Nuffield Health The Manor Hospital Oxford

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

Overall summary

Nuffield Health The Manor Hospital Oxford is operated by Nuffield Health Group. The hospital facilities include 25 consulting rooms, six surgical theatres, 71 private en-suite bedrooms, two minor procedure suites for day case and outpatient surgery, and a radiology unit including: mammography, ultrasound, MRI & CT scans. There was also a seven bedded critical care unit and a physiotherapy department;

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The hospital provides surgery, medical care, critical care, services for children and young people, and outpatients and diagnostic imaging.

The hospital is currently registered for the regulated activities surgical procedures, diagnostic and screening procedures, and treatment of disease, disorder or injury.

We inspected critical care services and services for children and young people. We inspected the services using our focused inspection methodology to assess if improvements had been made in children services, and to inspect the critical care service as the hospital was not providing the service at our last inspection. We carried out the unannounced inspection on 30 August 2018

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

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

During the inspection, we visited the children's ward, theatres and recovery, and the outpatient department.

Summary of findings

We spoke with eight members of staff including registered children nurses, registered general nurses, reception staff, medical staff, operating department practitioners and senior managers. We spoke with three patients and three parents. We reviewed 10 sets of patient records. Following our inspection, we had telephone conversations with parents of three children who had attended the hospital in the previous 12 months.

We also visited the critical care unit. We spoke with six members of staff including registered nurses, medical staff, and senior managers. At the time of the inspection there were no patients in the hospital who had used the critical care unit. Following our inspection, we had telephone conversations with five patients or their partners who had been in the unit within the last six months.

The children and young people's inpatient service had six single en-suite rooms in one dedicated area.

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Services we rate

Our rating of children's service improved from requires improvement to good.

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with relevant skills, training and experience to deliver safe care to children and young people.
- The service considered and took actions to lesson risks to children and young people.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service followed best practice when prescribing, giving recording and storing medicines.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and monitored the effectiveness of care and treatment via audits. Findings were used to improve the services.

Summary of findings

- The service assessed and monitored patients pain appropriately.
- Consent to care and treatment was obtained in line with national guidance.
- Staff cared for children, young people and their families with compassion. Feedback from patients and their parents was positive about the way staff treated them. The emotional needs of children, young people and their parents were fully considered.
- Staff involved children, young people and their patients in decisions about care and treatment.
- The service was planned around meeting the needs of the local population, with appointments and admissions offered to meet the individual circumstances of each patient.
- There was clear leadership of the children and young people's service. A lead nurse had responsibility and accountability for all the children and young people's services in the hospital. There was identified medical leadership.
- Governance processes supported improvement to the service.
- There was an inclusive culture, with staff of all professions across the hospital working together to deliver quality care to children and young people.
- There were processes for children, young people and their parents to feedback about their experiences of care and treatment at the hospital. Staff acted on this feedback to help plan and develop its service.
- The service was committed to improving services by learning from when things went well and when they went wrong.

However,

- The service did not use systems for identifying risks and planning to eliminate or reduce risks effectively.

We rated the critical services as good.

- Systems and processes were in place and followed by staff to keep critical care unit (CCU) patients safe.
- There were sufficient numbers of staff with relevant skills and experience and up to date mandatory training in safety systems, processes and practices to deliver safe care to patients on the CCU.
- There was a good track record on safety and staff understood their responsibilities to raise concerns and incidents.
- Care and treatment was delivered in line with current evidence based guidance and standards.
- The service monitored the effectiveness of care and treatment via audits and used the findings to improve the services.
- Staff cared for patients in CCU and their families with care and compassion. Staff in the CCU involved their patients in decisions about care and treatment.
- The CCU service was planned around meeting the needs of the local population, with appointments and admissions offered to meet the individual circumstances of each patient.
- There was clear leadership of the CCU; and a lead nurse had responsibility and accountability for the CCU. There was identified medical leadership in the CCU.

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

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and the South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Critical care	Good 	Critical care services had been reinstated in April 2018. The hospital had a seven-bedded critical care unit, which was staffed with the capability of providing Level 2 and Level 3 care. This was a new service and formed a small part of hospital activity. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Services for children and young people	Good 	Children and young people's services were a small proportion of hospital activity. We rated this service as good because it was safe, effective, caring, responsive, and well-led.

Summary of findings

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Summary of this inspection

Background to Nuffield Health The Manor Hospital Oxford

Nuffield Health The Manor Hospital Oxford is operated by Nuffield Health Group. The hospital facilities include 25 consulting rooms, six surgical theatres, 71 private en-suite bedrooms, two minor procedure suites for day case and outpatient surgery, and a radiology unit including: mammography, ultrasound, MRI & CT scans. There was also a seven bedded critical care unit and a physiotherapy department; and two intervention suites for radiology and cardiology. The children and young people's inpatient service had six single en-suite rooms in one dedicated area.

The hospital provides surgery, medical care, critical care, services for children and young people, and outpatients and diagnostic imaging.

The hospital is currently registered for the regulated activities surgical procedures, diagnostic and screening procedures, and treatment of disease, disorder or injury.

Our inspection team

The team comprised a CQC lead inspector, a CQC inspector, a CQC assistant inspector, and two specialist advisors with expertise in critical care and children and young people's services. The inspection team was overseen by Helen Rawlings, Head of Hospital Inspection.

Information about Nuffield Health The Manor Hospital Oxford

Nuffield Health The Manor Hospital Oxford is operated by the Nuffield Health Group, a not-for-profit organisation. The hospital was purpose built and opened in 2004. The hospital primarily serves the communities of the wider Oxford area. It also accepts patient referrals from outside this area.

It is registered to provide diagnostic and screening procedures, surgical procedures, and treatment of disease, disorder or injury.

During the inspection, we visited the Critical Care Unit (CCU) and the Children and Young Persons ward out-patients and the operating department provision with a focus on children's services. There were six private bedrooms available for children and young persons and the intensive care unit had seven beds.

We spoke with 14 staff including; registered nurses, health care assistants, medical staff, and senior managers. We spoke with three patients and three parents at the time of the inspection of the CYP unit. There were no critical care inpatients at the time of the inspection. Following our inspection, we had telephone conversations with the parents of three children who had attended the hospital in the previous 12 months, and with five patients or their partners who had been in the critical care unit within the last six months.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as Good because:

- Systems and processes were in place and followed by staff to keep critical care unit patients safe, and children and young people safe and safeguarded from abuse.
- There were sufficient numbers of staff with relevant skills and experience and up to date mandatory training in safety systems, processes and practices to deliver safe care to children and young people and to patients on the CCU.
- Risks to children and young people and to patients in CCU were assessed and staff acted to reduce identified risk.
- Children and young people and patients in CCU received their medicines as prescribed.
- There was a good track record on safety and staff understood their responsibilities to raise concerns and incidents.

However,

- We found that although the children's and young person's service had a process in place to identify, rate and monitor risk, the risk management approach was applied inconsistently.

Are services effective?

Good

We rated effective as Good because:

- Care and treatment was delivered in line with current evidence based guidance and standards.
- The service monitored the effectiveness of care and treatment via audits and used the findings to improve the services.
- Consent to care and treatment was obtained in line with national guidance.

Are services caring?

Good

We rated caring as Good because:

- Staff cared for patients and their families across both services with inspected with care and compassion.
- The emotional needs of children, young people and patients in the critical care unit and their parents were fully considered.
- There was effective use of distraction activities to reduce anxieties in children and young people.
- Staff in the critical care unit and in the children's and young people unit involved their patients (and parents) in decisions about care and treatment.

Summary of this inspection

Are services responsive?

Good

We rated responsive as Good because:

- The service was planned around meeting the needs of the local population, with appointments and admissions offered to meet the individual circumstances of each child, young person and adult patient. Children and young people were not seen in clinic without appropriately trained staff being available
- Critical care services were planned to take account of the needs of different people, for example, on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

Are services well-led?

Good

We rated well-led as Good because:

- There was clear leadership of the children and young people's service and of the critical care unit.
- A lead nurse had responsibility and accountability for all the children and young people's services in the hospital; and a lead nurse had responsibility and accountability for the critical care unit.
- There was identified medical leadership in both units.
- Governance processes supported improvement to the service across both units.
- There was an inclusive culture, with staff of all professions across the hospital working together to deliver quality care to patients and families.
- There were processes for patients, parents and relatives to feedback about their experiences of care and treatment at the hospital. Staff acted on this feedback to make improvements to the service.

Good

Critical care

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

Information about the service

Critical care services had been reinstated in April 2018. The hospital had a seven-bedded critical care unit, which was staffed with the capability of providing intensive care.

We spoke with registered nurses, health care assistants, medical staff, and senior managers. There were no critical care inpatients at the time of the inspection. Following our inspection, we had telephone conversations with five patients or their partners who had been in the critical care unit within the last six months.

Summary of findings

We rated critical care services as good. This was a new rating.

Systems and processes were in place and followed by staff to keep critical care unit patients safe. There were sufficient numbers of staff with relevant skills and experience and up to date mandatory training in safety systems, processes and practices to deliver safe care to to patients on the CCU. Risks to patients were assessed and staff acted to reduce identified risk. Patients received their medicines as prescribed. There was a good track record on safety and staff understood their responsibilities to raise concerns and incidents.

Care and treatment for patients in critical care was delivered in line with current evidence based guidance and standards. The service monitored the effectiveness of care and treatment and consent to care and treatment was obtained in line with national guidance.

Staff cared for patients and their families with care and compassion.The emotional needs of patients and their families were fully considered. Staff involved their patients in decisions about care and treatment.

There was clear leadership of the critical care unit. A lead nurse had responsibility and accountability and there was identified medical leadership in the unit. Governance processes supported improvement to the service. There was an inclusive culture, with staff of all professions across the hospital working together to deliver quality care to patients and families. There were

Good

Critical care

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Are critical care services safe?

Good

Our rating of safe was a new rating. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff received effective mandatory training in the safety systems, processes and practices of the hospital and unit. Staff were required to complete the following mandatory training: fire safety; health, safety and welfare; information governance; whistleblowing; business ethics; managing stress; reporting incidents; equality diversity and inclusion; intermediate life support (ILS); infection prevention and control; and safeguarding children and safeguarding adults.
- The hospital set a target of 85% for completion of mandatory training. Training modules were a mix of e-learning and practical sessions.
- For the six months (from when the unit opened) April to September 2018 the average compliance rate for mandatory training was 79%. This was not compliant with the organisations policy: HR 28: Mandatory Training Policy v18.0. Some bank members staff who had not achieved the mandatory training target had had their contracts cancelled.
- Sepsis is a serious complication of an infection which ca lead to death. There was a policy for sepsis, and staff had received training on sepsis management (Sepsis 6); including the use of sepsis screening tools and use of sepsis care bundles. All staff were up to date with sepsis training. The lead nurse for critical care was the departmental lead for sepsis. Staff were trained in the National Early Warning Score (NEWS) tool.

Safeguarding

- The hospital had comprehensive safety and safeguarding systems, with clear processes and practices which had been implemented and communicated to staff as part of mandatory training.

Good

Critical care

- All clinical staff (100%) were up to date with safeguarding training. Consultants had to submit evidence they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.
- All nursing staff were trained at level 2 safeguarding for both adults and children. The critical care nursing lead was trained at level 3 for adults. The safeguarding lead was the hospital matron who was trained to level 4.
- The hospital had a standard operating procedure (SOP) for female genital mutilation (FGM) which instructed staff how to respond if they suspected a patient was at risk of FGM. This included a reporting flow chart for staff to follow if they had concerns.
- We interviewed the lead nurse for critical care who was responsible for training critical care staff in safeguarding and he was fully cognisant of his responsibilities and what constituted abuse. We spoke to a Bank nurse (who was on duty on another unit but who worked on CCU) and she was fully aware of how to recognise abuse and report it.

Cleanliness, infection control and hygiene

- The unit had re-opened in April 2018 with new beds and equipment. All the beds, furniture and equipment was in good condition and all areas of the unit and all items inspected were visibly clean and tidy. Staff completed daily cleaning routines and cleaning records. Beds and equipment displayed dated and signed ` I am clean' stickers, indicating they had been cleaned and were ready for use.
- We reviewed the cleaning records during the inspection and found them to be up-to-date and complete. The most recent cleanliness audit was at 100% compliance.
- The unit was fitted with dedicated clinical hand wash sinks and there were hand sanitisers gel (which were full and working) available at entrances and exits and at sink locations.
- The hospital had a range of corporate infection control policies in operation to help control infection risk, these included the Management of Infection Prevention and control; Decontamination policy, Asepsis policy and C. difficile. There was an infection prevention nurse lead.
- There had been no incidents of MRSA, MSSA, or C. difficile in the critical care unit (CCU) in the six months preceding the inspection.
- All hospital staff completed infection prevention and control training as part of their mandatory training, including a separate practical course for relevant staff. Staff also had access to personal protective equipment, such as gloves and aprons in a variety of sizes. The corporate mandatory training target was 85% and, at the time of the inspection, the most recent performance was 80% of mandatory training delivered.
- Across the hospital there was an infection prevention annual audit program, including quarterly hand hygiene audits and twice yearly non-sterile glove use audits. Local audits in CCU from April 2018 were at 100% for hand hygiene technique, and at 100% and 92% for the second and third quarter hand hygiene observations. Observed use of personal protective equipment (PPE) was at 100% and sterile glove use was at 99%. These results were above the 90% performance target set by the hospital. There was an asepsis audit tool which detailed a range of procedures, for example venepuncture and cannulation, of which ten had to be observed and assessed over a three month period.
- We did not observe hand hygiene or aseptic technique as there were no patients in the unit. However, we had high confidence in the veracity of the audit. The infection prevention lead had a detailed grasp of infection prevention and sat on the infection prevention panel for the Nuffield Health organisation.

Environment and equipment

- The unit consisted of seven intensive care beds. Four of the beds were in a common ward area. Two of the beds were in separate rooms with private entrances; this allowed for care of vulnerable or at risk patients. There was also one isolation room. There were three ventilators available within the CCU.
- Each of the bed spaces had equipment that conformed to the relevant safety standards and all of the equipment was new. The service schedule was as per manufacturer's recommendations and the guidelines for the provision of intensive care services, 2015.
- The unit had sufficient facilities to keep people safe, including a resuscitation trolley and a basic airways

trolley. There was a difficult airway trolley situated just outside of critical care in the theatres complex. These were checked on a daily and weekly basis and the record sheets were signed and dated to show the checks had been done.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who used the critical care service and risk management plans were developed in line with national guidance for Level 3 and Level 2 patients. Level 3 patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. Level 2 patients are those patients requiring more detailed observation or intervention including support for a single failing organ system; or post-operative care and those 'stepping down' from higher levels of care.
- The National Early Warning System (NEWS), a simple, physiological score whose primary purpose is to prevent delay in intervention or transfer of critically ill patients, was used and there was a corporate NEWS observation chart available in order to continually assess patients.
- Venous thromboembolism (VTE) assessments were carried out and recorded in the patient's care record.
- At the time of the inspection the unit had received between three and four Level 2 patients a week since April 2018. The unit had not had any patients requiring Level 3 care since it had re-opened. None of the Level 2 patients had `stepped down` from Level 3 care.
- In the event that a Level 2 patient deteriorated and the service was unable to meet their needs there was an agreement in place with a local acute NHS trust who would accept the patient, and a local NHS ambulance service who would transport the patient. In the three months prior to the inspection two adult patients from the hospital had needed to be transferred. If a patient needed to be transferred there were six intensive care consultants from an NHS trust who were rostered on a 24/7 on call rota and within 30 minutes travel distance from the hospital. A resident medical officer was also present on the unit.
- There was a comprehensive sepsis policy (Sepsis 6), with guidelines and a management procedure in operation.

Nurse staffing

- The service had enough nursing staff with the right qualifications, skills, training and experience to care for Level 2 and Level 3 patients and to provide the right care and treatment.
- There were eight permanent members of nursing staff (six whole time equivalent), including the Band 7 nurse lead for critical care.
- Physiotherapy and pharmacy staffing support to CCU was drawn from the main hospital as required by the condition and medical needs of the patients on the unit.
- There were also 17 Bank staff all of whom were trained to care for Level 3 patients; and all of whom worked in an acute NHS trust in a critical care environment. This supported the service in ensuring staffing levels would meet the national guidance to support safe care and treatment for patients, as well as the flexibility to bring in extra staff when required.
- We examined the rosters and were satisfied that staffing levels met the required standard; which was a minimum of one trained nurse on a long day shift, and one trained nurse on a night shift. This would be increased depending on the number and type of patients booked into the CCU and in order to achieve the national guidance targets of a minimum of one nurse trained in Level 3 care allocated to a Level 3 patient, and a minimum of one nurse trained in Level 2 care allocated to every two Level 2 patients.

Medical staffing

- The service had enough medical staff with the right qualifications, skills, training and experience to keep critical care patients safe and to provide the right care and treatment.
- There were six consultants in Intensive Care Medicine & Anaesthetics with practising privileges at the hospital to provide dedicated 24 hour a day on call cover. One of the consultants was nominated as the clinical lead. The consultants were not resident but attended at least twice a day when patients were on the unit and were rostered to achieve this target.
- There were four full time resident medical officers (RMOs) dedicated to the unit. The RMO was required to have critical care experience and training. They were

contracted from a private provider of medical services to provide 24 hours cover a day and were required to complete an appropriate course of induction and training. They held indemnity insurance through their employer.

- The critical care consultants performed ward rounds twice daily when patients were on the critical care unit. All admissions were discussed with a surgical consultant prior to acceptance on the unit and were reviewed by a critical care consultant within 12 hours of admission.

Records

- At the time of the inspection there were no patients in the unit and therefore there were no open records to examine.
- A representative sample of individual care records from discharged patients were checked and were found to be written and managed in a way that showed that people were kept safe. This included ensuring that people's records were accurate, complete, legible, and up to date.

Medicines

- The unit had support from the hospital pharmacy department. There were SLA's in place for pharmacy support over and above the support the unit received from the hospitals pharmacists. Speciality bank/locum personnel included a critical care pharmacist and a general pharmacist.
- There was a locked and secure medicine cupboard in the unit.We checked the contents and found all the medicines were in date and stored correctly.
- There was controlled access to the controlled drug cupboard. Keys for this cupboard were kept locked in a box with a secure digital code lock. Once this had been unlocked the key for the drugs cupboard were in a pouch secured with a security tag. We checked the stock balance of controlled drugs and found it to be correct and all but one item was in date. A bottle of ketamine had expired in June 2018. This was removed by the pharmacist during the inspection.
- Medicines would be prescribed on a medicine chart which would be dated and signed by the prescriber. The chart included a record of patient allergies. NICE guidelines in respect of antimicrobial prescribing were observed.
- Medical gases were supplied through a piped gas system.
- The temperatures of fridges used for the storage of medicines were monitored by a centralised computer system. There were also temperature sensors in each room. Alerts were centrally monitored and reported.

Incidents

- Staff reported incidents using the hospital's electronic reporting system. The hospital provided mandatory training on how to use the system. Staff said they felt confident to report incidents and knew what constituted an incident.
- Staff understood the requirements of the duty of candour to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person
- There were no incidents since April 2018 in the CCU requiring the duty of candour. Additionally, there had been no never events, no serious incidents requiring investigation (SIRI) and no deaths requiring a mortality or morbidity meeting to review deaths as part of professional clinical development.
- Never events are serious and wholly preventable patient safety incidents that should not occur if the available preventative measures had been implemented. Death or harm is not required to have occurred for an incident to be categorised as a never event. A SIRI describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

Safety Thermometer

- The classic Safety Thermometer is a measurement tool for improvement that focused on the four most commonly occurring harms in healthcare: pressure ulcers, falls, UTI (in patients with a catheter) and (VTEs).
- < >he CCU was not using the safety thermometer tool at the time of the inspection.

Good

Critical care

Are critical care services effective?

Good

Our rating of effective was a new rating. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- The critical care service had been reinstated following a period of closure and had reopened as a new service in April 2018 with the intention of attracting consultant surgeons and their prospective patients with the facility of Level 3 critical care. Since opening they had not yet had a Level 3 critical care patient, though they had received approximately two to three Level 2 patients a week.
- Care pathways were based on guidelines from the National Institute for Health and Care Excellence (NICE) guidance and the Guidelines for the Provision of Intensive Care Services.
- At the time of the inspection the hospital was working towards registration with the Intensive Care National Audit & Research Centre (ICNARC) which would involve the hospital in the broad programme of international audit and research that ICNARC undertake. Until the hospital joins ICNARC it was not possible to assess the effectiveness of the CCU service compared to national standards.
- A sepsis screening tool was in place for staff to follow, using the Sepsis 6 methodology. Staff were aware of the circumstances that would require the sepsis screening tool to be completed.
- The hospital was a member of the Thames Valley Critical Care Network participating in policy, audit, and network arrangements.

Nutrition and hydration

- People's nutrition and hydration needs were identified, monitored and met, and a nutritional assessment was in place within the patient records. This would be reviewed daily. Patients who had been in the unit told us that staff were very good at ensuring drinks and food were provided as requested and in line with their treatment plan.
- The hospital was equipped with a full catering service and there was support available to the critical care unit from the hospital dietician service.
- It was hospital policy for nursing staff to ask patients about any food intolerance or allergies as part of their pre-assessment. This would also include specific dietary requirements, such as vegetarian or halal. The hospital kitchen was available to provide a range of food and drinks to meet client's needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Pain protocols used on the CCU were based on guidelines from the Faculty of Pain Medicine.
- Acute pain management was supervised by consultants, the resident medical officer and supported by unit nurses who had appropriate training and competencies.
- All patients with acute pain would have had an individualised analgesic plan appropriate to their clinical condition.
- There were clear corporate policies for critical care patients with acute pain to have regular pain assessment using consistent and validated tools. Patients who had been in the unit told us they were asked to describe their level of pain on a numerical basis with one being mild and 10 severe. For non-verbal pain assessment staff used the Wong-Baker facial grimace pain assessment tool.
- Patients who had been in the CCU told us that medical and nursing staff were extremely good at ensuring effective pain management whilst the patient was in the unit.

Patient outcomes

- The Manor Hospital was chosen to take part in a European study devised by the European Society of Intensive Care Medicine. It was also chosen to take part in the DecubICUs study, a multicentre international

one-day prevalence study on pressure injuries in intensive care units, with data collected on the 15th May 2018. The results were not available at the time of the inspection.

- The hospital was also a member of the Thames Valley Critical Care Network participating in policy, audit, and network arrangements.
- At the time of the inspection the hospital was working towards registration with the Intensive Care National Audit & Research Centre (ICNARC) which would involve the hospital in the broad programme of international audit and research that ICNARC undertake.
- Since the CCU opened it had cared for around two to three patients a week, who were mainly elective surgical post-operative patients requiring a short period of Level 2 care. At the time of the inspection there was no ICNARC data to show comparative outcomes and there was no other audit data on patient outcomes relating to their stay in the CCU.
- There was a policy and procedure for unplanned readmissions to operating theatres. At the time of the inspection no patient who had been in the critical care unit had been readmitted to an operating theatre from the critical care unit.

Competent staff

- Nursing and medical staff met the national standards for intensive care nursing and medical staffing as outlined in the professional standards, specifically the Guidelines for the Provision of Intensive Care Services, 2015.
- There was a Nuffield Health corporate practising privileges policy (May 2018). This document provided details of the criteria and conditions under which licensed registered medical practitioners would be granted authorisation by the hospital to undertake care and treatment of patients. All consultant staff were required to provide evidence of their accreditation, validation and appraisal before the hospital granted them practising privileges.
- All new critical care nursing staff undertook the hospitals' critical care preceptorship programme, which was a comprehensive learning package covering all competency elements for a critical care nurse.
- Nurse competencies were assessed at the Manor Hospital and signed off by critical care development nurses working at a local acute NHS trust. The competencies assessed were as set out in the national competency framework for registered nurses in adult critical care
- The CCU had a dedicated clinical nurse educator responsible for coordinating the education, training and continuing professional development framework for critical care nursing staff.
- We examined evidence that staff had qualifications in cardiac advanced life support, introduction to cardiothoracic critical care nursing, and adult intensive care transfer simulation training.
- Staff annual appraisal rates were at 88% which meant that only one member of staff had not had their appraisal within the agreed corporate timeframe.

Multidisciplinary working

- The critical care service was currently under development at the time of the inspection. The consultants were engaged, along with hospital management, in developing practice opportunities for more complex surgical procedures.
- All patients that were planned to come through the unit were holistically assessed by all necessary staff, including physiotherapists and dieticians, to ensure efficient planning and delivery of their care and treatment. This would have included a treatment plan discussed with a consultant intensivist.

Seven-day services

- The critical care unit was available for patients seven days a week. There was 24/7 consultant intensivist level cover, and a resident medical officer on the unit.
- When patients were in the critical care unit, the consultant intensivist led clinical ward rounds which occurred twice every day including weekends and national holidays.
- There was a minimum of five days a week cover from the pharmacy department and a minimum of five days a week cover from the physiotherapy department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Critical care

- Consent, mental capacity and deprivation of liberty safeguards (DoLS) all form part of mandatory training for staff working on the unit. All staff working on the CCU were up-to-date with their MCA and DoLS training.
- Patients who had been on the unit told us that they had been asked for consent for procedures by medical and nursing staff and that this had been documented. They also told us that the procedures had been fully explained in a clear and understandable way before consent was requested.
- We found policy and procedures for consent were in place and that capacity assessments and consent were obtained by the appropriate clinician. Should a patient develop post-operative delirium then this would be managed in accordance with the guidelines for the provision of postoperative care 2018 as set out by the Royal College of Anaesthetists.

Are critical care services caring?

Good

Our rating of safe was a new rating. We rated it as **good.**

At the time of our inspection, there were no patients in the critical care unit, nor were there patients in the rest of the hospital who had recently been in critical care. Accordingly, we spoke with five recent patients and immediate relatives on the telephone.

Compassionate care

- Staff told us they understood and were trained to respect people's personal, cultural, social and religious needs, and to take these into account when providing care.
- There were bedside curtains, as well as two side rooms and an isolation room available on the unit, to ensure that people's privacy and dignity was respected, particularly during physical or intimate care.
- Patients we spoke with and their relatives told us they had received exceptional care which was kind and respectful, and which respected their dignity and privacy.
- Patients told us staff were responsive to their needs ensuring pain relief and providing drinks on request. One patient told us she was in a lot of pain and, although she had been prescribed pain relief, it was taking time to have an effect. During that time a nurse sat with her comforting and reassuring her until she felt better.

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. Staff told us patients and their families and carers would be given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- All the patients we spoke with told us that they had received very good emotional support both during and after their operation from all staff. One patient told us they had a MacMillan nurse provided to support them. Another patient told us the anaesthetist had been very supportive during their stay and after discharge.
- All the patients and relatives we spoke with told us that they had been provided with plenty of clear information and guidance to help them understand their procedure as well as care management on discharge.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with told us that medical and nursing staff clearly communicated information to them so that they fully understood their care, treatment and condition; as well as management plans for their care after discharge.
- Staff recognised when people needed additional support to help them understand and to be involved in their care and treatment. One relative told us that they had been fully involved in the discussions at both the pre-operative assessment and pre-operative multi-discipline meetings.
- All the patients and relatives we spoke with were very complimentary about the way medical and nursing staff helped them at the pre-assessment stage to understand exactly what was happening about their procedure.

Are critical care services responsive?

Good

Critical care

Good

Our rating of effective was a new rating. We rated it as **good.**

Service delivery to meet the needs of local people

- The critical care service had been reinstated following a period of closure and had reopened as a new service in April 2018. At the time of the inspection, the hospital was in the process of planning to reintroduce general surgery for patients requiring Level 3 care and cardiac surgery in consultation with relevant stakeholders.
- Since opening in April 2018 the CCU had provided care for 40 patients which worked out as an average of eight patients a month.
- The facilities and premises were appropriate for the services that were being planned.
- Patients discharged from CCU would have appropriate access to a CCU follow-up clinic at the parent hospital of the consultant overseeing their care.
- There was no critical care facility available for children and young persons at the time of the inspection.
- Relatives had access to a lounge and café in the main building.

Meeting people's individual needs

- Critical care services were planned to take account of the needs of different people.
- The unit was not an emergency facility but was intended to operate as a planned facility post-surgery. Patients with individual and complex needs would have those identified by the consultant surgeon overseeing their care.
- The hospital could provide translation services, as well as support for people with learning disabilities.

Access and flow

- The critical care service was intended to provide post-elective care in Level 3 and Level 2 care beds for patients who were privately funded or insured for booked surgical procedures.
- As the beds would be pre-booked that would mean patients would have had timely access to initial assessment, diagnosis and urgent treatment.
- The unit could also admit other patients on discussion with their consultants, as the CCU did not normally have all beds occupied and could therefore take unplanned admissions if necessary.
- There had been no emergency admissions.
- At the time of the inspection the patient booking form was being reviewed to include further detail on pre-assessment and previous clinical conditions.
- As far as possible, people could access care and treatment at a time to suit them in consultation with their consultant.

Learning from complaints and concerns

- Nuffield Health had a clear complaints policy for people who used the service. The initial complaint would be managed by the location manager, with an option of further referral to the company's head office. The local hospital director had overall responsibility for the management of complaints.
- There was also a separate procedure within the policy for NHS patients who wished to complain.
- Patients we spoke to knew how they could make a complaint. One patient told us about having raised a concern about care post-operatively and that this had been handled immediately to their satisfaction.
- There had been no complaints about the CCU since April 2018, when the unit opened. Complaints, their outcomes and any learning were a standing item at the unit's regular monthly meetings.

Are critical care services well-led?

Good

Our rating of effective was a new rating. We rated it as **good.**

Leadership

- Leaders of the critical care service had the right skills and abilities to run the service. On a day to day basis the

critical care service was run by the CCU lead nurse who had accountability. The CCU nurse was supported by a lead consultant intensivist. They reported to the hospital matron.

- There were six consultants in Intensive Care Medicine & Anaesthetics from an acute NHS trust who were on a practicing privileges arrangement with the hospital to provide 24/7 on call cover. One of the consultant intensivists was nominated as the clinical lead.

Vision and strategy

- The hospital had a clear vision for critical care. It was seeking to establish a new critical care service to provide capacity for surgeons to offer more complex operations for adults where there was a post-operative requirement for Level 3 care, as well as Level 2 care. It was not intended for emergency utilisation unless a patient deteriorated and required Level 3 care as an emergency.
- In order to provide reassurance to surgeon's and their prospective patient's quality and safety have been the top priority. These, together with the vision, values and strategy for the unit, have been developed between the hospital management with significant input from the consultant intensivists on the roster.
- Staff knew and understood what the vision and values were, as these were an integral part of the development of this service. One member of staff told us that he was involved in the planning to develop cardiac and oncology services for the CCU.

Culture

- Staff we spoke with felt respected and valued. They told us that the Manor Oxford was a good hospital to work for and that everyone was very friendly and supportive.
- The staff we spoke with told us that the culture of the hospital and the unit was centred on the needs and experience of people who used services.
- They also told us that safety was paramount and the culture encouraged candour, openness and honesty.
- People using the service were provided with a statement that included terms and conditions of the services being provided to the person and the amount and method of payment of fees.

Governance

- There was a governance framework to support the delivery of the unit's strategy and good quality care.
- Staff were clear about their roles and understood what they were accountable for.
- Governance frameworks included monthly meetings for nursing staff and clinicians. These meetings were intended to provide guidance, advice and support on the implementation of policies, to identify, risks, implement the service delivery development plan, review incident reports and appropriate root cause analysis (RCA), monitor compliance to standard operating procedures (SOPs), policies and relevant NICE guidance, and to promote continual improvement in CCU practices.
- We reviewed the last three months minutes from these meetings which showed that safety, infection prevention, health and safety, resuscitation, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), customer service, and risk were considered. However, there were only three attendees at each meeting: the lead nurse of CCU (the chair) and two nurses. There was no representation at the meetings from doctors working on the unit. Without clinicians attending we could not be assured that the aims of the CCU department meetings could be fully met.
- Working arrangements with partners and third-party providers were managed through SLA's.
- The hospital had a clear policy on granting practising privileges to consultant level doctors which included ensuring that there was an appropriate level of valid professional indemnity insurance. The policy was last revised in May 2018. All six of the consultants working on the critical care unit had the correct level of indemnity insurance.
- In addition, it was an annual requirement of the practicing privileges policy for medical practitioners to provide the hospital director with satisfactory evidence of indemnity insurance, evidence of GMC registration and a current licence to practise, and evidence of participation in an annual whole scope of practice appraisal to include the appraisal summary and personal development programme.

Managing risks, issues and performance

Good

Critical care

- There was a critical care risk register which was discussed at the monthly departmental meetings. The most recent entry was about the upcoming CQC inspection.
- There was a quarterly audit programme which included infection prevention. The audits including asepsis, hand hygiene (observation practice, technique and surgical scrub), cleanliness, decontamination of re-usable patient equipment, the general environment - fabric and design, crash trolleys and daily crash test, and the Sepsis 6 box.

Engagement

- The critical care service was in development at the time of the inspection and staff felt actively engaged in the planning and delivery of the new services and in shaping the culture.
- Patients (who had been in the unit as a Level 2 patient since April 2018) were encouraged to provide feedback through the CCU patient feedback form which was given to them at the time of discharge.

Learning, continuous improvement and innovation

- Continuous learning, improvement and innovation were a feature of the monthly staff meetings, and of the monthly clinicians and managers meetings.
- There were regular `stress tests` conducted to rehearse the levels of knowledge and skill in any given scenario and to identify learning opportunities. For example, in June 2018 there was a stress test to examine the response to a deteriorating patient in CCU who was second day post-op after major colorectal surgery. In May 2018 there was an exercise to work through the setting up of an arterial and CVP (central venous) line, chest drains and the correct method to set up a ventilator. The learning from these events was then used to inform staff development.
- At the time of the inspection the hospital was working towards registration with the Intensive Care National Audit & Research Centre (ICNARC) which would involve the hospital in the broad programme of audit and research that ICNARC undertake. The information shared from ICNARC will enable the unit to benchmark care and safety and identify areas where improvements are required.

Good

Services for children and young people

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

Information about the service

The children and young people's inpatient service had six single en suite rooms in one dedicated area.

During the inspection, we visited the children's ward, theatres and recovery, the outpatient department. We spoke with eight members of staff including registered children nurses, registered general nurses, reception staff, medical staff, operating department practitioners and senior managers. We spoke with three patients and three parents. We reviewed 10 sets of patient records. Following our inspection, we had telephone conversations with parents of three children who had attended the hospital in the previous 12 months.

Summary of findings

We rated children and young people's services as good. This was an improvement from the previous rating of requires improvement.

There were systems and processes in place and followed by staff to keep children and young people safe and safeguarded from abuse. There were sufficient numbers of staff with relevant skills and experience and up to date mandatory training in safety systems, processes and practices to deliver safe care to children and young people. Risks to children and young people were assessed and staff acted to reduce identified risk. Children and young people received their medicines as prescribed. There was a good track record on safety and staff understood their responsibilities to raise concerns and incidents.

Children and young people's care and treatment was delivered in line with current evidence based guidance and standards. The service monitored the effectiveness of care and treatment via audits and used the findings to improve the services. Consent to care and treatment was obtained in line with national guidance.

Staff cared for children, young people and their families with compassion. Feedback from patients and their parents was positive about the way staff treated them. The emotional needs of children, young people and their parents were fully considered. There was effective use of distraction activities to reduce anxieties in children and young people. Staff involved children, young people and their patients in decisions about care and treatment.

Good

Services for children and young people

The service was planned around meeting the needs of the local population, with appointments and admissions offered to meet the individual circumstances of each patient.

There was clear leadership of the children and young people's service. A lead nurse had responsibility and accountability for all the children and young people's services in the hospital. There was identified medical leadership. Governance processes supported improvement to the service. There was an inclusive culture, with staff of all professions across the hospital working together to deliver quality care to children and young people. There were processes for children, young people and their parents to feedback about their experiences of care and treatment at the hospital. Staff acted on this feedback to make improvements to the service.

However, we found that although the service had a process in place to identify, rate and monitor risk, the risk management approach was applied inconsistently.

Are services for children and young people safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The Nuffield Health corporate mandatory training policy defined the mandatory training requirements of staff including bank workers and non-Nuffield Health employees working in the hospital. Mandatory training was split into three categories, group, business area and job role training and individual staff would have a list of mandatory training personalised for them.
- Staff working in a Nuffield Health Hospital were required to complete the following mandatory training, fire safety; health, safety and welfare; information governance; whistleblowing; business ethics; managing stress; reporting incidents; equality diversity and inclusion; basic life support (BLS); infection prevention and control, safeguarding children and safeguarding adults.
- Additional mandatory training was required for staff working in the children and young people's (CYP) service depending on their role in the department, this included consent to examination or treatment; paediatric intermediate life support and manual handling.
- Nuffield Health The Manor Hospital set a target of 85% for completion of mandatory training. Training modules were a mix of e-learning and practical sessions.
- Staff we spoke with told us there were no barriers to accessing mandatory training.
- We reviewed the training logs for the staff working in the CYP service and found compliance was 100% for all modules except for Basic Life Support (80%) and Intermediate Life Support (80%). We were told by the CYP lead nurse that the 80% in Life Support training was because if staff had completed Paediatric Intermediate

Life Support (PILS), there was no requirement to also complete the Basic Life Support and Intermediate Life support training. There was 100% compliance for PILS training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The Nuffield Health corporate policy for safeguarding (issue date April 2016, review date April 2019) and the Standard Operating Procedure (SOP) children & young people safeguarding (issue date April 2016, review date April 2019) provided staff with guidance about safeguarding children and young people and the level of training required by staff working with children and young people at the hospital. The safeguarding policy and SOP followed relevant national legislation and guidance, for example Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children publish 2015 and updated July 2018 and included information on child sexual exploitation.
- Safeguarding level 3 training was completed by the CYP lead nurse, all members of the CYP service, the hospital matron and director. As per the Nuffield Health corporate safeguarding policy all other staff working with children and young people had safeguarding level 2 training. This included consultants and practitioners with practicing privileges, the registered medical officer, nursing staff working in theatre recovery, physiotherapists and radiographers. All staff working in the CYP service were 100% compliant with safeguarding training. We did not request figures of safeguarding training for the rest of the hospital.
- Consultants had to submit evidence they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.
- We were shown records which showed that safeguarding training was in date for all staff working with CYP patients at the hospital.
- The hospital encouraged staff across the hospital who worked with children but were not part of the CYP service, to complete their level 3 safeguarding training. We were told by theatre staff they were going to complete their level 3 training as this would increase their awareness of safeguarding issues in children.
- All staff we spoke with were aware of the signs of abuse and demonstrated an understanding about safeguarding children and young people processes. They knew who the safeguarding leads were at the hospital and how to escalate if they had concerns. We were given examples when staff had needed to raise concerns and the actions that they had taken.
- We saw a list of safeguarding contact details at the children and young person's reception desk for quick reference and a poster on the wall indicating the actions needed to be taken if there was a safeguarding concern.
- We saw age appropriate posters in the outpatient playrooms and the ward play room informing CYP patients and their families about staying safe from abuse and information about staying safe online when using the internet.
- There was SOP for female genital mutilation (FGM) which instructed staff how to respond if they suspected a patient had suffered FGM. This included a reporting flow chart for staff to follow if they had concerns. We saw posters about FGM in the CYP play areas.
- There was a SOP for abduction which instructed staff how to respond in the event of an infant or child abduction or suspected abduction. This included a flowchart for staff to follow if they had concerns. In the policy it stated that a parent or staff member had to supervise children under the age of 12 years-old at all times.
- The Nuffield Health corporate policy for privacy and dignity (issue date January 2015, review date May 2017) and the Standard Operating Procedure (SOP) children & young people chaperoning (issue date January 2015, review date May 2017) provided staff with guidance about the minimum standards of chaperoning offered by the CYP service to patients in the clinical setting. The SOP listed when a chaperone must be present. This included issues specific to children and young people (under the age of 16 years) and stated no child or young person should be seen unaccompanied in any situation and a chaperone should always be present during any intimate procedures. This was generally the parent or

carer but if the child was Gillick competent (able to give consent without the need for parent permission or knowledge) and did not want their parents to attend, a chaperone had to be present. CYP clinical staff we spoke with told us they routinely accompanied the CYP patients as this provided comfort and support to patients and parents.

- We saw posters in the CYP play areas reminding parents and guardians that children should be supervised at all times and not be left unattended.
- CYP staff told us that parents and guardians of inpatients would be issued with a green wristband with an identifying number. This wristband gave people authorisation to access the CYP ward. A log was kept of identifying numbers against authorised persons. This meant only these known to the CYP team would be granted access to the CYP ward.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- Nuffield Health had corporate infection control policies to help control infection risk, these included the Management of Infection Prevention and control; Decontamination policy, Asepsis policy and C. difficile.
- All areas of the CYP inpatient ward including the play area, sluice and store cupboards were visibly clean and tidy. Staff completed daily cleaning routines and cleaning records. We reviewed these records during the inspection and found them to be up-to-date and complete.
- Children's toys used in the CYP service were cleaned, at a minimum once a day, to mitigate the risk of transmission of infections from the toys. During our inspection we saw a large fabric teddy bear. This would be difficult to clean and would pose an infection risk. We highlighted this to senior nursing staff at the time of inspection and it was removed.
- Paediatric emergency equipment, including the emergency suction equipment and the defibrillator kept on the CYP inpatient ward and in the outpatient department, were clean, tidy and dust free.
- All hospital staff completed infection prevention and control training as part of their mandatory training, including a separate practical course for relevant staff. Staff working in the CYP department were 100% compliant with their training.
- Staff were observed to follow good infection control practices to help stop the spread of infection such as 'bare below the elbow' and cleaning their hands before and after contact with patients. Staff also had access to personal protective equipment, such as gloves and aprons in a variety of sizes.
- Throughout the hospital and the CYP areas, hand sanitiser gel was available.
- We observed posters on notice boards in the CYP areas highlighting the importance of good hand hygiene. These posters were age appropriate for children with cartoon diagrams explaining what germs were and when hands should be washed. We also saw pictures of hands with bugs and germs on them which the CYP patients had coloured in to show the importance of 'cleaning your hands'.
- There was a local SOP for the recognition, diagnosis and treatment of sepsis in children and young people at hospital (issued Sept 2017). This SOP signposted clinical staff to the most recent guidance in the recognition and management of sepsis in children and young people and to enable the early recognition of Sepsis. A sepsis kit for children and young people was kept in the clean room on the CYP ward. The kit was sealed and had a set list of stock, which was all present and in date at the time of inspection. We saw posters in the play areas on the CYP ward and the outpatient departments explaining the signs of sepsis in children under and over 5 years of age. This could help parents and patients with early recognition of sepsis.
- CYP nursing staff carried out infection control risk assessments on all children and young people as part of their pre-admission assessment process. This included details about any recent illnesses; MRSA status and possible exposure to MRSA; whether childhood immunisations were up to date; which childhood diseases patients had in the past and exposure to infectious diseases in the month prior to pre-admission

screening. This highlighted infection risk at the earliest time in the patient's care pathway to ensure correct infection prevention and control practices were instigated.

- Across the hospital there was an infection prevention annual audit program, including quarterly hand hygiene audits and twice yearly non-sterile glove use audits. Local audits in the CYP service included monthly audits of cleanliness of the CYP areas and toy cleaning. We saw results of these audits from January 2018 to August 2018 which showed results of 80 -100% compliance with set criteria. Introducing an audit programme in the CYP service had been used to increase and maintain standards and help prevent the spread of infection.
- There were carpets throughout the CYP ward including the bedrooms and corridors this posed an infection control risk even though deep cleans regularly took place. The hospital management team recognised the hygiene and infection risks of having carpet and replacing the carpets with vinyl flooring was seen as a top priority for the CYP service and was hoped to occur in 2019 if funds were available.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- Since the last CQC inspection in 2016 the CYP service had moved to its own dedicated ward with six individual bedrooms.
- There was a dedicated CYP reception desk/ nurses station located outside the ward area. Access to the ward was through secured doors. These doors were kept open if the reception desk/nurse station was manned by CYP staff. This allowed patients and parents to move around the area easily. However, if the reception desk was not manned, the doors would be closed and entrance and exit to the ward was via a call button or staff swipe card. This meant that access to the area was controlled and staff knew who was in the ward area at all times.
- We observed during the inspection that meeting rooms, cleaning and storage cupboards and utility rooms were kept locked and secured at all times. This meant that access to areas unsuitable for children and young people was controlled.
- Bedrooms were all single bedded with ensuite bathrooms and had room for a temporary bed for accompanying parents to sleep. There was a television and WiFi access in each room.
- CYP nurses completed an environment assessment prior to admitting CYP patients to the hospital, with details recorded in the patient's care record. The assessment included, for example, making sure the bed was at a suitable height, the room had suitable age/ gender furnishings and hand sanitiser and other gels were out of reach of young children.
- There was a play room for CYP patients on the CYP ward and two play rooms in the outpatient department. CYP staff were responsible for the management of toys in these areas.
- There were occasions when children were in the recovery area at the same time as adult patients. To lessen the risks of children being exposed to distressing sights an area of the recovery area had been walled off to make a separate area for CYP patients.
- After the inspection we asked to see risk assessments for other areas in the hospital where children were cared for. The hospital supplied the risk assessments from the recovery area, physiotherapy outpatient department and the radiology department. The risk assessments covered the staffing and safeguarding aspects of children in these areas. However, they did not cover the environmental risks. Therefore, it was not clear if all the possible risks to children visiting these areas had been considered and mitigated for.
- There was dedicated children's emergency and resuscitation equipment on the ward and in the outpatient department. Trolleys were secured with anti-tamper tags so it was clear if someone had accessed the equipment. According to hospital policy there should be daily checks of equipment on top of the trolleys and weekly checks of equipment in the draws with staff signing to confirm that checks had been made. We inspected the two resuscitation trolleys and found all checks up-to-date and completed. This showed there was a consistent and regular approach to safety checks.
- When we checked the CYP resuscitation trolley on the CYP ward we found that there was a missing size six nasogastric tube and the intraosseous vascular access

needle and stabiliser kit had expired. We could see form the notes made by staff on the daily and weekly check lists that these items were on order and the hospital resuscitation team had authorised the continued use of the expired product until a new one arrived.

- Equipment for measuring height and weight were available. Staff we spoke with on inspection did not know when the weighing scales had last been calibrated and accuracy of reading checked. Post inspection the hospital supplied us with information that scales were calibrated yearly and given dates when they were last calibrated. All scales were in date for calibration. This gave assurance that measurements from these pieces of equipment were accurate.
- The height measuring tool in the CYP ward was attached to a wall in the corridor of the inpatients ward, meaning that patients heights had to be taken without confidentiality of being in a side room.

Assessing and responding to patient risk

The service considered and took actions to lesson risks to children and young people.

- Nuffield Health had a corporate children and young people in hospital policy (issued 2016, reviewed August 2019) which contained the requirements for the safe delivery of services to children and young people in Nuffield Health hospitals. The policy included standard operating procedures (SOP) and flow diagrams which were in place the CYP service to reduce the level of risk to CYP patients. Staff we spoke with were fully aware of these systems and processes and used them effectively when caring for patients.
- The booking SOP set out the safe and agreed criteria for the admission of children to the hospital. CYP patients under 3 years of age; or children over 3 years of age with additional pre-existing conditions, for example diabetes, epilepsy, cardiac, circulatory conditions; or children with complex needs would not routinely be admitted for treatment.
- Admission exceptions were only considered on the presentation of all relevant clinical evidence, a multidisciplinary team meeting with clear risk assessment and the mitigation of risk and with the agreement from all clinicians (nursing and medical) and the senior management team involved in the care of the patient.
- Once a patient was booked for surgery they had a pre-assessment to ensure they met the inclusion criteria for surgery. This assessment was carried out by a registered paediatric nurse for CYP patients up to 16 years of age. Young people aged 16 to 18, could have their assessment completed by a registered paediatric nurse or general registered nurse. This was in line with the pre- admission SOP.
- Face to face pre- assessment was preferred by the CYP team as this gave them an opportunity for visual assessment of the patient as well as discussing their forthcoming treatment and obtaining relevant past medical history. It also gave the patient and parent the opportunity to see the CYP facilities and meet the team before hospital admission which reduced some of the pre-surgery nerves.
- Nurses we spoke with acknowledged that it was not always possible for patients to attend the hospital prior to their admission date. In these circumstances, the registered children's nurse carried out a telephone pre-assessment.
- Information from the pre-admission assessment was recorded in the patient's care record. Information collected included health, social and emotional well-being. If the pre-assessment was via a telephone call this was noted in the care record and also details of who made the call. Information collect in pre-admission assessment was used to helped evaluate and highlight any potential patient risks. Potential risks could then be mitigated by the CYP nursing staff or flagged to other teams, for example surgeons, anaesthetists or physiotherapists for their attention.
- We observed one face to face and two telephone pre-assessments and found that all questions were covered and recorded in the patient's care records and any potential risks identified and passed to the relevant teams.
- Included in the patient care record was information on any allergies the patient might have. Care records we

reviewed showed this was completed. Nursing staff told us that patients with known allergies would wear a red wristband to alert staff of their allergic status and helped to mitigate the risk of allergic reactions.

- When a CYP patient was booked into the hospital it was the CYP lead nurse's responsibility to make sure the appropriate trained staff were available and other team were aware. This included having a second anaesthetist in the hospital when a child's surgery was underway.
- There was a risk based approach to nurse staffing for young people aged 16 to 18. Pre-admission assessment identified whether the young person was appropriate to follow the adult pathway. This meant they would be cared for my adult nurses. This process included considering the wishes of the young person.
- There was a weekly meeting between the CYP lead nurse, the theatre manager and senior nurses in the recovery area to discuss the CYP patients coming to the hospital for surgery in the following week. This meant appropriate staff and level of staffing could be worked out and any potential risks or issues planned for.
- The five steps to safer surgery was used by the hospital, which included the World Health Organisation (WHO) surgical safety checklist. The safety checklist is a recognised tool developed to help prevent the risk of avoidable harm and errors during and after surgery and should include safety-briefing, sign in, time out, sign out and debriefing. When we reviewed CYP patient care records the safety-briefing and debriefing elements were not recorded in the booklet. However, there was a tick box for staff to sign to say that the theatre team had reviewed key concerns for recovery and management of the patient, at the sign out stage.
- Venous thromboembolism (VTE) assessments were carried out and recorded in the patient's care record on admission and post-procedure.
- CYP patient's health and wellbeing was monitored using the nationally recognised paediatric early warning system (PEWS). This identified if a child or young person was at risk of deteriorating and identified when a child or young person's condition needed to be escalated to a medical practitioner. There were different scoring charts for children of differing ages, to support early detection of a deterioration in their condition.
- Our review of PEWS charts for 10 patients showed that although patient observations were mostly completed according to the guidance detailed on the PEWS observation chart, this did not always happen. For example, when scoring the PEWS chart, either a zero or one should be entered in the calculation grid. In some records we reviewed, a letter had been entered into the scoring grid rather than a zero or one. This meant the PEWS scores were not being completed as designed and total scores could be inaccurate which could lead to the wrong action being taken. This could have an impact on patients' care and safety.
- The hospital had an emergency resuscitation team and they met daily in the morning to allocate roles if a medical emergency should happen that day. In addition to adult life support training, certain team members had additional training in paediatric life support. The hospital porters had been trained in paediatric basic life support (PBLS). All ward co-ordinators, registered paediatric nurses, and nursing staff working in theatre recovery had paediatric immediate life support (PILS) training. The paediatric lead nurse, registered medical officers and the hospital matron had completed and were current in the European paediatric advanced life support (EPALS).
- The paediatric lead nurse told us there had been two paediatric emergency resuscitation scenarios run in the last year. These were carried out to help train staff, give the teams experience in case a real emergency should occur and highlight any areas needing improvement.
- The hospital had a local policy for the non-critical and critical transfer of CYP patients (dated: August 2016). This gave guidance about when and what to do if a child or young person required transfer to an acute NHS hospital.
- The hospital had an agreement with the local acute NHS trust for non-critical transfers of care. This included if a child's care could not be continued at the hospital for example if safe paediatric nursing levels could not be achieved, or when CYP patients were assessed as acutely unwell and needed medical intervention which was unrelated to the planned admission or outpatient attendance.
- The hospital had recently reopened its critical care facility however, at present it was not staffed

appropriate to admit paediatric patients to the service. Therefore, in an event of a child's condition deteriorating and requiring critical care facilities, they would be transferred to a NHS paediatric critical care facility using the local critical care retrieval service.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment.

- At the previous inspection of the CYP service in June 2016, there were concerns over the number of nursing staff employed in the service and staffing not being in line with national guidance from the Royal College of Nursing.
- The service employed a full-time CYP lead nurse who had accountability for all the children's services, including outpatient services. This met with the Royal College of Nursing guidance on defining staffing levels for CYP people's services. This stated there must be a registered children's nurse identified and available with responsibility and accountability for the whole of the children's pathway, including their pathway through outpatient departments.
- Following the last inspection, the hospital reviewed their provision of children and young people's service and had put in a business case to employ more full-time members of nursing staff and increase the number of bank nurses on the hospital books. This was supported by the hospital and staffing numbers in the CYP service had increased.
- The service now had five permanent registered children's nurses, three full time and two-part time. In addition, the service employed 10 registered children nurses on their bank on a regular basis and had access to four regular agency registered children's nurses. This made sure the service achieved staffing levels that met the national guidance and supported safe care and treatment for the patients and gave the service flexibility to bring in extra staff when needed, for example during permanent staff absences and during times of busy activity on the ward.
- During outpatient clinics, a registered children's nurse was rostered to work in the outpatient department. This meant there was always a CYP nurse to look after patients and their families and to support medical staff if needed.
- The service had a staffing ratio of one registered children's nurse to three CYP inpatients. The service always made sure there were two registered children's nurses in the hospital when there were children admitted to the ward., This meant even if there was only one child on the CYP ward there would be two registered children's nurses in the hospital, although one of the CYP nurses might be located in the outpatient department. We reviewed staffing rota's and saw the service had the required number of staff at the appropriate level rostered on duty when there were CYP inpatients on the ward.
- There was a on call rota which meant there was a registered children's nurse on call 24 hours a day.
- The CYP lead nurse was not counted in the staffing ratio and was supernumerary. This ensured there was effective management, training and supervision of staff.
- The Royal College of Nursing guidance details that there should be a minimum of one registered children's nurse in the recovery area. There was no registered children's nurse working in theatre recovery area. However, nursing staff working in theatres had experience working with CYP patients and had completed specific training or competencies to demonstrate their skill. The CYP service also tried to ensure there was a registered CYP nurse present in the recovery area to support the recovery staff caring for the child immediately postoperatively. In addition, there was access to a senior children's nurse for advice at all times.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment.

- All consultant surgeons, paediatricians and anaesthetists had to complete an application for paediatric admitting rights. This information was used by the hospital management team to determine whether the person had the required skills and

experience to carry out paediatric treatments at the hospital. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges.

- Each child was admitted to the hospital under the care of a named consultant with paediatric experience. The hospital required consultants to be available to attend to the child within 30 minutes of being called, which met the recommendations set out by the Association of Independent Healthcare Organisation (AIHO). Staff told us consultants and anaesthetists made themselves available to provide advice over the telephone or attended the hospital when required.
- There were 39 clinicians with practising privileges who provided a service for children. This included surgeons, physicians, anaesthetists and radiologists.
- There were robust processes in place prior to medical staff being granted practicing privileges at the hospital. The hospital director reviewed these every two years, with consultants submitting mandatory training, safeguarding training and appraisal information yearly. Consultants had to demonstrate they were competent to perform the procedures included as part of their practising privileges and they were working within their normal scope of practice.
- There was a registered medical officer (RMO) on-site 24 hours a day/ seven days a week. The RMO needed to have paediatric experience and to have completed EPLS training. They provided medical care to patients including CYP patients at the hospital during the day and out of hours.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.

- CYP patients seen solely in the outpatient department and not admitted to the hospital had a set of records held by the relevant clinician and a duplicate set of records held by the hospital.
- CYP patients that was admitted to the hospital for a procedure had a care record. This was a complete record in a booklet form, containing all information from when a patient had been booked in for a procedure until follow up care after discharge had finished. These records were used for every CYP patient and were multidisciplinary, meaning each clinical team wrote in the same set of records, including the surgical team.
- We reviewed 10 set of patient records and found them to include the relevant assessments of care needs, risk assessments and were patient centred and personalised.However, there was some inconsistency in the actual standard of record keeping in all 10 records these included; incorrectly totalled discharge scores, inconsistency in how pain scores were filled out with one record scoring an unconscious patient after anaesthesia as zero and other records recording no score for an unconscious patient; incorrectly filled out PEWS observations; and general omissions, for example, no signatures, information missing, boxes not ticked.
- There were no visual or audio recordings included in the 10 patient's records we looked at. However, if this type of patient information was required, consent needed to be obtained and information stored in accordance with the Nuffield health corporate consent to examination and treatment policy. This included the purpose and possible future use of the visual or audio recordings made.
- The CYP service had an audit programme to assess the quality of completion of patient care records. 10 CYP patient's records were checked each month against a set list of questions. We reviewed audit information from August 2017 to July 2018 and saw from the results records were between 94 – 100% completed correctly. Where errors had occurred or emerging themes seen, these had been highlighted and an action plan put in place for improvement. We saw feedback from documentation audits was included in the monthly CYP staff newsletter, with reminders to staff about the correct completion of patient records.
- Whilst CYP patients were on the CYP ward patient's records were stored securely behind the nurses station. Once patients had been discharged and no further follow up care was required, records would be stored by the hospital's medical records team.

Medicines

The service followed best practice when prescribing, giving recording and storing medicines.

Good

Services for children and young people

- Medicines and controlled drugs were securely stored in a locked cabinet, within a locked room with entry via a key pad. Keys for the drugs cupboard were kept in a key safe with only relevant staff knowing the code.
- All medicines were stored neatly. Drugs and documentation were in date except for some mouthwash tablets that had expired prior to the inspection.
- We found a bottle of acetone stored in the drugs cabinet alongside medicines. Acetone should be stored under the Control of Substances Hazardous to Health (COSHH) Regulations 2002, which says acetone must be stored in a cool, dry and well-ventilated chemical storage. Acetone is not a medicine, could be harmful to patients if administered in error orally and therefore should not be stored in cupboard used for the storage of drugs.
- The hospital had an on-site pharmacy that was responsible for the supply and top up of medicines used in the CYP service. CYP staff told us pharmacy staff provided a good service and were available and accessible when needed.
- The patient's care record booklet contained a prescription chart for once only or as required medicines. However, for the majority of patients had a separate prescription chart where all required medicines could be documented including regular medicines and oxygen. CYP staff recorded children and young people's weights, heights and allergies on the front page of the both the care record booklet and the separate medicine chart. This helped those prescribing the medicine to prescribe the correct therapeutic level.
- Medicines prescribed on the medicine chart were dated and signed by the prescriber. Prescriptions detailed the dose and the time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the CYP patient.
- Information that might be needed in an emergency was entered onto the front page of the CYP patient's care record, this included drugs that might be needed to be administered in an emergency, for example, adrenaline, glucose and amiodarone. The safe dosage of each of the drugs for the patient was worked out by CYP nurses prior to patient admission and entered on the form.
- Since the last CQC inspection in 2016 the CYP service had implemented a medication audit tool to ensure correct documentation on prescription charts. Patient care records and medicine charts we checked showed staff were documenting the information required and prescription charts were completed correctly.
- It was highlighted in the previous CQC inspection report (2016) that children's weight and height were not recorded routinely for patient's attending outpatient appointments. This information is used to accurate calculate medicine doses for children and young people. We observed a CYP patient outpatient clinic and saw that CYP nurses routinely took and recorded weight and height measurements from children prior to seeing the consultant.
- CYP patient's weight and height was also routinely measured when they arrived at the CYP ward as part of their inpatient checking in procedures.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

- Staff reported incidents using the electronic reporting system. The hospital provided mandatory training on how to use the system, with staff in the CYP service having 100% compliance with this training.Staff said they felt confident to report incidents and knew what constituted as an incident.
- From August 2017 to July 2018 there had been 13 incidents reported relating to the CYP service. These all resulted in no harm to the patient.
- Staff gave us examples of when change was needed as a result of an incident. For example, the soft play area had been rearranged and corner protectors attached to the toy storage units, after a small child had fallen off the soft play mat and banged their head on the storage unit.
- The hospital had monthly incident meetings where incidents and adverse events were discussed, investigations into incidents reviewed, the actions taken to reduce risk and reduce the likelihood of reoccurrence put in place and to see if there were any trends emerging. A representative from each area of the hospital had to attend these meetings which ensured

cross departmental reporting and learning. We reviewed minutes from the last meeting and saw there was a good attendance. There was a set agenda for these meetings which included, outstanding actions; trends; learning from incidents and wider sharing of incidents from all theof the Nuffield Health hospital sites.

- We saw evidence from minutes of meetings we looked at, that the findings from the incident meetings were reported quarterly to the clinical governance committee.
- Information from the incident meeting was feedback by the CYP lead nurse, who attended the incident meeting, in a number of ways. This included; on a one to one basis, via team meetings and emails and in the CYP service monthly newsletter.
- Staff we spoke with said they received feedback from reported incidents, both those relating to their immediate area of work and those that had been reported elsewhere in the hospital. This promoted shared learning from incidents throughout the hospital.
- 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.
- Duty of candour was not part of the hospital's mandatory training, however, staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. It was the responsibility of the monthly incident meeting group to ensure the principles of the duty of candour had been completed. We were not told of any incidents in the CYP service where the duty of candour had been applied.

Safety Thermometer

- The CYP safety thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. The tool focuses on; deterioration, extravasation, pain and skin integrity.
- Although some safety information was collected in the CYP service, the service was not using the safety thermometer tool as a way to support improvements in patient care and to prompt immediate action by CYP staff.

Are services for children and young people effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

- Children and young people's care and treatment took account of national guidance. Policies and procedures we reviewed referenced national guidance including the National Institute for Health and Care Excellence (NICE), the Royal College of Nursing, and other relevant bodies.
- Staffing of the CYP service followed the guidelines set out in the Royal College of Nursing; defining staffing levels for children and young people's service (2013), to ensure all staff caring for children and young people had the necessary skills and competencies.
- The CYP lead nurse was responsible for reviewing information sources such as the corporate Nuffield Health quality management system and the National Society for the Prevention of Cruelty to Children (NSPCC) for updates in guidelines. It was the CYP lead nurse's responsibility to ensure these changes were incorporated into the working practices of the hospital.
- At the previous inspection the CYP service did not have an identified audit plan in place which meant that learning from formal clinical audits, benchmarking or tracking clinical outcomes did not take place. At this inspection, we found a planned audit programme had been put in place. The audit programme included audits of documentation, health and safety, infection control, patient satisfaction and safeguarding. These audits were used to identify issues and monitor improvements in the delivery of the service.

- The CYP service audit results were used to benchmark the hospital against other hospitals in the Nuffield Health group which delivered paediatric services.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

- Nursing staff asked CYP patients about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary requirements, such as vegetarian or halal. This information was passed to the catering team who prepared the meals.
- The hospital provided suitable meals and drinks for children and young people, and offered meals for the family member staying with the patient. The children's menu was decorated with a teddy bear picture and colourful writing. Young people were offered a choice between an adults or children's menu. Vegetarian meals were available and special dietary requirements could be accommodated through the catering team.
- CYP patients and their patients or guardians were advised about pre-surgery fasting (that is omitting food and fluids except water before operation) times during the pre-assessment process. Fasting guidelines were found in the Nuffield Health corporate pre-operative assessment SOP. The service followed the Royal College of Anaesthetists guidance about pre-operative fasting to ensure CYP patients fasted for the safest minimal time possible. Written information about pre-surgery fasting times was also sent to the patient and their patients or guardians which reminded patients that fasting included chewing gum and sweets.
- If required, support was available to diabetic patients prior to their operation.
- The Nuffield health corporate children and young people in hospital policy stated that CYP patients should be placed at the beginning of the theatre list to ensure minimal fasting times and maximum recovery time whilst the anaesthetist and consultant were on site. The CYP lead nurse and the theatre manager confirmed this happened. If for any reason it did not, an incident would be raised and the matter investigated.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

- Pain protocols used at the hospital were based on guidelines from the Association of Paediatric Anaesthetists and found in the Nuffield health corporate pre-operative; post-operative and post-procedural care SOPs.
- Nursing staff discussed pain and pain relief with CYP patients and their parents or guardians during the pre-assessment process. This was documented in the patient's care record.
- We observed three pre-assessments and heard pain and pain relief post-surgery discussed with patients and their families.
- We reviewed CYP care records and saw that pain was assessed, documented and managed well throughout the patients care. Staff used a nationally recognised age appropriate tool for measuring pain, either cartoon heads ranging from happy to sad faces for younger children or a visual analogue scale for older children. The CYP staff had also created one of their own using emoji faces. Staff told us children identified well with this.
- Pain audits were carried out monthly to identify that pain was being assessed, recorded and appropriate action taken to minimise the patient's pain. We saw from the previous month's audit results that staff had not always been documenting the patient's pain score prior to their operation. The CYP lead nurse was addressing this and had reminded staff of the importance of this information in the CYP teams monthly newsletter.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

- Since our last inspection an audit plan had been put in place in the CYP service to monitor the effectiveness of care and treatment to patients.
- The CYP service analysed patient outcome data, such as outpatient activity, unplanned returns to theatre, unplanned transfers to other hospital and avoidable cancellation on the day of surgery to monitor trends and improve the quality of the service. We saw evidence

patient outcome data was discussed in the quarterly CYP governance committee meeting minutes. Post inspection we were informed surgical site infections (SSI) would be monitored through the post-surgery follow up calls made to CYP patients. Any SSI occurrences would be recorded as incidents and followed up at the incident reporting meetings.

- The CYP service did not take part in any national audits.

Competent staff

The service made sure staff were competent for their roles.

- Permanent and bank staff had to provide evidence of their registration as part of their pre-employment checks and at their annual appraisals. Agency children's nurses provided evidence of their registration, level of safeguarding and paediatric intermediate life support training to their employment agency.
- All staff working in the CYP service had to complete competency training on specific areas in order to work in the CYP service. This included clinical skills, medicine management, governance, infection prevention and control and record keeping. There was a training matrix which detailed the competences needed for each grade, senior staff nurse, staff nurse and healthcare assistant.
- Training was based on the Benner's stages of clinical competence that says to learn a skill you pass through five stages of development, novice, advanced beginner, competent, proficient and expert. Staff were signed off along the way as they developed the essential skills needed to work in the CYP service.
- The service kept an information folder on the ward for agency and bank staff to refer to. Staff were shown this as part of their induction training.
- Since our last inspection a CYP competency framework had been developed for theatre and recovery staff working with CYP patients. It included all the essential skills needed for looking after children. Training was based on the Benner's stages of clinical competence. Staff were signed off by the CYP lead nurse and the lead paediatric anaesthetist. Staff we spoke with in theatres welcomed this formal training and said it was improving their abilities and increasing their knowledge working with CYP patients.
- There was a Nuffield Health corporate practising privileges policy (May 2018). This document provided details of the criteria and conditions under which licensed registered medical practitioners would be granted authorisation by the hospital to undertake care and treatment of patients.
- All consultant staff were required to provide evidence of their accreditation, validation and appraisal before the hospital granted them practising privileges. All the paediatric consultants and anaesthetists with practising privileges were employed by local NHS trusts to perform surgical procedures on children and young people. The hospital had a number of dedicated paediatricians with practising privileges. The hospital medical advisory committee and the hospital director were responsible for granting and reviewing consultants practicing privileges every two years to ensure the consultants were competent in their roles. There was a specific Nuffield Health corporate checklist used to access consultants providing services to children and young people. The hospital also ensured yearly, that consultants had appropriate professional insurance in place; GMC registration and current licence to practice; an appraisal and personal development plan; infectious disease immunisation status; and their mandatory training was up-to-date.
- There was a Nuffield Health corporate policy. The CYP lead nurse carried out yearly appraisals for the CYP staff. The CYP lead nurse also supported the appraisal process for adult nurses and allied healthcare professionals around the hospital, by feeding back about their care of CYP patients. The CYP lead nurse had their appraisal carried out by the hospital matron. CYP staff we spoke with and information we reviewed, confirmed that the CYP team were up-to-date with their appraisals.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

- Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The children's nurses took full responsibility for communicating the needs of all inpatient CYP patients under their care with the general nursing staff, medical staff and other healthcare professionals as appropriate.

- Physiotherapists provided advice and treatment as needed to CYP patients admitted to the hospital.
- Staff we spoke with in the CYP service and the wider hospital told us there was effective working between all staff groups. When children were admitted the CYP lead nurse and senior CYP staff met with theatre staff to discuss the needs of the specific child. All staff we spoke with told us staff in the hospital worked as a team to support children and young people.
- During the inspection we observed effective, friendly and helpful interactions between all staff working at the hospital.

Seven-day services

- The hospital held outpatient clinics and admitted patients for procedures Monday to Saturday.
- CYP pre-assessment clinics ran three days a week, Monday, Thursday and Saturday.
- The hospital provided CYP nursing care seven days a week.
- The RMO was on site 24 hours seven days a week and was therefore available at night and at weekends.
- The diagnostic imaging department was available between 8am and 5pm weekdays. During the weekend and overnight, radiographers provided an on-call service.
- The hospital pharmacy service was available between 9am and 5pm Monday to Friday. During the weekend and overnight, pharmacy staff provided an on-call service.

Health promotion

Staff promoted health promotion well.

- There was no formal health promotion programme for CYP patients. However, we saw a range of age appropriate health promoting leaflets and posters displayed in prominent CYP areas, such as the play rooms in outpatients, the playroom on the ward and in patient's bedrooms.
- There was information on many topics including; healthy eating and drinking, alcohol and its journey through the body and the importance of brushing your teeth
- Each CYP bedroom had a copy of the 'Change 4 Life' booklet and 'top tips for top families' which promoted healthy living tips for families.
- Information about how to manage children's health needs were discussed during outpatient appointments, which we saw whilst observing the paediatric outpatient clinic during the inspection.
- Staff told us they took opportunities to discuss healthy lifestyles where appropriate with CYP patients and their parents. Staff told us older children were asked if they smoked, drank alcohol, or took drugs. If a patient told them they did then help and advice was offered. Depending on the issue, patients and their parents would be signposted to the relevant organisations or to their GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Nuffield Health corporate consent to examination and treatment policy (Aug 2015) with separate SOPs for the consent of children. All matters concerning obtaining consent for treatment in relation to children and young people were contained in the SOP. This included ages for consent, capacity and competency, overriding consent, parental responsibility and special situations.
- Patients and parents were signposted to the Departmental of Health guidance on consent; 'consent - what you have the right to expect – a guide for patients' and 'consent - what you have the right to expect - a guide for children and young people', if they wanted more information on the consent process.
- The hospital used a separate consent form for parental agreement to investigation or treatment for a child or a young person. However, there was a box in the patient's care record in the pre-procedure care section, to check that consent had been obtained prior to the surgery or procedure.
- We reviewed 10 consent forms and found they were signed and dated appropriately. We also found the appropriate box had been ticked in the patient's care record to double check consent had been obtained prior to surgery.

Good

Services for children and young people

- Staff told us that the parent with parental responsibility had to sign the consent form. If a parent without parental responsibility wished to consent then the procedure would have been stopped until valid consent was given.
- Staff were mindful of involving CYP patients as much as possible with decisions about their care. Staff told us that children and young people under 16 years old and where appropriate, were encouraged to sign the consent form as well as their parents.
- Staff understood when Gillick competency applied to children and young people, and could describe their responsibilities under the Mental Capacity Act 2005 for young people aged over 16 years old when giving consent.
- Mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training was part of the mandatory training for CYP staff. All CYP staff were up-to-date with their MCA and DoLs training.

Are services for children and young people caring?

Good

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

Compassionate care

Staff cared for patients and their families with compassion.

- Due to the low numbers of children being treated at the hospital during our inspection, we were only able to speak with two patients and their parents attending outpatient appointments, to listen to two pre-assessment screening via the telephone and to observe one face to face pre-assessment screening. Following the inspection, we had telephone conversations with parents of three children of varying ages who had undergone surgery at the hospital.
- Feedback from the patients and parents we spoke with at the time of the inspection and from our observations, showed staff treated patients and their families with kindness and sensitivity. Interactions between staff and CYP patients were polite, respectful and age appropriate.
- Parents we spoke with after the inspection spoke highly of the staff and the care their children had received during their time at the hospital.
- The hospital had a SOP on chaperoning which was contained in the Nuffield Health corporate privacy and dignity policy (2017). We observed children being chaperoned during the inspection and saw specific CYP signs offering chaperoning services to patients and parents.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress.

- The pre-admission assessment process was used to help relieve CYP patients and their families of anxieties about coming to the hospital. Children and young people and their parents were told what to expect during their admission to the hospital. It also gave them the opportunity to visit the hospital, view the ward and other areas and meet the staff who would be looking after them during their stay which helped relieve anxieties.
- Consultants, anaesthetists and theatre staff met children on the ward before surgery to explain what to expect when in the theatre environment. This meant CYP patients had met the staff that would be looking after them in the recovery area.
- Parents could if they wanted to, could accompany their child to the anaesthetic room staying with them until they were anaesthetised. They could also be taken into the recovery area when their child woke up.
- To help CYP patient's feel more comfortable they could wear their own night wear to theatres.

Understanding and involvement of patients and those close to them

Staff involved children and young people and their patients in discussions about their care.

- Staff told us they always explained what was happening to children in a manner they could understand. This was confirmed by patients and their parents, in the conversations we had and observations we saw, during and post inspection.

Good

Services for children and young people

- All parents we spoke with said they were fully involved and informed about their child's care and treatment. They told us they were given time to discuss any issues they might have with all the staff involved in their child's care and treatment.
- We were told by staff and parents of children who had surgery at the hospital, that descriptions of care and treatment were explained to children in an age appropriate manner, to help them understand what was happening to them.

Are services for children and young people responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of children and their families.

- Children and young people attended the hospital for planned surgical procedures, outpatient appointments, x-rays services and physiotherapy. Following national guidance, inpatient surgical services and outpatient services were only offered to children aged three and above.
- There was no dedicated children's waiting room in the outpatient department. However, the hospital tried to make sure children's outpatient clinics were only run from specific areas in the outpatient suite. To provide a dedicated child only space, the outpatient department had two children's playrooms, with games and toys and a soft play area.
- There was a main reception desk at the entrance to the outpatient department where patients and their parents/guardians booked in. In addition, the CYP service had its own reception desk, where the CYP nurse would sit. This meant there was a dedicated point of contact for CYP patients and their parents, and it was easy to find the CYP nurse if there were issues or questions.
- The CYP service had started offering preadmission assessments on a Saturday as well as in the week, on Monday and Thursdays. By offering this service on a weekend meant that families could attend without taking children out of schools and parents taking time off work.
- At the previous inspection in 2016, there was no dedicated inpatient children's ward in the hospital. This meant children were seen and treated in areas that adults were seen and treated in. However, since the last inspection the CYP service had been given its own dedicated ward with six individual ensuite bedrooms.
- This area had been decorated with posters, pictures and artwork to make the area more child friendly. The ward had a play room with separate areas aimed at different age groups. There was a blackboard wall where children were encouraged to draw, a soft toy area, and a seated area for older children where they could use computer tablets. Age appropriate bedding and artwork was used in the bedrooms to make them more homely and welcoming for children of different ages.
- The hospital had tried to make the CYP ward more child friendly, However, there was no use of colour, with the area being neutral in colour and corridors quite sparse.
- We were told by the hospital matron and hospital director the hospital hoped to secure some funding to improve décor in the CYP ward and other areas in the hospital where children and young people were looked after. Thinking how areas seemed from a child's point of view and having more child friendly décor could help improve the CYP patient's experience and make areas seem less clinical and institutional, especially to younger children.
- We observed staff in the children and young people's area all wore name badges that were individualised in style. One member of staff had a name badge with popular cartoon characters on it, and another member of staff wore a name badge in the shape of a dinosaur.
- The CYP ward had free Wi-Fi with leaflets in every room to show patients how to connect to the network.

Meeting people's individual needs

The service planned and provided a service that met the individual needs of children and young people.

Good

Services for children and young people

- Staff told us that outpatient appointments and surgical admission dates were planned with the families to meet the needs of the children. Parent's of patients we spoke with told us they did not have to wait long for appointment dates.
- The CYP patient's individual needs were discussed during booking and preadmission assessment. The information was used by staff to provide care and treatment in a safe way and mitigate any possible risk to the patient. If during preadmission assessment, staff identified the service could not meet the child or young person's needs, staff would not treat the patient at the hospital and refer the child to an alternative health care provider who could support the child and their parent. The hospital did not have the facilities to support the care of children with high complex needs. Therefore, this patient group was not admitted to the hospital. However, children who had a learning disability could be admitted but only after the appropriate assessments had been carried out.
- The service did not admit children who had known mental health diagnosis. However, there was clear guidance for staff about how to contact the local children and adolescent mental health services (CAMHS) if they had any concerns about a CYP patient's mental health. The CYP lead nurse had liaised with the local CAMHS service to ensure they had the correct details to contact appropriate professionals during the day and night. These details could be found on the hospitals local CYP CAMHS referral flowchart.
- Staff told us, if needed, interpreting facilities were available to support children and parents whose first language was not English. The need for interpreting services would be established at booking and was the responsibility of the CYP lead nurse to arrange when needed. The hospital had employed an Arabic interpreter as many of the hospital patients had Arabic as their first language.
- We saw child friendly information leaflets on a number of topics, this included; information about things children needed to do and remember before arriving at the hospital for their operation. This included; fasting times, what mum and dad had to remember, what to pack and how to take their medicines when they got home. However, some information was designed for adults. For example, the going home booklet patients and their families received on discharge from the hospital. The CYP service had made a bravery award that they could give to younger patients after having surgery at the Hospital.
- In the outpatient department and on the CYP inpatient ward there was child friendly, age appropriate information about having a general anaesthetic. Parents could use these booklets to help prepare their child for an anaesthetic, introduce them to people they might meet and some of the things that might happen.
- CYP staff told us, they tried to rota the same nurse on throughout a patient's journey, i.e. the nurse that carried out the preadmission assessment would be the nurse that looked after the patient pre- and post-surgery. The aim of this was for staff and the CYP patient to build up a rapport which could help improve communication and trust between them. This in turn could lead to better patient outcomes.
- The hospital had a local advocacy SOP and if needed the hospital could provide an advocacy for CYP patient's. An advocacy is someone who ensures that the views, wishes and opinions of children and young people are heard, respected and acted upon.
- The hospital had a local transitional needs of the adolescent patient SOP. This SOP contained information for the CYP staff on how to look after adolescent patients within the hospital.
- The hospital saw many patients from abroad. The CYP service had developed an international admission pro-forma to use alongside their normal patient care record. The pro-forma included; additional medical questions, additional questions regarding their stay and flight information.

Access and flow

Children and young people could access the service when they needed it.

- CYP patients attended Nuffield Health the Manor hospital as privately funded or insured patients and procedures were planned.

Good

Services for children and young people

- The hospital followed corporate and local policies and procedures for the management of the CYP patient's journey, from the time of booking the appointment until discharge and after care. Staff we spoke with were aware of these policies and procedures.
- The hospital had established a clear booking process for appointments and hospital admissions. Parents we spoke with told us the hospital had a good and efficient booking process.
- Patients were added by the booking team to the hospital's patient information management system (PIMs). This meant that patient details and appointments could be tracked by staff working throughout the hospital.
- The hospital had a written inclusion and exclusion criteria for children and young people. This meant the hospital only admitted CYP patients they had the facilities and expertise to care for.
- The hospital preferred CYP patients and their families to attend the pre-assessment appointment in person but nursing staff could complete this by telephone, if more convenient.
- Children's surgical procedures were booked at the beginning of theatre lists, which usually meant children and young people could recover and return home the same day. A registered children's nurse was always on duty when a child was admitted as an inpatient, this included when CYP patients had an overnight stay. The service had processes to ensure a registered children's nurse was on duty if a child had to stay unexpectedly overnight in the hospital. For example, if a CYP patient had not fully recovered from their operation and was not medically fit to be discharged home.
- There was no formal monitoring of referral to treatment time for children's services. None of the patients we spoke with complained of long wait times for appointments. However, as referral to treatment waits were not formally monitored the hospital could not be assured that children and their families were not waiting unduly long to be seen, even if they had been referred urgently.
- Once the CYP patients had been admitted into the hospital for surgery, there was no monitoring about how long they waited for their surgery. Therefore, the service could not identify if there were problems relating to theatre delays and the reasons for them.
- We saw evidence of increased and decreased lengths of stay of CYP patients being discussed in the minutes of the hospital's monthly governance meetings which the CYP lead nurse attended. It was unclear how this data was used by the service to make improvement to services.

Learning from complaints and concerns

- The hospital followed the Nuffield Health corporate complaints policy when investigating and responding to complaints or concerns. The hospital director had overall responsibility for the management of complaints.
- We saw complaint forms in the main hospital reception. Parents of CYP patients we spoke with told us they knew how to make a complaint if needed. We saw no complaint forms aimed for children.
- Staff in the CYP service told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team.
- Post inspection we requested data on how many formal complaints the CYP service had received in the last 12 months or how quickly these complaints were resolved. The hospital did not supply this data to us.
- We saw evidence of hospital complaints being discussed in the minutes of the hospital's monthly governance meetings which the CYP lead nurse attended.
- The CYP service had a patient satisfaction survey form they gave to CYP patients and their families to ask for feedback about the service. The form was brightly coloured with yes and no responses and a box for free text. Responses from the survey were used by staff to make improvements to the service.

Are services for children and young people well-led?

Good

Services for children and young people

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

Leaders of the children and young people's services had the right skills and abilities to run a service providing high quality sustainable care.

- The CYP service was run by the CYP lead nurse who had accountability for all the children's services at the hospital, including outpatient services.
- There was a lead paediatrician consultant who represented the CYP service on the Medical Advisory Committee (MAC).
- There was a lead paediatric anaesthetist who coordinated anaesthetist's availability for children's theatre lists.
- The service had support from the CYP lead nurse for Nuffield Health.
- Nuffield Health had developed a network where hospitals with CYP services supported each other. The CYP lead nurse from The Manor hospital was instrumental in the setting up of this group and an active contributor.
- Staff across the hospital valued the input of the CYP lead nurse to their services and felt supported if they needed any advice involving CYP patients.

Vision and strategy

The children and young people's service had a vision for what it wanted to achieve with workable plans to fulfil the vision.

- The service had a vision 'to improve patient care and outcomes by providing assurance of compliance with clinical standards and evaluating performance of changes that are implemented'.
- The service had a strategic plan in place how to achieve the vision by; ensuring compliance with NICE Guidance for specialist service requirements; ensuring all staff were trained in advanced safeguarding and resuscitation; having a staff development plan to facilitate clinical skill development and links to the local university; and to be compliant with patient needs as identified by parent, patient and peer feedback.
- The plan was reviewed monthly to support the delivery of the strategy. Staff we spoke with were committed and enthusiastic about improving the service, patient care and outcomes at the hospital.

Culture

Leadership of the children and young people's service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- There was a positive culture across all staff in the delivery of the CYP service. Staff outside of the CYP service spoke highly of the support received by the CYP lead nurse and the CYP team.
- Staff throughout the hospital were now embracing CYP services at the hospital and were keen to expand and develop the service.

Governance

The service used a systemic approach to continually improve the quality of services.

- The CYP lead nurse was fully involved in the planning and development of the CYP services at the hospital.
- Information gathered by the CYP team was collated into a PowerPoint presentation which the CYP lead nurse presented quarterly at the CYP governance meetings. These meetings were attended by the hospital matron and senior representatives from the other services at the hospital. We reviewed minutes from these meetings and could see key quality issues of safety, risk, clinical effectiveness and patient experience were discussed amongst the team. This information fed into the hospitals senior management quality meeting and in turn into the corporate governance reporting systems.
- There was a lead paediatrician consultant who represented the CYP service on the Medical Advisory Committee (MAC). The MAC's role was to ensure clinical services, procedures or interventions were provided by competent medical practitioners at the hospital. This involved reviewing consultant contracts, maintaining safe practicing standards and granting practicing

privileges. We reviewed minutes from the quarterly MAC meetings and saw there was a set agenda, including, the quarterly hospital directors report; the quarterly matrons report; practising privileges review; proposed new clinical services and clinical techniques; and any issues by hospital specialty. We were shown CYP presentations that had been presented to the MAC during 2018 to give them an overview of the service and improvements that had been made.

Managing risks, issues and performance

The service did not use their systems for identifying risks and planning to eliminate or reduce risks effectively.

- The CYP service held its own risk register. When we reviewed the CYP risk register there were only three items on it and all were added in Feb 2017. Post inspection we were sent a second CYP risk register, which was said to be the current one, this included risks identified in 2018. However, risks that senior CYP staff had spoken about during the inspection, for example nurse staffing levels, was not on the risk register.
- Whilst the service had a process in place, we were not assured that the risk process was being followed appropriately, with risks being identified, recorded and action taken in a timely way. Without an up-to-date database of recognised risks, the service was not identifying issues that could cause harm to patients and staff and put measures in place to mitigate for them.

Managing information

The service collected, analysed, managed and used information to support activities.

- The service had implemented an internal CYP service audit programme. Audits were used to identify issues and monitor improvements in the delivery of the service.

Engagement

The service engaged with patients, staff, public and other health care providers to help plan and develop its service.

- Patients were encouraged to provide feedback through the hospital patient feedback form which was given to them at the time of admission or just prior to discharge. In addition, the CYP service had introduced a patient satisfaction survey for children and young persons. Information gathered from these surveys was used to facilitate improvement.
- The service engaged with local stakeholders. For example, the CYP lead nurse held a paediatric symposium for the local GPs to inform them about the CYP services at the hospital.
- Information was displayed in the CYP play rooms for patients, relatives and staff. This included information on sepsis, safeguarding and health promotion.
- The CYP lead nurse had introduced a monthly CYP service newsletter.The newsletter was a way to share information with the team. It included information on patient feedback, infection prevention, audit results and other CYP issues.
- The CYP lead nurse was actively engaging with other teams in the hospital and forming better working relationships with them. This was improving the patient journey and safety of CYP patients. For example, the CYP lead nurse was running PBLS training sessions and was involved with paediatric competency training with the other hospital teams.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong and by promoting training and innovation.

- All staff involved with the service were passionate about developing it and increasing the number of CYP patients seen at the hospital.
- Since the last CQC inspection in 2016, the service had expanded from running one week every month to offering a daily service and had invested in more nursing staff. The service had completed a gap analysis to identify the difference between the CYP service's current knowledge and practices and the current evidence based best practices and issues highlighted from the last CQC inspection report (2016).
- Once gaps had been identified the CYP lead nurse had completed an action plan to address the issues. We reviewed these action plans and found them to be thorough and based on national guidance and best working practices. The action plan included, the finding,

action required, an action tracker, anticipated completion date and the evidence based outcome. All actions were RAG rated. We could see from the documentation and from changes we observed during the current inspection, that actions were being addressed.

- The CYP service had good links with the local NHS trust. These links were used to participate in training and to information share.
- The CYP service had recently collaborated with the local NHS trust to offer a craniofacial service. Patients came to the Manor hospital for their pre- surgical workup in coordination with craniofacial specialists from the local trust.
- The CYP service had started to offer CYP student nurse placements for 2nd year students. This had involved completing an educational strategy and clinical competency assessments.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all risks to the CYP service are identified, assessed and monitored consistently.

Action the provider SHOULD take to improve

- The provider should consider displaying results of safety thermometer audits.
- The provider should have age appropriate written information available for children and young people and their families about leaving hospital and their aftercare.
- The provider should consider monitoring for trends in patient outcome data to enable the service to assess and measure the quality of the service they are delivering.
- The provider should consider monitoring referral to treatment time to monitor patient wait times.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Current risks were not being identified, recorded and monitored appropriately in the children's and young peoples service. The service must ensure that issues that could cause harm to patients, staff or the service are recognised.