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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health The Manor Hospital Oxford was purpose built and opened in 2004. The hospital is managed by the Nuffield Health Group, a not-for-profit organisation. On-site facilities include six high-specification surgical theatres, 64 private en-suite bedrooms, two minor procedure suites for day case and outpatient surgery, and a radiology unit including: mammography, ultrasound, MRI & CT scans.

Over 300 qualified consultants have practising privileges and lead the medical and surgical services. The consultants who work from the hospital predominantly have substantive post with the local acute NHS trust.

The hospital had been transitioning through a period of immense change since December 2015, with a new clinical and hospital leadership. The current manager became the registered manager in February 2016.

We inspected the hospital as part of our planned comprehensive inspection programme. We looked at the four core services provided by the hospital: medicine, surgery, outpatient and diagnostic imaging, and services for children and young people.

The announced inspection took place on 8 and 9 June 2016, followed by an unannounced visit on 22 June 2016.

The hospital was rated good for safe, effective, caring, responsive and well led services.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean people are protected from abuse and avoidable harm.

- Staff were clear about their responsibilities to report incidents and there was a culture of learning from incidents that was promoted.
- Processes to protect people from harm, such as infection control, the safe handling of medicines and equipment safety checks were being followed.
- Patients were assessed and action was taken in response to risk. This included the assessment of patients to ensure only patients who the hospital could safely support received treatment.
- Patient records were accurately kept and stored securely. However, there were instances wherethere were no dates on prescriptions or signatures were not legible.
- Staff were aware of safeguarding and were clear about their responsibilities to safeguard people at risk.
- In General staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. This was not the case for children and young people's service as staffing was not in line withnational guidance.
- Staff compliance with mandatory training was generally good. Adherence with paediatric basic life support training was low.
- There was a good understanding of the principles of the duty of candour, and the need to be open and honest.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.

Summary of findings

- Staff were qualified and had the skills needed to carry out their roles effectively. Staff were supported to maintain and further develop their professional skills and experience, including through appraisal.
- When patients received care from a range of different staff, teams or services, this was coordinated.
- Staff had access to the information needed to assess, plan and deliver care to people in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance, however staff did not demonstrate a clear understanding of the procedures to follow for patients who lacked capacity.
- The hospital had robust systems in place for granting practicing privileges to consultants and when necessary suspended or removed these.
- In general, patient's pain was well managed, however for children and young people there were inconsistencies in the approach to managing their pain.
- Information about people's care and treatment, and their outcomes, was collected and monitored. There was participation in relevant local and national audits, and other monitoring activities such as reviews of services, benchmarking and peer review. However there was no evidence of monitoring of outcomes for children and young people.

Are services caring at this hospital?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- Feedback from patients and those close to them was positive. People were treated with dignity, respect and kindness. Patients told us they felt supported.
- Staff spent time talking with patients and they understood their care, treatment and condition.
- Staff supported patients to maintain their independence and connections with their family and friends.
- Results of the friends and family test were positive with the majority of patients recommending the hospital.

Are services responsive at this hospital?

By responsive, we mean that services are organised so they meet people's needs.

- The hospital planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service.
- Waiting times, delays and cancellations were minimal and managed appropriately. People were kept informed of any disruption.
- Patients had timely access to initial assessment, diagnosis and urgent treatment at a time to suit them.
- The needs of different people were generally taken into account when planning and delivering services, although no specific consideration had been given to ensure the service was able to meet the individual needs of people living with dementia. The general environment did not meet the needs of children and young people and provision of play and recreation within the hospital was limited to meet the needs of young children only.
- Written information was available for patients in a variety of languages, however there was limited age appropriate information for children and young people.
- Complaints and concerns were managed in a timely way, with learning from complaints shared and used to improve the quality of care.

Are services well led at this hospital?

Summary of findings

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

- There was a clear statement of vision and values, driven by quality and safety. Staff were aware of the values of the organisation and were passionate about good patient care.
- Governance arrangements to monitor the quality and safety of services were in place.Although those specifically designed to monitor the quality for the children's and young people's service were not fully established.
- Structures, processes and systems of accountability, including governance were clearly set out, understood and effective.
- Performance issues were escalated to the relevant committees and management team through clear structures and processes.
- The hospital management team engaged and involved staff working to ensure the voices of all staff were heard and acted on.
- Staff were positive about the local leadership and felt supported.

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

Importantly, the provider must:

- Review children nurse staffing for the service to ensure national guidance is met.
- Patient care records are completed to recommended national standards, including signatures for all staff providing care for the patient.
- Baseline assessments are completed, including a child's height and weight, prior to prescriptions being issued.
- Robust systems are developed for locally monitoring the quality of the children and young person service, including participation in clinical audits.

Importantly, the provider should:

- Ensure all staff are aware of and know the requirements in relation to The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.
- Consider displaying results of safety thermometer audits.
- Ensure all staff complete paediatric basic life support training.
- A review is completed to assess the need for a competency based programme for theatre staff caring for children and young people.
- The environment in areas where children and young people are cared for, is suitable for all ages, not just young children.
- Written information is available for children and young people about their condition and the care pathway when admitted to hospital.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Overall this service was rated as good for each of the key questions of safe, effective, caring, responsive and well-led. All areas of the service we visited were visibly clean and there were good infection prevention and control practices. Patient risks were assessed, reviewed and appropriately monitored during their stay. Staff were supported in their role. Staff were aware of the hospital's safeguarding process and were clear about their responsibilities. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance. The service was taking action to be able to meet current evidence based guidance. There were plans to drive towards achieving Joint Advisory guidance (JAG) accreditation in gastrointestinal endoscopy. Feedback from patients about their care and treatment was consistently positive. During the inspection, we saw that staff were caring, compassionate and sensitive to the needs of patients. Staff respected patients' privacy and confidentiality at all times. Patients told us they felt informed about their treatment and were included in decisions about their care. Staff told us anxious patients or patients with a learning difficulty were given the opportunity to visit the treatment area before their treatment and care commenced. Patients had a comprehensive assessment of their needs. The clinical staff monitored patients' pain levels regularly and responded appropriately with a variety of methods for pain relief. Patients told us they had adequate and timely pain relief.

Summary of findings

Staff across the service described being proud of working for the hospital because they were well supported and respected by visible and accessible managers, with good communication structures.

Surgery

Good 

Overall this service was rated as good for each of the key questions of safe, effective, caring, responsive and well-led.
Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Although the service used agency staff, wherever possible regular bank and agency staff were employed who were inducted and familiar with the service procedures. All wards and theatres had an appropriate skill mix during shifts. Generally, the staff-to-patient ratio was one to five and increased to one to four when needed. The hospital had an escalation policy and procedures to deal with busy times.
Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment, were reliable and appropriate to keep patients safe.
Staff knew the process for reporting and investigating incidents using the hospitals reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
At ward and theatre levels, we saw staff worked well together and there was respect between specialities. We saw examples of good team working on the wards between staff of different disciplines and grades.
Staff treated patients with compassion, dignity and respect. Ward managers and matrons were available on the wards so that relatives and patients could speak with them. We saw patient information leaflets explaining procedures and after care arrangements. Feedback from patients was continually positive about the way staff treated people.
The hospital did not consider the patients emotional and psychological needs of people such as those living with dementia. There was a lack of

Summary of findings

understanding and awareness concerning patients who may lack capacity to make particular decisions and these patients were not always recognised.

Services for children and young people

Requires improvement

We rated this service as requires improvement overall because:
Although patient care records were always available, in some records we found medical staff had not dated prescriptions or their signatures were not always clear. We observed and saw in patient records that staff did not record the height and weight for all children prior to a prescription being issued and the dosage calculated.
Nurse staffing for the service did not meet national guidance from the Royal College of Nursing. There was often only one nurse on duty covering the ward and outpatients. The hospital had recruited to additional posts but these staff had not yet started.
At the time of the inspection, senior management monitored the governance, and risk of the service, rather than this being done at local level. Senior management had identified concerns about the service and taken action to address these, including recruitment to a number of new posts.
The service leads had a number of good ideas to improve and develop the service but they did not have action plans or timelines to support how and when they would implement these. There was no local monitoring of patient outcomes or use of clinical audit.
There was no involvement of children, young people or their families in the design or running of the service, although the hospital had plans to address this. Nursing staff made inpatient rooms 'child friendly' but there was a lack of suitable entertainment and distraction for older children and young people in outpatients. There was no separate waiting area for children, although the layout in outpatients meant this was achievable.
We found the process for assessing and managing the pain of children and young people was not to a consistent standard.
While there was a good up-take of mandatory training in some departments, not all staff were not up-to-date with paediatric basic life support

Summary of findings

and safeguarding children and vulnerable adults training. The hospital were arranging additional training sessions for basic life support. Some nursing staff on the ward did not feel confident checking the paediatric resuscitation trolley.
Feedback from children, young people and their parents was positive. They described the excellent quality care they received and how staff took the time to explain things using age appropriate language. We saw and parents told us how staff had included their child in decisions about their care. Staff were friendly and understanding, providing additional support to children who were worried or anxious. Parents told us they valued how staff had offered them emotional support. Parents commented on the efficiency of the booking, admission and discharge process. They had experienced minimal waiting times for appointments or surgery dates.
We observed staff following good infection control practices when providing care to patients. All clinical and ward areas we visited were clean and tidy.
There was good multi-disciplinary working across all teams in the hospital so children and young people received co-ordinated care and treatment. In the event a patient became unwell, there were systems in place for staff to escalate these concerns to medical staff and refer the patient to another hospital if necessary.
Staff told us there was good access to additional training to enable them to develop in their role and they felt well supported by their manager and the hospital director. Medical staff were only granted practising privileges to work at the hospital if all pre-employment checks demonstrated they were competent to provide care and treatment for children and young people.
Staff were confident in describing the signs of abuse and knew the escalation process to follow if they needed to make a referral to the local safeguarding team.

Outpatients and diagnostic imaging

Good

We rated this service as good overall. We found outpatients and diagnostic imaging was good for

Summary of findings

the key questions of safe, caring, responsive and well led. We did not rate effective, as we do not currently collate sufficient evidence to enable a rating.

There were appropriate systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff undertook appropriate mandatory training for their role and they protected patients from the risk of abuse and avoidable harm. Staff followed hospital infection prevention and control practices and they monitored them regularly, to reduce the risk of spread of infections. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.

Staff planned and delivered patients' care and treatment in line with current evidence based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Managers supported staff to deliver effective care and treatment, through meaningful and timely supervision and appraisal.

Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole. We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

There was good availability of appointments for patients across all specialities. Staff planned and delivered services in a way that met the needs of patients. Access to appointments was timely; clinics were held on weekdays into the evening and on Saturdays to suit patients' preferences. Waiting times, delays, and cancellations were minimal and managed appropriately.

Summary of findings

Interpretation services were available when required and staff made practical adjustments to accommodate patients' individual needs, for example, when caring for patients with dementia.
There was openness and transparency in how staff dealt with complaints, which they investigated and changed if necessary.
There was a clear statement of vision and values, which was driven by quality and safety. Staff were well informed about issues relating to their department. Effective governance and risk management systems were in place.
Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Staff gave patients opportunities to provide feedback about their experiences and this was used to improve the service.

Summary of findings

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Good

Nuffield Health The Manor Hospital Oxford

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

Summary of this inspection

Background to Nuffield Health The Manor Hospital Oxford

Nuffield Health The Manor Hospital Oxford was purpose built and opened in 2004. The hospital is managed by the Nuffield Health Group, a not-for-profit organisation. On-site facilities include six high specification surgical theatres, 64 private en-suite bedrooms, two minor procedure suites for day case and outpatient surgery, and a radiology unit including: mammography, ultrasound, MRI & CT scans.

Over 300 qualified consultants have practising privileges and lead the medical and surgical services. The consultants who work at the hospital predominantly have substantive posts with the local acute NHS trust.

The hospital has been transitioning through a period of immense change since December 2015, with new clinical and hospital leadership. The current manager became the registered manager in February 2016.

We inspected the hospital as part of our planned comprehensive inspection programme. We looked at the four core services provided by the hospital: medicine, surgery, outpatient and diagnostic imaging, and services for children and young people.

Our inspection team

Our inspection team was led by:

Inspection Lead: Lisa Cook, Inspection Manager, Care Quality Commission (CQC)

The team included five CQC inspectors and seven specialist advisors including a children's nurse, outpatient's manager, theatre nurse, surgeon, oncology nurse, radiographer, and a governance lead.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information that we held about the hospital. We carried out an announced inspection visit between 8 and 9 June 2016, and a routine unannounced inspection on 22 June 2016. We spoke with staff and managers individually. We spoke with patients, relatives and staff from the ward, oncology unit, physiotherapy department, radiology, cardiology, operating department, endoscopy unit and outpatient services. We observed care and treatment and reviewed patients' records.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

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

Good

Medical care

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

Information about the service

The medical service provided by Nuffield Health The Manor Hospital Oxford includes oncology, cardiology and endoscopy, this core service report has focussed mainly on these specialties.

There were 1,145 endoscopy procedures over the last year. The endoscopy unit consisted of a treatment room, a scope washer room and drying room, a recovery area for four patients and two step-down sitting rooms. The hospital was working through the Joint Advisory Group (JAG) accreditation in endoscopy.

The oncology day unit had three en-suite rooms and a bay for five patients. The majority of oncology patients were insured. ,Patients who were not eligible for treatment on the NHS or patients that chose to pay for medicine not available on the NHS, self-funded their treatment. The oncology day unit was open 8.30am to 4.30pm. Oncology services included a chemotherapy service for patients with solid tumours and haematological malignancies. In the last year, they treated 865 patients.

The hospital undertook cardiac rehabilitation and cardiology intervention, specifically coronary angiography, percutaneous coronary intervention (PCI), implantable cardiac devices (i.e. pacemakers) cardioversion and trans-oesophageal echocardiogram (TOE), in two dedicated cardiac catheter laboratories. The cardiology suitehad nine consultants and provided a 24-hour response to urgent cases with emergency cases going direct to the local NHS hospital. The unit opens 8.00am, and provides evening and weekend clinics flexibly suiting patient's busy lives.

During our inspection, we visited the endoscopy unit, cardiology and oncology suite. We spoke with 11 patients and four family members. We spoke with 23 members of staff including, consultants, nurses, theatre staff, student nurses, ward administrators, the cleaning manager and team, physiotherapists, occupational therapists, and senior managers.

Throughout our inspection, we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment in use. We reviewed nine sets of patient records and we observed interactions between staff and patients.

Good

Medical care

Summary of findings

We found medical services were good for the key questions of safe, effective, caring, responsive and well-led.

- All areas of the service we visited were visibly clean and there were good infection prevention and control practices. Patient risks were assessed, reviewed and appropriately monitored during their stay. Staff were supported in their roles. Staff were aware of the hospital's safeguarding process and were clear about their responsibilities. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.
- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance.
- The service was taking action to be able to meet current evidence based guidance. There were plans to drive towards achieving Joint Advisory guidance (JAG) accreditation in gastrointestinal endoscopy.
- Feedback from patients about their care and treatment was consistently positive. During the inspection, we saw that staff were caring, compassionate and sensitive to the needs of patients. Staff respected patients' privacy and confidentiality at all times.
- Patients told us they felt informed about their treatment and were included in decisions about their care. Staff told us anxious patients or patients with a learning disability were given the opportunity to visit the treatment area before their treatment commenced. Patients had a comprehensive assessment of their needs. The clinical staff monitored patients' pain levels regularly and responded appropriately with a variety of methods for pain relief. Patients told us they had adequate and timely pain relief. Staff across the service described being proud of working for the hospital because they were well supported and respected by visible and accessible managers, with good communication structures.

Are medical care services safe?

Good

By safe we mean that people are protected from abuse and avoidable harm

We rated safe as 'good' because:

- Staff assessed, managed and monitored risks to patients daily. Nurses used the modified early warning score to identify patients whose condition might deteriorate and there were appropriate patient transfer arrangements to a local NHS hospital if required.
- Staff reported incidents, took appropriate actions and learning was shared. Staff understood their responsibilities to raise concerns and report incidents.
- Staff were aware of the hospital's safeguarding process and were clear about their responsibilities to safeguard people at risk.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who used services.
- All clinical areas were equipped to provide safe care and were visibly clean. Regular infection control audits were completed and monitored.

Incidents

- Oncology, endoscopy and cardiology staff were aware of how to report incidents on the electronic incident reporting system and followed the hospital's adverse event/near miss reporting policy (2015).
- There were identified leads to ensure incidents were investigated. The interim lead oncology nurse investigated oncology related incidents, unless the incident happened on the ward, in which case the ward sister investigated the incident. The leads for cardiology and physiotherapy investigated incidents in their department.
- Nursing staff were able to describe how learning from incidents had improved practice. For example, the lead nurse for chemotherapy now checks to ensure all patient weights are reassessed and documented.
- 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'andprovide reasonable support to that person. Most clinical staff we spoke with understood the principles of the duty of candour as being open and honest, offering verbal apologies and documenting errors in patient notes. There was a process for ensuring that events were reviewed, investigated and patients informed of the outcome.

- From January to December 2015, 777 clinical incidents had been reported. However, there was no breakdown of these figures to detail how many related to medical services. Ninety-eight incidents were due to extended length of stay for patients and 98 regarded documentation issues. There were no serious incidents reported within the same reporting period.
- Clinical governance meeting minutes confirmed that lessons were learnt following route cause analysis investigations. Action plans to improve the patient care were in place in a timely way and learning from incidents was shared with staff via clinical meetings and via the intranet. For example, staff told us about an unwell patient admitted, for a planned cardiac procedure. It took a week for a stool sample to be sent for investigation. This was later picked up as an incident when the results were positive for Clostridium difficile (C.difficile). The possible impact of this was discussed at ward meetings and clinical governance meetings highlighted the importance of early detection, patient isolation and hand washing to prevent an outbreak of infection in the hospital. In this case, the fact that the patient was in a single room had helped ensure there was no outbreak, despite the late confirmation of infection.
- We saw that patient discharge summaries to the GP included details of any incidents that had occurred whilst the patient was in the hospital.
- The hospital reported three expected patient deaths in 2015; these were expected deaths due to advanced disease. Staff had recorded the 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) status. The deaths were discussed at the clinical governance meeting. There was one unexpected death from January 2015 to December 2015. A senior member of staff employed at another Nuffield hospital conducted an full investigation and recommendations were made.
- The hospital matron received and disseminated medical and health regulatory (MHRA) safety alerts to relevant departments. The head of pharmacy received alerts relating to drugs and these were noted in the minutes of the clinical governance meetings.

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

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient 'harm or harm free' care. The hospital collects data for the NHS patients, which the hospital are caring for on the day of the data input. The submission included data on patient falls, pressure ulcers, catheter and urinary tract infections, and these showed 100% harm free care for the past year (March 2015 to March 2016) totalling 27 NHS patients.

Cleanliness, infection control and hygiene

- All areas of the service we visited were visibly clean, systems were in place to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures.
- One patient on the ward said the "cleaning staff come twice a day to clean the toilet and change the bins". Another patient we spoke with said "they hoover the room every day including the weekends" and a third patient said "everywhere smells fresh".
- From January to December 2015, there were no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Methicillin-sensitive Staphylococcus Aureus (MSSA) in the hospital. There was one single case of c-difficile. Staff worked within the hospital infection control policy (2015) and ensured no other patients were affected by this infection.
- In clinical area's we observed all staff adhered to the bare below the elbows policy to enable proper hand washing and reduce the possibility of cross infection. The infection control lead trained and competency assessed the cleaning manager to complete hand hygiene audits for all clinical staff. From January to March 2016, the results of the audit were 100% in the oncology department 98% in cardiology and 97% in endoscopy
- Personal protective equipment such as disposable aprons and gloves were readily available. We observed

staff wash their hands and wore gloves and aprons to administer chemotherapy. Staff wore long gloves and eye shields for endoscopy procedures to prevent the spread of infection.
- Staff were clear who was responsible for cleaning equipment and areas. 'I am clean' stickers were attached to equipment so that staff knew they were clean for use and the cleaning manager had a daily schedule to ensure all areas were cleaned on an on-going basis.
- Disposable single use equipment was available in all clinical areas such as disposable patient slings, which assisted in safe transfer of patients and reduced spread of infection to other patients.
- One of the staff in the endoscopy suite had undertaken a training and competency assessment programme to City and Guides level in decontamination. This staff member completed and documented daily endoscopy equipment cleaning and sterility checks. Two other trained staff members completed this task at all other times. The endoscopy manager audited the system in March 2016, which showed there was 100% cleaning compliance.
- Staff were trained in 'source isolation' to minimise the chance the disease spread to others. For example, to reduce the risk of spread of infection, staff identified the room nearest the toilet in the chemotherapy unit be used for isolation should this be required.
- The interim lead oncology nurse told us that an emergency sepsis pack should be in place on the wards as this was currently not available. The pharmacy manager was sourcing packs for the wards.

Environment and equipment

- Clinical equipment was serviced and tested according to the manufacturer's instructions. The cardiology manager was the medical devices lead and attended clinical governance meetings, to discuss concerns and review service level agreements.
- There was oxygen, suction and a bag and mask by each endoscopy patient's bed, ensuring the necessary equipment was available in case of an emergency. A defibrillator was available in case of a cardiac arrest. Staff documented daily checks for emergency equipment in the oncology, endoscopy and the cardiology unit.
- Emergency mobile resuscitation trollies were available in the cardiology, oncology and endoscopy recovery areas. Equipment was secured with tamper-evident tags and staff documented daily checks and tests.
- Consultants could request, on loan from the local NHS Hospital, smaller or larger scopes than standard prior to the patient's procedure.
- The cardiology department had new equipment as requested by the consultants and service level agreements were in place to ensure this equipment was safe.
- Nursing staff told us they had received 'spill kit training' and competencies to safely deal with a chemotherapy spillage, which included the necessary personal protective equipment, safe handling and disposal to ensure patients and staff were not exposed to unsafe levels.
- There was an established system for the removal of clinical and nonclinical waste monitored by the cleaning staff and the infection control lead.

Medicines

- All chemotherapy was prescribed through an electronic prescribing system, using local cancer network protocols. However, nurses were using paper copies of prescriptions to perform checks and record administration, which were later transcribed to the electronic system. This meant there was a potential for human error due to the transcribing from paper to electronic record. Staff told us that a computer was due to be installed in the oncology suite to support use of the electronic system.
- Chemotherapy was supplied pre-prepared to the hospital, and staff reported a timely service. The hospital pharmacists verified prescriptions and checked blood results before releasing any chemotherapy for administration. Pharmacists at the hospital had not completed specialist oncology training; we were told that they had recently enrolled on a course.
- Nurses worked within the hospital chemotherapy policy and did not administer chemotherapy to patients unless blood test results from within the previous 48 hours showed it was safe to do so.
- Nurses told us they had received training and competencies regarding medicine management and adhered to the hospitals policy. A registered nurse always held the medicine keys. We saw two nurses

correctly check chemotherapy drugs administered to the patient. The nurse checked the patient's details at the bedside to be sure the right dose was given to the right person, at the right time and by the right route.

- If oncology nurses saw a new drug prescribed, they accessed an official website and read the 'summary of product characteristics' (SPC) so that they knew all the necessary information before administering it or asked the in-house pharmacist to give advice. The oncology nursing staff arranged for drug representatives to visit to explain the risks and side effects at least twice a year at nurses meetings.
- There was no pharmacist on-call service to obtain medicines out of hours. In an emergency the resident medical officer and ward co-ordinator could together access the pharmacy to obtain the required medication.
- Nurses followed the medicine policy and discussed medicines with patients before discharge from the hospital; the pharmacist was involved if the medicine was high risk.
- The clinical staff locked and secured the medicine trolley within the locked treatment room when not in use.
- Ward medicine fridges were locked and clean with suitable minimal stock. Maximum and minimum temperatures were recorded daily and when checked were within safe parameters. There was evidence of pharmacy auditing fridge temperatures monthly to ensure that the fridge was at the correct temperature for medication storage.
- The designated staff nurse in each clinical setting completed medication stock checks. The hospital pharmacist checked the stock lists on a weekly basis. We saw that not all medicines had stickers to identify short dated products. However, the nurse completed date checks prior to administration. The clinical team told us that they were considering introducing a different system for checking expiry dates.
- Controlled Drugs (CDs) were stored in appropriate cupboards as advised by the Home Office 2016 drug licensing and compliant unit. The ward nurse completed a daily stock check and documented this in the CD record book. We saw administration, stock checks and receipts of stock signed and countersigned in the CD record books including patients own CDs. Pharmacy staff completed a quarterly CD audit and any deficiencies identified had action plans.
- Anaphylaxis kits were in all clinical departments. The pharmacist team sealed kits securely with tags and the kits were readily available if needed.
- Clinical staff told us that they did not use patient group directives, as the resident medical officer was always available. Patient group directives are written instructions for the administration of medicines to a group of patients who may not be individually identified before presentation for treatment.
- The pharmacy team included one pharmacist, two part time technicians, one pharmacy manager and one dispensing assistant. The pharmacist was responsible for accuracy checking of medicines and daily visits to the wards. The pharmacist attended the medical ward rounds and prioritised patients who would most benefit from pharmacy advice. We saw that the prescribing audit from December 2015 showed that 87% of errors were medicines not reviewed within 24 hours of admission by pharmacy. This workload challenge was not on the hospital risk register and there was no pharmacy risk register in place to record this potential risk.
- The hospital director is the named controlled drugs accountable officer for the hospital, attends the controlled drug local intelligence network meetings (CDLIN), and submits CDLIN reports prepared by the pharmacy team. The blood transfusion service provided by the local NHS trust complies with blood safety and quality regulations.
- Blood was stored in the hospital blood fridge. Qualified staff trained in the management of blood and blood products could access the fridge via a swipe card. Daily temperature recordings for the blood fridge were in place.

Records

- To prevent unauthorised access to patient information, oncology, cardiology and consultant service records were in locked cupboards/trolleys with a tracker to locate records if removed.
- Staff stored risk assessments in the main patient record to ensure colleagues accessing the clinical notes understood risks. Staff gave patients a paper copy of their summary record on discharge from the hospital.
- We reviewed eight sets of patient records. The care records contained patient assessments, observations,

medical and nursing notes plus ongoing risk assessments and discharge planning documents. All relevant timely assessments were completed entries signed, dated and legible.

Safeguarding

- The hospital followed corporate Nuffield policies for safeguarding children and vulnerable adults. The leads for safeguarding children were the children and young people lead nurse and matron; for safeguarding adults the hospital director and matron.
- Staff knew who the safeguarding lead was and told us they would contact a member of the on call senior management team if the lead was not available.
- The May 2016 training compliance for safeguarding children and vulnerable adult's level 1 training met the 85% target in endoscopy and on the wards.
- Frontline staff could describe the signs of abuse and knew the process to follow if they needed to raise a safeguarding concern. Flowcharts detailing the referral process were on display in departments, so staff could easily access information.
- Contact telephone numbers for the local councils' safeguarding team were displayed in the oncology, cardiology and endoscopy unit for staff to find quickly.
- The staff corridor clearly displayed safeguarding information provided by the hospital director and matron. The display included information about the various types of abuse associated with children and vulnerable adults, who staff should report concerns to, and steps for staff to follow in order to recognise, intervene and prevent abuse.

Mandatory training

- All staff were required to attend yearly mandatory training based on their job profile to ensure they trained to care for the patients safely. Mandatory training at the hospital included, consent, fire safety, the Mental Capacity Act 2005, safer blood transfusions and health record keeping. Staff could access training on line and face to face training was available for basic life support, intermediate life support, manual handling and aseptic technique.
- The training modules were a mix of e-learning and practical sessions and included, for example, information governance, incident reporting and fire safety.
- The hospital compliance target for mandatory training was 85%. The training compliance records were collected for two areas within the hospital theatres and wards. Therefore, it was not possible to give specific figures for cardiology, oncology and endoscopy. Training and compliance for basic life support resuscitation was good. Theatre staff completed 95% of training and ward staff completed 98% as of May 2016. The hospital was above the 92% national average. Four clinical staff members, including two resident medical officers had completed intermediate life support training (as of March 2016) with an action plan to train four more clinical staff members by June 2016.

Assessing and responding to patient risk

- Staff were aware of and worked within the hospital risk policy and process guide updated February 2016.
- We saw efficient medical patient care handovers between clinical staff. For example, staff on the wards introduced the next nursing staff shift to the patients to familiarise both the patient and staff to each other and highlight any patient allergies or anxieties such as needle phobia's.
- Staff met daily to discuss the crash team allocation, detailing who was in charge of managing this type of emergency. This ensured the patient care for unexpected cardiac arrest or severe breathing difficulties was managed safely.
- The cardiology manager had adapted the hospitals World Health Organisation Five Steps to Safer Surgery document to be used for procedure in the cardiology department such as pacemakers, ablation and angiograms. This was so that all steps were covered to help ensure risk was managed to promote patients safety and to ensure that all relevant information was in one document including patients' details and aftercare.
- Staff on the oncology unit only treated 'level one' haematology patients, this patient group would not normally be expected to result in complex side effects or bone marrow suppression, any patient who might require high dependency care was not accepted for treatment at the hospital.
- Patients requiring chemotherapy had a wallet-sized medical alert card to carry which advised them about the risks of developing an infection and told them what symptoms to act on and the hospital's contact numbers.
- If a patient attending for chemotherapy appeared to be unwell, nurses would follow the hospital protocol,

assess the patients, and discuss them with the consultant, treatment would not be given and tests undertaken to ascertain if the patients had an infection. If there was serious concern that the patients had an infection, intravenous antibiotics would be started immediately (before the blood test results were ready). The same procedure was followed if an oncology patient called and was unwell.

- The interim lead oncology nurse told us the hospital lacked an acute oncology policy to ensure patients received immediate accurate information. They were drafting a policy and had plans in place for training staff, especially at ward level.
- Staff scheduled complex chemotherapy regimens so that patient treatment times did not overlap, enabling staff to spend the required time responding to increased risks if presented.
- Staff told us that there was a service level agreement for patient transfers for the local NHS trust to accept patients who require acute treatment and care.
- Patients booked for endoscopy procedures completed a medical questionnaire, reviewed by nurses on arrival at the hospital to identify risks such as allergies prior to the procedure.
- Clinical staff in the endoscopy theatre were consistently following the World Health Organisation 'Five Steps to Safer Surgery', to reduce harm by consistent use of best practice, which included team brief, sign in, time out, sign out.
- Qualified nurses accompanied patients who had undergone an endoscopy back to the ward for further assessment and supervision. If a patient became unwell, they were taken to the theatre recovery area until their condition was stabilised.
- Patients were given out of hours telephone numbers on discharge from the hospital, in case they became unwell after their endoscopy, chemotherapy or cardiology treatment. Oncologists provided an on-call service for patients who felt unwell and needed to contact the hospital out of hours and the resident medical officer (RMO) supported this process. The patient was re-admitted to the local NHS hospital for ongoing treatment and care in two sets of patient's notes we reviewed.
- In the case of a patient's condition worsening, the RMO would review and liaise with the consultant for advice about managing increased risks.
- Patients assessed as high risk of falls had a red wrist label to alert this risk to all staff members.
- Staff demonstrated confidence and competence during discussions to request urgent medical assistance if a patient showed signs of deterioration using the Modified Early Warning System (MEWS). There was adequate medical cover and specialist availability for ongoing treatment and care.
- Nuffield Health produced an audit tool to measure compliance with the policy for prevention and management of venous thromboembolism (VTE). We saw evidence of compliance with this annual audit. Clinical staff achieved the 95% target for venous thromboembolism screening rate in the reporting period (January to December 2015).

Nursing staffing

- Endoscopy, chemotherapy and cardiology nursing staff told us they worked flexibly to meet any extra demands for the service. If permanent staff were unable to cover any extra work, bank staff filled the shift.
- The hospital used less than 20% agency staff in 2015.
- A months staffing rota for the oncology ward and endoscopy suite demonstrated the ratio of nursing staff was always two registered nurses on every shift.
- There was less than 20% use of bank or agency staff in all clinical areas of the hospital. The hospital used two accredited agencies contracted by Nuffield health and this allowed for continuity. Permanent staff working extra hours usually covered any gaps in numbers. Bank or agency staff did not take charge of the shift, as there was always a qualified permanent member of the team in each clinical area.
- The hospital was recruiting to increase staff numbers within their own bank. Staff told us all agency staff completed a local induction and could care for patients safely.

Medical staffing

- The hospital employed two Resident Medical Officers (RMOs) to ensure medical cover was on site 24 hours a day, seven days a week. They reviewed patients' daily prescribed additional medication and liaised with the consultants responsible for individual patients care. The consultant was available to attend the hospital in person within 30 minutes of an urgent clinical request or liaised with colleagues to ensure they were appropriate cover arrangements in place.

Good

Medical care

- The RMOs had appropriate advanced life support training and skills, supported by a twenty-four hour a day, seven days a week on-call contracted consultant cover rota.
- The RMOs reported that the on-call consultant covering their own patients was available at any time of the day or night and responded quickly to any clinical concerns in the hospital.
- We observed patient handovers between the RMOs, there was detailed and respectful discussion about the patients within the hospital, with appropriate signposting to patients requiring clinical reviews.

Major incident awareness and training

- Training in major incident awareness was available to all new staff during their induction and refreshed annually.
- Hospital business continuity plans were in place and the customer service manager discussed major incident plan details which managers would refer to if a major incident was declared. Arrangements included a back-up generator in case of power failure and a list of staff and volunteers with fully insured 4x4 vehicles to take essential staff to and from the hospital in adverse weather conditions.
- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Hospital-wide unannounced fire drills took place quarterly to test staff knowledge of the evacuation plan, we were informed the last one conducted was out of hours. All staff understood their responsibilities if there was a fire within the building.

Are medical care services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Care and treatment followed current legislation, nationally recognised evidence-based guidance and best practice.
- The unplanned readmission rate for 2015 per 100 discharges showed that readmission rates were lower for Nuffield Health The Manor Hospital Oxford compared to other hospitals within the Nuffield health hospitals group.
- The resident medical officers provided medical cover for the site 24 hours a day, seven days a week. There was a clear process for transferring un-well patients to the local NHS hospital.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- The hospital followed National Institute of Clinical Guidelines (NICE) guidance on the management of neutropenic sepsis and achieved 80% compliance in December 2015; this low score was because the resident medical officer documentation was not complete. We saw an action plan to improve documentation compliance.

Evidence-based care and treatment

- The hospital completed a monthly gap analysis of new National Institute for Health and Care Excellence (NICE) guidelines, assessed whether these were relevant to the services offered by the hospital and any action they needed to take to implement them. The interim lead oncology nurse had set up a bi-monthly oncology steering group and discussed action plans and timelines. This group had successfully introduced the 2014 NHS safety thermometer, for all patients, which provides a quick and simple method of surveying harm and analysing results by measuring and monitoring local improvement and harm free care over time. The group also introduced the National cancer institute 2003 stool toxicity assessment tool. We saw clinical staff using these tools to assess patient care during the inspection.
- The interim lead oncology nurse had initiated the first steps towards the award of the Macmillan Quality Environment Mark (MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. The oncology staff recognised this award would demonstrate that the unit was a place respectful of peoples' privacy and dignity, supportive to users' comfort and well-being, giving choice and control to people using the service. Listening to patients and achieving this award was a high priority for the hospital.

- The hospital used the National cancer intelligence network chemotherapy protocols, based on National Institute of Clinical Guidelines (NICE) 2014.
- The hospital followed NICE guidance on the management of neutropenic sepsis. Guidance recommended patients be assessed within 15 minutes of arrival and all tests were completed within 60 minutes. The hospital policy dated April 2016, stated that the resident medical officer would need to initiate immediate treatment on the consultant's recommendation.
- Oncology staff had received one-to-one training in assessing patients using the United Kingdom Oncology Nursing Society's (UKONS) 'Oncology/Haematology 24 Hour Triage Rapid Assessment and Access Tool Kit'. Plans were in place to train ward staff to ensure any patients that called the hospital for advice out of hours would be assessed and treated quickly.
- Oncology staff attended quarterly local cancer multidisciplinary team meetings and discussed patient care. The clinical staff completed an audit whether all patients were fully consented prior to chemotherapy. Results were discussed and action plans to improve were documented. For example, the team discussed that the resident medical officer did not always complete the United Kingdom Oncology Nursing Society paperwork as per hospital policy and an action plan and timeline to improve agreed and documented.
- Endoscopy staff booked procedures in line with British Society of Gastroenterology (BSG) guidance. Staff allowed sufficient time for procedures to prevent endoscopy staff failing to detect abnormalities.
- The endoscopy service was in the early stages of working towards Joint Advisory Group (JAG) accreditation. This is formal recognition that an endoscopy service demonstrates it has the competence to deliver against the measures in the global rating scale standards. The service had benchmarked its services against the JAG standards. There was a detailed action plan with timelines and named leads for completion.

Pain relief

- Patients told us staff assessed and scored their pain between zero and four; and clinical staff gave the patient prompt patient pain relief.
- Oncology nurses could refer patients to the NHS palliative care team for pain management advice if necessary.
- Patients reported nursing staff acted promptly and appropriately if they complained of pain. One patient said the nursing staff always explained the best way to take pain relief so they could sleep well.

Patient outcomes

- The unplanned readmission rate for 2015 per 100 discharges showed that readmission rates were 7% lower for Nuffield Health The Manor Hospital Oxford compared to other hospitals within the Nuffield health hospitals group.
- The hospital had joined the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was yet available.

Nutrition and hydration

- Clinical staff used the five step national malnutrition universal screening tool (MUST) to identify adults who are malnourished and followed guidelines to improve food intake.

Competent staff

- Nursing, therapists and health care assistants completed the organisational competency framework relevant to their role. All staff completed this competency assessment, even if they were experienced in a skill when they joined the hospital. Assessment included a wide variety of skills, such as cannulation and use of the hospital's medical devices.
- There was an interim lead oncology nurse, one clinical specialist nurse for breast cancer and four part time chemotherapy competent nurses within the oncology team. The interim lead oncology nurse had completed a Master degree in cancer care.
- The trained oncology nurses attended chemotherapy course updates every two years.
- The hospital had successfully appointed a full time replacement lead oncology nurse who would be in post in July 2016.
- Two ward nurses out of 26 nursing staff were trained in 'Care of the Patient Undergoing Chemotherapy'. The lack of training to ensure staff were sufficiently trained to care for patients who may contact the hospital and require admission out of hours was highlighted by the

interim lead oncology nurse who had developed a teaching plan to improve ward staff knowledge. However in the interim, calls were diverted to the RMO who had a clear understanding of the pathway.

- During quiet periods, nurse's accessed online training to increase their clinical knowledge such as management of chemotherapy induced nausea and vomiting and medical emergencies.
- Nurses working in the endoscopy, oncology and cardiology service had twice-yearly appraisals. Staff told us the appraisal system was worthwhile and engaged them in improving themselves and the service to patients. The appraisal highlighted manager and staff opportunities for further training and development. Staff told us that there was funding available for further training and managers supported staff to access further training and development.
- The cardiology manager discussed that he and the eight trained staff within the unit kept their competencies and skills up to date by working part time at the local NHS hospital. To be able to practice within the cardiology unit in the NHS, all staff must attend the yearly mandatory and competency training with assessment within an agreed standard and timescale. The training and competency checks were overseen by the NHS head of services.
- The hospital undertook robust procedures which ensured consultant who worked under practising privileges had the necessary skills and competencies. The consultants received supervision and appraisals. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's name.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings. Actions were created and completed before the consultant could practice at the hospital again.
- The Resident Medical Officer (RMO) who was employed through an agency underwent an additional recruitment process before they commenced employment. This involved checking their suitability to work at the hospital and checks on their qualification. They had one week of induction and shadowing before they commenced at the hospital. Staff told us that the hospital had refused RMOs in the past as they were concerned about their competencies. A consultant mentored all RMOs.
- Three staff members told us they had received training in Sage and Thyme, a National model developed in 2006 to teach clinical staff the core skills of dealing with people in distress.

Multidisciplinary working (in relation to this core service)

- There was strong multidisciplinary team working with a daily ward round attended by medical, nursing, pharmacist and therapy staff.
- There was a physiotherapy manager and thirteen physiotherapists and occupational therapists working seven days a week, ensuring physiotherapy and occupational therapy was readily available to patients.
- Patients were discussed and treatment protocols agreed by the cancer multidisciplinary team (MDT), as part of Nuffield health cancer standards, to ensure that a team of experts came to a decision in line with national guidance about what was the best treatment for a patient, rather than one doctor making a decision alone.
- Oncology, cardiology and endoscopy nurses had good working relationships with the resident medical officer and colleagues in pharmacy and x-ray. They told us oncology, cardiology and endoscopy consultants trusted them and listened to their opinion.
- Staff in the oncology unit had good working relationships with their peers in other local trusts for example; they administered the chemotherapy and prepared patients for stem cell transplant elsewhere.
- Oncology and cardiology nurses felt able to challenge medical staff if, for example, they noticed a drug protocol was not what they expected.

Seven-day services

- There was a laboratory to process blood tests on site from 8.30am to 4.30pm, Monday to Friday. However, if an oncology patient was unwell outside of these hours, they could attend the hospital for their blood test, and their blood sample would be couriered to the local NHS hospital for processing. The resident medical officer would not delay giving the patient antibiotics if these were required which was in line with hospital policy.

Good

Medical care

- Appointments for medical treatments of cancer could only be accessed Monday to Friday. However to accommodate people working office hours, appointments for clinical assessments were available between 5pm and 8.30pm.
- As per NICE guidelines, myeloma: diagnosis and management guidelines 2016, chemotherapy treatment was not administered out of hours.
- If a patient was admitted for symptom control, oncology consultants were on call to carry out weekend ward rounds.
- Other support services were available as standard at the weekend, such as physiotherapy.
- Chemotherapy patients could access advice from the oncology unit from 8am to 5pm Monday to Friday. During out of hours there was a system in place for calls to be diverted to the RMO.

Access to information

- The nurses and patients we spoke with agreed consultant notes were always present for the appointment time.
- Nurses had access to the local NHS hospital's pathology results so they could check the results of any chemotherapy patients' blood tests out of hours.
- Staff had access to the intranet, and folders with policies and procedures were in all clinical areas. Notice boards reminding staff about clinical information were in accessible areas such as the medication room.
- Patients and general practitioners received same day discharge information. This included future management of condition, supply of medication use and side effects, follow up advice, support and what to do in event of a problem.
- We saw that the oncology unit had a new service level agreement in place for patients to access the National Cancer Centre Care and a library of information leaflets were available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed an endoscopy procedure from admission to discharge and saw written and verbal consent was obtained.
- The interim lead oncology nurse audited chemotherapy consent forms and found 80% were fully completed from January to and March 2016. The results of the audit were discussed at the clinical governance and nurses meeting, highlighting the need to improve the completion all consent forms. A further audit was planned for the next quarter.
- One hundred per cent of staff were up to date with their mandatory annual Mental Capacity Act training. Training on the deprivation of liberty safeguards was included in safeguarding training; 100% of staff had received this within the last 12 months. Staff could describe the process for both deprivation of liberty safeguards and safeguarding examples for patients within the hospital were actioned.
- Staff understood the principles of mental capacity and told us of an example where one patient was frail and confused and the consultant recognised the patient could not make a decision regarding proposed treatment until a full mental capacity act assessment was completed.

Are medical care services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- Patients were treated with dignity, respect and kindness
- Staff took time to involve patients in their care. Patients told us staffinvolvedthem in alldecisions about their care.
- Flexible visiting hours allowed patients to maintain supportive relationships with those close to them. Staffsupported patientsto keep their independence and connections with family and friends.

Compassionate care

- Patients we spoke with said they found the care to be compassionate and understanding. One patient who had attended the oncology unit many times described staff as "cheerful, approachable and professional". One patient described the consultant and clinical staff as "outstanding, I am involved every step of the way and everything is explained and options discussed with me.

Another patient thanked the staff for their unfailing kindness and professionalism. A relative told us "I just know night or day the staffs are always there for me and my husband".

- Staff responded to call bells promptly and treated patients with dignity and respect when providing care, keeping bedroom doors closed to maintain privacy.
- The specialist cancer nurse accompanied the consultant endoscopist when telling patients they had cancer. This ensured patients and relatives had immediate access to support and information about the next steps.
- Oncology staff told us that patients did not have a 'named nurse'. This was because they did not want patients attached to the 'named nurse'. Instead, nurses introduced to the patient as a team before they attended for treatment.
- One consultant told us "I work with the patient and listen to their needs". They discussed how they would adapt treatments for patients with incurable cancer, so that pain and nausea was minimised but they could still do things that were important to them, such as attending social events or going on holiday.
- The hospital took part in the Friends and Family test. There was no breakdown of the figures therefore it was not possible to identify the significance of these statistics with regards to the medical services. For the reporting period July to December 2015, the hospital reported 91% to 95% of inpatients would recommend the hospital to their friends and families. The response rate was between 36% and 48%.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 93%, above the England average of 86% from February 2015 to June 2015.

Understanding and involvement of patients and those close to them

- Patients we spoke with in the chemotherapy, endoscopy and cardiology wards discussed being involved in their care. Patient relatives discussed and appreciated that they could stay as long as they liked.
- Patients told us that they received "constant reassurance" from the staff. The patient continued by saying 'the staff make sure you understand information and the consultant draws diagrams to help understand procedures." Another patient and his wife told us, "we have been coming here for so long now that the staff treat us like friends, they even got my husband a cake and a card on his birthday!" They added that the receptionist, the cleaning staff and the nurses were "really lovely and are the right people for the job."
- Family members were always involved where possible in discussions about care and treatment. Staff acknowledged chemotherapy affected all family members and included relatives in care planning. Staff considered the needs of the patients loved ones when planning cancer treatment.
- Patients told us about the positives and negatives of wearing a scalp-cooling hat during chemotherapy, as nurses understood it could be painful in certain circumstances. This meant patients understood what treatment involved and enabled patients to make informed choices about their care.

Emotional support

- All patients were given a Nuffield Health "going home" information leaflet. Staff told us and we saw they were individually tailored to suit the patient and family needs and gave information such as managing wounds, mobility and pain relief and whom to contact if concerned. Patients said this information was useful so they knew what to expect and did not become unduly anxious on discharge from the hospital.
- After endoscopy, we saw that if a diagnosis of cancer was suspected, nurses took the patient to a private room to discuss the findings, and then called the oncology clinical nurse specialist to speak with them.
- Patients told us the cancer specialist nurse rang them to ask how they were after their treatments.
- One chemotherapy patient told us, "I have been offered lots of support groups, but the best support is the team here at the hospital, I email the ward sister and she helps me get the chemotherapy treatment appointment I want and this lets me keep control."
- Patients couldaccess a clinical psychologist assigned from the NHS Trust if clinical staff assessed this was required, and staff could request on their behalf for a chaplain to visit from the neighbouring NHS Trust.
- Counselling services were available upon request from the NHS Trust via the oncology service.

Are medical care services responsive?

Good

Medical care

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- The hospital planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service. The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- There were good examples where staff adapted procedures and worked flexibly to meet individual requirements, such as working with patients to allow them to continue working whilst receiving chemotherapy treatment.
- Staff responded to complaints and concerns in a timely way. Learning from complaints was distributed in mandatory training sessions and used to improve the quality of care.
- The people who use the service have timely access to initial assessment, diagnosis and urgent treatment at a time to suit them.
- The hospital only cancelled care and treatment when necessary. The reason for the cancellation was fully explained in person. Access to further appointments for care and treatment was promptly arranged.
- The hospital engaged and planned services with people who are in a vulnerable circumstance such as chemotherapy treatment.

However,

- Staff told us they drew the curtains around patients waiting for, and recovering from endoscopy, as there were male and female patients in the four bedded recovery area. This was not compliant with JAG privacy and dignity standards.

Service planning and delivery to meet the needs of local people

- Staff delivered oncology services to meet the needs of patients. One member of staff told us, "the department's ethos is the patient comes first".
- Oncology staff told us they had funding approval to decorate their unit. We saw "mood boards" for patients and their family to choose the fabrics, colours and furniture of the unit.
- Consideration had been given to enabling relatives of patients receiving chemotherapy to dine together and they could purchase lunch for the small room menu. There was a coffee shop for all patients and their visitors could access.
- The hospital had service level agreements with the local NHS trust for acutely ill patients requiring intensive care treatment.
- The endoscopy department staff told us that they had taken proposals to clinical governance meetings. The proposal was to change the recovery area from four beds to four 'pods' with individual toilet facilities to ensure the JAG privacy and dignity requirements were met.
- The cardiology service manager was a practising cardiac physiologist and understood the unnecessary anxiety patients experienced waiting for diagnostic tests. Therefore, the layout of the cardiology unit was altered to ensure the cardiology consultation rooms all had cardiac ultrasound machines for echo cardiology. The clinical team could perform stress echo tests all in one place on the same day of the patient's appointment and avoid unnecessary delay in diagnosis.

Access and flow

- In 2015, the hospital met all of the NHS patients waiting times for admitted patients beginning treatment within 18 weeks of referral.
- Patients received timely treatment. One patient told us, "I started my first treatment three days after my appointment with the oncologist." We saw from patient notes that endoscopy procedures started within a week from initial consultation. All of the patients we spoke with told us they had short waits for their treatment. One patient told us his anxiety reduced greatly when given an appointment within two days of referral for cardiac tests.
- Patients suspected of having cancer, could access needle biopsies and mammograms on the same day as their initial consultant appointment.

- Staff gave chemotherapy patients a choice of appointment times, whilst at the same time patients were scheduled to ensure there was flow through the unit, taking into account patients' varying treatment times.

Meeting people's individual needs

- The staff knew that the hospital dementia lead was the matron who had received in-depth training. Eight staff members told us that they had attended a four-hour dementia awareness training course.
- Staff treated patients as individuals. Endoscopy staff gave an example of how they made reasonable adjustments for a patient living with dementia, by allowing their relative into the anaesthetic room to help ease anxiety for the patient.
- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2015), outlining arrangements for adults. We saw chaperone notices displayed around the hospital.
- Staff worked hard to ensure individual needs were met. A former patient sent a thank you card to staff for helping them choose times and dates to receive chemotherapy so they could remain working whilst receiving treatment. Two younger patients told us that staff offered patients a choice of times for chemotherapy, so that they could still attend work, or avoid traffic.
- Patients receiving chemotherapy stayed overnight in the hospital if they were frail or nauseous and had no support at home.
- Staff maintained patient privacy at all times.There were rooms available for patients to receive bad news in private.
- Staff did not receive any specific training about caring for individuals with learning disabilities, but recalled learning from their safeguarding adults training and told us that one patient with learning difficulties requiring an endoscopy was introduced to the theatre staff and shown the theatre layout the day before the procedure to reduce concerns. Patients with individual specific needs were able to visit the clinical environment prior to any treatment interventions to see the clinical area, meet staff and reduce fears.
- Staff told us they drew the curtains around patients waiting for and recovering from endoscopy, as there were male and female patients in the eight-bedded area. However, this was not compliant with JAG standards in relation to maintaining privacy and dignity. We saw action plans and meeting minutes that demonstrated the endoscopy manager gaining approval to alter the eight-bedded area into six "pods".
- Easy read books were readily available for patients with a learning disability diagnosed with cancer. Booklets produced by the National Cancer Care Centre covered all aspects of tests and treatment care.
- Patients and families received an information leaflet explaining different endoscopy, cardiology and chemotherapy procedures. Clinical staff reported that the National Cancer Care Centre produced leaflets in whatever language required for the patient. Leaflets were only available in English at the time of inspection.
- Staff we spoke with said they could access translation services for patients whose first language was not English. This meant that these patients were able to hold detailed discussions about their care and treatment.
- The hospital did not routinely provide end of life care. From October 2015 to April 2016, three patients who were in the final stages of life had been cared for. The nursing and clinical care notes documented these patients had been seen by the nursing and medical team every day and the patient and family were given full explanations and choices regarding care needs such as do not attempt resuscitation and whether or not to reinsert a feeding tube.
- All rooms in the oncology unit had televisions and free Wi-Fi was available.
- Patients told us the chef would try to tempt patients with tasty alternative options should the normal menu not appeal to them to ensure that their nutritional needs were met. We saw that special dietary requirements catered for on request. The hospital chef specially made a curry meal for a younger patient who requested it. One patient told us "I am sure I have put on weight as every meal is so tasty", another patient said "the food is nicely presented and there is lots of choice".
- Patients in the oncology unit could access fresh water, fresh juice and hot drinks. Patients in the endoscopy and cardiology suite were offered fresh water and food after treatment.
- The catering team told us that they took pride in presenting quality meals for patient, staff and visitors to the hospital.

Learning from complaints and concerns

Good

Medical care

- Patients and relatives had various ways of raising concerns. These included completing the patient satisfaction survey questionnaire, hospital website/ enquiry forms, written complaints or verbal complaints. Complaint forms were available in various locations around the hospital.
- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. There had been 11 complaints for the ward and the theatre suite for the period January 2016 to June 2016. There were four complaints concerning the ward. The majority of the complaints related to poor staff communication, delays in treatment times or cost incurred for treatment. Most complaints were resolved locally. The matron asked to see any patient that was unhappy in an effort to resolve the patient's concerns.
- The inspection team received one complaint relating to a delay in oncology medicines. Staff told us they had completed an incident form, the patient and family member had received and accepted an apology for the delay and action taken to improve the transportation of medication to ensure further delays did not occur in the future.
- We saw that staff responded to 98% of complaints within the hospital policy of 20 working days.
- We saw that the Annual Clinical Governance Report illustrated and discussed the complaints from 2015; one complaint identified that information about treatment payment charges was unclear. Staff took actions to ensure the issue did not occur again by amending the information leaflets given to patients at consultation.
- We saw that staff trained in the use of the complaints policy and gave examples of listening to concerns and acting to improve as soon as the concern was identified.
- Service improvements occurred as a result of a complaint from an oncology patient who telephoned requesting to speak to an oncology nurse and there was not one available at that time, causing unnecessary anxiety to the patient. The team discussed this and devised a new process to ensure a qualified oncology nurse is available when the patient calls. One other patient comment was that the nursing team were too far away from their room so the team moved the nurses desk nearer to the patient to suit the patient's needs.

Are medical care services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- Staff were aware of the values of the organisation and were passionate about good patient care. Staff had strategy 'built into' their appraisal process.
- Staff spoke positively about the 'no blame' culture of the team and of the visibility and support of managers.
- There was a governance structure, which oversaw quality, audit and risk.
- The people who use the service and those close to them were engaged and involved in the decision making of the service.
- Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture.
- Senior clinical leaders and staff strive for continuous learning, improvement and innovation in the delivery of clinical care.

Vision and strategy for this this core service

- The oncology strategy included providing a high level of service and updating GP clinics on the services provided in order to be the market lead. For 2016, the unit was working towards accreditation of the Macmillan Quality Environmental Mark (MQEM).
- The endoscopy manager developed a clear strategy for the service at this hospital linked to the hospital's overall strategy. Staff were given objectives to help the service meet its aims and could discuss the plans to obtain Joint Advisory Group (JAG) accreditation.
- The interim lead oncology nurse and the cardiology manager clearly described the vision in the oncology and cardiology unit, to give patients the best experience at a difficult time, be the market leader and offer the best clinical care in the area.
- Endoscopy, cardiology and oncology staff we spoke to were aware of the hospital's vision and strategy and could therefore demonstrate their role to improve patients services for the future.

Good

Medical care

Governance, risk management and quality measurement for this core service

- Nuffield completed an internal clinical review of the hospital service in December 2015, following concerns raised by the new hospital director about the governance processes across the hospital.
- Staff reported risks to heads of department who escalated them to the senior team as required. There was one hospital wide risk register. The register detailed 14 risks which were identified as a potential risk to the whole hospital. These risks included; documentation, inconsistent compliance with the World Health Organisation "Five Steps to Safer Surgery" and poor staff confidence in hospital fire evacuation drills.
- There was a clear governance structure in place with committees such as infection prevention, medicines management and medical devices, reporting to the senior management team who in turn reported to the medical advisory committee.
- A clinical governance report was compiled each quarter. This was presented and discussed at the governance committee and medical advisory committee (MAC) meetings.
- Each clinical department lead reported to the senior team through the bi-monthly leadership and governance meetings. The senior team reported to the medical advisory committee.
- The clinical governance committee met bimonthly and the minutes showed evidence that discussion on findings from audits, reported incidents and complaints took place. We saw clear evidence of action points proposed and improvement plans from agreed outcomes and decisions reached.
- Oncology, cardiology and endoscopy staff attended monthly team meetings where action plans and timelines for completion and learning from incidents and complaints were discussed.
- There was a rolling programme of audits. Action plans and re-audits showed improvements in the services. For example, the interim lead oncology nurse audited the United Kingdom Oncology Nursing Society rapid assessment and access triage tool and found that whilst 90% of oncology staff had fully completed the form, only 20% of the ward staff had completed the form between January and March 2016. Actions included publishing the results, a discussion with the ward sister and one-to-one training for the ward nurses. A date for re-audit was set for the following quarter.
- Senior clinical staff maintained quality measurement and performance dashboards for each service. They discussed outcomes at the clinical governance meetings and made comparisons with other Nuffield hospitals.
- The hospital monitored patient safety via the electronic reporting system. Staff reported the information gathered through this system in the clinical governance meeting, and they monitored it via the organisation's quality dashboard.
- Senior members of staff from each department met every morning on the ward to discuss any concerns within the hospital, such as staffing, power surges and theatre schedules.

Leadership and culture of service

- We observed a positive staff culture across the hospital. The interim lead oncology nurse told us they worked positively in "open and frank dialogue" with the nurses in their team. They described a "no blame culture". Nurses and administrative staff confirmed there was a supportive, nurturing culture within the hospital.
- The clinical staff said they "loved working at the hospital, everyone knows each other, it's a really lovely place to work" and that they felt valued, respected and listen to.
- Oncology, cardiology and endoscopy staff were encouraged and supported to develop and potential was recognised.
- Oncology, cardiology and endoscopy staff told us the senior managers kept them informed about what was happening in the hospital.
- One endoscopy nurse told us their manager had worked with them to make their "work/life balance work" and this action had encouraged them to remain working at the hospital.
- The culture of the endoscopy, oncology and cardiology team was nurturing and professionally supportive of each other.
- Oncology, endoscopy and cardiology staff told us senior staff were approachable and visible and had an "open door" to discuss concerns.

Public and staff engagement

Good

Medical care

- Staff asked all patients to complete a patient survey questionnaire. The matron sent copies of any patient satisfaction surveys to staff specifically mentioned by patients or families.
- The interim lead oncology nurse ensured oncology specific patient satisfaction questionnaires were sent to all patients treated in the previous quarter. We saw the results from 2015's survey showed high levels of patient satisfaction. The interim lead oncology nurse showed us action plans that they had written to address any concerns patients raised. All actions were completed to date by the interim lead oncology nurse and the team.
- A Nuffield Health employee survey was completed in October 2015, this incorporated the whole of the organisation. An action plan for the hospital (produced in January 2016) recommended improved communication with senior management through staff forums, which had started and newsletters from the hospital directors.
- Staff received both electronic and paper hospital newsletters highlighting good practice, new ideas and praised staff. Staff told us that there was an "open door" approach with senior managers to discuss ideas or concerns and staff said they 'felt valued and respected.'
- There was also a care forum for staff with representative from all areas of the hospital. This gave staff an open forum for engagement and discussion about staff well being. As a result of suggestion from this forum toasters are now available in the staff dining room as well as microwaves and the hospital now has a cash machine.
- To celebrate staff that had gone the "extra mile' the hospital employee recognition scheme was introduced in February 2016 rewarding staff with shopping vouchers. Most staff told us that this was a good idea.

Innovation, improvement and sustainability

- Management discussed plans to invest in the endoscopy service as they recognised they were not compliant to enable the service to become Joint Advisory Group (JAG) accredited. The improvement plan and start date had not been discussed with clinical staff.
- The design of the cardiology unit next to the radiography and catheter laboratories allows staff to run a "one stop shop" for cardiology outpatients as ECG and monitor fitting are available in one.

Good

Surgery

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

Information about the service

Nuffield Health The Manor Hospital Oxford provides elective surgery to patients who pay for themselves or who are insured. The hospital also offers services to NHS patients, including orthopaedic, general surgery and cataract surgery.

There were 6,130 admissions for surgery from January 2015 to December 2015. The five most commonly performed procedures were phacoemulsification of lens with implant (cataract surgery) (588), colonoscopy (459), injection into joints (434), gastroscopy (391), and endoscopic laryngopharyngoscopy (examination of the larynx) as an outpatient's procedure (377). Surgical specialities offered include, orthopaedics, ophthalmology, general surgery, gynaecology, bariatric, cosmetic, cardiac and thoracic surgery.

From January 2015 to December 2015, there were 411 NHS funded overnight inpatients for operations and 321 inpatient day cases. There were 2,417 other funded overnight inpatient stays and 4,859 other funded day case procedures.

The hospital has six operating theatres, three have laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination), two minor operating procedure rooms and two wards with 64 patient rooms suitable for inpatient and day case care. All rooms are single with en-suite facilities. There is a dedicated eight bed recovery ward located within the main theatre complex.

During our inspection we visited theatres, the wards, outpatient surgery and the pre-assessment clinic. We spoke with 16 patients, three relatives and 31 members of staff. The staff members included managers, health care assistants, registered nurses, medical staff, operating department assistants and administrative staff. We looked at the patient environment and observed patient care in all areas. We reviewed 10 patient records and 10 medication charts. Before, during and after our inspection we reviewed the provider's performance and quality information.

Good

Surgery

Summary of findings

We found surgical services were good for the key questions of safe, effective, caring, responsive and well-led.

- Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Although the service used agency staff, wherever possible regular bank and agency staff were employed who were inducted and familiar with the service procedures. All wards and theatres had an appropriate skill mix during shifts. Generally, the staff to patient ratio was one to five and increased to one to four when needed. The hospital had an escalation policy and procedures to deal with busy times.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment was reliable and appropriate to keep patients safe.
- Staff knew the process for reporting and investigating incidents using the hospitals reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- At ward and theatre levels, we saw staff worked well together and there was respect between specialities. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Staff treated patients with compassion, dignity, and respect. Ward managers and matrons were available on the wards so that relatives and patients could speak with them. We saw patient information leaflets explaining procedures and after care arrangements. Feedback from patients was continually positive about the way staff treated people.

However

- The patients emotional and psychological needs of people such as those living with dementia were not considered. There was a lack of understanding and awareness concerning patients who may lack capacity to make particular decisions and these patients were not always recognised.

Good

Surgery

Are surgery services safe?

Good

By safe we mean that people are protected from abuse and avoidable harm

We rated safe as good because:

- There were processes in place for reporting incidents and staff confirmed they received feedback and shared learning. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and the monitoring and maintenance of equipment were reliable and appropriate to keep patients safe
- Staffing levels and skill mix were planned and reviewed to keep patients safe at all times. Planned staffing levels for wards worked to a ratio of five to six patients per registered nurse in the daytime and maximum of eight patients per registered nurse overnight. In times of greater patient need, ward staff ratio increased to one to four and one to one care.
- Patients were risk assessed to ensure only those suitable received treatment. Risks were reviewed and actions updated during each patient's stay.

However,

- Infection prevention and control policies and procedures were not consistently followed, medical staff were not always bare below the elbows in clinical areas and infection prevention practical training was not meeting hospital targets.

Incidents

- Staff reported incidents through the hospitals electronic reporting system. All staff we spoke with were aware of the electronic incident reporting system and told us they were encouraged to report incidents. Staff told us the system was simple to use and accessible to all.
- Staff discussed and reviewed all incidents reported weekly at the 'lessons learnt' meeting. We observed appropriate actions and learning were taken in relation to incidents. For example, staff told us that collecting a patient for theatre had been changed after an incident. Patients were previously requested by name only and the wrong patient arrived into the anaesthetic room; theatre porters now collect patients using a collection slip which identifies the patient, and the patient is confirmed with the ward nurse.
- From January to December 2015, 777 clinical incidents had been reported. However, there was no breakdown of these figures to detail how many related to surgical services. Ninety-eight incidents were due to extended length of stay for patients and 98 regarding documentation issues. There were no serious incidents reported within the January 2015 to December 2015 reporting period.
- There was one case of unexpected death from January 2015 to December 2015, a senior member of staff employed at another Nuffield hospital conducted an investigation. There had been a full investigation and recommendations made.
- The hospital did not hold specific morbidity and mortality meetings. Staff recorded all unexpected outcomes and post-operative deaths and a summary report was produced. Relevant information was shared at staff meetings, these included; senior management team, leadership team, departmental and medical advisory committee (MAC) meetings.
- The infection control nurse monitored incidents of surgical site infections and took part in monthly audits. The results were discussed at clinical governance meetings. In the reporting period from January to December 2015, there had been 14 surgical site infections reported. These had been investigated by the infection control nurse and there were no identifiable trends or themes.
- The information governance lead reviewed all incidents to ensure any relating to information governance were identified and reviewed.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff could describe the principles of the duty of candour, and gave examples of when they had put it into practice.

- The hospital matron received and disseminated medical and health regulatory (MHRA) safety alerts to relevant departments. The head of pharmacy received alerts relating to drugs and these were noted in the minutes of the clinical governance meetings.

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

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. The surgical wards participated in the NHS safety thermometer for NHS patients only. Senior staff conducted monthly audits of patient falls, pressure ulcers, catheters and urinary tract infections. The audits showed that patients received predominantly 'harm free' care. However, information about the audits was not displayed. It is considered to be best practice to display the results of the safety thermometer audits to allow staff, patients and their relatives to assess how the wards had performed.
- From July to December 2015, 95% of NHS patients were risk assessed for venous thromboembolism (VTE). The hospital had no incidents of hospital acquired VTE during this period.

Cleanliness, infection control and hygiene

- There was a clear process for the management and prevention of infection. We observed ward staff adhered to the 'bare below the elbow' policy. Bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails. Staff, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves. However, on the unannounced inspection we observed on the wards that consultants visiting patients did not always adhere to bare below the elbow policy.
- Most staff had completed their mandatory training with 80% of theatre staff and 95% of ward staff compliant in annual infection control training as of May 2016. However, training records showed only 33 out of 44 staff in theatres (75%) and 31 out of 48 staff on the ward (78%) had completed the infection prevention practical training. The hospitals target was 85%.
- The ward areas were visibly clean and well maintained. We observed domestic staff on the ward with cleaning trolleys and using a colour-coded system to minimise the risk of cross infection.
- Clinical and domestic waste management was in line with guidance on the use of separate colours and receptacles. We observed staff handled contaminated waste and linen correctly.
- Clean linen was stored appropriately and readily available on the ward and in theatre.
- Hand sanitiser gel was available at the entrance to the ward and theatres, along corridors, and in each of the patient's rooms.
- Staff implemented policies and procedures for the isolation of patients to minimise the spread of infections, when required. All patients were cared for in individual rooms.
- Staff used green 'I am clean' stickers to show equipment was clean and ready to use. These were clearly visible, dated and signed appropriately.
- The theatre suite was visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment. The hospital used single use equipment where possible.
- Daily, weekly and monthly cleaning rotas were displayed in theatres. Staff were required to sign when cleaning had taken place. Senior staff monitored the completion of the cleaning tasks and the overall cleanliness of the department.
- In operating theatres, we saw staff following the infection control policy. Information was clearly displayed above sinks to remind staff about correct handwashing procedures. We observed staff were bare below the elbows and were seen washing their hands and using hand sanitiser appropriately.
- The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list.
- The hospital had an infection prevention and clinical outcomes nurse who monitored the implementation of policies and results of audits, provided guidance at senior nurse meetings and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.

- Staff routinely screened patients for Methicillin resistant Staphylococcus aureus (MRSA) if they were to undergo an invasive operation. There had been one incident of Clostridium difficile infection from January 2015 to December 2015.
- In the period January 2016 to March 2016, 100% of patients admitted to the hospital had MRSA screening and 76% were risk assessed for Carbapenemase-producing Enterobacteriaceae (CPE). Enterobacteriaceae a bacteria usually lives harmlessly in the gut of humans, if the bacteria gets into the wrong place, such as the bladder or bloodstream it can cause infection.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 99% for cleanliness, which was higher than the England average of 98%.
- There were carpets in some of the inpatient rooms and ward areas. The hospital recognised this was an infection control risk and there was a rolling programme for removal of carpets. We observed the carpets were clean and staff signed and dated to show carpet cleaning schedules were complete.
- An audit of 10 staff on the wards in May 2016 showed 71% compliance in hand hygiene. The audit included nurses, doctors and healthcare assistants. The hand hygiene audit undertaken in theatres showed 80% compliance. The target was 90%. The infection prevention and clinical outcomes nurse knew about these results and was working with link nurses in theatres and the wards to improve compliance.

Environment and equipment

- The wards and the theatre department had portable resuscitation trolleys for adults and children. The trolleys contained medication for use in the event of a cardiac arrest. We saw daily check sheets completed for all trolleys to ensure equipment was available and in date. The resuscitation trolleys all had tamper evident tags to alert staff to any potential removal of equipment.
- Equipment had been safety tested, stickers showed when the equipment was next due for testing. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff could access the equipment they needed and said they had sufficient equipment to care for patients. There was one hoist available for both wards. Staff we spoke with said they rarely used the hoist. Patients had access to physiotherapy equipment if required.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required.
- All theatres had an adjoining anaesthetic room where patients were prepared for their operation. There were adjoining set-up rooms between two theatres which allowed equipment to be prepared in advance for the next procedure.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements.
- Theatre staff kept registers of implants, for example hip and knee, ensuring details could be provided to the health care product regulator if required.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009) were being adhered to. Staff completed a logbook for each anaesthetic machine to record the daily pre-session check.
- Theatres had a 'difficult intubation' tray that contained equipment for use when a patient's airway was difficult to manage. Staff completed a checklist to indicate that daily checks were made.
- A Nuffield Hospital central hub provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if needed.
- Single use equipment such as syringes, needles, oxygen masks were readily available on the ward and in the operating theatre department.
- Equipment was available in theatres for bariatric patients, for example a larger operating table and hoist designed to manage a greater weight.
- Within the theatre, there was an eight bedded recovery ward, equipped with appropriate facilities to care for patients in the immediate post-operative period before they returned to the ward.
- The hospital maintained water supplies at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria colonisation.

Good

Surgery

Medicines

- The pharmacy team consisted of one pharmacist, two part time technicians, one pharmacy manager and one dispensing assistant. The pharmacist usually visited the ward daily.
- Pharmacy services were available Monday to Friday 8am to 5pm. The department was also open on Saturdays from 9am to 1pm but unable to assist with controlled drugs, as a pharmacist was not present. The senior nurse on the ward and Resident Medical Officer together had access to pharmacy out of hours.
- We looked at the prescription and medicine administration records for ten patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. However, the prescribing audit in December 2015 showed that the largest cause of errors (87%) were "medicine not reviewed within 24 hours of admission" by the pharmacy team. The pharmacy team reported that they were unable to reconcile medicines for all patients due to workload.
- Controlled drugs (CDs) require special storage arrangements. We saw that there were suitable arrangements in place on the ward to store and administer CDs. Stock levels were appropriate and monitored. When a patient had their own CDs, they were stored in the CD cupboard and returned to the patient on discharge.
- CDs were audited quarterly, the most recent audit (February 2016) showed recommendations had been made and actions taken in response.
- Emergency medicines including oxygen were available for use and expiry dates checked on a weekly basis. There were piped medical gases on the ward and in the theatre. Portable oxygen cylinders were available for the transfer of patients from the theatre to the ward.
- Appropriately packaged and labelled medication was available for patients to take home after their surgery. To Take Out (TTO) packs were available for patients, if discharged when the pharmacy was closed.
- Staff recorded allergies in the patients' care records and on patients' individual drug charts.
- Medicines should be kept at the correct temperature to ensure their efficacy. The pharmacy staff monitored storage of medication in refrigerators and logged weekly temperature checks, which were all within the correct limits.
- Clinical staff were following the hospitals 2015 antibiotic policy, however there was only one audit of antimicrobial prescribing completed in May 2016,despite listed as a monthly audit on the hospital's audit plan, and there was no explanation of the findings of the audit or actions taken as a result.

Records

- The hospital used specific Nuffield Health care records, which contained all information regarding patients' pre-admission, admission, treatment, post-operative care and discharge information. There were two versions of the care record; one for long stay care (more than 24 hours) and one for day and overnight care (less than 24 hours). We looked at 10 patients' care records and saw information was clear, factual and organised. Each entry was dated and signed by staff.
- The care records included the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist. There were pages to complete with details of the patient's care during anaesthesia, surgery and recovery as well as their discharge arrangements. Records were comprehensive, fully completed, accurate and up to date.
- We saw the theatre records section of care plans were clear and documented checks to ensure safe surgery and treatment was undertaken. Following each patient's surgical treatment, daily multidisciplinary records were maintained of all care and treatment provided.
- Physiotherapists documented patient care in separate notes and all staff could access these if required.
- Records were paper-based. Nursing records were stored in the patient's room. Medical notes were stored securely in a locked room near the nurses' station, which ensured they were kept confidential.
- Staff maintained an operating theatre register, which contained all the information needed to ensure an accurate record was kept.
- A record keeping standards audit was completed from January to March 2016, twenty-eight records were audited which showed the compliance varied from 0% (for staff making entries in the records had signed a

signatory list) to 100% (for entries in the records which identified any risks to patients and actions taken). Records that we reviewed had a signed signatory list in front of the notes.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. The hospital director, matron and the hospital's children and young people's lead nurse were jointly responsible for leading on all safeguarding for the hospital.
- The hospital director had links with Oxfordshire safeguarding adults' board and the Oxfordshire safeguarding children's board.
- There were flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.
- Safeguarding training was part of staff mandatory training. All members of staff had to complete level 1 and 2 safeguarding children and young adults training. We found that 98% of staff on the wards had received safeguarding vulnerable adult's level 1 training and 97% had received safeguarding children and young adults level 1 training against a hospital target of 85%.
- The staff corridor clearly displayed safeguarding information provided by the hospital director and matron. The display included information about the various types of abuse associated with children and vulnerable adults, who staff should report concerns to, and steps for staff to follow in order to recognise, intervene and prevent abuse.

Mandatory training

- Mandatory training at the hospital included, consent, fire safety, Mental Capacity Act 2005, safer blood transfusions and health record keeping. Staff could access training on line and face to face training was available for basic life support, intermediate life support, manual handling and aseptic technique.
- The induction programme for new staff including bank staff covered all the key statutory and mandatory training.
- An external specialist trainer provided resuscitation training, this included basic life support, immediate life support, paediatric basic life support and paediatric immediate life support.
- The hospital compliance target for mandatory training was 85%. Compliance with training was generally good. Theatre staff were below the target for information governance (84%) and moving and handling practical (80%). Plans were in place to ensure theatre staff reached the 85% target.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but the medical advisory committee checked assurance of mandatory training. The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems.

Assessing and responding to patient risk

- Patients' risks were assessed and monitored at surgical pre-assessment, and checked again before treatment. These included risks about mobility, medical history including testing for pregnancy, skin damage and venous thromboembolism (VTE). Patients had to meet certain criteria before they were accepted for surgery, these minimised risks to their health and wellbeing.
- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks which may compromise their treatment. Nurses discussed the health questionnaires with patients in the pre-admission clinics or via the telephone. If staff identified a patient as being at risk, they referred them by telephone or email to the anaesthetist responsible for the operating list.
- Day case patients underwent the same pre-assessment key health questionnaire and risk assessments, reviewed on the day of surgery.
- The care records included pre-admission assessments and investigative tests that ensured patients met the admissions criteria and were suitable for treatment at the hospital.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example, all care records contained risk

assessments for venous thromboembolism (VTE) assessments. Patients who needed to stay overnight or for longer periods also had manual handling, pressure ulcer risk and nutritional assessments. Patient's length of stay was in the majority of cases, no longer than four days.

- The cosmetic surgeon carried out psychological screening for cosmetic surgery patients. The surgeon identified if the patient needed additional psychological assessment in advance of agreeing to surgery.
- Ward nurses met for a handover at the start of their shift to discuss all patients on the wards. We observed thorough and patient-centred handovers and staff handed over changes in patient's conditions which ensured that actions were taken to minimise any potential risk to patients.
- Staff used the Modified Early Warning System (MEWS) to monitor patients and identify deterioration in health. This is a series of physiological observations which produce an overall score. The increase in score would note deterioration in patient's condition. A plan was available in each patient's records for staff to follow if the scores were to increase. The hospital management were planning to change the MEWS to the National Early Warning Score.
- On the wards, patients with a known risk of falls were accommodated in rooms closest to the nurses' station for close observation and to minimise risks of falls.
- In theatre, staff used the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning of each theatre list and the WHO surgical safety checklist (a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). We observed team briefings and the WHO five steps to safer surgery completed on each occasion.
- Staff completed an observational audit of the WHO "Five Steps to Safer Surgery" monthly. We reviewed these audits from March to June 2016 however, we were not satisfied that it was a robust process. Nonetheless, it demonstrated they were compliant over this period.
- The resuscitation officer had implemented a daily crash call meeting for the dedicated cardiac arrest team. This involved a review of roles during a cardiac arrest event and this was documented.
- A 'pre list brief' took place in theatres every morning prior to the list starting, this involved discussion for each planned procedure and for all staff in theatre on the day.
- Regular simulated cardiac arrest scenarios were carried out so staff could respond quickly and be rehearsed should a real life cardiac arrest occur. Feedback was given to individuals on their performance.
- In the event that a patient's condition deteriorated service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. From January to December 2015 there were 13 patients who had an unplanned transfer to another hospital. Staff gave us an example of a patient who had deteriorated during the night and had been transferred to the local NHS trust within twenty minutes.
- A resident medical officer (RMO) was on site at all times. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for immediate response e.g. in the case of cardiac arrest and for non-urgent queries.

Nursing staffing

- Staffing levels on the wards were sufficient to support safe care. The hospital's ward staffing levels were set using the guidance from the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidelines, a ratio of five or six patients to one registered nurse in the daytime and a maximum of one registered nurse to eight patients overnight.
- Staffing levels were calculated on a weekly basis, then checked and adjusted daily depending on changes and or patient requirements.
- There was a lower nurse to patient ratio for those patients requiring a higher level of care. The hospital had an on call registered nurse rota, which provided clinical cover out of hours.
- The nurse in charge of each shift had a zero or minimal patient caseload to allow for unpredictable or unplanned events.
- Staff worked flexibly, and said there were enough staff to provide safe care. The night shift was always staffed with at least two registered nurses, this included when patient occupancy levels were low. This enabled staff to respond to emergency situations.

- In theatre, they operated with a staffing ratio of nurse manager to nurse team leader of 1 to 3, a ratio of team leader to nurse of 1 to 10, a ratio of nurse to care assistant of 1 to 0.1 and a ratio of nurse team leader to operating department practitioner (ODP) of 1 to 0.3. Staffing levels were adapted weekly in line with scheduling.
- Staff in theatre and recovery told us that they were flexible and would stay late if needed. Ward and theatre staff told us that should the workload be anticipated as busy, extra staff would be requested.
- There was no theatre manager in post at the time of the inspection but, we were told that one had been appointed.
- In January 2016, the hospital reported 12% vacancies for ODPs and 13% for theatre nurses. We saw evidence of recruitment activity across the department to reduce periods of reliance on bank and agency staff.
- We reviewed the rotas in theatres and found appropriate numbers and skill mix of staff, in line with Royal College of Surgeons guidelines and the Association for Perioperative Practice (AfPP).
- There was an out of hours on call system which included a registered nurse, operating department practitioner a theatre support worker, one anaesthetist, and a recovery nurse. There was a process for staff to follow which started on the ward regarding who makes the call to the consultant and theatre staff.
- Usage of agency nurses in the theatre department was between 20% and 39% for the period January to December 2015, wherever possible the hospital used regular bank and agency staff.
- Handovers occurred at each shift change and involved all staff on duty for the shift; this meant all staff were aware of all patients' individual needs.
- Ward and theatre information boards identified who was in charge for any given shift and who to contact if there were any problems.

Surgical staffing

- There were 300 consultants with practising privileges at the hospital. All had their status reviewed every two years by the hospital Medical Advisory Committee to check they continued to be suitable to work at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector. We reviewed four practising privileges agreements and found them to be current and up to date.
- All consultants awarded practising privileges agreed to abide by the Nuffield Health practising privileges policy, and provided the organisation with standard information showing they fulfilled the criteria. All consultants maintained registration with the GMC and were on the specialist register.
- Consultants were required as part of the practising privileges hospital policy to remain available (both by phone and in person) or arrange appropriate alternative named cover if unavailable when they had inpatients in the hospital.
- A member of the nursing staff told us that medical cover was good and consultants were always obtainable. They said they would return to see their patients if necessary and always provided cover arrangements when not accessible. There was an on call anaesthetist and resident medical officers to provide support.
- The hospital employed two Resident Medical Officers (RMO). One RMO worked Monday to Friday and the other worked in one week blocks and was based on-site, available 24 hours a day, seven days a week. The roles of the RMOs were to review patients on a daily basis, prescribe additional medication and liaise with the consultants responsible for individual patients care.
- The Registered Medical Officers (RMOs) on duty were Advanced Life support (ALS) and Paediatric Advance Life Support (PALS) trained.
- Handovers between RMOs were effective and the RMOs also attended the handover from the night shift. This ensured that the RMOs had an understanding of the patients' needs on the ward.
- All patients were admitted under a named consultant who had clinical responsibility for their patient during their entire stay.
- There was a senior management on call rota in place seven days per week. This rota was circulated and all staff were aware of the senior contact for the hospital each week.

Major incident awareness and training

- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Hospital-wide unannounced fire drills took place

quarterly to test staff knowledge of the evacuation plan, we were informed the last one conducted was out of hours. All staff understood their responsibilities if there was a fire within the building.
- The staff we spoke with were aware of where to find local guidance and procedures to follow in the event of a major incident.

Are surgery services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Treatment and care was provided in line with national guidance and there were processes in place to update policies and procedures.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Nurses discussed pain relief with patients and provided information on the type of pain relief they could expect to receive as part of their procedure. Staff also gave information leaflets about their specific type of procedure.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, physical health and wellbeing, nutrition and hydration.

However,

- While staff had completed training about the mental capacity act, they did not demonstrate a clear understanding of the procedures to follow for patients who lacked capacity.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example the modified early warning system (MEWS) was used to assess and respond to any change in a patients' condition. This was in line with NICE clinical guideline 50.
- The hospital completed a monthly gap analysis of new National Institute for Health and Care Excellence (NICE) guidelines, assessed whether these were relevant to the services offered by the hospital and action they needed to take to implement them.
- Adherence to policies and national guidelines was discussed at management and departmental meetings to ensure care and treatment offered was up to date.
- Staff completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital.
- Patients undergoing knee surgery were assessed using the Oxford Scale, which measures muscle strength and range of movement. These assessments were completed pre and post operatively to review the rehabilitation progress. Out of 13 records audited by the hospital, 13 outcomes for patients were reported as improved.
- Patients' temperatures were measured and documented in accordance with inadvertent perioperative hypothermia, NICE guidance clinical guideline 65.
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines [CG74]. Following discharge, the hospital had implemented a follow up call for all hip and knee patients as part of the 30-day SSI audits.
- In line with professional guidance, the hospital had a process in place for the recording and management of medical device implants.
- There was an on-going audit programme to evaluate care and review clinical practice. These included audits such as, care record and VTE audits. Clinical staff achieved the 95% target for venous thromboembolism screening rate in the reporting period (January to December 2015).
- In January 2016 the hospital began monitoring performance by a local audit known as 'Gov 14'. Audit of the health records including: manual handling, slips, trips and falls, consent, the World Health Organisation (WHO) five steps to safer surgery checklist, infection

prevention, medicines management, discharge, documentation and clinical handover. Data provided showed that this audit programme was not yet embedded within the hospital and there was no explanation of the findings of audits or actions taken as a result.

Pain relief

- Pain relief was discussed pre-operatively, in theatre and on the ward. Post-operative pain was assessed by staff using a recognised one to ten scoring system and action taken as needed. Whilst in recovery pain levels were constantly monitored and the patient was only moved back to the ward when pain was under control. Recovery staff gave intravenous opiates titrated according to the patients pain score.
- Patients had access to a variety of pain relief appropriate to their operation. This included epidural and patient controlled analgesia. Patients, who required this type of pain relief, were assessed prior to their operation and information was given to ensure they understood how the delivery of the medication worked. Regular assessments were completed when this pain relief was in situ to ensure patients' pain levels were controlled, the equipment worked appropriately and to monitor for any unwanted side effects.
- Patients confirmed they were comfortable and pain relief was managed. All patients post-surgery told us they received pain relief as and when needed. One patient commented "they manage pain very well here".
- Nurses within pre-assessment discussed pain relief with elective patients and provided information leaflets about pain control and anaesthesia. This included information about different types of pain relief and pain scoring. We also observed anaesthetic consultants discussing post-operative pain relief with patients.

Nutrition and hydration

- Instructions about fasting times were given during the patients' pre-admission visit. Information included when they could have their last meal and how long they were able to drink water prior to their operation. The patients we spoke with confirmed they had received this information.
- We observed staff checking as part of pre procedure checks when the patient had last eaten or drank and this was recorded in the patients care record.
- The hospital offered light snacks and drinks for day case patients before discharge home.
- Patients had nutritional screening undertaken at pre-operative assessment or on admission. Clinical staff used the five step National malnutrition universal screening tool (MUST) to identify adults who are malnourished and follow guidelines to improve food intake. We saw MUST assessments to assess nutritional risk were recorded in patient notes. Nursing staff stated they would refer patients to the in house dietician if this was required.

Patient outcomes

- The hospital had joined the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was yet available
- There were eight cases of recorded unplanned readmissions to hospital within 29 days of discharge from January to December 2015.
- Three patients had unplanned returns to theatre from January to December 2015. CQC assessed the proportion of unplanned returns to be 'similar to expected' compared to the other independent acute hospitals we hold this type of data for.
- Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients perspective. Between April 2014 and March 2015 data from PROMS showed the hospital was within the expected range for primary hip replacement surgery. PROMs is a patient-reported outcome measurement, which contains 12 questions on activities of daily living that assess function and pain in patients undergoing total knee replacement.
- The hospital uploaded data to the National Joint and Ligament Registries, Patient Related Outcome Measures and public Health England (PHE) Surveillance for Breast, Hip and Knee patients (commenced Jan 2016). Only hip data was being reported due to insufficient numbers.
- The hospital was part of the Public Health England (PHE) surgical site surveillance programme. The

infection prevention and clinical outcomes nurse input their data into the PHE system. Staff carried out follow up telephone calls 30 days after surgery for patients who had had major surgery.

Competent staff

- A senior nurse or manager was on duty each shift to provide expert advice and support for more junior theatre staff and this was also the case on the wards.
- All new staff underwent a corporate induction which included a departmental orientation programme. As part of this process, staff were allocated a mentor who was a senior member of staff.
- Agency and bank nurses received orientation and induction to the ward area. This included use of resuscitation equipment and medicines management.
- Ward and theatre staff confirmed that appraisals took place and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in 2016, including administrative and clerical staff. We heard that the staff thought the appraisal system was effective as it formalised individual competencies achieved and identified training needs for the next year.
- The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies and that surgeons received supervision and appraisals. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's name.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings. Actions were created and completed before the consultant could practice at the hospital again.
- The Resident Medical Officer (RMO) who was employed through an agency underwent an additional recruitment process before they commenced employment. This involved checking their suitability to work at the hospital and checks on their qualification. They had one week of induction and shadowing before they commenced at the hospital. Staff told us that the hospital had refused RMOs in the past as they were concerned about their competencies. A consultant mentored all RMOs.
- There was a system to ensure qualified doctors and nurses' registration status had been renewed on an annual basis. Data provided to us by the hospital showed a 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres.
- Physiotherapy staff told us they had access to a set amount of funding for training each year, this was sufficient for them to access effective training.
- Staff were positive about access to further training and development courses. Courses were available externally or 'on-line' via the Nuffield Academy.

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers, good record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and therapies planned.
- We saw that medical and nursing staff, therapists and pharmacy staff worked in partnership on the ward. Daily ward rounds involved the ward co-ordinator, RMO, the infection prevention and clinical outcomes nurse and the pharmacist. Ward round timings had been moved from the morning to the afternoon to accommodate the pharmacist and ensure their attendance.
- We observed their 'daily huddle' which was held each morning for all theatre staff to review the operating lists and day ahead. Twenty eight members of staff attended including consultants and portering staff.
- Our review of records confirmed there were effective multidisciplinary (MDT) working practices which involved nurses, doctors, pharmacists and physiotherapists. For example, we saw physiotherapists had followed therapy guidelines documented by consultants.
- There were service level agreements were with the local NHS trust in the event a patient required rapid transportation to an NHS hospital.

Seven-day services

- The hospital provided elective surgery Monday to Saturday from 8am to 8pm. The type of surgery was

dependant on which consultant was booked in for which day. Staff were aware of the patient lists in advance to enable staffing levels and rooms to be available.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care.
- There was an out of hours on call theatre rota which included a registered nurse, operating department practitioner, a theatre support worker, an anaesthetist and recovery nurse should a patient need to return to theatre. This team were available within a 30 minute timescale to enable urgent return to theatre.
- Nursing staff and the RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of senior management was available to support staff as part of an on call rota.
- Radiographers were on call out of hours to provide imaging in case of an emergency.
- The physiotherapy service provided care to inpatients seven days a week, plus an on-call service out of hours.
- The pharmacy was accessible out of hours. The ward co-ordinator and the resident medical officer (RMO) could access the pharmacy to ensure medication was available at all times with the exception of controlled medication. However, there were no alternative arrangements in place to supply controlled drugs out of hours. There was no pharmacy on call service, but the pharmacist had been called out on occasions when controlled drugs had been required.

Access to information

- Staff confirmed patient records were accessible to staff across the service.
- Discharge summaries were faxed to GPs when patients were discharged from the hospital. Care and discharge summaries were given to patients on discharge.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment.
- Staff discussed their care in detail and explained what to expect post-operatively including length of stay, and involved patients in their plans for discharge. Ward staff gave patients a discharge pack with specific post-operative instructions.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgeons gained consent from patients for surgery. Information about the procedure was given to patients at their initial visit for assessment. On the day of the procedure the surgeon conducting the procedure recorded formal consent.
- An annual consent audit was conducted in June 2016, 10 sets of notes were reviewed. The hospital was compliant in all areas apart from three sets of notes where there was no evidence that consent for anaesthesia was documented on the anaesthetic record. There was no explanation of the findings of the audit or actions taken as a result.
- Staff told us they very rarely saw patients who may lack capacity to make an informed decision about surgery. We spoke with staff about informed consent and they were not clear about the procedures to follow for patients who lacked capacity. Ward staff informed us that within the last couple of months there had been an incident where a patient had been admitted to the ward who lacked capacity and this had not been recognised before admission.
- Ninety four percent of theatre staff and 100% of ward staff had received Mental Capacity Act training. The target was 85%.
- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were clear. Unless otherwise requested, all patients who had a cardiac arrest were to be resuscitated. We saw one correctly completed DNACPR form in place at the time of our inspection. Staff advised us it was rare for a DNACPR form to be in place. We observed this information cascaded at the handover of shift to ensure that all staff were aware that this was in place.

Are surgery services caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Good

Surgery

We rated caring as good because:

- Patients and relatives said they felt involved in their care and they had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained the reason for tests and scans. Patient feedback was very complimentary.
- People were treated courteously and their privacy was maintained. Patients were able to make informed decisions about the treatment they received.
- Patients were treated with dignity, respect and kindness during all interactions with staff. We saw staff treated patients with dignity in the operating theatre, and during the World Health Organisation Five Steps to Safer Surgery safety checklist process, for example they introduced the anaesthetised patient to the team.
- Flexible visiting hours enabled patients to maintain supportive relationships with those close to them.

Compassionate care

- The hospital took part in the Friends and Family test. There was no breakdown of the figures therefore it was not possible to identify the significance of these statistics with regards to the surgical services. For the reporting period July to December 2015 the hospital reported 91% to 95% of inpatients would recommend the hospital to their friends and families. The response rate was between 36% and 48%.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 93%, above the England average of 86% for the period from February to June 2015.
- We observed throughout our visit that patients were treated with respect and dignity. Staff knocked on doors and waited for permission to enter and patients told us they were called by their preferred name.
- The Nuffield group carried out their own patient satisfaction monitoring. During the period October 2015 to March 2016 between 83% and 90% of patients who responded would recommend Nuffield Health The Manor Hospital Oxford to family and friends. This score was similar to the average for other Nuffield Health locations at 88%.
- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received.
- We saw patients' bed curtains were drawn and doors closed when staff cared for patients on the ward and in the theatre and recovery area. A light was used outside of each room when a member of staff was providing care to a patient. This was a further measure to maintain patient's privacy and dignity and to inform other staff care was being carried out and they should not be disturbed.
- We observed staff took care to ensure patients' dignity was preserved. For example, they covered patients in the anaesthetic room, operating theatre and during transfers between the ward and theatre areas.
- During the World Health Organisation Five Steps to Safer Surgery safety checklist in the day surgery unit, patients who were having local anaesthetics were 'introduced' by their full name and each member of the team were introduced. This was respectful of the patient.
- We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner. Staff were friendly, polite respectful and courteous.

Understanding and involvement of patients and those close to them

- Patients on the wards said they understood their care and treatment and had adequate opportunities to discuss their surgery. Patients said, "Staff explained everything that was going to happen at each stage" and "I was kept informed at all stages".
- Patients and relatives told us they felt involved in their care. They told us they received full explanations of all procedures and the care they would need following their operation. The hospital's patient satisfaction survey, from October 2015 to March 2016 showed between 91% and 94% of patients said they were involved as much as they wanted to be in decisions about their care.
- Relatives we spoke with said staff were "polite, caring and approachable" and that "staff understand patients' needs and take time to explain procedures".
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.

Emotional support

- Sufficient time was allocated for the pre assessment appointment to allow patients time to discuss any fears or anxieties.

Good

Surgery

- Ward staff demonstrated sensitivity towards the emotional needs of patients and their relatives.
- There was open visiting on the ward to allow patients to have emotional support from family and friends.
- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience, throughout the process, the nurse was friendly, caring and talked through what she was doing with the patient.

Are surgery services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- The provider planned and delivered services in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service.
- The hospital dealt with complaints and concerns promptly and complaints were discussed at all staff monthly meetings. This highlighted any training needs and learning was identified as appropriate.
- Staff provided care in a timely way and NHS and private patients' experienced the same levels of care.
- Patients could access information in other languages, if needed. This meant patients for whom English was not their first language, could have full understanding about their care and treatment.

However:

- Mechanisms were not in place to ensure the service was able to meet the individual needs of people such as those living with dementia.

Service planning and delivery to meet the needs of local people

- The hospital worked with the local Clinical Commissioning Group (CCG) in planning services for NHS patients. Operating sessions were made up of a mix of patients who had selected the hospital through NHS e-Referral Service and private patients.
- All admissions were pre-planned so staff could assess patients' needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, mental or physical needs.
- The hospital used admission criteria for patients and only accepted patients for treatments with low risks of complication and whose post-surgical needs could be met through ward-based nursing care.
- The hospital provided elective surgery to NHS and private patients for a variety of the specialities which included orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery.
- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- The hospital had recently introduced "The Nuffield Health Promise" for self-funded patients. This enabled patients to have further care and follow ups at no extra cost if their expectations had not been reasonably met.

Access and flow

- The operating department was open from 8am to 6pm, Monday to Saturday although the department would extend the hours if cases required it. This meant there was a planned programme of activity.
- The hospital was a provider of NHS e-Referral Service which is a national electronic referral service for the NHS in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Dates for surgery were discussed with patients at their initial outpatients' appointment. Patients were able to choose to have their operations at times suitable for them.
- All of the patients we spoke with told us they had short waits for their surgery.
- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- The staff in the operating theatres provided an on-call service to ensure that the department could be opened if there was a need for a patient to return to theatre urgently.

- Consultant discharge guidelines had been devised to enable nurses to discharge patients from the ward. This meant patients did not have to wait for a consultant review and were discharged home in a timely manner.
- There had been 19 surgical operations cancelled on the day from June 2015 to June 2016, due to variety of reasons, for example staffing issues and medical conditions.

Meeting people's individual needs

- Pre-assessment was used effectively to ensure the hospital only treated patients if they could meet their needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance. If the nurse identified any concerns, they had good communication links with the surgeons for advice and discussion.
- Staff we spoke with on the ward informed us that there were no dementia friendly rooms and no dementia champions. Two healthcare assistants were being trained to undertake this role.
- The service did not treat complex patients or those with multiple co-morbidity due to not having a level two care facility (High Dependency Unit).
- The hospital had lift access to each floor and wide access for patients using a wheelchair or mobility aids.
- For patients' with visual or hearing loss, signage was available and a hearing loop was provided in the main reception of the hospital.
- We were told that should a patient require the support of a carer or a family member they were encouraged to stay at the hospital to offer familiar assurances and to assist with the rehabilitation process.
- For patients whose first language was not English, telephone translation facilities were available. In preoperative assessment, staff could change the size of the lettering of patient leaflets if patients had eye sight problems.
- Information that covered a wide variety of topics was displayed throughout the areas we visited. Information for surgical procedures for example, colonoscopy and arthroscopy was also available in Arabic, Bengali, Mandarin, Polish and Punjabi.
- All patients were cared for in individual rooms with private en-suite facilities, which helped maintain their privacy and dignity.
- There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- Larger patient bedrooms were available for relatives to stay with patients if they wished.
- Some patients we spoke with felt the billing process was confusing and they felt the information was not clear. For example, if payment would be taken at each stage of care or taken for the whole process.
- Patients who needed to stay overnight or longer after their procedure, were given a variety of menu choices. All the patient feedback on food and choices available was positive. Comments included "Very good", "Good selection of choices" and "Food is excellent".
- The housekeeper received a daily handover from the nurses. The handover indicated patients requiring special diets and those who may have food allergies. Menu options were available for patients who required special diets for religious or cultural reasons.
- In the Patient-Led Assessments of the Care Environment (PLACE) for February to June 2015 the hospital scored 92% for ward food which was above the England average of 89%.
- When the hospital treated a group of patients from overseas, the hospital had been proactive in seeking advice and support for staff so they were better able to understand the patients group culture and beliefs .

Learning from complaints and concerns

- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. There had been 11 complaints for the ward and the operating theatre from January to June 2016. There were four complaints concerning the ward and different aspects of care. We saw from minutes of ward meetings that complaints were discussed, for example, patients had complained that they felt abandoned especially after being admitted to the ward and staff were reminded to check on patients hourly.
- The hospital director and matron monitored all complaints and responded to them in-line with the hospitals policy. There was an expectation complaints would be acknowledged within two working days and a full response in 20 working days. Complaints were investigated by the relevant head of department, with involvement from consultants and nurses if needed.

Good

Surgery

- At the hospital clinical governance, leadership and the Medical Advisory Committee (MAC) meetings, complaints were discussed and information cascaded to departmental meetings.
- Patients had access to guidance on how to make a complaint at the hospital. There was also a leaflet that explained how to make a complaint on the Nuffield website.
- All of the patients we spoke with told us they had no complaints about the care and treatment they had received at the hospital.

Are surgery services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led in surgery as good because:

- The hospital had a strong focus on continuous learning and improvement and staff innovation was supported.
- The service was transparent, collaborative and open with relevant stakeholders about performance. Leaders at every level prioritised high quality compassionate care.
- Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale was good with staff supported on the ward and in the theatre department. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.
- Risk, quality and governance structures and systems, managed at departmental, hospital and corporate levels were in place to share information and learning.

Vision and strategy for this this core service

- All staff we spoke with were aware of the hospital wide values and were able to describe them to us which included being enterprising, passionate, independent and caring. There was a corporate vision for the hospital which included whole health and well-being.
- Staff demonstrated the hospital values and behaviours in the care they delivered. All staff we spoke with were passionate about the service they provided and believed they consistently put the patient first.
- There was a recent increase in staff stability and a more defined leadership at all levels. Staff spoke positively about these changes and how this stability had improved the working environment.

Governance, risk management and quality measurement for this core service

- The hospital had instigated an integrated governance and continuous improvement programme from January 2016. The primary objective was to stabilise clinical leadership and drive through significant long term change. This included relaunching the entire governance framework, review of committee members and frequency of meetings**.**
- There was a clear governance structure in place with committees such as infection prevention, medicines management and medical devices, reporting to the senior management team who in turn reported to the medical advisory committee.
- A clinical governance report was compiled each quarter. This was presented and discussed at the governance committee and medical advisory committee (MAC) meetings.
- The clinical governance committee met bimonthly; the minutes showed evidence that discussion on findings from audits, reported incidents and complaints took place. We saw clear evidence of action points proposed and improvement plans from agreed outcomes and decisions reached.
- Consultants from a variety of surgical specialities attended the MAC meetings on a quarterly basis. Records demonstrated a variety of topics were discussed for example, incidents, complaints and practising privileges.
- There was one hospital-wide risk register. The register detailed 14 risks which were identified as a potential risk to the whole hospital. These risks included; documentation, inconsistent compliance with the World Health Organisation “Five Steps to Safer Surgery” and poor staff confidence in hospital fire evacuation drills.
- Managers within theatre and the wards were aware of the specific risks to their areas of work.

Good

Surgery

- We reviewed the action plan for June 2016 and saw action taken to mitigate identified risks was detailed with named individuals and time plans for review dates.
- Senior members of staff from each department met every morning on the ward to discuss any concerns within the hospital, such as staffing, power surges and theatre schedules.
- Team meetings were held on the ward and theatres. These were used for the passing of two-way information.

Leadership / culture of service related to this core service

- There had been a recent change in the senior management. Staff spoke positively about these changes and how this had improved the working environment. One member of staff told us "it's really enjoyable to work here, I am happy and feel supported. There are now opportunities to learn, grow and improve."
- All staff told us the senior management team were highly visible throughout the hospital, often undertaking walks around all areas. Staff described knowing them on first name terms and were encouraged in conversation and feedback.
- The staff spoke about patients and their roles demonstrated a culture of patient-centred care. Staff told us they enjoyed their jobs, were proud of the hospital and of the treatment and care they provided to patients.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- The resident medical officers (RMOs) were positive about the culture and commented that all staff worked well together.
- All staff we spoke with were positive about working at the hospital, they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.

Public and staff engagement

- A Nuffield Health employee survey was completed in October 2015, this incorporated the whole of the organisation. Following this, an action plan for the hospital was produced in January 2016 which recommended improved communication with senior management through staff forums, which had started and newsletters from the hospital directors.
- A staff newsletter was issued weekly. Topics and themes included duty of candour and safeguarding.
- There was also a care forum for staff with representative from all areas of the hospital. This gave staff an open forum for engagement and discussion about staff well being. As a result of suggestions from this forum toasters and microwaves are now available in the staff dining room and the hospital now has a cash machine.
- The hospital had launched a monthly staff recognition scheme in 2016. Staff could be nominated by other staff members or patients for acknowledgement of their hard work. Staff skills and strengths were recognised. We were given examples where staff had been given development opportunities, for example the facilities manager completed green energy training and is now the green lead for the hospital.
- Staff encouraged patients to complete a patient satisfaction survey before discharge. The hospital used this with the 'Friends and Family test' feedback to evaluate the service provided to the patient.

Innovation, improvement and sustainability

- Staff said they were encouraged to suggest areas for improvement. For example, the ward had put forward a proposal to change a bathroom into a storeroom.

Requires improvement

Services for children and young people

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

Information about the service

The Manor Hospital Oxford provides services for children and young people as outpatients and inpatients. Children and young people (CYP) are seen in outpatients from birth to 18 years. Surgery is offered to CYP aged three to 18 years, both as a day case and as an inpatient; medical staff perform some procedures in outpatients. The hospital provides medical care for young people aged 16 to17 years, as an outpatient, in-patient or day case.

From January to December 2015, 2,020 CYP attended for appointments in outpatients. Eighty-three CYP had procedures performed that required an overnight stay and 177 procedures were performed as day cases. The hospital provides services for CYP who are NHS patients and self or privately funded, such as through private medical insurance. From January to December 2015, 73 CYP were NHS funded and 2,207 privately funded. Over the same time period, CYP care accounted for around 7% of all hospital activity.

The three most commonly performed surgical procedures were tonsillectomy, myringotomy with grommet insertion and adenotonsillectomy. Consultant led clinics were offered in outpatients, for specialities including ophthalmology, ear, nose and throat and general paediatrics. The hospital also offered CYP appointments for a number of other services, such as physiotherapy, dentistry and radiology.

There was no dedicated outpatients area or ward for CYP. In outpatients, toys were provided for younger children in the waiting areas. All patients were cared for in single rooms with en-suite facilities. There were facilities in some rooms for parents to stay overnight with their child. The hospital normally admitted CYP during a dedicated children's surgery week, with rooms in one area of the ward on level one allocated specifically for CYP.

During our inspection, we visited the wards, theatres, outpatients, diagnostic imaging and endoscopy. We spoke with 10 parents and nine children and young people during our inspection. We observed staff providing care for six children and young people. We reviewed care records for 12 patients. We also spoke with 24 staff, including nurses (registered children's nurses and registered general nurses), health care assistants, medical staff, administrative staff, theatre staff and senior management staff. We analysed data provided by the hospital before and after the inspection.

Requires improvement

Services for children and young people

Summary of findings

We rated this service as requires improvement overall because:

- Although patient care records were always available, in some records we found medical staff had not dated prescriptions or their signatures were not always clear. We observed and saw in patient records that staff did not record the height and weight for all children prior to a prescription being issued and the dosage calculated.
- Nurse staffing for the service did not meet national guidance from the Royal College of Nursing. There was often only one nurse on duty covering the ward and outpatients. The hospital had recruited to additional posts but these staff had not yet started.
- At the time of the inspection, senior management monitored the governance, and risk of the service, rather than this being done at local level. Senior management had identified concerns about the service and taken action to address these, including recruitment to a number of new posts. The service leads had a number of good ideas to improve and develop the service but they did not have action plans or timelines to support how and when they would implement these. There was no local monitoring of patient outcomes or use of clinical audit.
- There was no involvement of children, young people or their families in the design or running of the service, although the hospital had plans to address this. Nursing staff made inpatient rooms 'child friendly' but there was a lack of suitable entertainment and distraction for older children and young people in outpatients. There was no separate waiting area for children, although the layout in outpatients meant this was achievable.
- We found the process for assessing and managing the pain of children and young people was not to a consistent standard.
- While there was a good up-take of mandatory training in some departments, not all staff were not up-to-date with paediatric basic life support and safeguarding children and vulnerable adults training. The hospital were arranging additional training sessions for basic life support. Some nursing staff on the ward did not feel confident checking the paediatric resuscitation trolley.

However

- Feedback from children, young people and their parents was positive. They described the excellent quality care they received and how staff took the time to explain things using age appropriate language. We saw and parents told us how staff had included their child in decisions about their care. Staff were friendly and understanding, providing additional support to children who were worried or anxious. Parents told us they valued how staff had offered them emotional support.
- Parents commented on the efficiency of the booking, admission and discharge process. They had experienced minimal waiting times for appointments or surgery dates.
- We observed staff following good infection control practices when providing care to patients. All clinical and ward areas we visited were clean and tidy.
- There was good multi-disciplinary working across all teams in the hospital so children and young people received co-ordinated care and treatment. In the event a patient became unwell, there were systems in place for staff to escalate these concerns to medical staff and refer the patient to another hospital if necessary.
- Staff told us there was good access to additional training to enable them to develop in their role and they felt well supported by their manager and the hospital director. Medical staff were only granted practising privileges to work at the hospital if all pre-employment checks demonstrated they were competent to provide care and treatment for children and young people.
- Staff were confident in describing the signs of abuse and knew the escalation process to follow if they needed to make a referral to the local safeguarding team.

Requires improvement

Services for children and young people

Are services for children and young people safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm.

We rated this service as requires improvement for safe because:

- We were concerned that children were being placed at risk as not all children had their height and weight recorded on admission or during their outpatient appointment, prior to medications being issued, to ensure the correct dosage was calculated. Also, staff did not consistently document any allergies the patient had. We found instances where medical staff had not dated prescriptions or their signatures were not legible. Also, there were times where staff had not printed their name or provided their grade in the patient record.
- A registered children's nurse cared for all children and young people, aged less than 16 years old. At the time of the inspection, nurse staffing in outpatients, on the ward and in the operating department was not compliant with national nursing standards for staffing levels for children and young people's services . There was a potential risk to patients, as there were insufficient staff in each area and there was sometimes one member of staff on duty covering the ward and outpatients.
- There was poor compliance in some departments with paediatric basic life support training. The hospital were arranging additional sessions to address this. In three departments, the hospital target for completing safeguarding children and vulnerable adults training had not been achieved.
- Although senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support, we found the Duty of Candour process had not been fully adhered to following a serious incident.
- Nursing staff on the ward did not feel confident identifying and checking the equipment on the paediatric resuscitation trolley, this was an additional responsibility for the registered children's nurse to complete.

However:

- Staff felt confident to report incidents, learning had taken place and changes made to practice to keep patients safe.
- There were systems and processes in place across the hospital to keep children and young people safe, including an escalation and transfer procedure. Care was consultant led, with a resident medical officer on-site at all times to provide immediate medical care, with advice from the consultant. The hospital normally admitted children and young people during a dedicated paediatric surgery week. Outside of this week, senior staff completed a risk assessment prior to the admission being agreed.
- Clinical areas and patient rooms were clean and tidy. We observed staff following good infection control practices to reduce the spread of infection. Although hand hygiene results showed improvements were required. There was suitable equipment for the assessment and care of children and young people.
- All staff we spoke with could describe the signs of abuse and knew the process to follow to make a safeguarding referral. However, in some departments compliance with safeguarding children and vulnerable adults training was below the hospital target of 85%. More senior staff lacked knowledge on some aspects of their safeguarding role but knew who to ask and where to find this information

Incidents

- Staff reported incidents using the electronic reporting system. Staff told us they had completed training on how to use this system, felt competent to use it and able to report any concerns. The hospital followed the corporate Nuffield 'Adverse events' standard operating procedure to ensure incidents were reported and investigated appropriately.
- From January to December 2015, there were 777 clinical incidents across the hospital, only one of these related to CYP.
- Staff working in different clinical areas, gave examples of learning from previous incidents involving children and young people (CYP) and changes the hospital had made to clinical practice. This included reviewing the

administrative process for pre-assessment, ensuring a registered children's nurse was on-site or contactable, and ensuring theatre staff completed appropriate observations on CYP.

- 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'andprovide reasonable support to that person. Staff we spoke with understood their responsibility to be open and honest with the family when something had gone wrong. Senior staff were aware of their role to investigate a notifiable safety incident, keep the family informed and offer support.
- An incident occurred during 2015 that resulted in the hospital transferring a patient to a paediatric high dependency unit. Whilst a full root cause analysis was completed and actions implemented, the incident was not considered under Duty of Candour as the patient had not come to harm. However, the Duty of Candour process should be followed if there is a moderate increase in treatment and significant but not permanent harm.
- The hospital matron received and disseminated medical and health regulatory (MHRA) safety alerts to relevant departments. The head of pharmacy received alerts relating to drugs and these were noted in the minutes of the clinical governance meetings.

Safety thermometer

- The hospital did not use a children and young people's specific safety thermometer or local equivalent document, to enable a review of harm free care.

Cleanliness, infection control and hygiene

- All clinical areas and patient rooms we visited were visibly clean and tidy.
- Cleaning staff used a rota to ensure they cleaned all areas daily. The lead for housekeeping also completed additional spot checks. All rotas inspected were up-to-date.
- There were carpets throughout the outpatient waiting areas, ward corridors and patient rooms. Although deep cleans took place, the hospital management team recognised the hygiene and infection control risks of having carpet. Replacing the carpets with vinyl flooring was part of the business plan for 2016.
- Staff were observed to follow good infection control practices 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 that we saw being used appropriately.
- The lead nurse for CYP had promoted hand hygiene to CYP and their parents during a recent children's surgery week. Nursing staff had provided age appropriate leaflets to CYP to show good hand hygiene techniques. In addition, CYP recorded if staff cleaned their hands prior to assessing them.
- . Across the hospital, there was an infection prevention annual audit program, including quarterly hand hygiene audits. An audit of 10 staff on the wards in May 2016 showed 71% compliance in hand hygiene. The audit included nurses, doctors and healthcare assistants. T
- he lead CYP nurse cleaned the toys in the outpatient waiting area every two hours. The hospital had introduced toys in these areas three days prior to the inspection. Records showed the cleaning schedule had been followed however, we were concerned this schedule would not be sustainable as demand for the CYP service increased.
- From January to December 2015, there had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Methicillin-sensitive Staphylococcus Aureus (MSSA) across the hospital. There had been one incidence of Clostridium difficile but this did not involve a child. The hospital followed the corporate Nuffield policy 'Management of Multi Resistant Organisms', which did not require hospitals to screen all admitted patients. Instead, patients were screened depending on their answers to set questions about previous infection with MRSA , previous admittance to hospital and their planned procedure.
- All hospital staff completed infection prevention training as part of their mandatory training, including a separate practical course for relevant staff. As of April 2016, the hospital target of 85% compliance had been achieved for the theory aspect (90%) and very nearly achieved for the practical course (84%).

Environment and equipment

- The hospital provided suitable equipment for staff to use when performing observations or procedures on CYP. This included age and size appropriate blood pressure cuffs and oxygen saturation probes.

- There was access to paediatric resuscitation equipment in outpatients, on the ward and in the operating department. Records showed staff had completed daily equipment checks for the month prior to the inspection; the CYP lead nurse or registered children's nurses on the ward checked the trolleys. General nursing staff on the ward did not feel confident to check the paediatric trolley. They told us they were not familiar with the equipment.
- We found a size '0' airway was missing from the resuscitation trolley in outpatients, although staff had recorded it as present. Should a young child collapse the correct size airway needed to be available. We brought this to the attention of the CYP lead nurse who replaced it.
- Staff completed an environment assessment prior to admitting CYP and recorded the outcomes in the patients' care record. The assessment included for example, ensuring hand sanitiser gels were out of reach of young children and the bed was at a suitable height.
- There was a separate area within the main recovery room for CYP. Staff had access to suitable equipment to care for CYP immediately after their procedure.
- Safety goggles were provided for parents and staff whilst a patient had a laser procedure, in keeping with relevant safety guidance.
- The hospital had a contract with a third party provider for maintenance of equipment. The company were based on site so they could respond promptly when staff contacted them.
- The facilities manager maintained a central log of all equipment; each piece of equipment having an inventory number so staff could easily access the servicing and maintenance records. We checked two pieces of equipment and found them to be in date for servicing and safety testing.

Medicines

- The on-site pharmacy supplied medicines for all patients, including CYP. We saw medicines were stored securely in locked cupboards and medicine trolleys on the ward, in theatres and in outpatients.
- The CYP care pathway document contained a medication chart for once only or as required medications. For patients needing regular medications staff completed a separate chart kept with the health record. We found three out of six medication charts where staff had not dated the prescription, which does not meet standards for good record keeping.
- Three out of six patient records did not contain an identifiable prescriber's signature, meaning nursing staff could not raise concerns with the relevant clinician. Also, the patients' weight was not documented, allergy status not completed and there was no evidence of a pharmacy check. This was a potential risk as medicines for CYP should be prescribed based on their weight. In addition, lack of allergy information could result in reaction to a prescribed medication, which the pharmacist had not crosschecked.
- During two CYP outpatients observations, staff did not check the patient's height and weight prior to the consultant issuing a prescription. Outpatients nursing staff told us they did not routinely record this information for CYP attending outpatient appointments.
- Parents were happy with the information provided prior to discharge; nursing staff had given them clear verbal and written information about any medication their child needed to take.
- The resident medical officer (RMO) or ward co-ordinator (a registered nurse) sometimes had to dispense medications to CYP due for discharge, if the pharmacy was closed. Staff told us this was a concern, as they were not routinely involved in the care of CYP.

Records

- Nursing staff told us patient care records were available for CYP attending outpatients and for those admitted for surgery. The consultant's secretary was responsible for ensuring records were available for outpatient appointments. The administrative staff created a hospital record for patients attending for surgery. This was stored on-site at the hospital.
- Consultants provided key information for the patient's hospital record such as copies of letters to the patient's GP, showing why the patient needed a procedure and the planned outcome.
- We reviewed the care records for 12 CYP who had recently had surgery. We found in four records that there was at least one occasion where the healthcare professional reviewing the patient had not printed their name or did not provide their grade. However, records were clearly written and up-to-date.

- In two set of records, the parents had not signed the pre-admission assessment to confirm all the information they had provided was accurate. Nursing staff had completed these assessments over the phone.

Safeguarding

- The hospital followed corporate Nuffield policies for safeguarding children and vulnerable adults. The leads for safeguarding children were the CYP lead nurse and matron; for safeguarding adults the hospital director and matron.
- The leads had completed safeguarding training to the level set by corporate policy. However, they were not confident around certain aspects of safeguarding, such as the level of training staff needed to complete, the hospital abduction policy and the process should a staff member be accused of a safeguarding event. They did know where to access this information and would speak with the Nuffield wide lead for safeguarding if they had any questions. The national safeguarding training policy referenced the Intercollegiate document: Safeguarding children and young people: Roles and competencies for health care staff (March 2014) to determine the level of training staff needed to complete.
- Frontline staff we spoke with could describe the signs of abuse and knew the process to follow if they needed to raise a safeguarding concern. We saw flowcharts for the referral process on display in departments, so staff could easily access this information.
- Senior managers discussed different safeguarding topics, for example, child sexual exploitation or recent local area safeguarding cases at twice-monthly staff forums. It was important to managers that staff remained vigilant, as safeguarding is not just a concern in the NHS.
- If a CYP was admitted with a child protection plan in place, senior managers would speak with the national lead to ensure they followed the correct process, such as allowing access. The hospital relied on the patient's GP to highlight any safeguarding concerns.
- There was a standard operating procedure (SOP) in place for abduction. A parent or member of staff had to supervise all children under the age of 12 at all times. This SOP also covered restricting visitors for CYP and ensuring checks were made on the visitor's identity before they could visit a CYP.
- CYP under the age of 16 had to have a chaperone with them during an appointment or procedure, as stated in the Chaperone SOP. This was generally the parent or carer but if the CYP was Gillick competent (able to give consent without need for parent permission or knowledge) and did not want them to attend, the hospital had to provide a chaperone. Staff would ask the CYP lead nurse to chaperone where possible.
- All staff completed Level 1 safeguarding children training as part of their mandatory training. As of April 2016, compliance across the hospital was 89%, against the hospital target of 85%. For those staff needing to complete Level 2 and Level 3 safeguarding children training, compliance was 86% and 100% respectively. Eighty-nine per cent of staff had completed their safeguarding vulnerable adults Level 1 training. Training compliance for safeguarding children and vulnerable adults did not meet the 85% target in endoscopy, theatres and outpatients.
- Consultants had to submit evidence they had completed their mandatory safeguarding training in their substantive post, for their practising privileges to be renewed.

Mandatory training

- Staff across the hospital told us, and hospital training records confirmed, staff were generally up-to-date with their statutory and mandatory training. Staff were allocated training modules based on their job profile.
- The training modules were a mix of e-learning and practical sessions and included information governance, incident reporting and fire safety.
- The hospital compliance target for mandatory training was 85%. Although they had achieved this for 48 of the 55 modules, there was a poor level of compliance for basic paediatric life support training. The hospital achieved 41%, against the target of 85% as of April 2016. Compliance was particularly low for staff working in theatres (34%), on the ward (36%) and in physiotherapy (43%).
- Since the appointment of the lead nurse for CYP, they were providing additional training sessions for staff, to improve compliance and reduce the potential level of risk to patients. However, they had to fit this in around their other clinical responsibilities.
- In all the areas we visited at least one member of staff told us they had completed paediatric intermediate life support training, in addition to paediatric basic life

support. This hospital had not recorded this information on their mandatory training data; it was therefore not clear if staff had to complete this training or had chosen to do so.

Assessing and responding to patient risk

- There were systems and processes in place to reduce the level of risk to CYP. Staff were aware of these and used them effectively when caring for patients.
- All patients had a pre-assessment to ensure they met the inclusion criteria for surgery, listed in the Group Children's Service Policy: Children's Services in Hospitals (2013). If the nurse felt a patient did not meet these criteria, they discussed this with the consultant.
- A registered children's nurse completed all pre-assessments, other than for young people aged 16 to 18, where a competent registered general nurse could complete the assessment. This was in-line with the SOP on staffing for inpatient and day case patients.
- Although the hospital ran a dedicated paediatric surgery week to ensure suitably trained staff were present, the hospital sometimes admitted CYP outside of this week. The bookings team informed the lead nurse for CYP, hospital matron and resuscitation officer who completed a risk assessment before the CYP could be admitted. Further discussion on any risks took place as part of the daily hospital wide meeting during the patient's stay.
- Staff caring for CYP completed the Paediatric Early Warning Score (PEWS). The score obtained determined the level of escalation. Compliance with completing PEWS was monitored and audit data from March 2016 showed in nine out of 10 records, PEWS had been recorded, with no additional action needed as the score had been two or less. However, there was only one PEWS chart in the patient care record covering all ages, rather than one for set age bands as recommended by NHS Institute for Innovation and Improvement. Staff could not see at a glance observations, which were outside the normal range, they had to refer to the table in the care record. There was a potential risk of staff miscalculating the PEWS score and appropriate action not being taken.
- The hospital had a transfer policy should a CYP become seriously unwell and require emergency treatment at the local NHS hospital, which had critical care facilities. The RMO provided care for the patient whilst waiting for the emergency services to arrive.
- From September 2015 to May 2016, three CYP cardiac arrest practice scenarios took place. Feedback showed the teams provided appropriate care to the patient; with specific individual performance concerns fedback to the relevant manger and action taken.

Nursing staffing

- We had concerns around the nurse staffing for the CYP service due to the demands placed on current staff and staffing not being in line with national guidance from the Royal College of Nursing
- At the time of our inspection there was only one registered children's nurse employed by the hospital. During the paediatric surgery week, the service relied on bank and agency staff; outside of this week the registered children's nurse provided cover across all areas of the hospital.
- Guidance from the Royal College of Nursing on 'Defining staffing levels for children and young people's services' (2013) states the minimum essential requirements are a minimum of one registered children's nurse must be available in outpatients at all times to assist, supervise, support and chaperone children. It also advises there should be a minimum of two registered children's nurses at all time in all inpatient and day care areas and access to a senior children's nurse for advice at all times throughout any 24 hour period. In the operating department recovery area, there must be at least one registered children's nurse on duty when children are admitted for surgery.
- Staff told us one registered children's nurse cared for four patients in-line with corporate guidance However, the required staffing ratio was not contained within the Children's Services in Hospitals Appendix B: Staffing Grid for Children's Services (Nursing & Theatres) (2013). We reviewed the nursing cover for the paediatric surgery week in March and the service had staffed all shifts in-line with their agreed staffing ratio, although this did meet the minimum guidance as stated above. Shifts were recorded in a diary. It was not possible to decipher which shifts staff were working, or if the planned staffing levels were met, until someone explained this to us.
- From reviewing the diary and talking with staff, if there were four or less children admitted, only one registered children's nurse would be on duty, with no on-call support. Although other nursing staff were available, they were not children trained. Relief would be provided by the ward co-ordinator who would be trained in

Paediatric Immediate Life Support. Nursing staff on the ward staff, would answer call bells but did not provide direct care, other than in an emergency. There was a risk if the children's nurse was needed on the ward and in outpatients at the same time. Senior management had included the recruitment risk on the hospital risk register but there was no evidence a risk assessment had been completed for only one children's nurse being on duty.

- The hospital had recruited two additional registered children's nurses (one full-time and one part-time) who had not yet started. The hospital was also recruiting children's nurses to be on the bank and had successful recruited two health care assistants to work in the CYP service.
- The corporate 'Children's services' policy (2013) stated care for CYP aged 12 to 16 years could be provided by a registered general nurse with relevant competencies, however, following an incident at the hospital staff told us all CYP aged under 16 were cared for by a registered children's nurse. There was no written evidence of this local agreement, nor was this contained within the root cause analysis for the incident. This was confirmed by the Matron who said they stopped using these competencies in 2015.
- The theatre manager was aware of the paediatric surgery week dates so they could allocate staff with the appropriate experience to care for patients. Nursing staff working in theatres had experience of working with CYP but not all had completed specific training or competencies, to demonstrate their level of skill. There was no registered children's nurse working in the recovery area as stated in the national guidance.
- The lead CYP nurse was on-call all of the time, even when not on-duty, although they told us they were contacted infrequently. There were plans to develop an on-call system across CYP services within a region. This would reduce the amount of on-call for all lead CYP nurses. The lead CYP nurse also had overall responsibility and oversight for the care pathway for al CYP attending the hospital.
- The Royal College of Nursing document on 'Defining staffing levels for children and young people's services' (2013) also recommended at least one registered children's nurse on duty must have completed Advanced paediatric life support (APLS) or European paediatric life support (EPLS) training if patients were attending for day surgery.. The lead children's nurse had completed EPLS.
- Agency staff provided details of their training and any updates to their employment agency. The hospital did not spot check any of this information, as the service level agreement stated the minimum level of experience nursing staff needed.
- The hospital transfer policy advised if no registered children's nurse was present to cover a shift, staff should arrange for any CYP already admitted to be transferred to another hospital with suitable facilities and trained staff. Young people aged 16 to 18 could be cared for by a registered general nurse, so would not necessarily be transferred.

Medical staffing

- The CYP service was consultant led and delivered. Surgeons and anaesthetists had to be able to attend in person within 30 minutes, in case they needed to urgently visit a child or young person. If this was not possible, they had to arrange for another consultant to provide cover for them.
- Staff told us and we observed the consultant was responsible for arranging a paediatric anaesthetist to be present when any CYP were having a procedure in the operating theatre.
- Paediatricians provided outpatient clinics but there was no formal arrangement for consultants or nursing staff to contact them for advice.
- 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 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 an RMO on-site 24 hours a day. The Children's Services in Hospitals Appendix B: Staffing Grid for Children's Services (Nursing & Theatres) (2013) stated that the RMO needed to have paediatric experience. The hospital contract with the RMO agency required the RMO to have completed APLS. The RMO we spoke to confirmed they were up-to-date with their APLS. They provided medical care to patients and if concerned

contacted the CYP consultant or the lead paediatrician, if this was more appropriate, such as for a safeguarding concern. In addition, the anaesthetist remained on-site until all patients had recovered sufficiently after their operation and were back on the ward.

Major incident awareness and training

- Senior staff were aware of the hospital's major incident policy and knew where to access this.
- Fire drills took place every three months. The hospital risk register included lack of staff confidence in fire evacuation drills. The hospital had scheduled further evacuation exercises after refresher sessions had taken place for staff.

Are services for children and young people effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated this service as requires improvement for effective because:

- There was no local clinical audit programme in place to monitor, discuss and change practice in response to patient outcomes; to provide assurance the service was offering effective care and treatment to patients
- Systems were in place for senior managers to monitor compliance with best practice guidance. However, at service level there was no evidence of how this guidance was used to demonstrate how care and treatment was reflective of current evidence based guidance, standards and practice. .
- Children and young people did not receive the same standard of care for the pain they were experiencing. We observed good assessment and management of pain for two patients but also noted in two patient care records when staff had not responded appropriately. In addition, there was no recognised pain tool used for children who were unable to communicate their level of pain.

However:

- Staff across the hospital worked effectively as a team to provide co-ordinated care for children and young people, which focused on their needs. Patient care records were available for outpatient appointments and on admission. The service shared relevant information with the patient's GP and when appropriate with the school.
- The hospital had robust systems in place for granting practicing privileges to consultants and when necessary suspended or removed these. Any agency nursing staff had to demonstrate set competencies and training, however, the service lead did not spot check any of this information, they relied on the information from the employment agency. Permanent staff told us they felt supported to complete additional training and were up-to-date with their appraisal.
- The hospital had systems in place to ensure care was provide to children and young people who were inpatients seven days a week, including access to on-call theatre and diagnostic imaging staff.
- Parents told us they had made an informed decision prior to giving consent for surgery. Staff had a good understanding of Gillick competency and how to apply this if a young person wished to give consent for a procedure.

Evidence-based care and treatment

- The hospital completed a monthly gap analysis of new National Institute for Health and Care Excellence (NICE) guidelines, assessed whether these were relevant to the services offered by the hospital and action they needed to take to implement them. Therefore, any guidance relating to children would have been considered. Gap analysis assessment check list June 2016 showed that they had considered the clinical guideline 155 psychosis and schizophrenia in children and young people. However, we were unable to find evidence of how the service followed and monitored compliance with evidence based practice, to ensure they provided the most suitable care and treatment to patients.
- , such as from the Royal College of Paediatrics and Child Health.
- There was no evidence of any regular clinical audits specific to children and young people's (CYP) services, to monitor compliance with local policies, other than records documentation.

- The service did benchmark by visiting other CYP services but did not participate in any national accreditation schemes such as 'You're Welcome'. This enables a service to assess how well their service meets the needs and preferences of young people.

Pain relief

- Staff were not consistent in their assessment and management of pain experienced by CYP.
- We observed and two patients told us staff had managed their pain well, with medication given to reduce their level of pain.
- However, during an observation, nursing staff did not use a pain scoring tool when the mother of a young child aged three, mentioned their child was complaining of pain. The care pathway document contained the faces visual pain scale tool for children unable to quantify their level of pain. The pain was scored as zero based on observations staff completed and at no time was the child asked by the nurse if they were in pain.
- A patient's care record showed a pain score of five during two sets of observations. There was no reassessment of the level of pain prior to discharge and no evidence of any further action to manage the pain.
- Staff were reliant on CYP being able to self-report their level of pain, using a numerical scale from zero to ten or using the faces visual pain scale, which was suitable for patients aged three years and over. For younger patients or those who were non- verbal, staff used observations and spoke with the parent but there was no specific non-verbal pain tool used, such as the Face, Legs, Activity, Cry, Consolability scale (FLACC).

Nutrition and hydration

- Nursing staff asked CYP about any food intolerance or allergies as part of their pre-assessment. This also included specific dietary requirements, such as vegetarian or halal. They passed this information to the catering team.
- Parents told us nursing staff had given them information about when their child should stop eating and drinking prior to surgery, as part of their pre-assessment.
- We observed nursing staff asking if patients felt nauseous and providing anti-sickness medication as needed.

Patient outcomes

- The hospital told us they did not collect patient reported outcome measure (PROMs) data or participate in national audits, as the CYP surgery they performed did not have specific national PROMs or audits they could contribute to.
- The service did not analyse patient outcome data to enable it to monitor and improve the quality of the service and ensure the intended outcome for patients was being achieved
- From January to December 2015, there were eight unplanned readmissions to hospital. None of these were children. There was one CYP unplanned transfer to another hospital.
- The hospital had joined the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was yet available.

Competent staff

- Registered children's nurses provided care for children under the age of 16. Permanent and bank staff had to provide evidence of their registration as part of their pre-employment checks. Agency children's nurses provided evidence of their registration to their employment agency; they also had to provide evidence of up-to-date safeguarding children training to Level 3 and paediatric intermediate life support.
- Historically general nurses who had completed competency assessment had cared for young people aged 12 to 16 years; however, this had stopped in 2015.
- The service kept an information folder on the ward for agency and bank staff to refer to. This contained key information such as cardiac arrest information, parent information leaflets and algorithms for medications used. Staff were shown this as part of their induction.
- The lead nurse told us they had received an appraisal within the last 12 months.
- Consultants told us the senior management team at the hospital enforced the practicing privileges policy, suspending consultants who could not demonstrate the required standards. They had to send in evidence of their appraisal and completion of mandatory training annually, including resuscitation training. They also had to submit evidence they saw and performed surgery on CYP in their substantive post to be able to see these patients at the hospital.

Requires improvement

Services for children and young people

- The lead CYP nurse had a list of all consultants and the procedures they could perform under their practising privileges. This list was cross-checked when they received surgery dates from the administration team. This information was also kept on the ward so agency and bank children's' nurses could refer to it as needed.
- Theatre staff working during paediatric surgery week were experienced in caring for CYP. Bank and agency staff were sometimes used, particularly in recovery to ensure competent staff were on duty. Theatre staff had completed self-directed learning but there were no specific CYP competencies used by the hospital to provide additional evidence of their ability.
- In physiotherapy, staff recorded on the booking system the age and type of patient they were competent to assess and treat. This meant the appointments team arranged an appointment with the most appropriate member of staff.
- Medical and nursing staff raised concerns about the level of paediatric specific knowledge of some of the RMOs. They did not always have confidence in their ability and felt this was demonstrated through recent practice scenarios. They acknowledged it was hard for them to maintain their skills and competencies at the hospital as they only admitted CYP for one week each month.

Multidisciplinary working

- We observed effective multidisciplinary team working between all staff caring for CYP. The consultant had overall responsibility for the patient during their stay. The consultant and anaesthetist visited patients after their procedure to ensure their recovery went as planned.
- Medical staff told us they valued having the registered children's nurses to care for CYP, due to their specialist knowledge and experience. The RMOs often liaised with nursing staff when prescribing medication for CYP. The pharmacy service dispensed prescriptions for inpatients and day patients during their normal opening hours.
- Physiotherapists provided advice and treatment as needed to any CYP admitted to the hospital.
- The senior management were aware there was no access to play specialist at the hospital, they planned to send a new member of staff on a training course so they could provide this service in the future.
- The consultant was responsible for liaising and arranging transfer to an appropriate hospital, if a CYP needed more specialist care. Staff caring for CYP knew where to access the transfer policy.

Seven-day services

- The hospital held outpatient clinics and admitted patients for procedures Monday to Saturday.
- Nursing care was provided seven days a week for any CYP inpatients.
- Staff working in diagnostic imaging, pathology and theatres provided cover via an on-call system.
- The RMOs and some senior nursing staff told us they had to dispense medications as the pharmacy closed at 5pm. Patients were not always ready for discharge by this time. Staff could contact the pharmacist by telephone for advice.

Access to information

- Staff told us and we saw that patient care records were available when CYP were admitted for surgery and attended outpatients appointments.
- Consultants provided a minimum set of information for the hospital record for patients admitted for surgery, so all staff knew the reason for admission, planned procedure and expected outcome.
- The hospital sent a discharge letter to the patients' GP, once the patient or parent had given consent for this information to be shared. Medical staff also wrote a letter for the parent to share with their child's school.

Consent

- Patient care records contained completed consent forms, with the risks and benefits of surgery clearly listed. Parents and CYP told us and we observed they were able to ask questions prior to giving consent.
- Staff were mindful of involving CYP as much as possible with decisions about their care. Young people aged 16 and over signed their own consent form; those under 16 were encouraged to sign the form, with the parent normally signing as well.
- Staff we spoke with understood when Gillick competency applied and we saw young people under the age of 16 giving consent. Staff also understood they had to consider the Mental Capacity Act (2005) when young people aged 16 and over gave consent.

Requires improvement

Services for children and young people

- There was a corporate Nuffield 'Consent to examination or treatment' policy, with a separate standard operating procedure (SOP) for the consent of children. There was also a SOP for consent in young people who had capacity, but had an impaired level of consciousness.
- If medical or nursing staff did not consider parents were capable of making the best decision about their child's care, then the hospital would consider seeking the view of the courts.

Are services for children and young people caring?

Good

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated this service as good for caring because:

- The children, young people and parents we spoke with were very happy with the care and support they had received from staff. They felt all staff took the time to listen to their concerns and explained the planned care and treatment using language children and young people could understand. Where appropriate, children and young people were encouraged to be active partners in their care.
- Staff built up a good rapport with patients and endeavoured to make the visit to hospital not seem as daunting or frightening. Also, we saw staff providing emotional support to families, recognising the impact a hospital visit or stay had on everyone, not just the patient.
- Registered children's nurses often acted as chaperones, in accordance with hospital policy.

Compassionate care

- The majority of children, young people (CYP) and parents spoke highly of the care they had received from staff, praising them for their care and attention during treatment. We observed interactions between staff and children, young people and their families to be caring, sensitive and age appropriate.
- We observed staff offering additional support to patients who were anxious about their hospital stay.
- Staff responded to call bells promptly and treated patients with dignity and respect when providing care, keeping bedroom doors closed to maintain confidentiality. However, not all the parents we spoke with knew the process to follow if they needed to leave their child unattended for a period of time. Nursing staff had not told them this as part of the admissions process.
- The hospital had a standard operating procedure for chaperoning as part of the 'Privacy and Dignity' policy (2015), outlining arrangements for children and young people. We saw chaperone notices displayed around the hospital. Parents acted as the natural chaperone, although in certain circumstances such as during an intimate examination a chaperone would also be present. If the child or young person did not want their parent present, and was assessed as Gillick competent, the hospital would always provide a chaperone.
- One consultant we spoke with commented that chaperoning for children and young people had improved recently and they saw this as a positive change for the children's service.

Understanding and involvement of patients and those close to them

- Staff communicated with parents and CYP to ensure they understood information provided during outpatient consultations. Four of the parents we spoke with described staff communicating clearly and explaining their child's care and treatment. Parents told us they felt staff listened to their concerns and gave them time to ask questions. Parents felt actively involved with all stages of their child's care and treatment.
- Parents felt clinicians explained information to children in a way they could understand. We observed two outpatient consultations where children and young people had been actively involved in discussions about their care and treatment. We also observed a young person and parent jointly signing a consent form. The consultant described the risks and benefits of the treatment before gaining consent.
- Staff informed CYP undergoing surgery, what would happen at each stage of their admission. Staff explained procedures such as taking observations of temperature and blood pressure in age appropriate language to help the child feel more comfortable. We observed theatre staff interacting with children and young people to distract them from their procedure.

Requires improvement

Services for children and young people

- We heard a registered children's nurse giving advice and reassurance to parents prior to their child's operation as part of a telephone pre-assessment. There was clear explanation of what would happen before the operation, in the anaesthetic room and recovery.

Emotional support

- Staff recognised and supported CYP and their families emotionally throughout their hospital stay or during their outpatient appointment. Parents were encouraged to go with their child to the anaesthetic room and be present in the recovery area. We observed a parent being encouraged to lie on the bed with their child, in the recovery room, to provide comfort and reassurance.
- Parents were encouraged to stay with their child in hospital. The hospital provided an additional bed in the same room as the CYP.
- Parents we spoke with on the ward felt comfortable to leave their child in the care of the nursing staff, if needed.
- Staff considered the needs of children and young people during treatment. We observed a consultant providing reassurance and opportunity for breaks during a procedure in outpatients.

Are services for children and young people responsive?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

We rated this service as requires improvement for responsive because:

- Outpatient and ward environments did not all meet the specific needs of children and young people. Children, young people and adults were cared for in the same area, although inpatients and day case patients had individual rooms. The provision of play and recreation within the hospital was limited to meet the needs of young children only.
- Patient information sheets about surgical procedures were not age appropriate for children and young people. Children and young people did not consistently receive age appropriate information about their outpatients appointment and general anaesthetic.
- Children, young people and their families were not involved in the design or running of the service and the hospital did not have a child friendly complaints or feedback process.

However:

- The hospital had strict selection criteria to ensure they only admitted children and young people who they had the appropriate facilities to care for. Parents told us the whole process from booking the initial appointment to being discharged post-surgery was efficient and well-organised. There were minimal waiting times for outpatient appointments and surgery.
- Nursing staff made the inpatient rooms 'child' friendly prior to children or young people being admitted, such as with child friendly bed linen and providing a teddy bear. Also, some of the bays in the recovery area had been adapted to meet the needs of children and young people.

Service planning and delivery to meet the needs of local people

- Children, young people (CYP) and their families were not involved in the design and running of the service. Senior staff told us they planned to invite parents to join the hospital patient forum.
- There was no separate children's waiting area in the outpatient department. Toys were available in three of the four outpatient waiting areas. Staff told us they had recently ordered three tablet devices, which would be available for children and young people to use in all areas of the hospital.
- One consultant we spoke with told us the provision of toys in outpatients had improved, however, they felt it would be more appropriate to have a separate waiting room for children.
- The hospital had identified, through risk assessment, that although they nursed children in one area, in a set of rooms adjacent to the main ward but behind an additional set of double doors, it was not possible to monitor who entered and left this area. Therefore there was a potential risk to children's safety. The hospital was considering introducing an intercom or locking system to restrict access to these rooms.
- Staff made these rooms child friendly by using children's bed linen, providing colouring, and a teddy bear. We also observed child friendly hand hygiene leaflets available in the room.

- In recovery, some of the recovery bays had been adapted for children with child friendly curtains and wall art. These were located at one end of the recovery area.
- Staff told us children and young people are encouraged to bring in their own electronic devices to maintain links with their social network. The hospital provided free Wi-Fi access to visitors and patients.
- Parents spoke positively about the environment their child was cared in and valued being able to stay with their child. There was also a rest room for parents. Parents also commented on being able to park easily.

Access and flow

- The hospital had established a clear booking process for appointments and hospital admissions Parents told us they found this process efficient.
- The hospital had written inclusion and exclusion criteria so the hospital only admitted CYP they had the facilities to care for.
- The consultants' private secretary arranged outpatient appointments and confirmed the surgery date. The bookings team were responsible for transferring the surgical date to the patient appointment system, sending out the pre-assessment information and arranging the appointment. All relevant staff had printed copies of the scheduled for paediatric surgery weeks for the whole year to assist them with planning and booking of patients.
- The hospital preferred children, young people and their families to attend for the pre-assessment appointment in-person but nursing staff could complete this by telephone, if more convenient.
- Parents told us there was minimal waiting time from referral, for the consultant to see their child and they were offered an appointment at a time that was convenient for them. Two parents told us being able to communicate by email made it easier for them to contact the hospital or consultants' secretary. In one case, a GP referred a child on a Friday and they had an appointment three days later to see a consultant in the clinic.
- Parents we spoke with were clear on whether their child needed a further appointment and how soon this was needed.
- Parents were kept informed of any delays. A parent told us there was a delay in their child going to theatre and their child's surgery took longer than expected, however, staff informed them of the delay and kept them updated on their child's progress.

Meeting people's individual needs

- The hospital and CYP service recognised the need to meet the needs of CYP but currently did not always achieve this.
- In the outpatient waiting areas, the newly introduced toys were appropriate for children under the age of five. There was no provision of entertainment or distraction available for older children or young people. There was no action plan around how the service planned to address this.
- Patient information leaflets giving information about surgical procedures were not specific for children and young people. At the time we visited, we observed staff giving CYP and families information leaflets designed for adults. Staff told us they recognised this and planned to introduce child specific information leaflets although we did not see any formal actions plans or timescales to achieve this.
- We saw child friendly information about having a general anaesthetic and attending an outpatient appointment. These were broken down into three age groups, three to 10 years, 10 to 12 years and 12 years onwards. Staff told us the hospital sent this information out to parents and children before their appointment or surgery. However, one parent of a three-year old child told us they received an older child information sheet and some parents told us they had not received child friendly information leaflets prior to their child's stay.
- We reviewed the patient care notes for a young person with learning disabilities. Staff had recorded the young person's learning disabilities at pre-assessment but there was no evidence of an individualised care plan detailing how staff would meet the patient's additional needs.
- For CYP needing a computerised topography (CT) scan, a cartoon played in the machine during the scan to distract children. This started automatically when staff entered the child's date of birth.

Learning from complaints and concerns

- The hospital followed the corporate complaints policy when investigating and responding to complaints or

concerns. The hospital director had overall responsibility for the management of complaints but if the complaint related to clinical care, it was passed to the matron, who liaised with the relevant head of department.
- From January to December 2015, there had been 70 complaints across the hospital, an increase of 15 from the previous year. The hospital did not provide data on how many of these complaints related to the CYP service.
- We saw minutes from clinical governance and departmental meetings showing managers discussed learning from complaints with staff.
- The hospital did not have a child friendly complaints procedure in place or specific patient feedback forms for children.

Are services for children and young people well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated this service as requires improvement for well-led because:

- There was no service specific strategy in place, identifying the key risks to achieving the vision for the service.
- The local monitoring of the governance, quality and risk of the service was not developed. There was no local monitoring of patient outcomes, use of clinical audit and staffing was not in line with national guidance. The service could not demonstrate how it was using evidence based practice.
- At the time of our inspection there was only one permanent member of staff, who was responsible for managing the service and providing care to patients.

However:

- The leadership of the hospital had recognised the need to review the quality and safety of the service, with immediate and long-term actions identified to ensure patient safety.
- Staff valued having a lead nurse for the CYP service and appreciated their input into their services. Staff across the hospital felt able to raise concerns with any member of the senior management team, felt listened to and valued.
- A new CYP leads of service committee had started, along with a champions group, involving staff across the hospital with a desire to improve the CYP service. New feedback forms were planned to seek the views of CYP about the service as well as their parents.

Vision and strategy for this core service

- The vision for the CYP service was to move from monthly children's and young people (CYP) surgery week to two a month. Senior management would only consider this change once they considered the service was safe, including sufficient staff to manage the increased patient numbers.
- There was no service specific strategy in place to support how the vision would be achieved, including any risks in addition to needing more staff.

Governance, risk management and quality measurement for this core service

- Nuffield Health completed an internal clinical review of the CYP service in December 2015, following concerns raised by the new hospital director about the governance processes across the hospital. The immediate actions from this review to ensure patient safety were ensuring the service adhered to the Group Children's Service Policy: Children's Services in Hospitals (2013) and external regulatory guidance, to suspend the paediatric scoliosis service and for pre-assessments to be completed by the paediatric lead. A more detailed action plan was also produced. The corporate Nuffield team completed a further review in April 2016, with the majority of actions agreed as completed. Outstanding actions focused on recruitment and recording detailed information about consultants' experience of working with children in their substantive post as part of the appraisal process.
- There had been a period of rapid change for the CYP service since the initial review with the focus on patient

safety. This had included the development of a paediatric committee which would have responsibility for reviewing the quality and risk for this service at service level. However, there was no dedicated clinical audit programme for the CYP service or monitoring of patient outcomes. The senior management team had overarching responsibility for the service, while linking with the lead for the service, while their role was developed.

- The CYP lead nurse met twice a year with other CYP leads across the Nuffield group to share best practice and discuss learning from specific cases. Although senior management told us during the second visit to the hospital, they planned to arrange external support and coaching for the CYP lead nurse.
- The CYP service was included on the hospital wide risk register, with some of the risks we identified during the inspection included on the register for example lack of security control for access to bedrooms. The allocated member of staff monitored the risks regularly and updated the level of risk accordingly. There was no local identification or monitoring of the key risks for the service.
- Nurse staffing for the service could not demonstrate how they followed national guidance, potentially placing patients and staff at risk.
- The lead nurse for the CYP service attended the senior management team meetings so they could easily raise any concerns about the service. The recently appointed medical advisory committee (MAC) chair was a paediatric anaesthetist, who requested all medical staff must be able to demonstrate up-to-date safeguarding children training as part of the practicing privileges process. A paediatrician also attended the MAC meetings.
- Minutes from the MAC meetings in January and April 2016, showed members discussed practising privileges applications and suspensions, shared learning from never events at other Nuffield hospitals and key risks to current services offered by the hospital. Although, there was no detailed update about the CYP service at either meeting.
- The hospital management required staff working for consultants in outpatients, such as allied health professionals, to complete the same practising privileges process, before they could see patients at the hospital.

Leadership of service

- At the time of our inspection, the CYP lead nurse was the only permanent member of staff for the service.
- The senior management had recently recruited the lead CYP nurse. The hospital manager and matron were supporting them until they became competent at the management aspect of their role, including completing additional training.
- To provide additional local leadership a paediatric committee, which included a paediatrician, a consultant with a specific paediatric interest and other staff from the hospital involved with caring for CYP had been set up. The group had met once in May 2016. The committee had agreed terms of reference at this meeting and discussed key concerns for the service. The group planned to meet bimonthly.
- Staff across the hospital valued the input of the CYP lead to their service and felt well supported if they needed any advice.
- Staff involved with the CYP service felt able to raise any concerns to the lead or when appropriate to the matron or hospital director. All staff were positive about the recent change in senior management.

Culture within the service

- Staff we spoke with commented on the improved 'atmosphere' at the hospital since the change in leadership and said it now felt a positive place to work. Staff told us they felt encouraged to develop their service and were motivated to do so; morale amongst staff had improved.

Public and staff engagement

- Parents 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. There was no CYP specific feedback form in use. The service lead recognised this as a concern and told us they had plans to implement a specific child friendly feedback survey, although we did not see any formal actions plans or timescales to achieve this.
- As well as the CYP leads group, the service had recently started a children's champion group involving any staff across the hospital who wanted to be involved with

improving the service. Ideas from the group included more distraction toys, a specific menu for young people and providing child and young person specific dressing gowns.
- The hospital had introduced a staff recognition scheme in 2016; nomination forms were available throughout the areas we visited.

Innovation, improvement and sustainability

- All staff involved with the service were passionate about developing it and increasing the number of CYP seen at the hospital.
- Clinical and management staff recognised that offering a surgery week twice per month, would enable hospital staff to maintain their skills but the service needed to be staffed appropriately before this change could be made.
- The hospital had held a successful recruitment day and recruited two new staff for the service. They planned to support one member of staff to complete a play therapy course.
- The service planned to run a different health promotion topic during each children's surgery week.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at the Nuffield Health Manor Hospital Oxford provides a wide range of speciality appointments including orthopaedics, urology, and gynaecology, general surgery, ophthalmology, ears, nose and throat (ENT), cosmetic surgery, oral surgery, medical and cardiac. The diagnostic imaging service provides access to a computerised tomography (CT) scanner, ultrasound, x-ray, digital mammography, fluoroscopy, and interventional radiology. A magnetic resonance imaging MRI scanner is available but managed by outside contractors and outside of the remit of this inspection.

The outpatient area has 22 consulting rooms, including gynaecology suites, a dental suite (for consultation and treatment), two ophthalmology test rooms, two ENT rooms, and three general treatment rooms. The opening hours for the service are between 8am and 8.30pm, Monday to Thursday, 8am to 6pm on Fridays and 8am to 4pm on Saturdays. From January to December 2015, the outpatient department provided 15,071 new patient appointments and 11,843 follow up appointments. The majority of patients seen (83%) were between the ages of 18 and 74 years.

There was a physiotherapy department with space and equipment for sports rehabilitation in a small gymnasium. The physiotherapy department was open between 8am and 7.30pm Monday to Thursday, and 8am to 4.30pm on Fridays. A team of three provided treatment for in-patients at the weekend when required. Services provided include post-operative therapy for patients following joint surgery, spinal surgery, mastectomy and gynaecological procedures. The physiotherapy team also accepted self-referrals and GP referrals, mainly to treat bad backs and headaches. The team also had a number of staff who practiced acupuncture and provided this for pain relief.

During our inspection, we visited the outpatients department and the diagnostic imaging services. We spoke with six patients, four relatives and 21 staff including, nurses, healthcare assistants, consultants, radiographers, physiotherapists, administrators and managers.

Throughout our inspection, we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment in use. We reviewed nine sets of patient records and we observed interactions between staff and patients.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated this service as good overall. We found outpatients and diagnostic imaging was good for the key questions of safe, caring, responsive and well led. We did not rate effective, as we do not currently collate sufficient evidence to enable a rating.

- There were appropriate systems in place to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse. Staff undertook appropriate mandatory training for their role and they protected patients from the risk of abuse and avoidable harm. Staff followed hospital infection prevention and control practices and they monitored them regularly, to reduce the risk of spread of infections. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staff planned and delivered patients' care and treatment in line with current evidence based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits and other monitoring activities such as reviews of services. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Managers supported staff to deliver effective care and treatment, through meaningful and timely supervision and appraisal.
- Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole. We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.
- There was good availability of appointments for patients across all specialities. Staff planned and delivered services in a way that met the needs of patients. Access to appointments was timely; clinics were held on weekdays into the evening and on Saturdays to suit patients' preferences. Waiting times, delays, and cancellations were minimal and managed appropriately.
- Interpretation services were available when required and staff made practical adjustments to accommodate patients' individual needs, for example, when caring for patients with dementia.
- There was openness and transparency in how staff dealt with complaints, which they investigated and changes made if necessary.
- There was a clear statement of vision and values, which was driven by quality and safety. Staff were well informed about issues relating to their department. Effective governance and risk management systems were in place.
- Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Staff gave patients opportunities to provide feedback about their experiences and this was used to improve the service.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

By safe, we mean that people are protected from abuse and avoidable harm.

We rated safe as good because:

- Staff protected patients from the risk of abuse and avoidable harm in the outpatients, physiotherapy, and diagnostic imaging departments.
- Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff undertook appropriate mandatory training for their role and were supported to keep this up-to-date.
- Clinical areas and waiting rooms were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk or spread of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging service. The hospital did not use agency staff, however they occasionally employed longstanding bank staff to provide cover.
- Medicines were stored securely and well managed.
- Patient records were available prior to a patient appointment.
- Staff received training in basic life support to ensure they could respond appropriately in an emergency.

Incidents

- In the reporting period January 2015 to December 2015, there were 777 clinical incidents reported across the hospital, 66 of which were reported by outpatient or diagnostic department staff. There were no serious incidents reported over the same period; all of the 66 were graded as low or no harm incidents.
- Staff were confident they knew how to report an incident on the electronic incident management system, and could give examples of what to report. For example, a nurse described how she had recently recorded an incident upon finding ambiguity within a patient's notes.
- Learning from incidents was displayed for staff via a wall display in the staff entrance corridor. There was a weekly meeting attended by all heads of departments where incidents were discussed and learning shared. Learning was cascaded to teams at regular staff meetings.
- There were no radiation incidents reported within the reporting period; staff we spoke with were clear about the reporting process and described how they would report onto the electronic reporting system and inform one of the Radiation Protection Supervisors (RPS) at the earliest opportunity. They told us that near misses were also recorded and brought to the attention of the wider hospital team in daily meetings. Representatives from each department attended these daily meetings and then circulated the notes to wider teams.
- Non-clinical incidents were discussed at the health safety and risk meetings with outcomes and actions shared at the leadership team meetings.
- The hospital matron received and disseminated medical and health regulatory (MHRA) safety alerts to relevant departments. The head of pharmacy received alerts relating to drugs and these were noted in the minutes of the clinical governance meetings.
- The duty of candour (DoC) 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.' Staff were aware of the principles of duty of candour and could give examples of when a patient would need to be approached, although no staff recalled any incidents where DoC was triggered.

Cleanliness, infection control and hygiene

- The outpatient and imaging department including the consulting and treatment rooms and gymnasium were visibly clean and tidy.
- Signed cleaning schedules were in place for treatment rooms and all consulting rooms.
- Hand sanitiser points were widely available throughout the outpatient department including the waiting areas to encourage good hand hygiene practice. We observed

staff adhered to the national 'bare below the elbow' guidance, which enabled thorough hand washing, and reduced the risk of spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff used them appropriately.
- Staff labelled clean equipment to indicate it was ready for use, for example, blood pressure monitors.
- Utility rooms were clean and uncluttered with PPE available for staff.
- The infection control lead nurse produced quarterly infection control audit results for each department. The outpatient department were 91% and 90% compliant for their cleanliness and hand hygiene audits for the first quarter of 2016; the physiotherapy team and the radiology department were 100% compliant for cleanliness and hand hygiene.
- The imaging department achieved 83% for the mattress audit in the most recent quarterly audit. Staff told us that mattresses unfit for purpose were removed and replaced with new ones.

Environment and equipment

- The outpatient areas were well signposted and corridors were free from clutter.
- Toilets were cleaned twice daily with a record signed by the cleaner.
- Staff kept the clean utility room locked on the corridor side but accessible to the two clinical rooms either sides. This prevented inappropriate access from unauthorised people.
- The porters signed the record of waste collection daily, and staff segregated waste bins and clearly labelled them. This demonstrated good practice, which prevented contamination.
- During the inspection, we saw equipment labelled as serviced, and electrical appliance tested. For example service stickers were evident on the weighing scale (serviced June 2015), scopes (serviced May 2016) and furniture (next service due May 2017).
- Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment.
- Staff kept the room used for laser eye surgery locked with an instruction on the door "to keep door locked" – clear warning signs were visible on the door and a warning light.
- There was a laser policy and the laser protection supervisor (LPS) was the department manager. An external contractor provided laser protection advice (LPA). We saw a report the LPA produced in August 2015 that showed laser equipment was 100% compliant with safety checks.
- Staff maintained resuscitation equipment, and made sure it was ready for use in an emergency. The outpatient staff checked the resuscitation trolley daily, and the outpatients' manager checked it weekly. All checks were found to be complete. Staff recorded expiry dates of items to identify items that were due for re-ordering easily. Staff secured the trolleys with tamper evident seals.
- In radiology, we observed clean waiting areas with a variety of seating to cater for differing patient needs.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- The computerised tomography (CT) scanner was very modern and was run by a superintendent radiographer who wrote the protocols with the department deputy.
- A radiation protection advisor (RPA) from an external organisation undertook equipment and paperwork audits.
- The annual RPA audit against ionising radiation (medical exposure) regulations IR(ME)R 200 and the ionising radiation regulations (IRR) 1999 took place in August 2015; the outcome report showed that the hospital radiology department was fully compliant with no improvements required.
- The department had a full maintenance contract with the manufacturer who provided support on the end of the phone if required, and could attend the department within hours.
- Radiation signs were visible outside each room and access to the CT area was via a locked door with keypad.
- All new equipment was risk assessed and applications training carried before use.

Medicines

- Medicines were stored safely. Staff locked all medicines cupboards and the lead nurse on duty held the keys. Fridges were centrally locked and alarmed and temperatures checked daily and logged to ensure medicines were stored at the correct temperature.

- Outpatient prescribing was on private prescription pads, which were held securely in the pharmacy and usage tracked and monitored. Carbon copies of all prescriptions on pads were returned to the pharmacy.

Records

- All the hospital's own records were kept on site, or recalled from a medical records store in time for patients' outpatient appointments. The consultants' secretaries, whether internal or external, provided the consultant's own notes prior to any outpatient appointment.
- There was no evidence that patients were seen without adequate clinical information.
- We saw for example, dermatology records were comprehensive and included a consent form, booking form, pre-procedure checklist, and care during procedure, post-procedure care, multidisciplinary evaluation and variance.
- Outpatient consultations within the hospital were consultant-led. All patients attending outpatients had an accompanying GP referral letter or their current medical records from a previous appointment or admission. A consultant would retrieve their own patient records for patients who were self-funding or covered by medical insurance.
- Arrangements were in place to ensure all patients who attended nurse-led clinics, for example, for post-operative wound care, had their notes available. The day prior to the appointment, administration staff transferred patients' notes to the outpatient department in preparation.
- The picture archiving and communications system (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.

Safeguarding

- Safeguarding training for vulnerable adults and children was mandatory for all staff. All the staff we spoke with, knew when to raise a concern and the process they should follow, but could not recall raising any safeguarding concerns. Compliance with safeguarding training was 100% in diagnostic imaging and 80% within the outpatients department (April 2016).
- Eight clinical staff in the outpatients department were required to complete level 2 safeguarding training for adults and children and compliance was at 80% (April 2016).
- The staff corridor clearly displayed safeguarding information provided by the hospital director and matron. The display included information about the various types of abuse associated with children and vulnerable adults, who staff should report concerns to, and steps for staff to follow in order to recognise, intervene and prevent abuse.
- On the outpatients department notice board there was further information about safeguarding for staff use. It included the escalation process involved to safeguard a child.
- Two new registered nurses were both able to explain duty of candour in depth and gave a good example of its' use

Mandatory training

- The hospital mandatory training matrix included training requirements for staff dependent on their role. For example, information governance, health safety and welfare, and fire safety was applicable to all staff whereas infection prevention, deprivation of liberty safeguards (DoLs), and medical gas cylinder safety training was only for staff that required the necessary skills in these areas. Most training was done by e-learning with the Nuffield on-line academy, in some cases followed by workshops and assessments. Staff completed their training during their work time when possible or they could access their e-learning accounts from home if they preferred.
- Some mandatory training was provided by external agencies e.g. Intermediate Life support (ILS).
- Regular bank staff were also expected to complete mandatory training and if they completed it at their NHS workplace, the hospital manager at The Manor Hospital Oxford checked this.
- An automated system alerted managers and individual staff members when they were due for training.
- Mandatory training for the out-patients department nine staff was 77% compliant overall at the time of our visit (the hospital target was 85%) The department achieved 100% in many of the elements of the mandatory training programme but aseptic technique; basic, paediatric, and intermediate life support; infection prevention; and safer blood transfusions level 1 and 2 all fell well below

the 85% target. This involved 1 or 2 staff in several of the elements, but only one staff member had completed the paediatric life support training out of the eligible eight.

- The radiology staff were 86% compliant; the staff were 100% compliant in most of the subjects but fell short in basic life support 60% (4 staff); practical infection prevention (2 staff) and 1 staff member had failed to complete the manual handling training. This was because of several new staff members in post who were still to complete all their training objectives.
- The physiotherapy team were 98% compliant overall, however three out of seven eligible staff members had not completed their paediatric intermediate life support (PILS) training. The hospital had a target of 85% which meant that six out of seven staff should be compliant.
- The hospital director's personal assistant monitored consultants' compliance with their practising privileges agreement. This included evidence of a current revalidation certificate.
- There was a mandatory competency programme in place for staff throughout the radiology department on all equipment including for plain film processes, interventional radiology, and CT scanning.
- Healthcare Assistants had awareness training in local rules for IR(ME)R to ensure they understood the safety elements of working in an environment where radiation is used.
- Annual IR(ME)R updates were provided by the radiation protection advisor (RPA) for all staff in line with current regulations.

Assessing and responding to patient risk

- Staff in each department were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues to care for a deteriorating patient. All physiotherapists, radiographers and registered nurses had received training in immediate life support, with all other staff trained in basic life support.
- It was a requirement of the hospital's practising privileges (PP) policy that consultants remained available or arranged appropriate alternative named cover at all times when they have inpatients in the hospital. Practising privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. Outpatient staff reported no difficulties in contacting the consultants for patients who attended the department for a follow up appointment.
- Signage for the radiology department was clear with radiation warning lights and yellow warning symbols evident.
- Staff told us that approximately 80% of scans had the potential to require contrast; they told us that there were very few patients who reacted to the contrast, but in these cases, the resident medical officer (RMO) was called for medical assistance. There was a policy for patient transfer in the event of a patient having a serious allergic reaction or deterioration of a patient's condition. The RMO assessed the patient's condition and initiated the service level agreement with the local NHS Trust if required.
- Radiographers recorded any reactions to contrast media in the Nuffield Patient information Management system which fed directly into the Computerised Radiology Information System (CRIS).
- The radiologist we spoke with told us they carried out their ultrasound reporting as they go along. They dictated into a recorder and used voice recognition software on the computer, which they reviewed on the monitor, printed, and signed off for the patient records. This practice minimised the possibility of errors in the reporting process.
- All radiologist reports were checked prior to signing; the dictated reports are signed and verified by the radiologist and the administration team checked against the request form and also checked that the radiologist had not voice dictated something that did not make sense. This provided another level of safety by minimising risk of error.
- There was a pregnancy status check policy in place and radiographers checked the status of all women of childbearing age prior to examination.

Nursing staffing

- The outpatient staffing had increased considerably during the six months prior to our visit. The staffing numbers at the time of our visit included one sister who was the department manager, five registered general nurses, three regular bank nurses and three healthcare

assistants. There were no set guidelines on safe staffing levels for the outpatients department, but the sister told us that they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner.
- Staff teams had daily morning meetings to share important updates, such as changes to planned clinics or staffing for the day.
- Staff were willing to be flexible when needed and told us they liked the work, and patient safety was a priority.

Physiotherapy staffing

- The superintendent physiotherapist managed a team of predominantly part time staff. The team included an assistant who also undertook administrative duties and an occupational therapy practitioner.

Radiography staffing

- The superintendent in the diagnostic imaging department was recruiting at the time of our visit, but we observed that there was adequate cover and no patient waited more than a minute.
- A loan senior radiographer usually runs the computed tomography scanner (CT) but a healthcare assistant (HCA) was designated to support when required. The department had HCAs for support tasks but they did not administer radiation.
- Radiographers were available to undertake mobile imaging in the theatres and wards.
- The team regularly used one bank radiographer and one bank HCA but there was very limited agency use.

Medical staffing

- There were 300 consultants with practising privileges at the hospital. All had their status reviewed every two years by the hospital Medical Advisory Committee to check they continued to be suitable to work at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector. We reviewed four practising privileges agreements and found them to be current and up to date.
- The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the general medical council and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- Physiotherapists worked closely with consultants to develop bespoke treatment plans for patients.
- Radiographers reported there were no difficulties with availability or contacting consultants in the imaging department.
- Nursing and radiography staff called on the RMO when required and said they were very responsive.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams. Within the outpatient department, consultants covered all specialities for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.

Major incident awareness and training

- All clinical rooms contained a red panic button, which alerted the hospital crash team. One of the regular test scenarios took place in the scanner recently, which raised the issue of access to this controlled area. As a result staff are now aware that a staff member must be stationed in the doorway in the event of a real situation to enable access for the crash team.
- The facilities manager was the health and safety lead for the hospital They told us they conducted quarterly unannounced fire drills to test staff knowledge of the evacuation plan; they conducted the last one out of hours. They also undertook control of substances hazardous to health (COSHH) emergency drills with staff. They completed a report each quarter and presented it to the clinical manager and the health, safety and risk committee. They identified themes and developed action plans. Feedback from the meetings were placed on an action log, and disseminated to heads of departments, staff, and available on the intranet.
- The hospital had a business continuity plan in place for use in the event of disruption caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage, or due to external circumstances beyond the control of the hospital (e.g., bomb threat). The hospital senior management team held overall responsibility for initiation of any action and formed emergency response teams, which were contactable at all times.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this.

- Staff took account of national and local guidance when providing care and treatment. For example, guidance related to diagnostic imaging to ensure safe exposure.
- Staff were encouraged to participate in training and development to enable them to deliver good quality care. Managers supported them in their role through a performance review process and they all had regular appraisals.
- Patients' pain needs were met appropriately during a procedure or investigation.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- There were audits of clinical practice undertaken regularly.
- Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R audits were undertaken in line with regulatory requirements. Results indicated the service performance was in line with national standards.

Evidence-based care and treatment

- Staff in in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- The hospital completed a monthly gap analysis of new National Institute for Health and Care Excellence (NICE) guidelines, assessed whether these were relevant to the services offered by the hospital and action they needed to take to implement them.
- The laser protection advisor had reviewed the service documentation in April 2016, and there was a register of signatures of authorised operators and their training in place with certificates. Annual reports and audits were also available.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited; Nuffield Health had an IR(ME)R audit proforma in place, which the lead radiographer completed as part of clinical self-audit against procedures on an annual basis. They shared the outcomes with staff and any non-compliance was addressed with an action plan.
- Staff followed Royal College of Radiology guidelines for administration of contrast media and we saw that guidelines were available in folders in the viewing room, catheter laboratory and interventional rooms.
- Radiation Exposure/diagnostic reference levels were audited every six months and evidence of the audits were seen during inspection. Diagnostic reference levels are intended for use as a simple test for identifying situations where the level of patient dose is unusually high. If it is found that procedures are consistently causing the relevant diagnostic reference level to be exceeded, there should be a local review of procedures and the equipment in order to determine whether the protection has been adequately optimized. If not, measures aimed at reduction of doses should be taken.
- Radiographers undertook clinical audits in diagnostic imaging. For example, audits were carried out on records of patients who had received intravenous injections, request forms, and image reject analysis
- The radiologist checked and verified all radiology reports before they sent them to the referrer.
- Radiographers checked all referrals to ensure patients were booked for the correct imaging tests and the requesting information was fully completed.
- Mammography symptomatic and screening investigations were undertaken; these were double reported to ensure compliance with the government document on diagnostic procedures and reporting in breast screening. The hospital diagnostic service had a service level agreement for this process with another provider.

Pain relief

- Staff discussed options for pain relief with patients before they performed any procedure. Many procedures were undertaken with the use of local anaesthetic, which enabled patients to go home the same day.
- Staff gave patients written advice on any pain relief medicines they may need to use at home, during their recovery from their outpatient procedure.
- Patients' records demonstrated pain relief was discussed when local anaesthesia was used for minor procedures.
- The physiotherapy department provided and acupuncture service to patients who required pain relief.

Patient outcomes

- Nuffield Health produced an audit tool to measure compliance with the policy for prevention and management of venous thromboembolism (VTE). The most recent audit took place four weeks before our visit and we saw evidence of compliance with this annual audit. The audit showed some areas of non-compliance, for example risk assessments for the risk of VTE or bleeding on admission and re-assessment within 24 hours. The clinical lead for this audit had begun to address this non- compliance with training workshops. The audit report was due to be presented at the next MAC meeting.
- Patients were offered the opportunity to take part in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement and inguinal hernia repair (PROMS measures the quality of care and health gain received from the patients perspective).
- The hospital had joined the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was yet available.
- All radiology reports were audited for compliance with the reporting times. A designated staff member oversaw this process, and discussed the audit results with the radiologists. This ensured that a system was in place to prevent unverified reports causing delays to patient care. We saw the report for January 2016, which showed that radiologists completed 92% of reports within 48 hours.
- The hospital did not participate in the Imaging Services Accreditation Scheme or the Improving Quality in Physiological Services.

Competent staff

- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Managers supported staff to maintain and further develop their professional skills and experience.
- The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies and that consultants received supervision and appraisals. Practicing privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- A radiologist told us that their practising privileges were granted when evidence of their indemnity, general medical council registration, NHS appraisal and (DBS) checks were produced and this was reviewed annually.
- For consultants who were granted practising privileges to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's name.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings. Actions were created and completed before the consultant could practice at the hospital again.
- The Nuffield Induction programme was provided monthly for all new staff. This included; fire training, customer service training, infection control, manual handling and safeguarding level 1. Following induction, nursing staff completed one month of on-ward training that involved shadowing all aspects of nursing care, from dressings to using medical devices. For each competency, the outpatients' manager observed staff practice before they were allowed to work alone. The manager explained they were assured the skills of their team were of a good standard because they met with them after one week, four weeks and eight weeks into their probationary period to assess their practise revisit their objectives, and offer extra support where required.
- Staff said they were supported to develop their learning and progress. For example, the hospital had provided

funding for healthcare assistants to study nursing at a local university. Nursing staff were encouraged to take on more responsibility, including enrolment onto a management course.

- The physiotherapy manager told us that Nuffield Health provided optional training modules for physiotherapists to enhance their skills in specific treatments; for example, one of the team was a hand therapist.
- The outpatient department manager had taken part in the Nuffield leadership programme. They told us that they had 1:1 meetings with matron who helped identify their training needs. They completed a coaching course and their key clinical roles were infection prevention. This included the set-up of the wound management service, and training in urodynamics and photodynamics.
- All radiographers were qualified with either the Diploma of the College of Radiographers or a BSc in diagnostic imaging. All were Health and Care Professions Council registered and this was checked by the lead superintendent every two years.
- All staff had annual performance reviews; they told us that the Nuffield organisation was supportive of staff development For example, one of the HCAs was now training to become a radiographer.
- Nuffield provided and updated mammography training and supported radiographer attendance at the symposium mammographica where delegates share best practice. Symposium Mammographicum is a registered charity which organises a biennial Symposium.
- The CT lead radiographer told us they completed the College of Radiographers cannulation course accredited by the University of Hertfordshire.
- Specialist radiographers ran the catheter laboratory where diagnostic and interventional procedures are undertaken.
- Radiographers had to complete a set of competencies for all pieces of equipment, and the line manager reviewed their progress against these at appraisal. We saw evidence of this during our inspection.
- The administration team in diagnostic imaging also told us that they received annual appraisals.

Multidisciplinary working

- We observed there was effective team working between all staff groups. The daily morning hospital wide meeting facilitated this, where a representative of each department was present. We observed one meeting, which enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.
- Departments worked closely to ensure patients did not have to make unnecessary visits. For example, radiographers offered patients x-rays on the same day as their clinic appointment, if needed and results were available electronically for consultants to view in the clinic.
- Radiology administration staff knew that the patients should have all previous images available and they checked with the patients as to whether they had received x-rays or scans before, when making the appointment; and requested any previous images from source in preparation. Staff documented such requests and made images available according to the daily clinic lists.
- Staff told us that all the consultants worked well together in specialist teams and always covered for each other's absences.
- Staff told us that medical staff were supportive and advice was sought when needed.
- In radiology, patients' scans were reviewed at appropriate multi-disciplinary team (MDT) meetings and radiologists reported on all images in agreed session times.
- Some research in cardiac studies was undertaken in collaboration with the University of Oxford following appropriate ethical approval.

Seven-day services

- The outpatient department was open from Monday to Saturday, with clinics running from 8.00am to 8.30pm Monday to Thursday, 8am to 6pm on Fridays, and 8am until 4pm on Saturdays. Patients we spoke with reported good access to appointments, and at times which suited their needs.
- In diagnostic imaging, scans, x-rays and ultrasounds were available between 8am and 5pm Monday to Friday. With cover provided for evening clinics when needed. During the weekend and overnight, radiographers were on call.

Access to information

Good

Outpatients and diagnostic imaging

- Patients' clinical notes were available to ensure continuity of care. Hospital notes were kept on site and hospital secretaries made the consultants' own notes available.
- Ward staff faxed discharge summaries to patients' GPs, which ensured that the GP understood what procedures had been undertaken, and what follow-on care may be required.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. This enabled prompt discussion with the patient on the findings and treatment plan.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records. For example, a copy of the record was transferred with the patient to the receiving provider for their treatment.
- All policies were kept on the hospital computer drive, for example infection prevention and use of translator. Staff showed us that they kept policies relating to imaging in a folder in the viewing room for easy access.
- Staff followed the Royal College of Radiologists (RCR) guidelines for administration of contrast media, and these were available in folders in the viewing room, catheter laboratory, and interventional procedure rooms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations an understanding about their role with regard to the Mental Capacity Act (MCA), although no staff recalled its formal use.
- Patients gave verbal consent for general x-ray procedures, outpatient procedures and physiotherapy treatments carried out.
- Patient signed written consent forms for all minor surgical procedures.
- Radiographers told us that they received Mental Capacity Act (MCA) training in the past but staff relied on the referrer to flag up any mental capacity issues and vulnerable patients always came with a carer who was often the best source of information regarding the patient's capacity to understand the procedures
- Staff gave an example of how they gained consent for an imaging procedure from a patient living with dementia. They described how the patient's carer was able to explain the process to the patient in a way they knew the patient would understand, and at a time when the patient was at their most responsive.

Are outpatients and diagnostic imaging services caring?

Good

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good because:

- All feedback received from patients was positive, including the Friends and Family Test and the patient satisfaction survey. Staff treated patients with dignity and respect and confidentiality was maintained at all times.
- The department provided a chaperone service that was clearly signposted in waiting areas and consultation rooms.
- Staff informed patients about their care and treatment, and spent time with patients to discuss concerns and answer questions.
- Staff gave patients appropriate support and information to cope emotionally with their care, treatment or condition.

Compassionate care

- Staff treated patients with dignity and respect and patient confidentiality was maintained at all times. Patients were treated in private consultation rooms and staff kept doors closed during consultations. Although the main outpatient department reception desk was situated away from patients in the waiting area, it was possible for other patients to overhear conversations between staff and patient, particularly if the patient spoke loudly. For more private conversations, a quiet room was available for patient use.
- Patient feedback was consistently positive. We observed all staff to be courteous, professional and friendly when interacting with patients. One patient at the hospital told us 'this place is the tops' they went on to say they were greeted and treated better here and felt more

cared for than in other health organisations they attended. Patients praised the consultants for their friendly manner and personal skills, particularly when treating patients with a mental health condition.
- The outpatients department provided a chaperone service during intimate personal care. Signs offering chaperone services were clearly displayed in the main waiting areas and in all consultation rooms.
- The results of the Friends and Family Test (FFT) in April 2016 showed 98% of patients would be 'likely' or 'extremely likely' to recommend the hospital to their friends and family.

Understanding and involvement of patients and those close to them

- Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information. Written feedback supported this; 87% of patients reported that they received a clear explanation of the outcome of their treatment in April 2016. This was marginally better than the Nuffield national average of 86%.
- Patients described the staff as knowledgeable and were confident in their abilities. Appointments were not rushed and staff spent time with patients to discuss concerns and answer questions. Two patients we spoke with had travelled over 150 miles to see a particular consultant.
- Patients understood how they would book their next appointment and who to contact if they had any concerns following treatment.

Emotional support

- Staff showed a clear understanding about the importance of supporting patients, emotionally and socially, who were in distress. This understanding was demonstrated in the treatment of a patient living with dementia. Prior to the patient's appointment, staff gave the patient's carer contrast media for the patient to drink before attending the appointment, alongside a full explanation for administration. The radiographers then arranged the appointment so that the patient had no waiting time before or after their appointment, reducing the time spent at the hospital. This flexibility by the staff resulted in the patient experiencing as little distress as possible.
- Staff gave patients and their carers appropriate support and information to cope emotionally with their care, treatment or condition. A quiet room was available for staff to take patients who had received bad news. Staff were able to print out various information leaflets for patients to help explain their care and treatment plan. Specific information leaflets about cancer support were readily available within the department.

Are outpatients and diagnostic imaging services responsive?

Good

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good because:

- Staff planned and delivered services in way that met the needs of the local population. Patients told us that there was good access to appointments with time slots that suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services carried out.
- Information was available to patients in several languages.
- Diagnostic test results were available to consultants and patients in a timely way
- Patients requiring physiotherapy had access to a variety of treatments including, for example, acupuncture.
- Staff made adjustments to accommodate patients' individual needs, for example, patients with hearing difficulties.
- Senior managers dealt with complaints with openness and transparency.

Service planning and delivery to meet the needs of local people

- Managers planned services around the needs and demands of patients. Outpatient department clinics were arranged in line with the demand for each speciality. Clinics were held Monday to Friday until 8.30pm in the evening and on Saturdays, to accommodate patients with commitments during the working week.

Good

Outpatients and diagnostic imaging

- The outpatients' area was a comfortable environment with adequate seating and refreshments available. The reception was clearly visible to patients when they entered the department. There was parking available for patients attending the hospital, with clear signage directing people to the hospital main reception. Car parking was free but availability was variable depending on appointment times. One patient described how the calm atmosphere of the waiting room makes a significant difference to their experience as an anxious patient.
- Patients were sent appropriate information prior to their first attendance, this contained information such as the consultant or clinic they were to see, length of time for the appointment and written information on any procedures which may be performed at the first appointment, including the cost of the appointment and subsequent procedures.
- The hospital participated in the NHS e-Referral Service. General practitioners from clinical commissioning groups referred patients to the hospital for a limited range of orthopaedic elective surgical procedures.
- The physiotherapy service provided acupuncture alongside routine treatments.
- There was a quiet room available for patients who maybe upset and need to be away from others; however it was in need of redecoration.
- In radiology there were small sub waiting rooms close to each imaging room; we saw that patients hardly waited at all, as staff took them into clinical rooms straight after they were booked in at reception.
- There was a large panel in the ceiling above the scanner, which has a light behind it depicting the sky; the staff told us that the patients appreciated this as it made them feel less claustrophobic.

Access and flow

- The majority of consultants managed their appointments using their own private secretary. The hospital also had medical secretaries available for consultants to use for assistance. For nurse appointments, patients booked their appointment directly with the reception staff.
- Administrators offered patients a choice of appointments, including same day appointments if needed. Patients we spoke with described the department as 'efficient', with short waiting times.
- The clinics we observed mostly ran to schedule, but patients could wait up to 20 minutes to see their consultant. Staff told us if there were delays, they would speak to patients and keep them informed. Delays occurred occasionally when consultants were held up at other clinics.
- The hospital had very low 'Did not attend' (DNA) rates. Administrators telephoned all patients who missed their appointment and made another appointment if required.
- Patients entered the hospital via the main entrance and were registered at the main reception desk where they were directed to the appropriate waiting area. Staff used an electronic system, which tracked patients from the time they arrived at reception and indicated how long they had been waiting.
- We observed that radiographers x-rayed patients almost as soon as they arrived; staff told us that they would make an appointment for the following day if preferred. There were no waiting lists.
- The radiologist-led ultrasound service had two spacious rooms and a dedicated toilet with wireless flow meter available for patients with prostate problems. This provided enhanced patient privacy and dignity. A urine flowmeter calculates the amount of urine passed, the flow rate in seconds, and the length of time it takes to empty the bladder completely.
- There was a one-stop breast clinic run by specialist radiographers; radiologists reported on the imaging within 24 to 48 hours. Images were also peer reviewed by the professional lead for the organisation. This ensured that staff could provide patients with results quickly which reduced patient anxiety.
- The radiographer in charge of the CT scanner scanned 15 to 20 patients on average per day and could provide flexibility for appointments.
- Radiologists reported imaging on either the day of examination for ultrasound and CT or the next day for plain film. A radiologist from the local NHS trust was available to come to the hospital for urgent reports when necessary.

Meeting people's individual needs

- There was ample seating in the waiting areas. All consulting rooms and communal spaces were wheelchair accessible.
- Free Wi-Fi with easy patient access was available in all waiting areas, as were hot and cold drinks.

Good

Outpatients and diagnostic imaging

- There were written information leaflets in the main reception area and all waiting areas about general health and wellbeing and services offered by the hospital. Some leaflets for more common procedures for example, colonoscopy and arthroscopy were also available in Arabic, Bengali, Mandarin, Polish and Punjabi.
- For patients' with visual or hearing loss the hospital provided signage and a hearing loop in the main reception.
- For patients whose first language was not English staff had access to telephone translation facilities.
- In diagnostic imaging, a range of leaflets was available and provided to patients about diagnostic imaging procedures. Patient information leaflets were sent to patients prior to their appointment.
- Staff saw patients who attended for gynaecology appointments in dedicated consulting rooms, which had separate connecting examination rooms to ensure they protected patients' privacy, and dignity.
- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff said it was very rare for them to provide care or treatment to a patient with complex or additional needs, for example, dementia or a learning disability. Equality and diversity did not form part of the mandatory training programme for staff.

Learning from complaints and concerns

- Managers listened to, and acted upon patient's comments and complaints. There was a complaints policy in place and the hospital director took overall responsibility for the management of complaints; if the complaint was about clinical care then the matron would lead the investigation. We saw evidence that complaints were discussed at the clinical governance meetings.
- Administrators recorded complaints on the electronic reporting system and the matron completed an analysis of the complaints data for the year January to December 2015 and put together actions to address any outstanding issues.
- The hospital reported that there were 70 complaints during 2015; six of which related to the outpatient department (8%) an increase on the previous year of 27%, however there were no reported complaints in 2016, up to the date of our visit.
- If a patient wanted to make a complaint, staff told us that they would ask their immediate line manager/ service manager to speak to the patient. Most complaints were resolved locally.
- There was information about how to make a complaint in the waiting areas. Staff told us that they received very few complaints and those were usually related to delays.

Are outpatients and diagnostic imaging services well-led?

Good

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- Effective governance and risk management systems were in place. Staff were well informed about issues relating to their department.
- Managers were committed to providing high quality care and improve services and facilities for patients.
- Staff in all areas stated they were well supported by their immediate line managers. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.
- There was an open and supportive learning culture.
- Patients were given opportunities to provide feedback about their experiences and the hospital used the information to improve the service.

Vision and strategy for this this core service

- Nuffield Health's quality partners undertook a full clinical review of the hospital in December 2015 followed by an integrated governance and continuous improvement report. This resulted in a rewritten clinical governance strategy; the stated primary objective was to stabilise clinical leadership to drive through significant long-term change.

Good

Outpatients and diagnostic imaging

- Department leaders we spoke with were pleased with the changes and were already beginning to see the impact. Departmental meetings took place regularly and we saw evidence that managers shared the changes with teams in outpatients and diagnostic imaging.

Governance, risk management and quality measurement for this core service

- There was a clear governance and reporting structure at the hospital, following the clinical review undertaken in December 2015. Heads of department identified and discussed issues at monthly meetings and escalated to the clinical governance meetings. Outpatient department and diagnostic imaging managers participated in these meetings.
- Team leaders told us that they were much happier with the structure of meetings as they felt that each meeting fed sensibly into the next and the cascade of information to teams was timelier.
- The outpatient manager held team meetings every four weeks; staff confirmed this and told us how useful they were, as they felt more included in the hospital plans.
- The hospital had a risk register in place, which included actions for senior hospital managers. However, we did not see evidence that department managers used the register as a means of escalating issues.
- We saw evidence that staff discussed, for example, new policies, incidents, and complaints in clinical governance meetings and leadership team meetings.
- An annual audit plan was followed and monitored at local clinical governance meetings. Specific relevant department audits, such as diagnostic imaging audits, were discussed at the radiation protection committee.
- Staff also told us that the hospital wide daily meetings held every morning, attended by a manager from each department were invaluable. They discussed major incidents as well as day-to-day staffing issues. We observed one of the meetings, and staff at the meeting said that it had improved cross-sector relationships and multidisciplinary working. A brief email containing notes from the meeting was disseminated amongst staff.
- Staff had access to policies and standard operating procedures for radiological examinations. Local rules (local instructions relating to radiation protection measures for the service) were on display in every x-ray room.
- The medical advisory committee (MAC) had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete twice-yearly reviews with the MAC chair, where they discussed data on their clinical performance. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals.
- The radiologist we spoke with told us if they had any concerns or developments they wished to take forward they were able to do so via the radiologist representative on the MAC.

Leadership / culture of service

- Staff told us they were impressed with the changes made since the new hospital director was in post. Reception staff felt they were lucky to have both clinical and non-clinical managerial support in their role.
- The hospital director published a news bulletin each month, which they distributed via email, displayed in the staff corridor, and printed copies were available in the canteen.
- Staff in the outpatients department praised their manager's leadership and strong clinical skills.
- One nurse told us they loved working at the hospital, being able to follow patients through from the wards – "everything is like a military operation and there is no compromise to patient care" Another member of staff described the outpatient manager as "a great manager." Another said "I love working here, there's plenty of specialties and lots to learn"
- Many of the staff told us about the "great support for training; plenty of job satisfaction, and good clinical support."
- Staff told us that the hospital director undertakes a daily morning round and that the matron was accessible and supportive of staff.
- Staff believed the culture of the outpatients' service encouraged openness, honesty and quality patient care.
- The department manager told us they intend to do some shadowing with the matron to develop their leadership experience. They also told us they were keen to be a manager with a strong clinical focus. A Nuffield outpatient manager forum was formed in 2013, which gave them the opportunity to share experiences and learning from others in a similar role.
- A ward nurse in outpatients also told us that the hospital director was a very good communicator, was

approachable and their door was always open so they were very responsive. We were told that the hospital director worked with the department heads and they felt part of the developments and not excluded.

- The radiologist told us that they liked working at the hospital, as staff were friendly and considered the level of patient care to be very high. They found the staff and indeed the whole Nuffield infrastructure to be enthusiastic, obliging and responsive, particularly if they wanted to develop the service further or procure new equipment.
- Staff also told us how pleased they were now they had gym membership as employees (gym equipment was purchased by the company for the staff) and that they were able to self-refer to the physiotherapy team if required.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. At the time of our inspection, the outpatient response demonstrated that 97% of 309 responses would recommend the hospital.
- Patient satisfaction, trends and complaints were discussed at a monthly patient focus forum as a way to improve the patient experience. Previous patients of the hospital attended this forum.
- Patients received a satisfaction survey to complete at the once their treatment plan was complete. The customer service manager told us that response rates within outpatients were low as the questions were more directed towards inpatients. To rectify this, the outpatients department created their own feedback form, available to collect from the main reception desk. However, at the time of our inspection, response rates were still low.
- Staff told us that they received feedback on patient survey information at their monthly meetings.
- The hospital had introduced a staff recognition scheme in 2016; nomination forms were available throughout the areas we visited.

Innovation, improvement and sustainability

- The CT service leads told us that they were planning to submit a business case to expand the cardiac and muscular skeletal work.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Review children nurse staffing for the service to ensure national guidance is met.
- Patient care records are completed to recommended national standards, including signatures for all staff providing care for the patient.
- Baseline assessments are completed, including a child's height and weight, prior to prescriptions being issued.
- Robust systems are developed for locally monitoring the quality of the children and young person service, including participation in clinical audits.

Action the provider SHOULD take to improve

- Ensure all staff are aware of and know the requirements in relation to The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.
- Consider displaying results of safety thermometer audits.
- Ensure all staff complete paediatric basic life support training.
- A review is completed to assess the need for a competency based programme for theatre staff caring for children and young people.
- The environment in areas where children and young people are cared for, is suitable for all ages, not just young children.
- Written information is available for children and young people about their condition and the care pathway when admitted to hospital.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(g) **How the regulation was not being met:** • Staff did not always check and record a child's height and weight prior to issuing a prescription, to ensure the correct dosage was given.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b)(c)(f) **How the regulation was not being met:** • Patient prescription charts were not always dated and the prescribers signature was not always identifiable. • Governance processes to assess and monitor service quality and risk were not embedded at a local level.

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1)

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

The nurse staffing for the children and young people's service was not in line with national guidance from the Royal College of Nursing.