were planned to meet patients' needs. The flow of patients through the hospital was well organised. Patients felt well informed about the procedure and what to expect during their recovery.
- Services were tailored to meet the needs of individual patients and were delivered in a flexible way.
- Complaints were responded to in a timely manner and any learning was taken forward to develop future practice. Staff actively invited feedback from patients and their relatives and were very open to learning and improvement.
- There was level access into the building and a passenger lift to all floors ensuring patients could move around the building.
- The hospital had reviewed the quality of the service and made reasonable changes where required, to ensure they could provide a safe service in a way that would suit the needs of children and young people.
- Where young people may feel sensitive about a procedure, arrangements were made to provide an advocate who was independent of their family or professionals providing direct care.

Are services well-led?

Good

- The hospital had a vision for developing the service and shared this with their patients.
- There were clear governance processes in place to monitor the service provided.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice would be introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible. Staff had confidence in leadership at each level and felt they would be listened to.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the patients in their care, their staff and the unit.

Summary of this inspection

- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was a high level of staff satisfaction with staff saying they were proud of the departments as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary
- Actions were monitored through audit processes and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Information about the service

Nuffield Health Exeter Hospital carried out routine, non urgent surgery for adults and children who met strict eligibility criteria. The hospital had two wards with 37 inpatient beds provided in single en-suite rooms. There were a further six single rooms with shared toilet facilities, used mostly for day cases and children.

There were three operating theatres and an endoscopy/ laser room within the theatre suite. There was a six bay recovery (post-anaesthetic) area in the theatre suite, with one being paediatric friendly. The hospital had 11 outpatient consulting rooms, a small pathology laboratory and an on-site pharmacy.

Theatres one and two had a laminar flow; this is a specialised air filtration system. Surgery provided included orthopaedic surgery, cosmetic, ear, nose and throat surgery, gynaecology, urology, colorectal, vascular, ear, nose and throat, ophthalmology and spinal. The service carried out gastroscopies and colonoscopies and a variety of laser treatments in the endoscopy/laser room.

There were 3,829 visits to the theatre between January and December 2015. Of these 547 were NHS funded inpatients that stayed overnight and 723 were NHS inpatient day cases. The remaining patients were self-pay or funded by their insurance companies.

The five most common surgical procedures performed between January and December 2015 were:

- Adult cardiac catheterisation (360)
- Total knee replacement (352)
- Knee arthroscopy (237)
- Total hip replacement (233)
- Diagnostic colonoscopy (169).

The theatres are open for sessions Monday to Friday between 8am and 8pm. Theatre one and two are open alternate Saturdays between 8am and 5pm.

During the inspection we visited the operating theatres and recovery area, the endoscopy suite and the surgical ward. We spoke with five current patients, six past patients and approximately 19 staff. These staff included consultant surgeons, consultant anaesthetists, nurse managers and nurses in a variety of roles. We also spoke with administrative and housekeeping staff. We reviewed comments made by patients on comment cards available to patients before our inspection visit.

We saw care being given to patients. We reviewed 10 sets of patient's records.

Before and after our inspection we reviewed information and data provided about the service. We spoke with local stakeholders for example the local clinical commissioning group, to find out their views of the service provided by the hospital.

Good

Surgery

Summary of findings

We rated surgical services to be good overall because:

- Staff were encouraged to report incidents. Learning was taken from their own incidents and those reported at other Nuffield hospitals.
- The systems in place to monitor patient safety including the World Health Organisation (WHO) surgical safety checklist were in place and well managed.
- Treatment was provided in line with national guidance and staff were aware of the NICE guidance related to their practice.
- Policies and procedures were in place to support staff and were available to all staff at all times.
- Staff had mandatory and role specific training to enable them to competently provide the care and support needed by patients.
- Feedback from patients and their relatives about the care provided was positive. Staff were seen to be kind and caring and provided individualised care.
- Services were planned to meet patient's needs. The flow of patients through the hospital was well organised.
- Complaints were responded to in a timely manner and according to Nuffield Health's policy. Learning was taken from complaints to develop good practice.
- There were clear governance processes in place to monitor the services the hospital provided.
- Managers were visible at each level, approachable and responsive. Staff had confidence in the leadership team.

However:

- The hospital did not yet have Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) (recognition granted to organisations which meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service.
- There were on-going issues with an occasional infestation of cluster flies in the roof space above the operating theatres. We were shown reports about visits by an external contractor in July 2015 and April 2016, that showed no insect activity was present. We also saw a report that showed that work to reduce the risk of the flies entering the roof space had been carried out by an external contractor.

Good

Surgery

Are surgery services safe?

Good

We rated surgical services as good for safety because:

- The hospital promoted a culture of reporting and learning from incidents. Incidents were fully investigated with actions for improvement identified and put into place.
- The management of medicines and infection control was in place with audit tools used to monitor practice.
- Staff were clear about safeguarding practices and knew what actions to take if they had concerns.
- Records were stored securely and audited for compliance with protocols.
- Surgical safety checklists were completed as required and a modified early warning score system was in place to support staff to recognise a deteriorating patient.
- The provider had a compliance level of mandatory training target of 90%. Most mandatory training achieved 100%.

However:

- The hospital did not yet have Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) (recognition granted to organisations which meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service.

Incidents

- The provider had in place a Standard Operating Procedure (SOP) for the reporting and managing of adverse events (2015). A Nuffield Health Adverse Event was defined as 'any unintended or unexpected incident which could have, or did lead to harm for one or more individuals, or an incident on/to Nuffield Health property'.
- All adverse events such as transfers to other hospitals, returns to theatre and re-admissions were investigated. The investigation results were discussed at the monthly Hospital Board and Heads of Departments' meetings and the quarterly Quality and Safety, Clinical Governance and Medical Advisory Committee meetings.
- Nursing staff said they were encouraged to report incidents. They said they always received feedback if they reported an incident. Learning was then cascaded via team meetings and during handovers. Learning was shared from incidents reported from other hospitals in the group.
- Pharmacy staff said there was an open no-blame culture for reporting medicine incidents. They used a pharmacy form and their electronic reporting system to report incidents. In the first instance the nurse reported the incident to the resident medical officer (RMO) as the wellbeing of the patient was their immediate concern. The pharmacist was then approached for advice and to investigate the incident. The incident would be escalated to the senior corporate team if necessary. Matron reported any feedback or learning to staff.
- There were 26 medicines 'near misses' recorded since February 2015. They were recorded using the Royal Pharmaceutical Society (RPS) template. We saw the log and it included wrong quantities and form or strengths dispensed. Labels from bottles/boxes involved in the incident/near miss were kept as evidence.
- The pharmacist identified trends and chaired the pharmacy meeting (6 -8 weekly). There was a set agenda. If individuals missed the meeting, then issues were picked up in 1:1 discussions.
- There was a pharmacy newsletter produced regularly in response to issues highlighted in other hospitals. It included topics on learning, recalls, risk management and Never Events.
- There were 54 pharmacy SOPs ranging from chemotherapy, controlled drugs, temperature monitoring, ward pharmacy and dispensary processes. All were in date and review dates identified. Unsigned SOPs were on the relevant action plan.
- The hospital did not hold morbidity and mortality meetings. There was one unexpected death between January and December 2015. All patient complications were reviewed by the Medical Advisory Committee (MAC).

Good

Surgery

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff spoke confidently about the duty of candour. Training had been provided for relevant staff.

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

- The safety thermometer was completed for all NHS and private patients one day each month and the data submitted to the NHS. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This covers areas including falls, venous thromboembolism (VTE) and catheter associated urinary tract infections.
- The Nuffield Health Exeter Hospital used a system called GOV14 to review 30 patient records per quarter for venous thromboembolism (VTE), falls, catheter care and monitoring of the World Health Organisation (WHO) checklist. This system applied to both NHS and self-pay patients.
- The provider reported 100% compliance with VTE screening rates in each quarter of the reporting period (January to December 2015). There was one incident of hospital acquired VTE or pulmonary embolism reported in December 2015. We saw completed VTE risk assessments in the patient care records we reviewed in line with Nuffield Health policy. The risk assessment referred staff to the reference tool for VTE risk management and asked for interventions taken to be recorded. Staff were aware of the need for the risk assessments and the actions to take if a patient was assessed as having risks.

Cleanliness, infection control and hygiene

- All areas of the hospital we visited appeared visibly clean. We saw staff followed hospital procedures for infection prevention and control. They were bare below the elbow and used personal protective equipment and hand gel appropriately. All infection control policies were Nuffield corporate policies and were accessible to all staff via the Nuffield Group intranet system.
- Staff explained the importance of good hand hygiene and compliance was audited. In March 2016 compliance was 70%. An audit action plan stated compliance of above 90% was to be achieved by the end of 2016. We saw hand washing taking place before and after patient contact. Some staff reported that consultants did not always comply with hand-washing practices and wearing of gloves. We were told that consultants were trained by the NHS trusts for which they worked, and enforcement was therefore difficult.
- The Director of Infection Prevention and Control (DIPC) annual report 2016 stated that 'An Infection Prevention Strategy is developed each year to ensure Nuffield Health Exeter Hospital has effective infection prevention and control arrangements to protect patients, visitors and staff from risks of infection and related adverse consequences'. One of the outcomes for the 2016 programme was to complete hand hygiene compliance to a 100% level by the end of quarter two in 2016.
- There was no reported incidence of Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) or Methicillin Sensitive Staphylococcus Aureus (MSSA), between January and December 2015.
- Matron was the director of infection prevention and control for the hospital with support from 'link' staff in each area. Support and guidance was available from the Nuffield Health corporate infection prevention and control lead. Monthly infection prevention meetings were held. All identified infections had an investigation performed. Outcome of investigations and results of infection prevention audits were shared with all the teams in the hospital.
- Surgical site infections were monitored and recorded. Between January and December 2015 there was one recorded in abdominal surgeries, one in hip surgeries and one in knee surgeries.
- A summary of all infections was submitted to the Medical Advisory Committee (MAC) meeting and emailed to all relevant consultants. There was a Nuffield Health Adult Sepsis Screening and Action Tool (issued 08/10/2015). The tool was to be used with all adult patients, who were not pregnant and who had a suspected infection. Staff were able to describe how to use the tool, although there were no patients in the hospital during the inspection that had needed to have one completed.

- The patient's admission document included a section completed by staff which confirmed that the patient had showered prior to admission to reduce the risk of infection during surgery.
- We saw daily cleaning records were completed to identify when and where staff had completed their cleaning. Cleaning staff undertook daily cleaning of the ward and operating theatres, with theatres being cleaned overnight. The housekeeper carried out regular walk abouts. Heads of each department carried out a monthly walk about to monitor the standard of hygiene.
- Cleaning audits were in place to ensure the environment was being closely monitored.

Environment and equipment

- We saw resuscitation equipment, for both adults and children, available in the operating theatres and the ward. The resuscitation trolleys were checked daily. All portable equipment we saw had been serviced within the last year.
- Hoists were available on the ward for patients who required assistance to transfer.
- Equipment safety checks were undertaken daily in the operating theatres. The anaesthetic machines were checked again by the anaesthetist prior to use.
- The sterile equipment for theatre was provided by Nuffield Health sterile services unit that was off site. The lists for surgery were prepared in advance which enabled staff to plan for and order equipment. We were told staff completed an equipment checklist when the surgical trays were opened and again checked post-surgery. The theatre manager said if there were any instruments missing from the sets they worked with the off-site sterile supplies team who ensured the sets were audited and contained the correct equipment.
- The hospital did not have Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) (recognition granted to organisations which meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its competence to deliver against the measures detailed in the endoscopy standards. The current facilities did not allow for segregation of clean and dirty equipment as it was all managed in the same small room. Once the scopes had been washed by mechanical means they were hung up to dry in an endoscopy cupboard. There was no specialised air cupboard for drying the scopes. The provider had evidence to show how they intended to improve their facilities to meet the JAG accreditation. This issue was detailed on the hospitals risk register. There was no specific timescale in place for the work to achieve accreditation to be completed.
- The dispensary was secure and temperature controlled.
- There were ongoing issues with an occasional infestation of cluster flies in the roof space above the operating theatres. We were shown reports about visits by an external contractor in July 2015 and April 2016, that showed no insect activity was present. We also saw a report that showed that work to reduce the risk of the flies entering the roof space had been carried out by an external contractor.

Medicines

- Medicines were stored securely in locked cupboards, personal lockers, fridges and medicine trolleys. Intravenous fluids (IV) were stored in secure rooms. Medicine security was audited monthly.
- Stock-takes were undertaken quarterly. Expiry dates were checked on a monthly basis.
- There was daily monitoring of temperatures in all locations using a remote automated system which showed average, maximum and minimum temperatures over each 24 hour period.There was a backup plan and a Standard Operating Procedure SOP in place if the system alarmed.
- Routine access to medicines was restricted to trained nurses. Out of hours access to pharmacy was permitted using a two key system accessed by the Resident Medical Office (RMO) and a trained nurse.
- Requests for non-formulary/stock list medicines were auditable and all requests were authorised by the Medicines Advisory Committee (MAC).
- Controlled drugs (CDs) were managed well and appropriately secured. The hospital held low and accurate stocks. They were checked regularly (daily and weekly) in line with Nuffield Health policy (including nil stocks).Matron conducted random checks on the controlled drugs to ensure checks and controls

remained in place at all times. The hospital director was the appointed Controlled Drugs Accountable Officer (CDAO) and had authorised the finance manager, who was independent of the pharmacy and clinical services, to witness the destruction of both out of date and patient's own CDs. We saw records that showed out of date CDs were managed and destroyed appropriately.

- Pharmacy routinely delivered stock to all departments. There was good access to medicines out of hours if necessary.
- Expired medicines were returned to pharmacy for disposal in correct pharmacy waste bins. Records were kept of the waste returned. We were told that full bins were transferred to the secure clinical waste compound for collection by a contracted waste disposal company.
- Areas where medical gases were stored had warning signs, were ventilated and empty and full cylinders were labelled and kept separately. There was piped oxygen for routine use and cylinders for when patients were being moved, for example from the operating theatre to recovery and/or the ward. The Nuffield authorised person carried out a Medical Gas Pipeline Service (MGPS) Audit in April 2012. A quarterly audit was carried out by the pharmacy team and was last recorded on 8 April 2016.
- Emergency medicines were monitored by the pharmacy department. Emergency boxes were made up by pharmacy and they had records of where boxes were and expiry dates. They were recorded on top up sheets and pharmacy did monthly checks. If a box was used it was the ward/departments responsibility to return it to pharmacy for a new box. The boxes had tamper proof seals.
- There were four ward resuscitation trolleys in place. There were also resuscitation trolleys in the operating theatre and recovery areas. They were tamper proof. Contents were checked daily and weekly (full check) and the trolleys were well maintained. The contents were all in date.
- An anaesthetist told us that emergency and surgical medicines for patients were drawn up for each patient. Drugs were labelled and disposed of after each patient. Operating department practitioners (ODPs) could draw up saline and other medicines only under direct supervision.
- Medicines were stored in locked cupboards in the operating theatres anaesthetic rooms.
- We reviewed six patient medicine charts and records. They were: all signed by prescribers, allergies (or none) noted, as required (PRN) prescribing was in a separate section, the maximum dose or frequency was recorded, variable doses were recorded, what was given and timing of analgesia if different from prescribed times was circled on the relevant chart, any dose changes or medicines stopped were signed by the prescriber, there were no missed doses seen on inpatient prescription charts, oxygen was prescribed correctly, prevention of deep vein thrombosis (DVT)/ and pulmonary embolism (PE), risk assessments were complete and reviewed in line with national guidance, anticoagulant medication was correctly prescribed, if needed.
- We observed a medicine round and observed: good checks and patient engagement which included confirmation of patient identity, explanation of what medicines were being given and reasons for delaying one medicine (ibuprofen) until after lunch, patients' own medicines were held in lockers, nurses prompted patients to take these medicines when they were due, the medicines trolley was locked when unattended, prescription charts were checked/signed after administration.
- Medical alerts were sent to the pharmacy manager and matron, through the national Central Alerting System. Stock was checked, and any actions were recorded on the local Drug Alert response form.
- There was a system in place for prescription security. Patients could have their prescription dispensed at the hospital or could take it to a community pharmacy as a private prescription. The pharmacy held records of all the prescription pads and recorded when pads and their numbers were sent to the departments/ward. When a pad was empty they were returned to the pharmacy, recorded and audited. The audit checked that the prescriptions had been written for Nuffield patients and none were missing. The pads were then then signed and stored/archived by the pharmacy.

Records

- There were "Nuffield Health Drug Charts" and "Care Record" charts in place for each patient on the ward. They included a prescription sheet, a green sheet for

medicines recorded on admission (stage 1 completed by the resident medical officer), pharmacy care record sheet with stage 2 medicines recorded by pharmacy, and medicines recorded on discharge.

- Each patient had a care record. This was a booklet for either day and overnight surgery or long stay surgery (more than 24 hours). The long stay record included a key health questionnaire to be completed by the patient or their representative, pre-admission health checks, investigations and results and risk assessments including a patient handling assessment and a nutritional assessment. This document was used to ensure that patients met the criteria to have treatment at the hospital. Once admitted, the same care record was used and included pre-procedure care, anaesthetic room care, care during the procedure, postoperative and recovery care. Each day post procedure, the record included daily evaluation by the multidisciplinary team and details of interventions and outcomes. All entries were signed and dated by staff.
- We reviewed 10 sets of patient records and found them to be completed and easy to read. The records of the patient's time in theatre were fully completed and included the World Health Organisation (WHO) surgical safety checklists.
- Patient records were in paper format and were stored securely in locked cupboards.

Safeguarding

- A safeguarding policy was in place and accessible to all staff. Staff showed an understanding of their safeguarding responsibilities and safeguarding procedures.
- There had been no safeguarding concerns reported to CQC between January and December 2015.
- The Quality Assurance Review (QAR) action log for March 2016 stated that the number of staff who had received adult safeguarding training was below the expected rate of 90%. By May 2016 staff who had received adult safeguarding training was 92%.

Mandatory training

- Mandatory training included basic life support, fire safety, moving and handling, infection prevention and health and safety. Training dates were organised for staff to attend. Senior hospital managers monitored compliance rates.
- The provider had a compliance level of training achievement level of 90%. The service currently had an overall compliance rate of 93%. Examples of areas that had not achieved full compliance were the practical part of moving and handling, aseptic technique and safer blood transfusions 1&2. We saw minutes of meetings where compliance had been discussed and actions introduced to ensure future compliance.

Assessing and responding to patient risk

- Two registered medical officers (RMO) were employed by the organisation. RMOs were trained in advanced life support to assist if a patient became unwell. They told us they received good support from visiting consultants. RMOs received a full induction, and had access to a range of support including accessing services out of hours, an on-call pathologist, pharmacy and consultants. However, there was no access to an on call anaesthetist, but generally anaesthetists were able to be contacted for 72 hours after a patients operation.
- If patients became medically unwell they could be transferred to the local acute NHS trust by ambulance if required.
- Every patient had consultant led care for both day surgery and inpatient admission. This meant that the consultant for each patient was the overall person in charge of their care. The consultant undertook all post treatment reviews. Consultants were available out of hours if needed. We saw they had been called on some occasions. The Registered Medical Officer (RMO) was available to provide medical support on a day to day basis and when a consultant was not available. However, the consultant was responsible for arranging cover for their patients if they were not going to be available.
- An escalation procedure was in place for nursing staff to escalate concerns to the RMO and for the RMO to escalate to the patient's consultant.
- Prior to admission for day case or inpatient surgery all patients were seen in the outpatients department.

During this appointment a key health questionnaire was completed which included questions about previous and current health conditions. A pre-assessment was then completed which reviewed all the patients' health information and completed risk assessments. Discharge planning was commenced at this appointment to ensure patients had any equipment or support in place for when they went home following their surgery. If staff felt they were not able to ensure the safety of a patient due to their risks a discussion with their doctor would be initiated and a decision made as to whether the patient was able to be admitted to the hospital for their treatment. The hospital did not provide care and treatment for patients who had complex needs or needed care the hospitals staff could not safely provide.

- The theatre staff followed the five steps to safer surgery. This involved following the World health Organisation (WHO) surgical safety checklist before, during and after each surgical procedure. We visited anaesthetic rooms and theatres and saw the WHO surgical safety checklist completed, verbally and in writing, on each occasion. We saw that for endoscopies and colonoscopies the checklist was modified to enable it to be suitable for purpose.
- There was a weekly audit of compliance with the WHO surgical safety checklist carried out by the matron and theatre manager. In the quality assurance review we saw that compliance with the WHO checklist was monitored and actions put in place if the results fell short of expected targets.
- Staff used the Modified Early Warning System (MEWS) to monitor patients to identify deterioration in health. This is a series of physiological observations which produce an overall score. The increase in score would mean a deterioration in a patient's condition. There was a MEWS escalation flow chart in each patient care record that showed staff steps to take depending on the patient's score.
- Patients were given a number to call if they had any concerns following their discharge. Staff would then be able to advise the patient of the best course of action for them.

Nursing staffing

- Agency and bank staff received specific induction training from the hospital. The induction included: first day - orientation to the department they were to be working in, location of fire exits and what do in the case of a fire and an introduction to policies and where to find them: first week - expectations of conduct and performance, use of IT systems and helpdesk, duties and responsibilities and a health and safety presentation: second week - record keeping and confidentiality, information security training and work station assessment.
- Ward staffing levels were calculated using a dependency tool. The tool compared patient dependency hours (based on co-morbidities, which procedure was planned and the aftercare required) to nurse hours available and also took into account National Institute for Health and Care Excellence (NICE) guidelines and Royal College of Nursing (RCN) recommendations on safer staffing levels. Staff told us they felt there were enough staff and, if needed, regular bank or agency staff were used. Staffing on the ward was five patients to one trained nurse and a 'co-ordinator who was extra to numbers' if needed.
- Handovers took place at the start of each shift on the ward. We did not observe a handover but were told they were comprehensive and not rushed.
- We spoke with senior ward and theatre staff who confirmed the staffing level varied depending on the planned daily activity. At the time of inspection the staffing levels had been achieved for the identified level of activity.
- At the time of our inspection there were sufficient operating theatre and recovery staff to meet the planned theatre activity. We were told that no more than two patients were in recovery at any time.
- We saw there was a senior nurse on duty at all times on the ward. There was a clinical on-call rota out of hours consisting of a manager and a senior clinical team which supported the ward outside of core hours. The clinical on-call person offered telephone advice, and where required, would attend the hospital to provide practical support. When on call, this individual was required to remain within a thirty minute journey of the hospital.
- If a patient needed to return to theatre out of hours, there was an on call theatre team, which included radiography and pathology staff.

Good

Surgery

- There were low rates of sickness (less than 10%) for nurses and operating department practitioners (ODP) working in the operating theatres. The exceptions were nurses where sickness levels were between 10% and 19% in October 2015 and the same for ODPs in June 2015. Care assistants working in theatres experienced mainly moderate levels of sickness of between 10% and 19% in the reporting period.

Surgical staffing

- There were 156 consultant surgeons and anaesthetists employed at Nuffield Health Exeter Hospital with practising privileges. Practising privileges were granted to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. Most of the consultants worked in the NHS and so received their appraisal and revalidation with the trust they worked for. Revalidation information was shared with Nuffield Health Exeter Hospital when required.
- All surgery at Nuffield Health Exeter Hospital was consultant led. This meant that consultants were responsible for their own patients 24 hours a day. It was the responsibility of each consultant, who had been granted practising privileges to work at Nuffield Hospital Exeter, to cover their absences and ensure that the person appointed to cover for them had the appropriate skills and a practicing privileges agreement in place.
- Each patient was seen by their consultant and anaesthetist pre and post operatively and were available on call until the patient left the hospital.
- The anaesthetist for each patient was on call for the duration of that patient's admission. Should the anaesthetist not be available, the provider had an agreement in place with the local provider of anaesthetic services. This service would ring their contact who would organise an anaesthetist to attend.
- The Registered Medical Officers (RMO) provided ward support and were the first line of contact for ward staff should they need immediate medical advice in the absence of the relevant consultant.
- There were two RMOs who alternated a week on/week off 24/7 rota. Should the RMO need to be absent for any reason, the provider agency had a standby available.

Pharmacy staffing

- Pharmacy was staffed with 2.87 whole time equivalent (WTE) staff. The hospital employed a medicines management lead pharmacist, a part time clinical pharmacist, a part time bank clinical pharmacist, a pharmacy technician (Pharmacy Service Supervisor – 25 hours, and 10 hours as Health and Safety lead), a full time assistant technical officer (ATO) and 2 bank pharmacy assistants. They were interviewing at the time of the inspection for extra posts to provide better cover on weekdays and Saturday mornings. Pharmacy assistants were not allowed to work alone. The team was managed by Matron in Clinical Services and supported by the Corporate Pharmacy team.
- Appraisals and development plans were completed.

Major incident awareness and training.

- There was a major incident policy and plan in place. There was a senior manager for the on call rota every day for any such event.
- There were closed circuit television (CCTV) screens on the ward and security staff attended the hospital at night. The hospital doors were locked after 9:30pm. Access to the building was by intercom and supervised by staff with security staff in attendance if necessary.
- Theatres were all locked at night with keys stored securely on the ward. If the theatre opened at night the keys were signed in and out for audit purposes.

Are surgery services effective?

Good

We rated that surgical services were effective because:

- Needs were assessed and treatment was provided in line with legislation and using National Institute for Health and Care Excellence (NICE) guidance. Staff were aware of the guidance relevant to their area of work.
- Policies and procedures incorporating national guidance were in place and available to all staff.
- Staff were trained to ensure they were competent to provide the care and treatment needed. Staff training and appraisal was on-going. Consent to care and treatment was discussed and obtained in line with legislation and guidance.

- Mandatory training levels were above the organisations target of 90%. Systems were in place to monitor compliance.

However:

- There was no evidence of a decontamination policy for laryngoscope handles and blades in line with the Medicines and Healthcare Products Regulatory Agency (MRHA) Alert 2011.

Evidence-based care and treatment

- The hospital provided care, treatment and support in line with National Institute for Health and Care Excellence (NICE) guidance. A centrally based Nuffield Health system ensured all of their hospitals were updated about new guidance and provided updated policies and procedures that took the changes into account. NICE guidance was available to staff on the ward and in the operating theatres.
- When we asked if there was a decontamination policy for laryngoscope handles and blades in line with the Medicines and Healthcare Products Regulatory Agency (MRHA) Alert 2011 no policy could be found. We asked staff to describe how they cleaned the equipment and their system was effective.
- The patient care record referenced where the organisation had sourced the information and guidance used in the document, for example, the oxygen use and observation was taken from the British Thoracic Society guidance. The care record also directed staff to refer to the e-pathway for the evidence base for the care record as a whole.
- We saw the operating theatre department policies and procedures manual version seven, review date due December 2016. This contained relevant policies such as swab and needle count policies.
- Patients undergoing hip and knee surgery consented to their data being submitted to the National Joint Registry. The data was submitted to enable the NHS to monitor the performance of joint replacements and incidences of infections post operatively.
- The hospital told us they participated in a number of national audit programmes such as the National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS). All patients having hip or knee replacements, varicose vein surgery or groin hernia surgery were invited to complete PROMS questionnaires to help the NHS measure and improve the quality of its care. They also participated in Public Health England Surveillance and Patient Led Assessment of the Care Environment (PLACE) assessments which were undertaken annually by patients together with the hospitals Infection Prevention team and an external verifier.
- There were regular reviews of the effectiveness of surgical procedures. Medical Advisory Committee (MAC) meetings took place monthly where any issues and incidents were reviewed to ensure good practice was maintained.
- The hospital's Patient Led Assessments of the Care Environment (PLACE) scores ranged from 83% for an environment suitable for people living with dementia to 94% for the food.

Pain relief

- Pain relief was discussed with each patient pre-operatively, in theatre and on the ward. As part of the World Health Organisation (WHO) surgical safety checklist, pain relief that was planned to be given was discussed. Whilst in the recovery area pain levels were monitored and the patient was only moved back to the ward when their pain was controlled. Post - operatively patient's pain was monitored and recorded on the modified early warning system (MEWS) chart using a scale of 1-10. Pain relief was given as required.
- We saw patients mobilising post-surgery. Pain relief was managed so it did not impact on recovery. This meant pain relief was sometimes prescribed before physiotherapy sessions to help with mobilisation.
- Patients told us their pain was well managed.

Nutrition and hydration

- All patients had a nutritional risk assessment recorded to assess each patient's level of nutrition and hydration. Any nutrition and hydration needs were discussed and documented to ensure all staff were aware if there were any needs to be met.

- Instructions about the timescales for not eating and drinking pre-operatively were given during the patient's pre-admission visit. We saw staff checked, during pre-procedure checks when the patient last ate or drank and this was recorded in the patients care record.
- There was no access to a dietician at the hospital. Staff said they would contact the local trust, with whom they had good working relationships, for advice if required.
- Feedback from current and previous patients we spoke to was very positive regarding the meals provided.

Patient outcomes

- The Hospital sent data to the National Joint Registry, Patient Related Outcome Measures (PROMS) and Public Health England (PHE) Surveillance.
- PROMS for Nuffield Health Exeter Hospital for April 2014 to March 2015 for groin hernias showed 128 patients were eligible but no questionnaires were returned. For hip replacement procedures, 230 patients were eligible, of which 16 reported an improvement in health and one reported no change in health. For knee replacement procedures, 383 patients were eligible, of which 34 reported an improvement in health, one reported no change in health and three reported worsening health.
- NHS referral to treatment waiting times (RTT), meaning patients began their treatment within 18 weeks of referral, were abolished in June 2015. However prior to that date the hospital did not meet the standard of 90% of RTT. This was because the vast majority of Nuffield Health Exeter Hospital's patients were waiting list initiative transfers from the local acute trust. Because of this there was a clause written into the hospitals contract with the Clinical Commissioning Group (CCG) which said late patient transfers from the acute trust in order to help their waiting list pressures, would not result in a penalty. Therefore it would not have been possible to meet the RTT times because of the length of time patients had been waiting on a list before being seen by Nuffield Health Exeter Hospital on behalf of their local acute trust.
- There were ten unplanned returns to theatre between January and December 2015. This represented a variable rate of unplanned returns to theatre (per 100 inpatient discharges) over the same period. We looked at records provided and saw that the majority were related to blood clots (haematomas) formed after breast augmentation surgery. There was no common factor such as the same consultant or piece of equipment found during investigation of the incidences.
- There were ten cases of unplanned transfer of an inpatient to another hospital between January and December 2015. This represented a variable rate of unplanned transfers (per 100 inpatient discharges) over the same period. There were no trends identified.
- There were 11 cases of unplanned readmission within 29 days of discharge between January and December 2015. This represented a variable rate of unplanned readmission within 29 days of discharge (per 100 inpatient discharges). There were no trends identified.
- The hospital was working towards accreditation with Joint Advisory Group for endoscopy units. We saw evidence to support this.
- Competition and Markets Authority (CMA) coding data was commenced in January 2016 which would be uploaded to the private healthcare information network from September 2016. This included the volumes of specific procedures each consultant performed plus their outcomes (including variances) to enable patients to make an informed choice about their surgery.
- The organisation benchmarked each service against defined criteria. This meant that when national data was not available against which the service could compare its outcomes, the service could compare its results against those within the organisation.

Competent staff

- Practicing privileges is an authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection, including an example of where a consultant was refused practicing privileges because they were under investigation by another employer.
- We spoke with the Hospital Director's personal assistant (PA) and saw records that showed all consultants for both surgery and anaesthesia had registrations that were in date and that they were only performing surgery they were sufficiently skilled to do. The PA showed us

the systems in place to alert them when registrations were due for renewal and when consultant's appraisals were due. The system used showed when updated documents had been received. The PA confirmed that should there be any delay in receiving proof of registration the HD would be informed and the consultant would have their practising privileges suspended until proof was received.

- The hospital's responsible officer had a good relationship with the medical director of the local NHS trust where the majority of the consultants who worked at Nuffield Health Exeter Hospital worked.
- Expiry dates for indemnity insurance were tracked. Letters were sent to the consultant to remind them to submit their documents. The system was well organised and robust. We were told a letter was sent to consultants advising them their practising privileges would be suspended until indemnity cover was produced. We were told consultants quickly produced their documentation when they had received a letter.
- We saw two sets of medical staff records all of which contained two professional references, proof of professional registration, GMC registration, indemnity cover, appraisal documentation and DBS checks.
- All new applications for practising privileges and requests by consultants to undertake new procedures were discussed and agreed by the Medical Advisory Committee (MAC) before being approved. We saw evidence of this in minutes of MAC meetings. Once approved by the MAC, consultants were sent a formal agreement to sign to agree to work within the organisation's practising privilege policy and within the scope of practice agreed.
- When reviewing practising privileges each surgeon was asked to review the procedures they had carried out in the last year and confirm these were still in their scope of practice. Where the number was low for any procedure a discussion was held, with the MAC, to confirm whether or not they would be able to continue to carry out any of these at the Nuffield Health Exeter Hospital.
- Where a consultant wanted to add a procedure to their practising privileges they were required to evidence they were undertaking the procedure in another hospital before submitting the application to the MAC for approval.
- Ward and theatre staff told us and records confirmed, on-going training was provided. Staff said they were supported to attend training and it was considered important by the organisation. Some staff told us of role specific training they had done and as a result felt valued by the organisation.
- The service reported that 100% of theatre staff had received appraisals between January and December 2015. This showed a significant increase from the 2014 figures.
- Records showed agency and bank staff undertook induction and training to ensure they were competent to work at Nuffield health Exeter Hospital.

Multidisciplinary working (in relation to this core service only)

- Staff said there was good communication between departments and good handovers of patient information. We saw communication between nursing staff and other health professionals in relation to pain relief, moving and handling and discharge arrangements.
- The consultants handed over any relevant information to the Resident Medical Officer (RMO) before leaving the hospital. We were told the RMO contacted the consultants at home if they needed to and found them easy to contact.
- If a patient needed to be transferred to the local acute hospital there was a standard operating procedure in place supported by a Nuffield Health policy. This told staff that the consultant in charge of the patient must contact the local trust to arrange the transfer. A checklist was completed to inform staff of the procedure the patient had undergone and any medicines required/ taken and any other relevant information.
- There was an on call physiotherapist who could be called for advice by the ward staff out of hours.
- Discharge planning was started at the pre admission stage. This was to ensure patients and their families

would be aware of their needs when they returned home. This also meant that equipment could be delivered to the patient's home and any short term adjustments made to the environment to ensure patient recovery could be on-going.

- On discharge each patient's GP received a letter that detailed the procedure undertaken, any information the GP may need to know and any planned follow up by the service.
- If the patient already had community support at home, nursing staff contacted the relevant community team to update them and ensure the services would recommence on discharge.
- If the patient needed any community support services such as community nursing or physiotherapy, the ward staff would contact them via the patient's GP, prior to the patient being discharged.

Seven-day services

- Theatres were open for sessions Monday to Friday between 8am and 8pm. Theatre one and two were open alternate Saturdays between 8am and 5pm.
- Nursing staff and an RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of the senior management was available at all times to provide advice and support.
- There was an out of hours on call theatre rota including consultants and anaesthetists for individual patients should they need to return to theatre.
- There was an on call rota for radiologists should an urgent x-ray be required. Other staff that provided a 24 hour on call service were pharmacists and physiotherapists. If urgent diagnostic tests were needed there was a member of the pathology team on call.

Access to information

- Patient records were kept at the nurse's station and travelled to and from theatre with them. This enabled medical and nursing staff to record any activity/ procedure that had taken place. Observation charts were kept in the patient's own rooms for completion by staff.
- The hospital records were kept on site, or recalled from a medical records store in time for patient's outpatient appointments. We saw records were in the right place at the right time for patient's appointments and/or admission date.
- The patient's GP was informed of the patients discharge. Information included detail of the procedure that had taken place and any special instructions for the patient's on-going care.
- Occasionally a consultant had asked to take patient's notes off site. If a consultant requested this the Nuffield Health policy 'Local Procedure for the Safe and Confidential Transportation of Medical and Consultant Records' had to be adhered to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that the Nuffield Health Exeter Hospital did not take referrals for patients who lacked the capacity to consent to treatment. We saw 10 sets of records and all showed that the patients had capacity to consent.
- Patient care records showed if a patient had given consent for their health conditions to be discussed with their next of kin and if they gave consent for their information to be shared with their GP.
- Consent was gained by the consultant at the pre-admission visit and again prior to the procedure. Consent was sought for the use of bed rails if required post surgery, for some medications that may be required post surgery, for patients' data to be included in the National Joint Registry and for the patient's name being displayed on their door and their care records being kept in their room. The care record included a section to check the patient had a clear understanding of the proposed procedure.
- In the care record, the section for blood transfusion care required 'written consent covering the risk of requiring a transfusion recorded on the consent form, or verbal consent obtained from the patient and documented in the medical record. If the patient is unconscious and unable to consent to the transfusion ensure retrospective consent is obtained and information about the transfusion given to the patient'.

Good

Surgery

- A flow chart was available on the ward for staff to follow if they had concerns about a patient's mental capacity and escalation of those concerns was needed.
- Records of patient's choices around resuscitation were not kept. This was because the hospitals pre-assessment process for routine elective surgery, considered all patients to be for resuscitation.

Are surgery services caring?

Good

We rated surgical services as good for caring because:

- Patient feedback about the service was positive. Patients said staff were kind, caring and supportive. We saw staff were kind and caring, their focus being excellent patient care. Staff described occasions when they had been flexible at short notice to ensure patients had their procedures carried out
- Patient privacy and dignity was maintained at all times.
- Between July and December 2015 there were high satisfaction scores (85% and above) with the NHS Friends and Family Test.

Compassionate care

- We spoke with five current and six past patients who were very complimentary about staff and the care they had received. They told us staff had been kind, caring and supportive and had treated them with dignity and respect. They added nothing was too much trouble for the staff and everything was well organised. Past patients said it was nice to see the same staff when you attended outpatients appointments and on the ward.
- We observed staff knocked on doors before entering rooms. We heard staff asking patients for consent before carrying out any activity with them or procedure on them.
- The hospital board meeting minutes noted for February 2016 that patient satisfaction was 96%; overall. This was higher than the Nuffield Health average. Patients who would strongly recommend the service was equal to the Nuffield Health average and the response rate to the patient satisfaction survey was 45%, which was above the Nuffield Health national average.
- The organisation had a Privacy and Dignity Policy that was accessible to all staff. We saw staff treating patients with utmost dignity and respect. Doors were closed when consultations were taking place. Staff addressed patients in their preferred way.
- The NHS Friends and Family Test scoring system was in place. The NHS Friends and Family Test (FFT) was created to help service providers understand whether their patients were happy with the service provided, or where improvements were needed. Between July and December 2015 there were high satisfaction scores (85% and above). The response rates were between 30% and 60% for the same reporting period. We had no data to benchmark how this compares to NHS FFT response rates.

Understanding and involvement of patients and those close to them

- Each patient had a named nurse on each shift so they knew who was caring for them. We saw that visiting was allowed for most of the day. If a carer or patient's relative who provided a caring or support role wanted to stay at the hospital this was possible and ensured the patient remained more relaxed and comfortable.
- All patients completed their pre-operative assessment and health questionnaire. This was discussed with them during their outpatient assessment appointment. Patients told us they felt updated and included in their plan of care.
- Patient advice and individual care plans were provided by the physiotherapy and nursing staff to ensure safe mobilisation following their orthopaedic or cardiac surgery.
- If the patient was paying for their own treatment, costs and fees were discussed at the pre admission visit to enable the patient to make an informed decision about going ahead with the treatment. We saw documentation to confirm discussions had taken place

Emotional support.

- Staff told us that should a patient with learning disability or care and support at home, the carer would be able to stay with and support the patient. This would

be assessed and discussed at the pre- admission assessment to ensure the patients/carers needs were discussed and how the situation was going to be managed.

- Staff told us they could access clinical nurse specialists or other health care professionals via the local acute trust for advice and support if necessary.
- Theatre staff gave us examples of when they had been able to change the theatre list at short notice to ensure patients had their procedure completed so they could visit family members that were ill or to attend an important event.

Are surgery services responsive?

Good

We rated surgical services good for responsive because:

- Services were planned to meet patients' needs. The flow of patients through the hospital was well organised. Patients felt well informed about the procedure and what to expect during their recovery.
- There was level access into the building and a passenger lift to all floors ensuring patients could move around the building.
- Complaints were responded to in a timely manner and any learning was taken forward to develop future practice.

Service planning and delivery to meet the needs of local people

- The hospital accepted referrals from the NHS on the choose and book system, self-referrals who were self-pay patients or had health insurance and from GPs. The service catered for the needs of the population of Exeter and immediate surrounding areas. They also provided some specialist treatment to patients from further afield who could not access the treatment nearer to home for example paediatric laser skin surgery.
- Patients arrived at the hospital at different times throughout the day to enable staff to manage admissions and to reduce the waiting times for patients.
- Staff in theatre and recovery told us that they were flexible and could stay late if needed, for example if the operating list was running behind time. Ward staff told us the workload was anticipated as they knew what type of patients were coming in for what type of procedures. The staff rota was developed to take this into account. However, staff said if they became very busy they were able to access bank or agency staff to meet the increased need.
- Patient satisfaction surveys were undertaken, the results collated and actions taken when necessary. Comments were seen to be generally positive. Feedback was shared with the relevant departments.
- In order to help patients consider their own health and wellbeing there were health information leaflets available in the outpatients department.
- Senior staff said reasonable adjustments could be made for patients that had a learning disability. We heard that the service did not often care for people with a learning disability as they often did not meet the pre admission criteria due to identified risks.

Access and flow

- Systems were in place to manage flow through the hospital. Admission times varied so that patients did not all arrive on the ward at the same time. We saw reception staff greeted patients and showed them to their rooms. Staff were made aware the patient had arrived and they greeted and attended to the patient soon after their arrival.
- Length of stay per patient was between one and four days dependent on the type of surgery they had. It was rare that patients stayed longer than four days and if this was the case staff had to manage admissions to try to avoid cancelling another patient's surgery.

Meeting people's individual needs

- Patients told us they felt well informed about their treatment prior to their admission. On discharge patients were given a 'Going Home' pack which had an area to write the contact details for the ward and their consultant should they have any concerns. This pack also included advice about pain relief, wound care, mobility and any complications they may encounter.
- There were disabled parking spaces near to the entrance of the hospital and a ramp to the front entrance. There was passenger lift access to each floor.

- Specialist diets could be catered for. We saw hot drinks were provided on request and that relatives could also eat with the patients. There was a varied menu available and flexibility around when individual meals were served.
- Visiting times were flexible during the day. Patient's carers or support staff could stay overnight to help care for the patient and make them feel settled, for example if a patient was living with dementia or had a learning disability.
- Relevant patients were seen by physiotherapy staff after their operation to ensure they started to mobilise and carry out prescribed exercises. Advice leaflets were given to patients to remind them of the exercises they needed to do and how much mobilising they should be doing.
- The theatre manager gave us an example of the consultant and theatre team fitting a patient into a Saturday theatre slot without much notice as the patient needed to go and visit a sick relative at the time they were due to have their procedure.
- Information about patients procedures were sent to their GP. More complex patients, who might need more care and support following discharge were discussed with the community or practice nurse to ensure they were aware of the expected date of discharge and what further support the patient may need.

Learning from complaints and concerns

- On the patient satisfaction survey there was a dedicated section for patients to raise concerns with assurances they would be responded to within two working days of the survey company passing the complaint to the hospital. The hospital website had an enquiry/ complaint form that people could complete and send into the service. Complaint leaflets were displayed in all reception areas.
- CQC had not received any complaints about the hospital between January and December 2015.
- There had been 17 complaints in 2015 of which we reviewed two at random. Both had been completed in a timely manner, and the responses were well written with appropriate apologies given and due regard for the concerns raised. Both had resulted in actions that needed to be taken to improve service, and we were shown evidence that actions had been completed, and of the learning being disseminated through the hospital and discussed at team meetings.
- The Hospital Director (HD) was responsible for ensuring that all complaints were acknowledged in writing within two working days of the day on which the complaint was received. In the absence of the HD, the HD's personal assistant made matron aware of the complaint being received and an acknowledgement letter would also be sent.
- A full written response would be sent to the patient within 20 working days of receipt of the complaint. If, during the investigation, it became clear the issues were more complex than first thought or key staff would not be available within the timescales the patient would be informed a longer timescale would be needed and a new response date would be given. The HD and matron said that they often contacted the person who had made the complaint to get more information about their complaint and offer them a face to face meeting to discuss their findings. They said most people preferred the personal approach rather than written correspondence. However, following a face to face meeting a formal written response was still sent. The timescales, set out in the Nuffield Group Complaints/ Concerns Management Process, had been achieved with all complaints received and all complaints had been resolved at a local level. There was a three stage process for complaints management: stage one – local resolution, stage two – an organisational review by the Nuffield Chief Executive Officer (CEO), supported by the Corporate Clinical team if the complaint was of a clinical concern or the Medical Director if the complaint was about a consultant, stage three – involvement of an independent review by the Independent Sector Complaints Adjudication Service (ISCAS).
- The HD and matron discussed a clinical complaint upon receipt and commenced an investigation. The complaints were discussed on a monthly basis at the Hospital Board Meetings and Heads of Departments' meetings, and on a quarterly basis at the Medical Advisory Group (MAC), Quality and Safety and Clinical

Governance meetings. The HD and matron said that as few complaints were made about the service it was easy to recognise any themes or trends and deal with them accordingly.

- If the complaint involved a consultant with practising privileges then either the HD alone or Matron and the HD would meet with that individual to discuss the complaint, involving the MAC Chairman as necessary.
- If a complaint was non clinical the HD involved the relevant Head of Department in the investigation. There was a process in place for a complaint to be investigated by somebody not connected with the area being complained about if necessary.
- Learning from complaints was disseminated via the senior management team meetings, the MAC meetings, Integrated Governance Committee meeting*s, Clinical Governance meetings and departmental meetings where appropriate. Complaint reports were inserted into the minutes of meetings so the issue could be seen and that those not attending the meeting could see lessons to be learned from complaints investigations. An example of lessons learnt and changes made as a result of a complaint involved a delay in processing a blood sample meaning the patient had to have a repeat test as the life of the sample had expired. Meetings were held with relevant departments and the pathway of the particular type of blood sample was tracked. Once the transport arrangements and the logistics of the laboratory processing the sample were understood, the consultants' secretaries were asked to take into account public holidays and the time needed to get samples to the laboratory for testing in a timely fashion.

Are surgery services well-led?

Good

We rated surgical services as good for well led because:

- The hospital had a vision for developing the service and shared this with their patients.
- There were clear governance processes in place to monitor the service provided.
- Risks were identified and ways of reducing the risk investigated. Any changes in practice would be introduced, shared throughout the hospital and monitored for compliance.
- Leadership at each level was visible. Staff had confidence in leadership at each level and felt they would be listened to.

Vision and strategy for this this core service

- All staff we spoke to were aware of the hospital's values and were able to describe them to us.
- The hospital were planning to install a hybrid theatre in the near future. This would combine a state of the art surgical operating theatre combined with diagnostic imaging such as X-ray and ultrasound enabling less invasive surgery for patients. Staff throughout the hospital were aware of the plans and the potential benefits for patients.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure for the surgical service. Service wide meetings were held which oversaw quality, audit and risk activity performance.
- All service wide meetings reported to the medical advisory committee (MAC).
- The MAC and the Quality and Safety committee reported to the board. Information travelled from board level to the various departments via meetings, newsletters and the presence of board members in and around the service regularly.
- The hospital board had four members, the Hospital Director, the matron, finance manager and the sales and services manager. Matron was the clinical representative on the board. The board met formally monthly and discussed a set agenda. They met informally and regularly during the working week. They were all present and available throughout the inspection.
- We reviewed board minutes and saw the agenda included review of the risk register, complaints and incidents reported.
- Consultants and managers from a variety of surgical specialities attended the MAC meetings on a quarterly basis. We saw from records that a variety of topics were

discussed, for example incidents, complaints, practising privileges, and the risk register. The integrated governance committee met one week prior to the MAC and provided a clinical governance report. Action plans were identified and monitored at the meetings. Consultants and senior managers described the MAC as "focusing on high risk issues", and "deliberate and methodical".

- New legislation guidance and National Institute for Health and Care Excellence (NICE) guidelines were cascaded from Nuffield Health head office.
- The service had one hospital wide risk register. The register detailed nine risks which were identified as a potential risk to the hospital as a whole. These risks included: cluster flies in roof space; water hygiene; the endoscopy unit not Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accredited and inadequate waste storage.
- Managers within wards and theatres were aware of the specific risks to their areas of work. They had action plans in place to manage and control the identified risks. Prescription security was audited as part of the audit cycle. The last audit was completed in February 2016 t. We saw some issues had been picked up and an action plan had been developed to address them with completion required by June 2016.
- Complaints were discussed monthly at the Hospital Board meeting and Head of Departments' meetings and on a quarterly basis at the MAC, Quality and Safety (Q&S) and Clinical Governance Meetings. Any themes or trends were discussed at these meetings.

Leadership / culture of service related to this core service

- All staff we spoke with were passionate about the beliefs and culture of the hospital. Staff felt the beliefs were fundamental to the culture of the hospital and that patients came first.
- All staff spoke positively about the executive team and the senior members of staff at the hospital and the Nuffield Group. One member of staff told us "they are very impressive"
- The senior managers gave us examples of 'hands on' customer care and described a good working relationship with consultants and the Medical Advisory Committee (MAC). They also attended staff meetings every six months to provide staff with an update on patient's satisfaction and finance, and also provide an opportunity for staff to have informal discussions and engagement.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- All staff were positive about their relationships with their immediate managers. Staff in all areas told us they felt they worked well as a team. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to. We heard about meals out and nights out with colleagues that helped to strengthen relationships.
- Each department had a head of department who reported to Matron.
- Staff told us they felt the board members and heads of departments were visible and approachable. The theatre manager and ward managers were very proud of their teams. They felt the teams had good ideas for continual improvement of the service. They said their teams worked well together and felt they provided a good service to their patients.
- For self-paying patients, discussions about fees took place at the pre-admission outpatient's appointment at which terms and conditions were agreed. The agreed package of payment covered all eventualities including return to theatre if required.

Public and staff engagement

- Staff asked patients to complete satisfaction surveys about the quality of care provided every month. Figures for November and December 2015 were positive, with all areas rated green. The results of the surveys were discussed at governance meetings, and actions recorded where improvements could be made. For example, it was identified that patients were not always clear on the outcome of their treatment, and that there was a requirement for consultants to improve the information given to patients.
- The Patient Group were a very pro-active group. They felt informed by the hospital and felt their ideas and input were valued.

Good

Surgery

- Staff felt engaged with the service and felt they were consulted with and kept up to date with any changes to the service. This was either by face to face conversation, emails, news-letters or during team meetings.
- The senior management team described how they engaged their staff and rewarded them for their hard work, this took the form of occasional meals out and team or individual treats when they had been praised or had a hard time with something.

Innovation, improvement and sustainability

- In 2015 a magnetic resonance scanner (MRI), with cardiac capability, was installed in the hospital. This enabled detailed scanning of patients some of whom it would help inform a decision if surgery was required or not.
- A business case had been written for a hybrid theatre to be installed at the hospital.

Good

Services for children and young people

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

Information about the service

Nuffield Health Exeter Hospital offered the following services to children from the age of three to the age of 18:diagnostic interventions (such as allergy testing), radiological investigations (if they could lie still), surgical and laser procedures as day cases or inpatients. Laser procedures could be carried out on children of any age.

The most commonly performed procedures for children and young people between January and December 2015 were laser destruction of skin lesions and surgical excision of lesions of skin or subcutaneous tissue (53 in number). Other conditions treated included procedures for ear nose and throat, dental extractions, circumcision and orchidopexy (procedure for undescended testes) The number or these procedures ranged between two and eight for this period of time.

Between January and December 2015, 69 children and young people underwent procedures; 11 as inpatients and 58 as day cases. 20 Of these were NHS patients and 49 were funded by alternative methods. Within the same period there were 180 outpatient attendances for under 18 year olds. 47 of these were NHS funded patients.

Physiotherapy consultations were offered for children and young people who could be referred by a health professional or on a self-referral basis.

The ward consisted of 37 single rooms over two floors of the hospital which were used for any age of patient. 31 of these rooms had private facilities. Six of the rooms were located on the floor adjacent to theatre suite and a laser surgery room. Toilet facilities for these six rooms were shared.

The theatre suite had three theatres for surgical interventions. The post anaesthetic recovery area was used by adults with screens available to separate children from adults.

Children and young people could be seen in any of the 10 outpatient consulting rooms and received treatment in the treatment rooms. This included outpatient consultations, non-urgent surgery, laser procedures and physiotherapy.

Radiology has rooms for general X-rays, and other rooms for more specialist investigations such as magnetic resonance imaging, ultrasound and mammography.

At the time of our inspection we visited outpatient department radiology, physiotherapy, ward areas, laser room and surgical theatres. Our initial visit had no children or young people attending the hospital. We attended four weeks later to view planned interventions for five children and young people undergoing laser surgery.

We spoke with 24 staff members including nursing staff, receptionists, medical staff, allied health professionals and administration staff. We reviewed eight sets of patient records and spoke with six parents and two children.

Nursing staff with experience and qualifications to care for children and young people are employed by the hospital. Consultants authorised to practice at the hospital offered services that mirrored their NHS practice.

An agency supplies trained medical staff who acted as resident medical officers in the hospital.

Good

Services for children and young people

Summary of findings

We rated children and young people's services as good overall because:

- Investigations of incidents, comments and complaints identified where improvements were needed and these were acted upon wherever possible.
- A six monthly audit of the service reviewed safety and quality. National standards such as Royal College of Nursing (RCN) guidelines and National Institute for Health and Care Excellence (NICE) guidance were used as benchmarks. Gaps in service were identified and actions taken to develop systems that would meet the guidelines.
- Governance systems monitored standards of care and ensured appropriately trained staff cared for children and young people.
- Consultants were monitored for competency in their field of surgery and were required to provide evidence of their practice before being allowed to practice at this hospital. If consultants performed procedures less frequently at this hospital they had to provide evidence that they had performed these procedures in other settings such as NHS premises, on a more frequent basis.
- Plans were being made to further improve the service in safety and responsiveness to children and young people's needs such as using audit to ensure record keeping protocols were followed by staff and engaging patients and the public in assessing the service.
- All hospital staff were aware of when they would need support from registered children's nurses or a paediatrician and how to access them.
- Children and young people had their individual needs assessed and plans were put into place to meet those needs wherever possible. This was to make their hospital stay less traumatic.
- Areas used were not dedicated solely for use by children and young people but were adapted where possible to make them more appropriate for any age of child. For example, beds for children and teenagers had different linen and activities were provided to entertain and distract all ages.
- Staff provided information for parents and for children in suitable formats.
- Parents we spoke with felt informed and that their children were treated as individuals.
- There was representation at leadership meetings and other committees throughout the hospital.

However

- Some areas needed more thorough monitoring such as cleanliness of equipment.
- Some equipment posed a potential risk to young children who were patients or visitors, such as hot drinks machines. The appointment letter and notices in the department reminded parents that they were responsible for the safety of their own children when visiting the hospital.
- We found one occasion where staff did not follow policies designed to protect children and young people.
- The hospital did not receive information on the outcomes of surgery. Individual consultants held this information but did not share it with the hospital as a routine.

Good

Services for children and young people

Are services for children and young people safe?

Good

We rated services as good for protecting children and young people from avoidable harm because:

- Incidents were fully investigated with actions for improvement identified and put into place.
- Equipment specific to children's needs was available for use.
- There were comprehensive safeguarding procedures.
- Staffing levels met the RCN guidance on defining staff levels for children and young people's services.
- Infection rates were monitored.
- Records were stored securely and audited for compliance with protocols. Actions were taken to improve non-compliance.

However

- Some surface dust was visible in areas where children received invasive procedures.
- Hot drinks machine was low enough to be within reach of a young child.
- The chaperone policy was not always followed correctly.

Incidents

- The hospital had a system for reporting incidents, concerns and near misses to the senior management of the hospital. The lead paediatric nurse was informed of, and monitored any incidents regarding children and young people. There had been no serious incidents affecting children and young people between the period of January and December 2015. Incidents were discussed at senior management meetings and actions identified to prevent a re-occurrence. As an example, we saw records of discussion at the medical advisory committee of 26 January 2016 regarding the treatment of a child in the outpatient department without a children's nurse being present. This was a variance from the hospital policy. The booking procedure was reviewed and a local operating procedure was written to guide staff as well as a flowchart being provided for secretaries and booking staff. Staff we spoke with were able to describe their role in supporting children and young people who were being seen at the hospital.
- National patient safety alerts affecting children and young people's services were reviewed at the Medical Advisory Committee (MAC) meetings and cascaded to the lead paediatric nurse and nominated lead consultant paediatrician for required action. This had recently resulted in reminding staff to ensure paediatric oral medications were measured and administered correctly.
- There had been no unexpected child deaths at the hospital within the previous 12 months. Paediatric staff told us cases of concern were discussed at MAC meetings.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation that was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. We saw a copy of a letter demonstrating how the hospital had apologised to a young person and parent regarding an investigative procedure that needed repeating due to an error of medication. Analysis of the event had taken place and a change in protocol put into place to prevent a repeat of the event.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff spoke confidently about the duty of candour. Training had been provided for relevant staff.

Cleanliness, infection control and hygiene

- Systems were in place to monitor and prevent the spread of infection within the hospital.
- There were no reported infections affecting children or young people between January and December 2015.

- Hand sanitising gel was available at the entrance to every department with instructions for use attached. Reception staff encouraged patients and their parents to use the hand gel on entering the hospital.
- Children and young people were screened for the presence of any infection prior to their admission to the hospital if they were undergoing invasive procedures.
- Protective personal equipment (such as aprons and gloves) was available for use where it was required, to prevent the spread of infection.
- We saw staff washing their hands between patient contact and following hospital policy of being bare below the elbow.
- Where toys were available, we saw cleaning logs documented and signed as having been completed.
- The laser room we visited had visible dust on lower surfaces of equipment.

Environment and equipment

- Consideration had been given regarding risks presented to children by sharing the same facilities as adults. Adaptations had been made to facilities and the environment for children but some risks were still present such as hot drinks dispensers within reach of young children.
- Resuscitation equipment was available for all ages of patient. Paediatric resuscitation equipment for first response was in pink bags to ensure they could be easily recognised and transported to where they were needed if an urgent situation arose. Paediatric emergency trolleys containing suction, further equipment and emergency medications were kept in the recovery area and near the outpatient department. If the trolley near the outpatient department was in use a notice was left to inform staff where the trolley could be located. As an example, the emergency trolley would be moved near to where children were undergoing procedures to ensure it was easily accessible. Daily and weekly equipment checks were logged as completed by staff.
- We saw that maintenance checks for equipment had been carried out and the date of next safety check was indicated.
- The laser area was arranged in a suitable way for children and young people. It enabled children post surgery to play in the unit and still be monitored by staff.
- The paediatric lead nurse had identified a risk to children's safety in an emergency situation. This was because the paediatric emergency trolley had no appropriately sized suction equipment attached to it. This had been discussed at the paediatric resuscitation group and new equipment had been ordered. The new suction equipment was attached to the paediatric emergency trolley at the time of our visit.
- Equipment that may cause a potential risk to children was stored securely with high handles on doors to areas such as sluices and storage rooms.
- The waiting area in the outpatient department was used for adults and children with a play table available for use by young children. There was a machine dispensing hot drinks which was within reach of young children. Information was supplied to parents about the need to supervise their children to maintain their safety. We were told of plans to provide a child friendly barrier to prevent children easily wandering to the hot drinks machine. However, the supplier had been unable to deliver this before our visit. for us to view how effective it would be in ensuring child safety.

Medicines

- Arrangements were in place to store and administer medicines and medical gases safely. Medicines management meetings were held quarterly and included representation from the paediatric lead nurse.
- Medicines were stored in locked cupboards but were accessible to staff if they were needed. Drug storage areas in the hospital were audited by pharmacy every three months for safety, compliance with national standards, cleanliness and expiry dates of medicines. The report for quarter four 2015 had identified radiology and outpatients departments needed new cupboards in order to comply with national standards. New cupboards had been ordered but not installed.
- Radiology had recently changed their protocol for storing contrast media in response to an incident. Different strengths of contrast media were stored in separate cupboards and involved additional checks to prevent them being confused.

- We viewed four medicine charts. Three of these had documented allergies and one had omitted to mention allergy. Prescriptions were appropriate for the child's weight which was documented on the chart.

Records

- The hospital had systems in place to ensure secure storage of records and monitored quality of record keeping.
- Records for patients on the ward were in paper format and stored in a locked cupboard with a key available for staff to access them. Secretaries ensured outpatient records for children and young people were available for professionals to view. Consultants were able to access NHS records if they felt it necessary to provide more detailed medical history. Physiotherapists were provided with a referral record from a consultant or GP detailing the treatment required. They kept an electronic record of the ongoing physiotherapy treatment provided. Following treatment or consultation, records were retained within the medical records department of the hospital.
- Individual care records for children were kept by their bed. These records gave details of assessments of the needs of the child or young person and documented vital signs such as heart rate, blood pressure and temperature. All entries we saw were signed, timed and dated by the professional completing the assessment or delivery of care.
- An assessment tool was used to support the nursing staff in identifying risks relating to a deteriorating condition with guidance included on recommended actions to escalate the risk. We saw this had been completed and used appropriately on the records we viewed.
- The World Health Organisation surgical safety check list was included in the paediatric care record for completion when a child or young person attended for an invasive procedure. This had not been audited at the time of our visit as there had not been a great enough number of procedures for children and young people to give a significant result. We were told this was to be undertaken when numbers had accumulated.

Safeguarding

- Safeguarding lead professionals were identified in the hospital and safeguarding processes were monitored to ensure staff were aware of procedures to protect children and young people from harm.
- Consultants with practising privileges at the hospital (consultants with authorisation from senior hospital managers to deliver care) were required to demonstrate evidence of safeguarding training to the Medical Advisory Committee (MAC).
- Safeguarding was monitored and reported at clinical governance meetings six monthly. At the MAC at the meeting of 19 January 2016 staff compliance levels with safeguarding training had been discussed.
- Staff attendance at training for safeguarding children and young people met national guidelines as set out in Safeguarding Children and Young People: Roles and competencies for healthcare professionals 2014. The hospital identified staff who needed to complete level one, two and three training depending upon their roles within the hospital. For example, level two training should be attended by all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers with children and young people. The hospital had a target for staff compliance of 85%. In March 2016, 87% of staff had completed level one training and 100% had completed level three training (including all registered children's nurses, hospital director and matron). Level two training had been introduced to the hospital within the previous 12 months and on 10th May 2016, 96% of staff had attended the level two training.
- Training for staff caring directly for children included information on female genital mutilation and child sexual exploitation. Systems were in place to identify any child or young person who may be at risk. An advocate from within the hospital but who was not involved in their direct treatment was offered to any young person receiving treatment of a sensitive nature such as labioplasty (a surgical procedure to remove excess labial tissue). Assessment of clinical need for the procedure was undertaken by paediatrician and senior nurses. The advocate ensured they had conversations with the young person without the parent being present.

- PREVENT training had been completed by eight out of nine heads of department. This was a course to support staff in recognising children and young people who may be at risk of radicalisation and being drawn into terrorist activities.
- There had been no incidence of reported safeguarding concerns within the previous 12 months but staff we spoke with were able to describe how they would recognise children at risk of harm and how they would report it.
- Most staff were aware of the hospital's chaperone policy. However, one staff member we spoke with did not routinely offer a chaperone (a parent would usually be present) but would use their professional judgement of a young person's competency and cognitive age to assess the need for a chaperone to be present. The outpatient consulting rooms contained information for patients and their parents about the offer of a chaperone. All children and young people received a written offer of a chaperone before their admission and if they attended without a parent were offered a nurse chaperone.
- A local standard operating procedure had been written and cascaded to staff to prevent abduction of a child while they were on hospital premises. This detailed actions needed at pre admission assessment through to discharge.
- The lead paediatric nurse and paediatrician had established links for advice and updating knowledge, with the local Multi Agency Safeguarding Hub (MASH) and safeguarding leads for the local hospital foundation trust. The lead nurse had signed up to receive updates from CASPAR which was a series of updates to practice published by the National Society for the Prevention of Cruelty to Children (NSPCC)

Mandatory training

- Mandatory training included fire safety, whistleblowing, health, safety and welfare. Training dates were organised for staff to attend and senior hospital managers monitored compliance rates. Staff were reminded by e mail from the electronic training system when any refresher training was due for them to complete. All hospital staff were expected to update safeguarding children and young people at level one at induction and refresh every 12 months. Rates of staff completion of these training sessions were above the 95% hospital target level.
- Further training was mandatory for staff to complete if they cared for children and young people. Paediatric intermediate life support had been completed by all staff in recovery.

Assessing and responding to patient risk

- Children and young people were assessed as being suitable for treatment according to hospital policy, before being accepted for any procedure. The lead nurse for children was informed of any procedure planned for a person less than 18 years of age. They assessed whether the child or young person would need pre operative assessment by a registered children's nurse or, if the child was above15 years of age, by a registered adult nurse. The assessment would identify children and young people who were unsuitable to be treated at the hospital. As an example, a child or young person with epilepsy or cardiac conditions would not be accepted for any surgical procedure at the hospital. A registered children's nurse delivered care when the patient was admitted for the procedure. Meeting notes of the 'children and young people group' on 4 February 2016 stated that all over 13 year olds were to be risk assessed for potential development of venous thrombo-embolism (blood clots). Patient records we saw documented this had been completed and nurses demonstrated their knowledge of the procedure.
- Each child or young person admitted as a day case or inpatient had a care record. This had been designed by hospital nursing staff and was specific to the needs of under 18 year olds. A paediatric early warning tool was in use to identify at an early stage when a condition may be deteriorating. Instructions were included to guide staff in appropriate steps. The records we viewed had the tools completed post-operatively.
- For each child we saw attending for surgery, we witnessed the appropriate completion of the World Health Organisation's checklist for safer surgery.
- A child or young person nursed on the ward was allocated a room and closely observed by a paediatric nurse until discharge. If there was more than one child the allocated rooms would be next to each other.

Good

Services for children and young people

- The hospital had no critical care facilities for children or young people. They had a service level agreement with the local NHS trust if a child needed stabilisation of their condition. The child could be transferred back to the Nuffield hospital if their condition improved sufficiently. There was also a service level agreement with an organisation independent of the hospital to transport the child if they needed more specialist critical care than the NHS trust could provide.
- The paediatric emergency trolley contained algorithms for treating emergency situations and medication calculation charts for easy reference.
- Parents were provided with a number to call at any time, if there were any concerns when their child had been discharged. The nursing staff could contact the paediatrician or anaesthetist if further advice was needed.

Nursing staffing

- Systems were in place to ensure that children and young people were cared for by appropriately trained staff. The Royal College of Nursing (RCN) guidance on defining staffing levels for children and young people's services was used to assess how many nurses registered to care for children should be on duty. This meant that at any one time, one registered children's nurse could care for three children who were under two years of age and four children who were over two years of age.
- If children were booked to be cared for as a day case, inpatient or for an invasive procedure in outpatients, a paediatric nurse was rostered to be on duty. For unexpected overnight stays, registered children's nurses were used from the nursing bank or from an alternative hospital in the Nuffield Group. These nurses had completed an induction at the Exeter Nuffield Hospital and were familiar with the layout of the wards and hospital protocols. The lead children's nurse and the bank children's nurses worked in any area of the hospital where children were cared for.
- Nursing rotas we saw showed on the days when children were undergoing procedures, an appropriate number of registered children's nurse were on duty until the child or children were discharged. On the day of our visit two registered children's nurse were on duty for five patients between the ages of four and 18 years. This meant one nurse could remain in the day case area when the other nurse accompanied the child to the theatre area.
- The day case area was adjacent to the theatre and recovery area. Nursing staff in recovery area who had completed immediate and emergency paediatric training were rostered to be on duty if children were to be cared for in their department.
- The lead paediatric nurse was informed of any planned procedure for a child or young person under the age of 18 years and ensured that a registered children's nurse was in attendance. This was reviewed at weekly meetings with matron.

Medical staffing

- The hospital had arrangements in place to ensure consultants had appropriate skills and experience to care for children and young people. Experience and revalidation was monitored by the Medical Advisory Committee (MAC) and the senior management team. Reminders were sent to consultants who needed to provide further evidence before they could practice at the hospital.
- Consultants were responsible for the care of their own patients and collected them from the outpatient waiting room if the patient was attending for a consultation. Resident medical officers (RMO) were provided by an agency to cover the day to day needs of patients on the ward and were trained in advanced paediatric life support. A consultant paediatrician was available for advice and support at all times if a child was in the hospital.
- Anaesthetists who cared for children were required to be on call and within 30 minutes travel time to the hospital for the post-operative period of a child's recovery.

Major incident awareness and training

- Staff we spoke with were aware of emergency procedures. They were not immediately aware of their role in a major incident but knew where to view the policy.

Good

Services for children and young people

Are services for children and young people effective?

Good

We rated services for children and young people as being effective because:

- Children and young people's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- National Institute for Health and Care Excellence (NICE) guidelines were reviewed for appropriateness of use within the service and actions taken.
- Policies incorporated national guidance and were available for staff to view.
- Staff knew where to access guidance and policies.

However

- Measurement of patient outcomes was held by the individual consultants and not routinely shared with the hospital.

Evidence-based care and treatment

- Systems were in place to assess care and treatment that was delivered using legislation, standards and evidence-based guidance.
- NICE guidance had been discussed at the Medical Advisory Committee (MAC) meeting of 26 January 2016. For example NG29 Dec 2015 regarding intravenous fluid therapy in children had been reviewed by the paediatric lead nurse and the Paediatric Group on 4 February 2016. Actions to implement the guidance were identified such as printing algorithms and placing on the emergency trolley. This was written in the paediatric communication book for staff to be aware and sign once they had read the information. QS102 Oct 2015 Bipolar disorder, psychosis and schizophrenia in children and young people had been reviewed by the MAC and no further actions were required. This was because children with mental health issues were not treated at this hospital.
- A policy had been written using national guidance such as the Royal College of Nursing (RCN) document - Caring for Children and Young People – Guidance for Nurses Working in the Independent Sector. This informed staff of the standard operating procedures they could refer to and the required mandatory training if they were caring for children and young people. Standard operating procedures were written to give standard guidance for staff in specific activities such as inpatient admissions and outpatient laser admissions. Staff learnt about these procedures in team meetings and by ward communication books.
- Systems and processes were audited on a regular basis. As an example a documentation audit for children and young people's records had been completed on 11 March 2016. The results had shown some omissions including recording that height and weight had been double checked, parental responsibility was not always completed and recording of patient temperature was not always present. Actions for improvement had been identified and cascaded to staff with a repeat audit planned for six months later.

Pain relief

- A pain management process was in place that was specific to children and young people's needs. Guidance for staff had been written by the lead paediatric nurse and pharmacist and was reviewed at clinical governance meetings. It detailed prescribing guidelines for all ages, identifying level of pain and appropriate medication, and any associated risks. Guidance was also included for pain relief when patients were discharged.
- If children and young people were in pain staff could refer to hospital guidance for the most appropriate medications to use. Tools for assessing pain in all ages of child were available on the individual care record. This used smiley faces and 0-10 range of pain.
- We saw how staff assessed pain experienced by children post-operatively using age specific assessment tools.
- Topical local anaesthetic was used for children who needed intravenous cannulation to numb the area and prevent pain.
- Patient feedback we saw and parents we spoke with stated that everything had been done to control pain for children and young people.

Nutrition and hydration

Good

Services for children and young people

- The hospital provided suitable meals and drinks for children and young people.
- Post-operatively intravenous fluids were prescribed by the consultant/anaesthetist and monitored by nursing staff.
- Alternative menus were available for children to choose from to encourage them to eat and drink normally. This included foods to appeal to younger children such as chicken goujons and yoghurts.
- One parent told us of how staff protected a child against an allergic reaction by checking with the kitchen if the food chosen contained nuts.

Patient outcomes

- Consultants monitored the results of procedures and treatment for their patients.
- There was no established system for monitoring readmission rates. Parents were encouraged to contact the hospital if there were any concerns post procedure. We were told the local NHS Trust hospital would inform the consultant of any child who had been admitted following a procedure at the Nuffield Health Exeter hospital.

Competent staff

- The hospital had systems in place to ensure that staff had the relevant knowledge, skills and experience to deliver effective care for children and young people.
- Practising privileges for consultants (authorisation from the hospital director for consultants to practise at their hospital) and GPs were monitored by the MAC. Consultants were required to demonstrate their field of practice, numbers of procedures performed in NHS or independent settings, ages of children treated and training updates. If there was enough evidence to meet the hospital standards the consultant would be approved to work at the hospital. If further evidence was required the consultant would be requested to provide it before continuing practicing at the hospital. We saw records of the MAC meeting for October 2015 where practising privileges were granted to two consultants.
- The hospital ensured consultant's appraisals were up to date. Information was shared with and from the local NHS hospital about consultant's relevant practice regarding consultations and procedures for children and young people. Consultants had been requested to provide evidence of their level three safeguarding children training. the MAC meeting of October 2015 identified there had been few responses and were to be reminded and given a date by which to return the information. this training was included on a training matrix used by consultants for appraisals. Appraisals were to be completed within 12 calendar months of the previous appraisal and contributed to the approval of their practising privileges within the hospital.
- All registered children's nurses had attended paediatric immediate life support training and updated their skills and competencies by attending training at the hospital.
- Staff were encouraged to develop their skills and competencies. The lead paediatric nurse and specialist laser nurse had attended Great Ormond Street Children's Hospital (GOSH) for specific training on laser procedures. The lead paediatric nurse had plans to update her knowledge and experience by visiting more specialist areas. She made contact with the local NHS hospital to arrange some shifts on the paediatric unit and she had an honorary contract with GOSH which would allow her to work there on an ad hoc basis.
- Emergency scenarios relating to young children had been simulated to allow staff to practice responses without patient harm. Responses were reviewed and learning points identified including that all clinical staff were to attend children and young people basic life support and identifying a sick child was to be added to this training.
- Radiographers and physiotherapists had completed paediatric training within their original qualification. Ultrasound scans for children were performed by radiologists experienced with children and young people.
- There were no specialist paediatric pharmacy services but staff had a link to the local NHS hospital if they needed advice on any paediatric pharmacy issues.

Multidisciplinary working (in relation to this core service)

- Information regarding services for children and young people was shared with all staff by registered children's nurses and at team meetings.

Good

Services for children and young people

- The lead paediatric nurse was a member of a number of committees within the hospital including infection prevention and control, resuscitation, clinical governance and laser group.
- The hospital had service level agreements with outside agencies such as a retrieval service for critically ill children and the local NHS hospital if a patient transfer was needed.
- GPs and other community staff were informed of a child or young person's consultation or procedure with details of ongoing care needs where appropriate
- Safeguarding organisations were contacted for advice and updates to knowledge.

Seven-day services

- Children and young people were able to attend outpatient appointments in the evenings which would allow them to avoid missing school.
- Parents were able to contact the ward for advice after the discharge of their child and a paediatrician could advise staff further if needed.
- Medications to take home were provided by the hospital after a procedure but a community pharmacy would be used if any out of hours medication was required.

Access to information

- Information was available for staff to continue ongoing care of children and young people. Consultants arranged for records to be available in the hospital at the first outpatient appointment and records were stored on site for any follow up procedures. Medical records were kept securely on the ward but were easily accessible for relevant staff by accessing a key for the locked cupboard.
- Nursing records commenced at pre-assessment clinic or on admission if the child or young person was a day case. This recorded any base line observations such as heart rate, blood pressure. It documented any other clinical needs the nursing staff would need to be aware of such as diabetes. These records followed the patient to the ward, theatre and continued post-operatively. Nursing records were kept in the room post-operatively for staff to access and record further observations of condition.
- GPs were informed of a patient's discharge by fax which was sent by the wards receptionists within 48 hours of discharge. We saw how these letters detailed the procedure undertaken and ongoing care needs after discharge.

Consent

- The policy for gaining consent for examination or treatment of a child was revised August 2015 and was available for staff to view. This included information to guide staff on consent issues such as where a parent was unable to consent on behalf of a child due to lack of mental capacity, and gaining consent from young people as well as their parents. This had been cascaded to staff in team meetings and staff we spoke with were aware of the process for gaining consent from children and young people. Consultants had the information distributed to them by e mail. A documentation audit showed that not all consultants were gaining a child's signature on the consent form in addition to the person with parental responsibility. One of the records we viewed had a child's written consent which was countersigned by their parent. An action from the audit was to remind consultants to gain evidence of a child's consent where possible and appropriate and re audit at a later date.

Are services for children and young people caring?

Good

We rated services for children and young people as being caring because:

- Paediatric staff used age appropriate distractions for their patients to relieve anxiety.
- Comments from patients and their parents specified the positive effect staff attitude and approach had on their stay.
- Staff responded to parent's and children's emotional needs by recognising and responding to anxieties. They did this by providing information and reassurance appropriate for age and understanding.

Compassionate care

Good

Services for children and young people

- We observed appropriate and caring interactions between staff, parents and their children. Staff took time to build trust in children by playing with children in spare moments. We saw bubbles blown and toys dancing as a way to distract children when they were about to have their anaesthetic. Parents told us staff understood their anxieties and supported them. Children were able to wear their own clothes to the anaesthetic room and were accompanied by their parent.
- Children, young people and their families could feedback their views of the service using adult and separate children's feedback forms. Children could draw how they felt about their care. Some of the comments received from children between December 2015 and May 2016 included "I really liked my room and all of the activities there were to do (drawing, colouring and the TV)", "Every nurse and doctor were kind and helpful!!! I enjoyed the ice cream". Comments from parents and older children included "Everyone who looked after me were brilliant". Children we spoke with told us they liked the staff.
- When we visited, each child was cared for in a separate room where parents could stay with them and doors could be left open or closed to provide privacy.

Understanding and involvement of patients and those close to them

- We saw how children and families were involved in their care planning. Children were asked which toys they were taking to theatre and if they wanted parent with them.
- Patient feedback forms stated that parents had felt informed and understood the plans for their child's care and that they were informed of who to contact if they had any concerns about their child's condition after discharge.
- Young people were able to have their parents accompany them to a consultation. If their procedure was sensitive they would be encouraged to have an advocate to support them through the procedure and decision making. The advocate was one of the senior hospital staff but independent of any staff involved in the young person's treatment.
- Staff we spoke with described how treatments would affect children and young people showing an understanding of how patients may feel.
- Parents told us they were kept informed and felt involved in the care plan of their child. Children we spoke with told us they felt everything was explained to them and they knew what to expect.

Emotional support

- Children and young people were not treated for their mental health conditions at this hospital. Facilities were provided for young children to distract or entertain them in all areas they would visit. We were told it was routine for all young children visiting for procedures to be given a small bag of toys (goodie bag) which they could take home, have a choice of larger toys to play with and a DVD player was provided for their own videos. Patients were able to use their own electronic devices and access the hospital Wi Fi. The intention of this provision was to relieve anxiety patients may experience.
- Parents we spoke with told us how the nursing staff talked to them and their children to relieve any anxieties. One parent stated they felt they were being offered extra support and felt special. Any delays were fully explained to the parent. A comment from patient feedback forms was "children's nurse, consultant and anaesthetist were all fantastic with her and made a little girl happy and less frightened".

Are services for children and young people responsive?

Good

We rated services for children and young people as responsive because:

- The hospital had reviewed the service they provided for children and young people within the community against other providers.
- The hospital had reviewed the quality of the service and made reasonable changes where required, to ensure they could provide a safe service in a way that would suit the needs of children and young people.

- Comments and complaints were monitored and changes made wherever possible.
- Where young people may feel sensitive about a procedure, arrangements were made to provide an advocate who was independent of their family or professionals providing direct care.
- Agreements were in place with other providers where the hospital had limitations of service.

However

- No children's focus group was established but there were plans to develop one.

Service planning and delivery to meet the needs of local people

- The hospital had planned its activities around the needs of the local population. They accepted referrals from the NHS on the choose and book system, self-referrals and from GPs. Staff told us they were the only NHS provider in Devon and Cornwall to offer laser skin surgery for children and young people. All appointments were booked through administration staff who consulted with the lead paediatric nurse before allocating an appointment.
- An audit of children's services had been undertaken in January 2016 and had been reported to matron who had discussed this at the Medical Advisory Committee (MAC) meeting of 26 January 2016. This identified where the service met national guidelines or improvement was needed. Progress of these actions had been reviewed in May 2016.
- Any surgical procedures for children and young people were planned in a way that would keep them safe such as ensuring the appropriately trained medical and nursing staff were on duty. There was a regularly used bank of registered children's nurses who could be called upon to work on shifts when children and young people were inpatients the hospital.
- The hospital had no critical care facilities for children and screened their patients to ensure the hospital had suitable facilities to treat them. Processes were in place to deal with unexpected outcomes. Service level agreements had been arranged between the local NHS hospital and a critical care retrieval team to ensure patients could be cared for if their condition deteriorated and required more specialist care.
- The hospital had an active patient focus group but this did not include children, young people or their parents. The lead nurse told us of plans to gather patient views by encouraging parents and their children to attend a forum in May 2016. Another plan was to invite children and parents to assess the service using a '15 steps challenge' approach. This challenge involved using members of the public to review the service from a patient's perspective within 15 steps of entering a hospital or ward area. These plans had been documented in an action log following the audit of children and young people's services in January 2016 and presented to the high risk governance meeting of 23 February 2016.
- A variety of waiting areas were available for children and young people to wait for their appointment. They varied in size and were close to the area where their appointment was booked. All these areas were used by adults but could be used solely for children if needed. The main outpatient waiting area contained facilities to occupy children.

Access and flow

- Processes were organised for care and treatment to be provided by the hospital in a timely way.
- Patients were provided with appointment times to suit their commitments. This could be before or after school and between school term times.
- The paediatric lead nurse was informed of all under 18 year olds attending for a procedure at the hospital. There was a weekly meeting between matron, the lead paediatric nurse and clinical heads of departments to review all planned paediatric admissions to ensure there were appropriate staff on duty. Patients were screened to ensure admission was appropriate before they were allocated a date for the procedure.
- Receptionists accompanied patients and their families to the appropriate area to wait and informed staff of their arrival.
- Surgical lists were organised as children's only lists where possible and younger children were seen earlier

than older children. Children were seen before adults if adults were attending for surgery with the same surgeon. The target was that the child would have recovered from an anaesthetic by 4pm to allow them to go home at a reasonable time.

- We were told very few children and young people attended the radiology department but were seen as soon as was possible and were shown to a smaller waiting area with their parents.

Meeting people's individual needs

- Individual needs of children and young people were assessed by the paediatric lead nurse, paediatrician and matron where necessary. This was to ensure the safety and wellbeing of patients.
- Pre admission assessments were performed for all children and young people undergoing invasive procedures at the hospital. Patient attendance was encouraged but choice was given for a telephone assessment as an alternative. This informed staff of any difficulties or special needs the patient may have.
- Where possible the hospital would accommodate the individual need. As an example, we were told of special arrangements for a child with learning difficulties who needed repeated laser procedures. The hospital arranged for the child to arrive at the hospital as close to the time for their procedure as possible, the nurse caring for child wore ordinary clothes instead of a uniform and the same ward area and anaesthetist were used for the procedure.
- General needs of children and young people were accommodated. There was a DVD player for children and teenagers to view their own material, activities such as colouring, toys available, screens to ensure they did not view adult behaviour in recovery. If children were apprehensive of using a mask for oxygen or anaesthetic, pens could be used to make the mask smell of strawberries or bubble gum. Parents told us their children had their individual needs met.
- The day case area where children waited for their laser surgery was adapted to be appealing for children. We saw a display of children's feedback around a bear picture, a photograph introducing the nurse who would care for them, larger toys available, and "hello" which was written in 13 different languages. Children received a 'gold medal' and certificate following their procedure.
- Children as inpatients, were cared for in a single room on the ward. When admission of a child was planned this room was prepared for the child by changing the bed cover to more child friendly material, supplying toys and colouring facilities. We saw beds made up in the laser area for young children and teenagers with age appropriate bedding and distraction facilities.
- Waiting areas were flexible with toys books and colouring books and pens available when children and young people were attending them. The main outpatient area contained a television, and play table for young children. Children and young people needing to attend the ward waited in their room and for day case procedures waited in a small waiting area with facilities for a variety of age groups.
- Children and young people attending surgery as an inpatient at the hospital received a letter giving comprehensive information in a clear and simple format. It detailed what they should expect at their admission, facilities available for them to use and equipment they may like to bring with them. It also included links to web sites about anaesthesia and staying in hospital. Patients were encouraged to take DVDs, music devices or favourite toys in to hospital. Letters sent to patients for outpatient appointments received the same information as an adult. This did not give the detail that would be relevant for a child visiting the hospital or other sources of information about what to expect at their appointment.
- Young people admitted for sensitive procedures such as labioplasty or breast surgery were assessed by the lead paediatrician, lead paediatric nurse and matron to ensure it was clinically necessary. They were then encouraged to accept an advocate from the hospital staff who was not directly involved in their clinical care but accompanied them on their journey through the hospital. The advocate could be male or female and supported the young person to express their views and preferences for treatment and have their needs met.

Good

Services for children and young people

- A package of information was provided on discharge for patients and their parents. These varied in format to make them suitable for their age and understanding. The type of information included how they might expect feel and what to do if they were worried about anything.

Learning from complaints and concerns

- The lead paediatric nurse was informed of any complaints involving children and young people. These were discussed at senior management and MAC meetings. There had been no formal complaints raised within the reporting period of January and December 2015. Concerns had been raised by a parent of a child with learning difficulties who found hospital processes difficult. This had been investigated and special arrangements had been made for the child when they visited the hospital.

Are services for children and young people well-led?

Good

We rated children and young people's services to be well-led because:

- The hospital had a vision for developing the service for children and young people and shared it with the staff.
- Staff in the children and young people service felt involved in developing the strategy to achieve this vision.
- Risks were identified and methods of reducing the risk investigated and put into place where possible.
- Actions were monitored through audit processes and reported to leadership and governance committees.
- The service ensured they were using skills and experience of organisations and specialists independent of the hospital.
- There was some engagement with patients and their parents and there were plans in place to increase patient involvement in planning services.

However

- The paediatric lead consultant had not attended a Medical Advisory Committee (MAC)) meeting more frequently than 12 monthly although a verbal agreement been made between hospital management and the lead paediatrician for more frequent attendance in the future.

Vision and strategy for this this core service

- The vision of the leadership team was to deliver an excellent service to the children and young people who attended the hospital for treatment and consultation. They wanted to ensure that their current service was excellent before expanding numbers of patients seen.
- The staff we spoke within the children and young people's service were clear they wanted to expand numbers of children seen and achieve excellence in their service. They expressed how it would benefit patients who needed repeated laser procedures to be able to access a high quality, child focussed service more locally.
- They were striving for excellence in their service by using audit tools measured against national standards and used professional expertise to inform service delivery.

Governance, risk management and quality measurement for this core service

- Children and young people's services were governed by senior staff who monitored risk and quality of service.
- A paediatrician was a senior advisor for the service and representative who was a member of the Medical Advisory Committee (MAC) meeting and had attended on 26 January 2016. The hospital had recently made a verbal agreement that this attendance should be increased from 12 monthly to six monthly as a minimum requirement. Matron attended each MAC meeting and would represent children's services if the paediatrician was unable to attend. The lead nurse would attend MAC meetings when she was requested to or needed to present information to the members. As an example, a review of children's services had identified actions for improvement such as establishing links with safeguarding board, reporting safeguarding issues to the MAC meetings and ensuring consultants were following hospital policy regarding their practicing privileges. Meeting notes we viewed demonstrated that progress of these actions was being monitored. Quarterly and annual reports for this service were also prepared and presented to the MAC.

Good

Services for children and young people

- All staff we spoke with were clear about their roles in caring for children and young people and when to access support from a paediatric nurse or paediatrician.
- Some partner agencies had formal agreements regarding how they would support the service and others were contacted by the lead paediatric nurse and paediatrician to seek support and advice when needed. The latter was the case in safeguarding issues and informing the Multi Agency Safeguarding Hub (MASH) of the service provided by the hospital.
- Groups had been initiated to monitor the safety and quality of the service such as the children and young people quality group, children and young people group, laser quality group. Children and young people's services were represented in many other areas of the hospital. The lead paediatric nurse was a member of various committees across the hospital: infection prevention and control, governance, resuscitation, medicines management and health and safety.
- Audit results were reported to meetings of the senior management team, MAC and the hospital board. We saw an audit of the effectiveness of Children and Young People quality group dated 12 February 2016. This used a set of standardised criteria and showed that the group was achieving its aims.
- The service audit identified where risks of failing to comply with hospital standards existed. These were being actioned and did not meet the criteria for being placed on the hospital risk register at the time of our visit.
- The lead paediatric nurse identified risks and took steps to mitigate them with improving equipment, additional training and cascading information followed up by further audit. There were no paediatric issues on the hospital risk register for March 2016.

Leadership / culture of service

- The hospital had a clear management structure led by the hospital director with Matron leading all clinical services, a finance manager and a sales and service manager.
- Decisions about the service were made jointly by the hospital board after gaining expert advice from the nominated lead paediatrician and the lead paediatric nurse. The Children and Young People Group meeting was chaired by the lead paediatric nurse and included membership from all departments of the hospital, Matron and the lead paediatrician. We saw meeting minutes from February and April 2016 which documented progress of actions and new developments. On both occasions the lead paediatrician had been unable to attend but would receive the meeting minutes.
- All staff we spoke with knew who the paediatric nurses and paediatrician were and felt they could approach them at any time for advice.
- Practice had been shared throughout the hospital with the lead paediatric nurse attending team meetings to inform all staff of changes or new policies and standard operating procedures.
- Actions were taken to address performance following resuscitation scenarios. This had highlighted where training programmes could be improved and who needed to attend. Staff we spoke with valued the training.
- There was a culture of positive action to improve the service in safety and quality. Meeting notes we saw documented how identified improvements were being acted upon. Staff were able to tell us the changes they had made to meet the needs of children such as outpatients department providing activity packs for children. Audit process monitored improvement actions which reported to the hospital governance team, the board and MAC.
- Staff we spoke with felt valued and listened to. They felt they had a voice that could make positive changes for the service.

Public and staff engagement

- Staff in other areas of the hospital told us they felt included in planning children's services.
- Some hospital staff had worked in other settings with children and young people. Staff in other areas of the hospital were invited to attend the children and young people group meeting to offer their views on improving care.
- Some systems were in place to gather feedback from patients and their parents and plans were in place to increase public engagement but final arrangements still

needed to be made. This included setting up a feedback session with adults and children using the '15 steps' approach. This would give a parent and child's perspective of how it feels to visit the hospital within 15 steps of entering the hospital.

Innovation, improvement and sustainability

- Improvement actions for the service had been discussed between the lead paediatric staff and senior management team. We were told by paediatric staff that facilities requiring funding had always been approved by the senior management team.
- Records we saw indicated that opportunities to improve the service were acted upon wherever possible. For example using audit, comments from parents, visiting other providers and views of staff members.
- Training was altered to improve outcomes for children and young people such as using emergency scenarios and adding preventative actions to the paediatric life support training.
- Staff we spoke with talked positively of children and young people services and were keen to support any improvements.
- Areas were adapted where it was possible to improve the environment for children and young people.
- Paediatric staff were ensuring they maintained and improved their skills and competence by accessing other organisations and learning from specialists. This had resulted in changes to practice to improve care. Such as laser techniques and safeguarding processes.

Good

Outpatients and diagnostic imaging

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

Information about the service

Nuffield Health Exeter Hospital offers outpatient and diagnostic imaging services to adults and children from the NHS and those using other methods of funding.

The specialities seen in the outpatients department are orthopaedics, neurology, rheumatology, renal, paediatrics, ear, nose and throat, gynaecology, plastics, psychiatry, oral and maxillofacial, cardiology, cardiothoracic, psychology, colorectal, dermatology, vascular, spinal orthopaedics, oncology, haematology, urology and a private GP service.

The diagnostic imaging service provides a range of general and specialist imaging services including plain x-rays, ultrasound, mammography and Magnetic Resonance Imaging (MRI). In 2015 a £2 million state of the art MRI scanner, including cardiac capability was installed within the building. The new MRI scanner has a wider bore to help reduce the "closed in" feeling of traditional MRIs. Many scans can be performed with the head outside of the system.

There are 11 consulting rooms, two cardio physiology rooms and two treatment rooms where procedures are performed under local anaesthetics. Procedures include the removal of benign lesions, melanomas, squamous cell carcinomas, basal cell carcinomas, pinnaplasty, brow lifts, labiaplasty, cystocopies, skin grafts, carpal tunnels, trigger finger, insertion of reveal device implant, upper blepharoplasty, nipple correction, flap repair, banding of haemorrhoids, foam sclerotherpy, colposcopies, dating scans, endometrial biopsies, polyp removal. Gynaecological procedures are also carried out such as smear testing and Harmony testing (a non-invasive pre-natal screening for chromosomal conditions). There are changing areas for patients undergoing procedures.

A waiting area is available for patients attending outpatient appointments. It is equipped with comfortable chairs, a hot drinks machine, water, magazines and comment cards and box. An area for children is situated in one corner with a table and chairs and an activity table. There is a sub waiting area in diagnostics and imaging with changing rooms where gowns and dressing gowns are provided.

We spoke to 18 members of staff including nurses, health care assistants, radiographers, physiotherapists, managers, administrative and housekeeping staff. We observed consultations, a health MOT, a pre-operative assessment and a minor operation procedure. We reviewed eight sets of patient records.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the service as good because:

- Risk was managed and incidents were reported and acted upon with feedback and learning provided to staff.
- Treatment and care were effective and delivered in accordance with best practice and recognised national guidelines. There was excellent multidisciplinary team working within the service.
- Patients were at the centre of the service and the priority for staff. Innovation, high performance and the high quality of care were encouraged and acknowledged. Patients and their relatives were respected and valued as individuals. Feedback from those who used the service had been exceptionally positive. Patients spoke highly of the approach and commitment of the staff who provided a service. Staff went above and beyond their usual duties to ensure patients received compassionate care.
- Patients received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with patients and their families.
- Staff understood the individual needs of patients and designed and delivered services to meet them.
- There were clear lines of local management in place and structures for managing governance and measuring quality. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- All staff were committed to patients and their relatives and to their colleagues. There were high levels of staff satisfaction with staff saying they were proud of the department as a place to work. They spoke highly of the culture and levels of engagement from managers.
- Staff worked in an open and honest culture with a desire to get things right.

However:

- The design of the flooring in treatment and consulting rooms and the use of most clinical wash-hand basins did not facilitate good infection prevention and control practices to enable thorough access, cleaning, disinfection and maintenance to take place.
- Dust was found on high and low levels in particular under some examination couches.
- There was a lack of security of some confidential information.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We have rated the safety of outpatient and diagnostic imaging services as requires improvement because:

- There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents.
- Nursing and medical records had been completed appropriately and in line with each individual patient's needs.
- Staff we spoke with were knowledgeable about safeguarding processes and were clear about their responsibilities. Mandatory training was monitored and most staff were compliant with their training.
- Systems were in place for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs.

However there were a number of issues requiring improvement:

- Most clinical wash-hand basins were found to be non-compliant with HBN 00-09 which includes guidance on clinical wash-hand basins.
- Dust was found on high and low levels in particular under some examination couches. Dust was also found on light pendulums and above picture frames.
- Not all staff observed hand hygiene practices.
- The hot drinks machine in the waiting area was low enough to be within reach of a young child.
- There was a lack of security of some confidential information that was left unattended in unlocked treatment / consultation rooms.

Incidents

- Staff were open, transparent and honest about reporting incidents. There were systems to make sure incidents were reported and investigated appropriately. All staff said they would have no hesitation in reporting incidents and were clear on how they would report them. All staff received training on incident reporting and risk management.
- A Standard Operating Procedure (SOP) set out the processes for reporting, investigating and managing incidents. The policy described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process. All staff were responsible for making themselves aware of the contents of the SOP and undertaking the parts of the process for which they were involved as and when required.
- All incidents were reported using an electronic system. Once reported, incidents were reviewed by the appropriate clinical manager and where necessary investigated. Staff said they were provided with feedback on incidents they reported.
- All investigations were supervised or carried out by staff who had experience in or undertaken training in Root Cause Analysis. Nuffield Health had adopted the National Patient Safety Alerts (NPSA) Root Cause Analysis tool for undertaking investigations into serious adverse events, including never events and unexpected deaths.
- The results and reports including lessons learnt from such investigations were discussed at the quality and governance committees, and analysed to assess trends and ensure appropriate actions were taken. We saw minutes of team meetings where incidents from Nuffield Exeter and other Nuffield Hospitals had been discussed and changes in practice made as a result.
- There had been no serious incidents affecting patients in the outpatient department between January and December 2015. No never events were reported. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.
- The diagnostic imaging department had not reported any incidents where an exposure was much greater than intended. It is a requirement for certain radiology incidents to be reported to the Care Quality Commission and staff were aware of their duty to report such

incidents under the Ionising Radiation (Medical Exposures) Regulations 2000. These regulations help protect patients from unnecessary harm caused by over exposure to ionising radiation.

- The NPSA affecting the services were reviewed at the Medical Advisory Committee (MAC) meetings and cascaded to the heads of department for required action.
- Most staff demonstrated an understanding of Duty of Candour responsibilities. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation which was introduced in November 2014. This Regulation requires the hospital to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. Staff told us they had received information about the Duty of Candour. We observed posters around the department which confirmed this.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff spoke confidently about the duty of candour. Training had been provided for relevant staff.

Cleanliness, infection control and hygiene

- Systems were in place to monitor and prevent the spread of infection within the hospital.
- There were no acquired methicillin resistant staphylococcus aureus (MRSA) infections or incidences of acquired Clostridium difficile (C diff) affecting patients attending outpatients and diagnostic imaging services between January 2014 and December 2015.
- We observed most clinical staff, including doctors, nursing staff and radiographers washing their hands and using anti-bacterial gel before and after patient contact in line with infection prevention and control guidelines. Non-clinical staff including reception and administrative staff and cleaning staff were also observed to be following the guidelines. Staff could explain the importance of good hand hygiene and audited compliance with hand hygiene. Poor practice and behaviour was challenged.
- However, staff reported that some consultants did not always comply with hand- washing practices and the wearing of gloves. This was brought to the attention of the senior management team.
- Patients were asked to wash their hands and use alcohol gel when arriving on the units and this was freely available and clearly visible. Hand basins in public areas did not have hand washing signs, and we were told this was a corporate decision, as this did not follow the corporate image. All staff, as required, were bare below the elbow when working in the departments. We saw staff wearing aprons and gloves, and couches were cleaned and bedding changed in between patients.
- In the two treatment rooms there were facilities for health professionals to decontaminate hands.
- Precautions were taken in diagnostic imaging when seeing patients with suspected communicable diseases. For example, if a patient had an unknown infection status i.e. C diff or MRSA a decision would be taken whether testing could be delayed until the patient's status was known, or the patient would be treated as if they were infectious to minimise risk.
- Waiting area furniture was clean and in good condition, fully wipeable and fully compliant with the Health Building Note (HBN) 00-09: Infection control in the built environment.
- Most clinical areas were found to be non-compliant with Paragraphs 3.31 and 3.32 of HBN 00-10 Part A: Flooring. Carpets were found in treatment and consulting rooms and there were no coved skirting boards which meant there were gaps between the flooring and the skirting boards.
- The areas of non-compliance were discussed with the hospital director. The gaps identified in between the floor and skirting boards were filled by the following morning.
- Where carpets were in use in non-clinical areas (for example interview rooms, counselling suites, consulting rooms), we saw that a documented local risk assessment was in place. Infection control staff had

been involved in developing the risk assessment and a clearly defined pre-planned preventative maintenance and cleaning programme were in place. We saw the procedure for cleaning of spillages.

- Most clinical wash-hand basins were found to be non-compliant with HBN 00-09: Infection control in the built environment. Most sinks had plugs and some had overflows that had been bunged off with transparent sealant. Paragraph 3.31 states that basins should not have a plug or a recess capable of taking a plug. A plug allows the basin to be used to soak and reprocess equipment that should not be reprocessed in such an uncontrolled way. Paragraph 3.32 states that clinical wash-hand basins should not have overflows, as these are difficult to clean and become contaminated.
- We saw cleaning work schedules which recorded items such as cupboards, sinks, equipment furniture, fittings and frequency and the staff group responsible for the task. There were daily schedules and weekly tasks, alongside 6-monthly deep cleaning or as and when required if earlier.
- Communal areas were found to be visibly clean, well-organised and tidy. However, dust was found on high and low levels in particular under some examination couches. Dust was also found on light pendulums and above picture frames.
- Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers. Nursing staff said these were emptied regularly and none of the bins or containers we saw were unacceptably full.
- We saw the 2016 infection prevention and control annual report. An infection prevention strategy was developed each year to ensure the hospital had effective infection prevention and control arrangements to protect patients, visitors and staff from risks of infection and related adverse consequences.
- The infection control team worked with a local school where a school project ran hand hygiene sessions throughout 2015. The plan to complete 90% compliance in 2015 was not achieved, however, the programme was continuing into 2016.Interactive training was delivered and reached 95% compliance.
- There were quarterly water hygiene meetings to ensure processes were in place for monitoring and acting on water sampling, specifically pseudomonas and Legionella.

Environment and equipment

- Facilities and premises within outpatients and diagnostic imaging were designed in a way that kept people safe. Systems were in place to ensure the safe use and maintenance of equipment. The hospital maintained equipment according to manufacturer's instructions and tested it for electrical safety. We saw clinical equipment was labelled to indicate it had been serviced and when it was due to be serviced next. We saw up to date maintenance logs for all the equipment we looked at. Records of service and maintenance arrangements were discussed at medical devices meetings.
- Resuscitation equipment for adults and paediatrics was available and accessible for use in the outpatients and radiology departments. There was clear guidance of how often it should be checked according to the hospital policy. We observed the register had been signed daily by the person completing the check.
- Consulting rooms contained facilities appropriate to the specialty of the consultant practitioner, for example gynaecological equipment.
- Reprocessed surgical instruments were used in the treatment rooms for minor operations and were supplied by a local theatre sterile supply unit.
- Staff in diagnostic imaging did not have any concerns about the equipment they used, and told us senior managers were very supportive to requests for new equipment if it improved outcomes for patients. In diagnostic imaging, all scanners were replaced every five years, with dose reduction to patient a factor in equipment selection. The ultrasound was due to be replaced towards the end of year.
- We saw records which showed that radiography machines were checked monthly. This included weekly testing by the radiology team and six-monthly testing by the manufacturer. The records of the testing we saw showed that the equipment was working within the manufacturer's specified recommended limits.

Good

Outpatients and diagnostic imaging

- The imaging service carried out prompt and thorough risk assessments for all new or modified use of radiation. These risk assessments addressed occupational safety as well as considerations of risks to people who used the service.
- In diagnostic imaging rooms, Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) local rules were available and up-to-date. Staff had read them and knew where they were.
- The imaging service ensured that non-ionising radiation premises, including the MRI scanner, had arrangements in place to control the area. Access to all imaging equipment and rooms was via key coded doors. Patients were escorted to the x-ray room, ultrasound room or MRI scanner by a member of staff.
- Staff used the safety guidelines for MRI equipment in clinical use provided by the Medical and Healthcare Products Regulatory Agency (MHRA) to govern usage.
- Staff said more consulting / treatment rooms were required to meet the growing demand for appointments. However, the hospital had expanded over the years to meet growing healthcare demands and was now landlocked with little opportunity to expand further, either for accommodation or car parking, which remained a challenge.
- The waiting area was equipped with chairs and the reception desk was clearly visible on entry.
- A number of operational services were outsourced to a third party to provide catering, maintenance, medical devices management, medical officers and laundry.

Medicines

- Staff had access to the hospital's medicines management policy which defined the policies and procedures to be followed for the management of medicines and included obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines. Staff were knowledgeable about the policy and told us how medicines were ordered, recorded and stored.
- We looked at the medicines storage audits, incidents and complaints, storage security, medicines records, and supply and waste-disposal processes. Medicines, including those requiring cool storage, were stored safely and kept within recommended temperature range appropriately. During our inspection we found all medicines stored securely, and were only accessible to authorised staff. All cupboards were locked and the stocks well organised. However, a cupboard in one of the treatment rooms did not meet British Standards. This had already been highlighted in the audit in quarter four of 2015 and a new cupboard had been ordered.
- There was daily monitoring of temperatures using a remote automated system which showed average maximum and minimum temperatures through 24 hour temperature graphs.
- Pharmacy conducted a routine delivery of stock. There were target stock lists and quantities which were topped up weekly and audited monthly. Stock takes were undertaken quarterly. Expiry checks were carried out monthly.
- Medicines management meetings were held quarterly and included representation from the outpatient department.
- Incidents involving medicines were reported using the electronic reporting system. The pharmacist was approached for advice and to investigate and escalate to the corporate team as required. Pharmacists identified trends and chaired the six to eight weekly pharmacy meeting. A pharmacy newsletter was produced regularly in response to issues highlighted including topics on learning, recalls, risk management and never events.
- The majority of medicines in outpatients were prescribed. There was a process in place to monitor overall usage of prescriptions. Prescription pads were stored in a box file on an open shelf, in a manned and locked office (key padded access by authorised staff only).Two pads should have been in outpatients at the time of our inspection according to pharmacy records. There was a sign out sheet, which was supplied with a pad to enable doctors to write patient details next to each prescription. One pad and sheet was in use at the time of our visit, the other pad had been signed out but the cover sheet was not provided with a pad for the prescriber. We advised staff and this was immediately

corrected. However, from the sheet we saw, doctors did not always record prescriptions in the right order, this meant that it was not always immediately clear if any were missing.

- There was one patient group directive (PGD) in place in the outpatient department for staff flu vaccine. This had been signed and authorised with an expiry date of August 2016.Three healthcare professionals were authorised to administer the vaccine.
- Medicines reconciliation was incorporated as part of the pre-assessment check carried out in the outpatient department prior to admission where the patient's GP was asked to provide their medication history and allergies.
- There was a well-resourced pharmacy team of 2.87 whole time equivalent (WTE) who were available between 8.30am and 4.30pm, Monday to Friday. The hospital had identified the need for more pharmacy support on Saturday mornings through audits and patient satisfaction surveys. This was being reviewed. There was currently a service level agreement for out of hours support with the pharmacy department at the Royal Devon and Exeter NHS Foundation Trust.

Records

- Standard Operating Procedures (SOPs) outlined the processes that were followed for the management of health records. Processes for the creation, storage, tracking, access, disclosure and destruction of health records were in line with the requirements of the policy and were ratified locally through the integrated governance committee. This included employees, bank workers, agency workers, self-employed/freelancers, and volunteers, consultants, GPs and other independent clinical practitioners with practising privileges and third party service providers.
- The policy applied to all types of health records, (including records of patients treated on behalf of the NHS within Nuffield Health) regardless of the media on which they were held. These included patient health records, x-ray and imaging reports, output and images, photographs, slides, and other images, microform (i.e. microfiche/microfilm), audio and video tapes, cassettes, CD-ROM and DVD, computerised records and scanned records.
- Compliance to the policy was monitored through the completion of an audit tool. An action plan was developed to address audit findings and submitted to the clinical governance committee and to the Medical Advisory Committee (MAC) as part of an internal assurance process.
- The Picture Archiving and Communications System (PACS), a nationally recognised system used to report and store patient images, was available and used across the hospital. Image transfers were managed electronically using the Image Exchange Portal (IEP), but the department was unable to share images with the local NHS trust.
- Systems were in place to ensure medical notes were available for clinics. An internal audit had been completed to assure that notes were available for all patients.
- The majority (85%) of consultants who used the outpatient consulting facility had secretaries on site and the notes were pulled for each clinic and for each patient. If for any reason the notes were not made available, this would be highlighted and the secretary would be phoned and the notes brought down to the clinic. Therefore, access was always available to the patients' notes. If the patient had not visited the hospital in over 12 months, the notes would be stored off site and the secretary would request the notes to be returned in time for the clinic. There was a tracking system in place to identify the location of medical records in other departments within the hospital.
- There were only a few consultants with secretaries off site. They brought their own notes with them for their clinics and took them back to their consulting rooms once the clinic had finished. It was a requirement of their practising privileges that they registered as a Data Controller with the Information Commissioner's Office. Any breaches in information security were reported through the incident risk management system.
- Very occasionally, consultants might request to take notes off site and if this happened, a hospital policy "Local Procedure for the Safe and Confidential Transportation of Medical and Consultant Records" was adhered to. This gave clear and concise instructions as to how notes were handled and processed to protect both patient safety and data protection.

Good

Outpatients and diagnostic imaging

- Most records were stored securely in locked filing cabinets. However, there were a number of breaches of confidentiality. In an unlocked cardiology physiology room we found diary lists of patients undertaking exercise tolerance tests which contained their name and date of birth. A list of patients was also found in another examination room used for gynaecological procedures where patients' details were listed along with their procedures. In treatment room 1 we found 15 years of theatre operation records in a cupboard in an unlocked room.
- We looked at eight sets of patient medical notes. They were legible, clear and factual, and gave a clear plan for ongoing medical review. Notes were signed and dated by the patient and by all staff involved in the patient's care including medical and nursing staff, allied health professionals and pharmacy. One set of notes did not have the patient's name at the top of every page which meant that if they became detached there would be no way of identifying the patient.
- Notes were kept in medical records for 12 months and then archived. Staff said the storage room was cluttered and this caused difficulties for those filing records

Safeguarding

- There were policies, systems and processes for safeguarding and protecting vulnerable people. The policy clearly described the roles and responsibilities for staff in reporting concerns about patients.
- Staff we spoke with were knowledgeable about the safeguarding policy and processes, and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of abuse. They described what actions they would take should they have safeguarding concerns about a patient.
- Staff were trained to the appropriate level relevant to their role and responsibilities. Records indicated that safeguarding training was up to date for all staff with compliance at 100%.
- The hospital director and the matron were responsible for leading on all safeguarding within the hospital. Both had completed their level 3 Safeguarding Children and Young People training. All members of staff had completed level 1 safeguarding training and this included information on the government's Prevent strategy which covers the protecting of children from the risk of radicalisation. All nurses had completed level 2 training. We saw flow charts in the outpatient department detailing the action to be taken and who to contact in the event of adult safeguarding or Prevent issues arising. Matrons and key heads of department had also completed additional Prevent training.
- Diagnostic imaging staff had undertaken on-line training for safeguarding children and were able to describe how to identify different types of abuse, and were aware of their responsibilities and how to escalate a potential safeguarding concern. The diagnostic imaging department did not see many paediatric patients, however, staff told us a paediatric nurse always accompanied the patients, and gave us an example of when a nurse stayed with a child during their MRI scan.
- Processes were in place to ensure the right person had the right radiological scan at the right time. The diagnostic imaging department had a nine point patient identification check to ensure that the correct patient was being examined, and the correct body part was being scanned. These included: patient name; date of birth; address; justification of test; and confirmation of appropriate authorisation.
- We saw staff using the WHO Surgical Safety Checklist in the treatment room ahead of a minor procedure. This was a core set of safety checks used when carrying out minor operations in the treatment rooms and for non-surgical interventional radiology to ensure the right patient had the right operation.

Mandatory training

- The hospital provided a programme of mandatory training for staff which included basic life support, business ethics, incident reporting, fire safety, infection prevention, information governance, safeguarding, whistleblowing for non-clinical staff and consent to examination or treatment, health record keeping, manual handling, medical devices in practice, Mental Capacity Act, safer blood transfusions, update training for radiographers for clinical staff. Training was delivered on one day a month and could be accessed at home if required. Emergency scenarios were carried out followed by a de-briefing and learning session.
- There was a mixture of learning methods to suit personal learning preferences and staff were

encouraged to take control of their own learning. There were lunch and learn sessions and training was available out of hours where necessary. Meetings were held with other Nuffield hospitals to share learning.

- Compliance was reported by department. Mandatory training compliance was at 90%. This meant that most staff remained up-to-date with their skills and knowledge to enable them to care for patients appropriately.
- The diagnostic imaging manager had completed an annual refresher training on guidance and legislation, quality assurance, and dose reference levels. However, update training for radiographers was at 67%. There was a clear focus on improving compliance with dates booked to attend training in the near future.
- Staff told us that mandatory training updates were delivered to meet their needs and that they were able to access training as they needed it and could manage their learning by accessing "My learning" through the on-line learning directory.
- Staff had access to a rolling catalogue of training and external courses and staff said they had ongoing discussions with their line manager about clinical professional development.
- An induction file for new starters was available with credit card sized laminated instructions about systems processes i.e. transferring a call, on-call arrangements.
- Information about new guidance and processes were disseminated from the head of department and team leaders and was also displayed on the notice board.
- Staff training analysis reports were available to enable attendance to be reviewed, thereby enabling staff and managers to check their compliance with mandatory training. The manager was aware of the current status for staff and details were displayed on the noticeboard in the office to alert the team.

Assessing and responding to patient risk

- Patient risk assessments were completed and evaluated. There were clear pathways and processes for the assessment and management of deteriorating patients within outpatient clinics or the radiology departments who were clinically unwell and required hospital admission.
- There were processes in place for escalating care during exercise tolerance tests. A crash trolley was situated in the room used for tests and GTN (glyceryl trinitrate for angina) was administered for patients experiencing pain and for patients with uncontrollable chest pain an emergency 999 call was made. Cardiac scenarios were carried out every three months to ensure staff were competent and confident to manage escalating care
- The radiation protection advisor was accessible via telephone and email for providing radiation advice. An on call radiographer was available outside of standard working hours to provide emergency cover for the wards.
- There were clear signs and information in the diagnostic imaging department informing people about areas and rooms where radiation exposure took place.
- The imaging department ensured women who used the service who were, or may be pregnant, always informed a member of staff before they were exposed to any radiation. Imaging request cards, and pre-imaging questionnaires were used to document a patient's pregnancy status, and staff verbally asked patients when they attended for their examinations.
- A pre admission assessment was carried out for patients undergoing procedures who needed to be admitted to the hospital. This assessment would identify any risks to the patient based on their medical history, whether these risks could be minimised and if the hospital could safely care for the patient.

Nursing staffing

- There were adequate nursing staff levels to safely meet the needs of patients. The team consisted of 1.0 whole time equivalent (WTE) nurse manager, 1.6 WTE nurse team leader, 5.4 WTE nurses and 2.4 WTE care assistants.
- A dependency tool was used to ascertain staffing requirements. It compared patient dependency hours to nurse hours available and also took into account NICE guidelines and Royal College of Nursing recommendations on safe staffing levels.
- The staffing rota was planned and reviewed weekly utilising staff skills and seniority working on potential daily patient numbers. All patient dependency hours and staffing hours available were calculated

approximately 24 hours before time and reviewed at least in the morning and afternoon on the day to which they applied. Changes and adjustments to staffing levels were made to maintain patient safety.

- The team had a number of vacancies during the past year and vacancy rates had been particularly high for care assistants. Vacancies had been covered by bank staff with no reliance on agency staff. A recruitment business plan had been submitted to the board and ratified. New staff were now in post with an additional administrative apprentice.
- Radiology cover was sufficient in diagnostic imaging areas. There were 3.0 WTE radiographers and all staff were senior clinicians, although not all staff were able to carry out MRI scans or mammography scans. The staffing rota was, therefore, planned in advance to ensure the appropriately trained staff were on duty for planned procedures.
- There were no current vacancies in diagnostic imaging. Agency staff had been used to cover previous gaps within the department. An induction programme for agency staff was available and we saw completed induction records. A bank of staff who had previously worked in the department or who were able to provide additional hours, was now available to cover annual leave or sickness.
- Sickness was managed in line with hospital policy. Rates for the period January to December 2015 ranged from between 0 to 5% for nursing staff and between 0 to 35% for care assistants. The levels for both staff groups were at their highest in October 2015. This had been as a result of a mixture of short term and long term sickness absence and had been attributed to the high levels of vacancies in the team.

Medical staffing

- There were adequate medical staffing levels to safely meet the needs of patients.
- Consultants held regular clinics and were responsible for the care of their patients. The majority had secretaries based in the outpatient department who organised the clinic lists around consultant availability. If the consultant was delayed or unable to attend it was their own responsibility to provide cover for any clinics, with an alternative appropriately skilled consultant who also had practicing privileges at the hospital.

Major incident awareness and training

- There was a major incident plan which outlined the decisions and actions to be taken to respond to and recover from a range of consequences caused by a significant disruptive event. The staff we spoke to were aware of the major incident plan and how to access this.
- Outpatient staff told us there was regular testing of fire alarms and drills where the department had to be evacuated. Notice boards displayed who the fire marshal was that was on duty each day and relevant numbers to call. Emergency generators were in place in the hospital to maintain services in the event of a power cut.
- There were effective arrangements in place in case of a radiation or radioactive incident occurring and staff were aware of the procedures and their roles and responsibilities in the process.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic was not rated due to insufficient data being available to rate these departments' effectiveness nationally.

We found:

- Patients had good outcomes as they received effective care and treatment to meet their needs.
- Treatment by all staff was delivered in accordance with best practice and recognised national guidelines.
- Regular audits were carried out to monitor performance against national patient outcomes and to maintain standards.

Good

Outpatients and diagnostic imaging

- Patients were at the centre of the service and the priority for staff. High quality performance and care were encouraged and acknowledged and all staff were engaged in monitoring and improving outcomes for patients.
- Staff skills and competence were examined and staff were supported to obtain new skills and share best practice.

However:

Consultants monitored the results of procedures and treatment for their patients and information about patient outcomes were not routinely shared with the hospital.

Evidence-based care and treatment

- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the policies were available to all staff via the intranet system and staff demonstrated they knew how to access them. The diagnostic imaging department used diagnostic reference levels (DRLs) as an aid to optimisation of medical exposures to keep patients safe. These levels were used to help staff make sure the right amount of radiation was used to image each part of the body. Staff were able to locate and explain how they used DRLs to make sure that staff used the correct amount of radiation to image each part of the body. Staff also told us of new machines and systems that had been introduced to reduce and minimise exposure to radiation.
- DRLs were audited annually and evidence of this was seen during the inspection. Audits were performed by staff with the support of the Radiation Protection Advisor (RPA). An action was noted that the new digital radiology imaging system required a lower radiation dose for existing image quality and dose parameters had been adjusted accordingly and communicated to all staff. Staff also undertook regular DRL checks throughout the year.
- Clinical audits were undertaken in diagnostic imaging including an annual audit plan, which included peer review audits. The results of these were seen during the inspection. Audits covered: quality of image; positioning; dosage; and markers. Learning was shared with individuals as well as broader lessons shared across the department. For example one agency radiographer had not recorded radiation dosages properly. This was shared with the radiology manager and all agency staff were contacted regarding the correct way to record radiation dosages.
- IR(ME)R audits were undertaken in line with regulatory responsibility. Copies of these audits, outcomes, actions and results were seen during our inspection.
- All patient referrals to the diagnostic imaging department were made by registered healthcare professionals as defined under IR(ME)R 2000, and clear referral criteria was in place, including for non-medical referrers, such as osteopaths.

Pain relief

- Staff said it was unusual to have to ask patients in outpatient clinics to rate their pain although all staff demonstrated a good understanding of simple comfort scale methods available to them for the management of patient's pain.
- Pain relief was available if required following procedures carried out in the department.

Nutrition and hydration

- During our inspection we saw water coolers and tea and coffee facilities throughout the department. Staff demonstrated a good understanding of the importance of assessing nutrition and hydration needs.
- Arrangements were in place in terms of food and drink for patients who were in the department for any length of time. Patients and relatives were advised to allow up to two and a half hours for some appointments and if there were unexpected or long delays in clinics, staff prepared hot drinks.

Patient outcomes

- A governance framework was in place to ensure that a range of outcomes were reviewed and discussed.
- Consultants monitored the results of procedures and treatment for their patients. However, information about patient outcomes was not routinely shared with the hospital.
- A number of regular audits were carried out to monitor performance against national patient outcomes and to maintain standards. We saw a schedule of the audits

completed during the period from January 2015 to February 2016. Recent audits included hand hygiene observations, the processes for patients requiring a chaperone and the appropriateness of urine testing for patients undergoing operations who were suffering with urinary symptoms or if they had a history of urinary tract infection.

- Where areas required improvement following participation in audits action plans would be put in place and reviewed to monitor progress.
- Patient outcomes were reported in a format that allowed the hospital to compare their results with other private providers and the NHS. On a monthly basis there was a quality governance sign off report submitted to the corporate quality manager for acute services. This looked at benchmarked data across the company for certain clinical quality indicators in the five CQC domains of safety, effectiveness, responsiveness, caring and well led, such as infections, incidents, unplanned events and cancellations. Data showed the hospital performed in line with other hospitals across the company and also with other private providers.

Competent staff

- Systems were in place to ensure all staff had the specialist knowledge and skills to deliver effective care to patients with their presenting conditions.
- Arrangements were in place for the granting and reviewing of practising privileges to enable consultants and GPs to practise at the hospital. Authorisation was given by the hospital director and monitored by the Medical Advisory Committee (MAC). This ensured that consultants working under practising privileges arrangements only carried out treatments, procedures or reporting that they were skilled, competent and experience to perform.
- All staff administering radiation were appropriately trained to do so.
- Staff learning and development was identified through the appraisal process and through one to one meetings. Performance and continuous improvement was also assessed through discussions about essential training, clinical skills and competencies. Processes were embedded for performance management enabling early intervention and support.
- All the staff we spoke with said they had received an appraisal during the last year. The figures provided by the hospital showed a compliance rate at February 2016 as 100%. Appraisals were carried out by the head of department and team leaders. Annual appraisals were held in February with six-monthly reviews in August.
- The hospital ensured consultant's appraisals were up to date. Information was shared with and from the local NHS hospital about consultant's relevant practice regarding consultations and procedures.
- There was a commitment to training and education within the department. Staff felt well supported to maintain and further develop their professional skills and experience. They were encouraged to develop their knowledge and skills and were supported in their continuous professional development. There were opportunities to attend external training. For example we spoke to a member of staff who was undertaking a postgraduate certificate and had been granted study leave to enable them to complete the course.
- Most staff we spoke with were positive about the quality and the frequency of clinical supervision they received. Attendance was monitored by managers with follow up for non-attendance ensuring staff received training and regular updates for maintaining a level of competence appropriate to each individual's employed role.

Multidisciplinary working

- We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. This was to ensure care was coordinated to meet the needs of patients. Staff reported good multidisciplinary team working with meetings to discuss patient's care and treatment.
- All staff worked together to assess and plan ongoing care and treatment in a timely way. This included when people were due to move between teams or services.
- As part of the justification process to carry out exposure to radiation, the imaging service always attempted to make use of previous images of the same person requiring the test, even if these had been taken elsewhere. For example, a patient attended for a procedure, and the diagnostic imaging department had the patent's previous images imported onto the hospital x-ray computer system for the consultant to look at.

Good

Outpatients and diagnostic imaging

- Diagnostic imaging staff told us of good multidisciplinary team working. They ensured clinical guidance for report turnaround times were met for medical staff requesting diagnostic imaging to be carried out. An annual consultant satisfaction audit was undertaken in February with excellent feedback from consultants who felt that overall patients were scanned within appropriate timescales and that the service met their requirements.
- Physiotherapy was available for outpatients. Although located within the footprint of the outpatient department the service was managed by a different line management structure within the corporation. However, there were plans in place to incorporate the service within the umbrella of the hospital. Referrals for physiotherapy were made by consultants, GPs or by patients themselves.

Seven-day services

- The hospital operated a six day outpatient service, Monday to Saturday, from 7.15am to 9pm.
- In diagnostic imaging, scans, x-rays and ultrasounds were available Monday to Friday between 9.00am and 5.00pm. A 24-hour on call rota was in place to provide emergency cover for the wards.
- All pharmacy services were available Monday to Friday between 8.30am and 4.30pm.

Access to information

- Information to deliver effective care was readily available. There was a range of documentation and this was easily accessible. An electronic booking system was used to track the movement of patient paper records around the hospital. An audit of the number of patient paper notes that were prepared for clinics showed that above 99% of notes were available in good time. Staff confirmed records were provided relatively quickly. There was a range of patient information leaflets available, however, they were not available in other languages.
- The medical teams said there was good and quick access to test results and diagnostic and screening tests.
- Diagnostic images and results were available electronically and were accessible by the clinician during clinic appointments. They were available for the patient's next appointment or in some cases were available for certain clinics on the same day. This enabled prompt discussion with the patient on the findings and treatment plan.
- Information was displayed on a whiteboard in the outpatient office and included the hospital's objectives and areas for improvement such as the continued improvement on the patient survey and a working knowledge of items on the risk register. There were details about the clinics running that day, training and meetings, equipment and repairs, the senior manager on duty, the resident medical officer (RMO) on duty and the bleep holder. Details of mandatory training were also displayed together with daily and weekly task check lists which included updating and preparing consultants' rooms, resuscitation trolley checks, glucose calibration, cholesterol calibration, rooms stocked, toys cleaned, waiting room checked and equipment cleaned.
- Information was shared with the team at morning briefings, one was held at 8.45am and again at 10.00am to inform staff arriving on a later shift of any worries, meetings for the day and any incidents or learning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff were aware of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff had attended mandatory training and knew what their responsibilities were and how to apply them within everyday practice. In both the outpatient department and diagnostic imaging extra time would be allowed for an appointment if staff were made aware that a patient had learning difficulties and may require extra time.
- Staff said they obtained consent from patients prior to commencing care or treatment. They said patients were given choices when they accessed their service.
- Throughout the inspection we saw staff explaining the assessment and consent process to patients and any need to share information with other professionals such as GPs, before obtaining written consent. We saw consent forms signed appropriately by patients.
- We heard staff discussing the treatment and care options available to patients.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

We rated the care given to patients as good because:

- Feedback from patients and relatives had been exceptionally positive. They praised the way the staff really understood their needs and involved their family in their care. Patients were treated as individuals.
- Patients said staff were caring and compassionate, treated them with dignity and respect, and made them feel safe. Staff went above and beyond their usual duties to ensure patients experienced high quality care.
- Staff were skilled to be able to communicate well with patients to reduce their anxieties and keep them informed of what was happening and involved in their care.
- Relatives were encouraged to be involved in care as much as they wanted to be, while patients were encouraged to be as independent as possible. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand.
- We observed staff treating patients with kindness and warmth. They were polite, calm and reassuring. The departments were busy and professionally run, but staff always had time to provide individualised care.
- Staff talked about patients compassionately with knowledge of their circumstances and those of their families.

However:

- Privacy and dignity could not be guaranteed in the mixed sex waiting area outside of the changing area for patients awaiting procedures.

Compassionate care

- Throughout our inspection, we observed patients being treated with the highest levels of compassion, dignity and respect. We saw all staff going the extra mile to support patients' personal and cultural needs. For example, staff made great efforts to pass on specific nuances about a patient to the theatre teams to ensure a smooth transition.
- We observed interactions between staff and patients and their relatives. Staff were open, friendly and approachable but always remained professional.
- We observed all staff taking time to talk to patients. They involved and encouraged both patients and their relatives as partners in their own care.
- There were positive results from patient satisfaction surveys with data from June 2015 to January 2016 showing that between 96% and 99% of patients would be either likely or extremely likely to recommend the service to friends and family if they needed similar treatment or care.
- During our inspection we observed excellent interactions between staff, patients and their relatives. We saw these interactions were very caring, respectful and compassionate. For example, when a patient became concerned about the length of time their relative had been waiting for them a member of staff went to find the relative to let them know how much longer they would be waiting. The member of staff returned to reassure the patient.
- Staff were skilled in talking to and caring for patients. Patients were encouraged to be as independent as possible and relatives were encouraged to provide as much care as they felt able to.
- Patients we met spoke highly of the service they received. All the feedback we received from the patients was very positive about the care they received. The comments we received included, "the staff have been fantastic", "I'm very happy with the care I've had … I can't fault it", "the service was like a hotel." Patients in the diagnostic imaging department were also unanimous in their praise and comments included, "the staff are amazing, kind and lovely", "I was really scared about the scan but the staff explained everything and helped me to stay calm", "They really know their stuff."
- A chaperone policy set out the policy and standard operating procedures for promoting the privacy and dignity of patients. We observed good attention from all staff to patient's privacy and dignity. The main

outpatient reception desk and the diagnostic imaging reception were sufficiently distant from waiting areas to enable patients to speak to reception staff confidentially, without their conversation being overheard. We observed voices being lowered to avoid confidential or private information being overheard on arrival at the reception area. All patients said their privacy and dignity was maintained. We saw all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.

- However, there was a mixed sex waiting area outside of the changing area for patients awaiting procedures and although staff said appointments were staggered and it would be unlikely for a patient to be waiting with another patient, privacy and dignity could not be guaranteed in this area.
- Care from the nursing, medical staff and support staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth and reassurance.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. We observed staff explaining things to patients in a way they could understand. For example, during a complex explanation, time was allowed for the patient or their relative to ask whatever questions they wanted to.
- Patients and relatives were encouraged to be involved in their care as much as they felt able to. Patients that we spoke with all confirmed this was the case.
- All healthcare professionals involved with the patient's care introduced themselves and explained their roles and responsibilities.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. They were knowledgeable about the framework to support communication with families who were non-English speakers, or for whom English was a second language. Support was also available for patients with hearing or visual impairment, or who had learning disabilities.

Emotional support

- We observed staff providing emotional support to patients and relatives during their visit to the department. Patient's individual concerns were promptly identified and responded to in a positive and reassuring way. One patient who regularly attended the department said that "nothing was too much trouble for the staff … from the doctors and nurses to the administration team."
- Patients and their relatives were spoken with in an unhurried manner and staff checked if information was understood. We overheard staff encouraging them to call back at any time if they continued to have concerns, however minor they perceived them to be.
- Staff were kind and considerate to patients. During a comprehensive preoperative assessment we saw a patient, who was provided with the aids that would be required after their operation, given clear instructions and time to practice using the equipment. The patient was also given advice about what to expect during their stay and after discharge. The patient raised concerns about their operation and was reassured by the member of staff that they would not be discharged until they were able to use all the equipment confidently.
- Opportunity for patients to ask any questions or raise any concerns was also observed during a health MOT. Staff responded in a reassuring and knowledgeable manner and the patient told us they felt "so much more relaxed about the whole thing … and I know can phone if I need to go over what to do again."
- Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them both emotionally and socially.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsiveness as good because:

- Services were tailored to meet the needs of individual patients and were delivered in a flexible way.
- There were good facilities for patients.

- There were no barriers for those making a complaint. Staff actively invited feedback from patients and their relatives and were very open to learning and improvement.

  However:

- The parking facilities did not always meet the demand leaving patients unable to find a space in a timely manner.

Service planning and delivery to meet the needs of local people

- The hospital had planned its activities around the needs of the local population. They accepted referrals from the NHS on the choose and book system, self-referrals and from GPs.
- There was an umbrella approach to providing additional help and support for patients with complex needs and processes were tailored to suit individual needs. Capacity meetings were held with the matron, heads of department, theatre managers, team leaders and representative from the booking department to ensure there was a co-ordinated approach for patients transitioning through various departments of the hospital.
- Patients were able to locate the outpatients and diagnostic imaging departments because they were clearly signposted and there were members of the reception team available to help.
- Information was provided to patients in accessible formats before appointments, such as contact details, a hospital map and directions, the consultant's name, information about any tests including the predicted length of the appointment and if any samples would be taken such as blood or urine.
- The hospital had an active patient focus group.
- There were comfortable waiting areas with sufficient chairs, television, drinks machine, magazines and a small play area for children, which included a table and chairs and an activity table. Notices reminded patients that the hospital did not take responsibility for children visiting the area and asked adults to be vigilant regarding children's safety and well-being.
- Parking was available for patients free of charge with four disabled spaces and drop-off areas at the main entrance. An additional 15 car parking spaces had been created which gave patients priority parking onsite. Patients and relatives told us that parking was often a problem. A patient told us when she had come for a previous appointment her husband had not been able to come into the consultation because he had not been able to park. Comments about the lack of parking had been written in the comment book in the waiting area.

Access and flow

- Processes were organised for initial assessment, diagnosis or urgent treatment and care to be provided by the hospital in a timely way.
- Patients could access care and treatment with a choice of appointments being offered when required. Medical secretaries took the patients initial call and gathered their details. They discussed the referral with the consultant who made a decision to see the patient. With the booking process in place a date was agreed and appointments were confirmed by letter from the consultant's secretary with the date, time and name of the consultant. Patients were asked to telephone to confirm safe receipt and acceptance of the appointment. They were invoiced after the consultation and advised to make payment by cheque or in cash. For patients covered by medical insurance patients were advised to contact their insurer to obtain an authorisation code for the consultation and asked to advise the receptionist of the number on arrival at the hospital.
- Patients were advised that chaperones were available to support them at any time during their appointment and advised to ask a member of the nursing team. Patients were also advised that the hospital could not be responsible for unsupervised children and were advised to make suitable child care arrangements.
- There was a maximum two weeks waiting time for outpatient appointments with some appointments offered the same day or next day when required. Once patients arrived in the department they were seen promptly and if clinics were running late staff informed them on arrival and regularly checked with patients in the waiting room. A notice in the waiting room advised patients to inform a member of staff if they had been

waiting longer than 15 minutes. One patient said they had been informed the consultant was running 10 minutes late when they arrived. The consultant collected the patient just after 10 minutes.

- There were few occasions when patients did not arrive for their appointment. Reasons were monitored to look for themes and actions taken to address any problems. We were told about an example where a patient with learning difficulties persistently missed appointments. Staff realised that the patient required a reminder on the morning of their appointment and the action was clearly recorded on the patient's notes. A telephone call was made for subsequent appointments and the patient had arrived on time.
- Care and treatment was only cancelled or delayed when absolutely necessary. Patients told us that cancellations were always explained to them, and they were supported to access care and treatment again as soon as possible.
- The diagnostic imaging department had a system to ensure that results of scans were reported to patients quickly. A database seen during the inspection confirmed that consultants shared the results of the majority of scans within two days, and the radiographer was able to send email reminders to consultants. We saw that there was no backlog of results at the time of inspection.
- The diagnostic imaging department had specific referral criteria that every new referral had to meet.
- There had been 7,783 outpatient appointments for the period from January to December 2015 The data was divided into first attendance and follow-ups for NHS funded patients and those funded by other means. Data showed that for NHS funded patients there were 1,253 first attenders and 1,280 follow-ups; and for other funded there were 3,713 first attenders and 1,517 follow-ups.
- The department had not met the 92% target of patients being treated within 18 weeks of referral. However, the vast majority of patients were waiting list initiative transfers from the local NHS Trust and targets were not met due to the length of time patients had been waiting before they were transferred. The local clinical commissioning group had agreed not to apply sanctions for those cases not meeting targets where they were transferred from the acute trust lists after 14 weeks. The head of department had personally held assessment clinics at the NHS Trust to reduce any further delay.
  Staff recognised the need for supporting people with complex or additional needs such as people living with dementia or a learning disability. The hospital consistently planned services and delivered and coordinated them to take account of people with complex needs. For example, the outpatient and diagnostic imaging services arranged appointments so that new patients were allowed time to ask questions and have follow-up tests.
- There was easy access for disabled users including disabled parking spaces near to the entrance of the hospital, a ramp to the front entrance and a lowered section of the reception desk for wheelchair users.
- Pre-operative assessments were conducted to determine if a patient was physically fit enough to have surgery and an anaesthetic. This involved a health MOT with a full review of the patient's medical history and current medical problems. The tool provided a full picture of overall wellbeing with a specific focus around cardiovascular risks and identified opportunities to improve overall health. Patients were provided with a report identifying any potential risks for surgery and suggested lifestyle improvements.
- Patients were given detailed advice what to do on the morning of the operation, including when to have food and drink, a pre-op shower using the supplied impregnated body wash sponge and keeping their body warm on the journey to the hospital. Patients were also advised what to bring with them i.e. the type of footwear to bring that was supportive and non-slip to wear after surgery. Staff went through exactly what would happen on the morning of surgery from who would be doing what, the process in recovery from having a drip and a catheter and inflatable bootees to reduce the risk of blood clots, and details about the open visiting and where relatives could wait.
- Translation services were readily available if required, and staff could tell us how they would access them. In most cases, staff told us about the telephone translation services available.

Good

Outpatients and diagnostic imaging

- Staff were not certain about the systems or processes in place or appropriateness of equipment for treating bariatric patients.

Learning from complaints and concerns

- There was a detailed standard operating process for complaints and concerns. The hospital director took overall responsibility for the management of complaints in line with the policy. However, if the complaint involved any aspect of the clinical care in the outpatient or diagnostic imaging, the matron would lead on the investigation but ensured the relevant head of department was fully involved so that the investigation became a 'lessons learnt' experience for everyone involved.
- If the complaint involved a consultant with practising privileges then either the hospital director alone, or the matron and the hospital director met with that individual to discuss the complaint.
- The hospital director and the matron discussed a clinical complaint as soon as it arrived and commenced an investigation. On a monthly basis these were discussed at the board meeting and head of department meetings and on a quarterly basis at the Medical Advisory Committee (MAC), quality and safety and clinical governance meetings. disseminated.
- There had been no formal complaints raised within the reporting period of January and December 2015.As the department received very few complaints it was easy to recognise developing themes and address these immediately.
- Patients were actively encouraged to leave comments and feedback via the patient feedback form. Comments and complaints leaflets were available in waiting areas and reception for patients who wished to make formal complaints. However, the leaflet did not give any contact details for the hospital, such as address, phone number or named individual.
- Patients who raised a concern were treated with compassion. During the inspection we were informed by a patient that there was an issue relating to the disabled toilet where the grab rail was too close to the wall and they were unable to securely hold on to the rail. The incident was noted by the outpatient head of department and the rail had been removed by the end of the day, and a plan was in place to replace it the following day. The patient was informed of the action taken.

Are outpatients and diagnostic imaging services well-led?

Good

We rated the leadership of the service as good because:

- The leadership, governance and culture were used to drive and improve the delivery of high-quality care. The clinical managers were committed to the patients in their care, their staff and the unit.
- Frontline staff and managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was a high level of staff satisfaction with staff saying they were proud of the departments as a place to work. They showed commitment to the patients, their responsibilities and to one another. All staff were treated with respect and their views and opinions heard and valued.
- Patients were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Vision and strategy for this this core service

- Nuffield Health's strategic objectives set the framework for objective setting throughout the organisation. Objectives for Nuffield Exeter were described within the divisional strategies and business plans and influenced annual business plans. Objectives incorporated both clinical and non-clinical areas.
- Nuffield Health's mission was to support, enable and encourage people to improve their health and wellbeing in order to help them get the most out of life. The core values, to be enterprising, passionate, independent and caring were central to quality in health and wellbeing. The organisation believed in being the best it could be;

being open and transparent; doing the right thing; empowering people to take control; putting the needs of members and patients first; enabling member and patient choice; and providing the best outcomes for all.

- The outpatient strategy was aligned to the core values and aimed to provide a safe and caring environment which ensured privacy, dignity and confidentiality. Patients were encouraged to participate in their care and treatment and health awareness and education were promoted. There was a continual emphasis on improving and expanding the service to meet increasing demands.
- Staff had a good understanding of the core values of the service and were committed to providing patient-centred care.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure for the outpatient department. Governance processes were reviewed quarterly to ensure they remained fit for purpose**.**
- Service wide meetings were held which oversaw quality, audit and risk activity performance. All service wide meetings reported to the Medical Advisory Committee (MAC).
- Consultants and managers from a variety of specialities attended the MAC meetings on a quarterly basis. We saw from records that a variety of topics were discussed. These included a review of external inspections and audits, safety alerts, clinical incidents, complaints, infection prevention, clinical audits, antimicrobial stewardship, point of care testing, policies, NICE guidance, and training. Actions were tracked to keep them reviewed and updated.
- The MAC meeting had contributed positively to influence clinical practice where necessary. An example of this was the decision not to employ a consultant and to refuse practicing privileges because they were currently under investigation with another employer.
- The clinical governance committee met one week prior to the MAC meeting and provided a clinical governance report. Action plans were identified and monitored.
- We saw minutes from a range of regular meetings. Agenda items for the heads of department's included vacancies, sickness, training compliance, health and safety, finance, clinical, business update and projects. The senior team board meetings discussed items including quality and safety governance, risk register, financial, people workforce management, sales and customers. Standard agenda items for the outpatient department meetings ranged from a review of incidents and complaints, clinical audits, patient satisfaction survey results, medicine management, training and a review of the heads of department meeting minutes.
- Regular auditing took place with evidence of improvement or trends. Performance data and quality management information was collated and examined to look for trends, identify areas of good practice, or question any poor results.
- The departments understood, recognised and reported their risks. A hospital wide risk register was in place and we noted that this had been kept up to date. Risks were shown by specialty and risk level and mitigating actions were recorded with review dates. Each head of department had a department level risk register for which they took accountability and provided the senior management team with a weekly report. The risk register was monitored monthly at the board meeting and quarterly at the information governance committee where action was taken to mitigate risk.
- A report detailing all significant incidents was discussed at the hospital's Quality & Safety Committee and again at the quarterly Medical Advisory Committee. Patients also had the opportunity to provide feedback via the patient satisfaction survey. The survey results were reported through the governance structure to all areas.
- There was a robust complaints system and individual complaints were investigated and discussed within the hospital to establish lessons learnt.
- Clinical policies and guidelines were available for all staff via the hospital intranet system. Staff were able to show us how to access policies and guidelines and the electronic incident reporting system and said the systems worked well.

Leadership / culture of service

Good

Outpatients and diagnostic imaging

- The local leadership of the outpatient and diagnostic imaging departments had the skills, knowledge and integrity to lead the teams. The clinical managers were an experienced and strong team with a commitment to the patients who used the service, and also to their staff and each other. They were visible and available to staff, and we saw and heard about good support for all members of the team. We received consistently positive feedback from staff who had a high regard and respect for their managers.
- Managers encouraged learning and a culture of openness and transparency. They had an awareness that staff required different leadership styles and were flexible in their approach to the needs of their teams.
- Through the content of governance papers and talking with staff, we saw the leadership of the unit reflected the requirement to deliver safe, effective, caring and responsive and well-led services.
- The culture encouraged candour, openness and honesty, and staff told us they were not frightened or worried to talk to their managers if something had not gone as planned.
- Staff spoke positively about the executive team and the senior members of staff at the hospital. One member of staff told us "they are brilliant… they are always out and about… always able to come up with an answer." Another described the team as "dynamic and positive … very loyal and will bend over backwards to help."
- Most staff told us that the senior management team was very visible and approachable. The hospital director was known to all staff and visited the departments on most days and knew most staff by name.
- Staff said they could raise any concerns which were listened to and acted upon. For example, a member of staff told us about a request for additional cupboards and shelves required within the MRI room which were provided promptly.

Public and staff engagement

- There were systems to engage with the public to ensure regular feedback on services. This was used for learning and development.
- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The results of the survey were used by departments to improve the service.
- The surveys covered the patient's overall satisfaction of experience and how likely they were to recommend the hospital to friends and family if they needed similar care and treatment. Patients were asked about the friendliness and efficiency with which calls were answered and the quality of information provided before arrival and if staff told them who to contact if they were worried about their condition or treatment after they left the hospital. They were also asked about their confidence and trust in all staff from clinicians to housekeeping and catering staff and the clarity of explanations about their treatment and procedures and how to take medicines; and if they were treated with dignity and respect. Patients' views were also sought about accommodation and the upkeep and state of repair of the hospital. Results were consistently high for the period June 2015 to January 2016.
- There were systems to engage with staff. They were able to express their opinions and raise concerns through a number of forums. Monthly meetings and emails and bulletins provided opportunities for feedback about governance issues such as incidents, complaints and risk assessments. Hospital updates were announced by the senior management team on multiple dates and during breakfast, lunch and afternoon meetings to capture as many staff as possible. Team briefing updates at 8.45am ensured everyone was happy with the patient list for the coming day.
- Clinical managers worked in the departments and were able to engage with staff and see for themselves any issues staff faced. Staff confirmed they were visible and approachable.
- There were rewards for staff who had been outstanding and these were announced at staff meetings.
- All staff we met said they felt valued and part of the team. They said the hospital was an "enjoyable place to work" with a "diverse and interesting range of job opportunities." Staff felt supported by their team leaders and heads of departments and their colleagues. Staff said they felt supported by most of the senior management team and particularly acknowledged the

hospital directors very visible presence in the department on a daily basis. Staff felt valued and told us about social events that were held i.e. quiz nights, rounders and general get-togethers where everyone was invited and lunches for new starters. They also told us about the birthday cards received by all staff, a bottle of wine at Christmas and an Easter egg and thank you cards for staying during adverse weather conditions. Staff appreciated a welcome greeting on arrival by the reception staff and other colleagues. A number of staff had also been inpatients at the hospital and told us they "wanted to be looked after by my colleagues as I know they're good at what they do."

- There was a week on week off parking scheme for staff, promotion of a cycle to work scheme which included new bike racks at the hospital and lift share was encouraged.
- Staff told us about colleagues who were involved in fundraising events such as a London to Paris bike ride and the marathon and how much this was appreciated by the senior management team.

Innovation, improvement and sustainability

- Staff were clear that their focus was on improving the quality of care for patients. They felt there was scope and a willingness amongst the team to develop services.
- The outpatient department was working with other Nuffield Health hospitals to compare and improve practices. The pre assessment nurses attended a 6 monthly group forum and a yearly conference.

Outstanding practice and areas for improvement

Outstanding practice

- There was good caring to patients. The surgery team were able to be flexible to meet patients' needs when their circumstances changed. For example moving a patient planned surgery date forward to enable them to see a sick relative.
- Frontline staff and senior managers were passionate about providing a high quality service for patients with a continual drive to improve the delivery of care.
- There was excellent local leadership of the outpatient and diagnostic imaging service. Senior clinical managers were strong and committed to the patients who used the service, and also to their staff and each other.
- The hospital had held simulated emergency situations for staff to practice their skills for children without risk to patient safety. Learning points had been taken from the scenarios and incorporated as preventative measures in training that all staff had to attend.
- A letter had been developed to give information to parents and their child prior to admission as an inpatient. It was written in language easily understood by a young person. It contained electronic links to web sites that would provide further information. It also gave practical detail of what to expect, what to bring in to hospital and how to prepare for the procedure.
- Safeguarding processes were comprehensive. Staff created their own opportunities to develop links with external agencies and specialist advisors independent of the hospital.
- Staff had understood that some young people who attended the hospital may be at risk of female genital mutilation. A system of assessing clinical need for certain procedures had been set up and an advocacy service for young people had been developed.
- The needs of a child with learning difficulties were identified and changes were made to the usual admission process for this child. It helped to reduce the anxiety experienced by the child when they were receiving treatment.
- Systems were in place to measure quality and effectiveness of the service and its governance and actions were taken when improvements were needed.
- Staff felt involved and empowered to make changes which improved the service.

Areas for improvement

Action the provider MUST take to improve

- Gain Joint Advisory Group (JAG) accreditation or Endoscopy Global ratings Scale (GRS) (recognition granted to organisations which meet standards that require continuous improvement in structures, processes and outcomes) for its endoscopy service. To ensure a safe service is provided to patients.
- Ensure compliance with infection prevention control protocol in respect of flooring in clinical areas in accordance with Health Building Note (HBN) 00-10 Part A: Flooring, and clinical hand-wash basins in accordance with HBN 00-09: Infection control in the built environment.
- Closely monitor the cleaning of all areas to ensure they are dust free.

Outstanding practice and areas for improvement

Action the provider SHOULD take to improve

- Continue to investigate and monitor the occasional infestation of cluster flies in the roof space above the operating theatre.Continue to ensure staff complete mandatory training as required to reach the organisations target of 85% compliance.
- There was a decontamination policy for laryngoscope handles and blades in line with the Medicines and Healthcare Products Regulatory Agency (MRHA) Alert 2011.
- Closely monitor compliance with hand hygiene protocol for all staff including consultants.
- Make sure all confidential records are stored securely.
- The service should ensure children are protected from scald injuries wherever possible.
- Consider close monitoring of hygiene standards in all areas children and young people attend.
- Consider close monitoring of staff compliance with hospital protocols including chaperone policies.
- Consider ensuring children are protected from scald injuries wherever possible.
- Consider close monitoring of hygiene standards in all areas children and young people attend.
- Consider close monitoring of staff compliance with hospital protocols including chaperone policies

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The outpatient department was not as clean as it should have been in all areas. Dust was visible under treatment couches, light fittings and picture frames. • The clinical hand-wash basins in the outpatient department did not comply with infection prevention control in accordance with Health Building Note (HBN) 00-09: Infection control in the built environment.