Nuffield Health Guildford Hospital

Quality Report

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

Ratings

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

Overall summary

Nuffield Health Guildford Hospital is operated by Nuffield Health. It is an independent hospital and has 49 beds. The hospital has 4 operating theatres, diagnostic imaging and outpatient services

The hospital provides surgery, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery (including endoscopy), services for

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children and young people and outpatients and diagnostic imaging. We did not inspect oncology services, but will inspect this service within six months, as the service had recently moved to a refurbished ward.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 17 to18 November 2016 and an unannounced visit on 1 December 2016.

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

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

The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery core service.

We rated this hospital as good overall because:

- Staff confidently escalated any risks that could affect patient safety and we saw effective systems for reporting, investigating and learning from incidents.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training for their roles. Completion rates for mandatory training including key topics such as safeguarding was better than the target set by the Nuffield Group.
- The hospital was visibly clean and there were appropriate systems to prevent and control healthcare associated infections. We saw that rooms were equipped with sufficient equipment and consumable items for their intended purpose. The waiting areas were spacious and well-appointed with amenities for refreshments and comfortable seating, including a variety of seat heights available to assist those recovering from surgery.
- Medicines were managed safely in accordance with legal requirements and checks on emergency resuscitation equipment were performed routinely.
- Staff responded compassionately when people needed help and support to meet their basic personal needs. Staff also respected people's privacy and confidentiality at all times. Patients' feedback through interviews and comment cards was positive.
- People were always made aware of waiting times and meals were offered to those delayed or in clinic over meal times. Any concerns or complaints were listened and responded to and feedback was used to improve the quality of care.
- We saw strong leadership at the location with an open and transparent culture. The hospital director used the Heads of Departments forum as a governance and performance management tool to maintain and improve the quality of the service. There was a clear vision and focused strategy to deliver good quality care.
- The governance framework ensured staff responsibilities were clear and that quality, performance and risks were all understood and managed. Services continuously sought to improve and develop novel approaches to enhancing care, such as exercise courses offered to the public.
- Staff were overwhelmingly positive about their experience of working at the hospital and showed commitment to achieving the provider's strategic aims and demonstrating their stated values. Staff told us they were supported by the hospital director and the new matron, both of whom were visible and approachable.
- We found evidence of multidisciplinary team (MDT) working across all of the areas we visited and we saw good collaborative working and communication amongst all staff in and outside the department. Staff frequently reported they worked well as a team and liked the "family" feel of the organisation.
- There were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems. The hospital offered rapid access to diagnostic imaging

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and physiotherapy services, usually within a week. The hospital was above the 90% national referral to treatment (RTT) waiting time target for the majority of the year.

However, we also found the following issues that the service provider needs to improve:

- The provider must improve the way it manages records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided'.
- Staff should ensure all entries in the theatres CD register are legible and in line with Nursing and midwifery council (NMC) Standards for medicine management.
- The provider should ensure that they are assured at all times that staff are complying with the bare beneath the elbows policy.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, to help the service improve. Details are at the end of the report.

Name of signatory

Professor Edward Baker

Deputy Chief Inspector of Hospitals (London and the South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated this service as good because it was safe, effective, caring, responsive and well led. Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. • Incidents, accidents and near misses were recorded and investigated appropriately. Incidents were discussed during departmental meetings and at handover, so shared learning could take place. Staff were familiar with the process for duty of candour and carried it out in practice. • Risk assessments were completed at each stage of the patient journey from admission to discharge, with an early warning scoring system used for the management of deteriorating patients. The Five Steps to Safer Surgery checklist was completed and monitored appropriately. • The hospital had a monthly medicine management forum meeting, we saw evidence of these meetings, which contained a review of any national guidance or safety alerts, and when relevant, detailed how these were actioned. At alternate meetings safe management of medical gases was discussed. • Although the hospital did not use a recognised staffing acuity tool, there were processes to ensure safe nurse staffing levels. All departments were appropriately staffed. • We saw the hospital had a duty of candour policy and staff were aware of the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency. • Patients received care and treatment in line with national guidelines such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. The hospital participated in national

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audit programmes including performance related outcome measures (PROMS) and the National Joint Registry. Results showed patient outcomes were within expected levels when compared to national averages.

- Throughout our inspection we observed patient care was carried out in accordance with national guidelines and best practice recommendations.
- Several patients described the care as excellent, commenting the nurses had time to stop and talk to them. Patients also commented the nurses introduced themselves on entering the patient room. One patient commented specifically that they was very pleased with the 'very good specialist care' from the physiotherapist.
- Throughout our inspection we witnessed excellent staff interaction with the patients.
- Staff told us there was a flexible approach to working during busy times. There was an ability to extend clinic times and the pre assessment service if necessary. Additional cases could be added to theatre lists allowing for appropriate consent and screening times.
- We saw the blue pillow initiative was being used for a patient with dementia. The use of the blue pillow had been explained to the patient and relative and the patient had consented to this. There was a personalised plan of care and clear allocation of one nurse to provide continuity of care for this patient. The nurse looking after the patient explained how she had ensured the theatre department was aware of this patient and a blue pillow sign was put on the door of the patient's room to ensure all other staff were aware this patient had complex needs.
- The hospital had a clear process in place for dealing with complaints. Patients we spoke with understood how to complain. There was information leaflets in each patient room and around the hospital informing patients of the complaint process. Staff were aware of the

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complaints process and were able to tell us about changes to practice as a result of complaints investigations and how this information was shared.

- The hospital followed its corporate complaints policy for managing complaints. The policy was currently in date and contains detail on handling written and verbal complaints.
- As part of a large independent healthcare provider Nuffield Health have a corporate vision, values and beliefs which have been put in place at the Guildford hospital.
- The staff we spoke to were proud to work for the organisation. One member of staff described how they were encouraged to work hard and focus on what was needed to be done to give the best care to the patient. A number of staff spoke about an open culture with good communication and stated the senior management team were accessible and visible in the clinical areas.
- The hospital had a patient feedback system that operated across the Nuffield Health group.

However

- There was evidence in the nursing notes of daily visits by the Consultant but in six sets of records there was no documentation by the Consultants. We were told that that the Consultants keep their own sets of records with their secretaries usually on site at the hospital. This is not in line with the Health and Social Care Act 2008 (regulated activities) Regulation 2014 which requires the registered person to: 'maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.'

Services for children and young people

Good

We rated this service as good because it was safe, effective, caring, responsive and well led.

- The service planned, implemented and reviewed staffing levels and skill mix to keep children and young people safe at all times.

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- The service had a good track record on safety. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The service gave sufficient priority to safeguarding children and young people. Staff at all levels took a proactive approach to safeguarding and responded appropriately to any signs or allegations of abuse.
- The service assessed monitored and managed risks to children and young people who used services on a day-to-day basis. These included signs of deteriorating health, medical emergencies and emotional wellbeing.
- The service planned and delivered children and young people's care and treatment in line with current evidence-based guidance, standards, best practice and legislation. The service monitored this to ensure consistency of practice.
- Children and young people had comprehensive assessments of their needs. These included consideration of clinical needs, wellbeing, and nutrition and hydration needs. The expected outcomes were identified and staff regularly reviewed and updated care and treatment plans.
- Staff were suitably qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The service had a robust induction process for new staff which included a thorough assessment of competency.
- The service supported staff with supervision and appraisal. Hospital data showed 100% of staff who cared for children and young people had an up-to-date appraisal at the time of our visit. The service supported relevant staff through the process of revalidation, and 100% of relevant medical and nursing staff had up-to-date revalidation at the time of our visit.
- Staff from different disciplines worked together to meet the needs of children and young people who used the service.

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- Staff provided compassionate and respectful care to patients and their families. The service provided a supportive setting for children and young people to receive inpatient and outpatient care.
- The hospital allotted the time necessary for children's nurses to build a relationship with patients and their families. This enabled the nurses to provide reassurance, information and support to patients and families.
- Doctors interacted with patients as individuals and considered their age and abilities to provide meaningful and age appropriate information. Doctors provided thorough information to families as appropriate to the patient's age.
- Staff gave holistic care. The team, including a named child's nurse, consultant and anaesthetist all met with the patient and their family. This ensured that the team had a thorough understanding of the patient's diagnosis and the care they should receive.
- People could schedule urgent appointments as necessary and in-hospital waiting times were low.
- The setting was responsive to children's needs. Outpatient and inpatient rooms were decorated with the Nuffield monkey motif and children's spaces were all equipped with books, toys and other entertainment for children of various ages.
- Literature and communications were child-centred. The hospital provided children's leaflets. One leaflet informed children about handwashing and another explained the experience of visiting Guildford Nuffield Hospital to children and young people.
- The hospital responded to complaints by providing meaningful written responses to all complainants and shared learning from complaints with staff.
- The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately.
- Information on children and young people's experiences were reported and reviewed alongside other performance data.

Summary of findings

- Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

However:

- Consultants kept their records in locked filing cabinets in their offices. As consultants' records were not integrated into the patient's medical notes, this may have made it difficult for all members of the multidisciplinary team to easily access all the information they needed to assist with clinical decision making. This is not in line with the Health and Social Care Act 2008 (regulated activities) Regulation 2014 which requires the registered person to: 'maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.'

Outpatients and diagnostic imaging

Good

We rated this service as good because it was safe, caring, responsive and well led.
We do not rate effectiveness in outpatients and diagnostic imaging.

- Staff demonstrated a good understanding of how to use the incident reporting system. Staff told us feedback from incidents were discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn. Staff were able to give us examples of incidents that had been reported in the past.
- Staff in the diagnostic imaging department had a clear understanding of what was a reportable incident. A Radiation protection Advisor (RPA) was available for advice, by telephone if required. Staff showed us the incident reporting policy they followed for incidents where patients had received an unintended dose of radiation.
- All the areas we visited in the outpatients and diagnostic imaging departments were visibly

clean and tidy and we saw there were good infection control practices. We saw the cleaning schedule for the rooms and toilets in the outpatients and diagnostic imaging departments were completed on a daily basis when the department was open.

- We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example, the National Institute for Health and Care Excellence (NICE) guidelines, The Royal Marsden Manual of Clinical Nursing Procedures and the Royal College of Radiologists.
- In the outpatient and diagnostic imaging department staff demonstrated how they could access NICE guidelines, the Royal Marsden and relevant policies on the hospital's computer system.
- We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.
- Services were planned to give patients a choice of convenient times for them to attend for their appointments. The departments were open Monday to Friday. The outpatients department 8am to 8.30pm, diagnostic imaging 8.30am to 7pm, physiotherapy 8am to 8pm and pathology 9am to 5pm.
- Patients told us they had been offered a choice of times and dates for their appointments.
- The majority of patients were privately funded and there were very few NHS funded patients. There were 23,235 outpatient attendances in the reporting period July 2015 to June 2016 at the hospital. Of these, 19 were NHS funded.
- The hospital achieved above the national target of 95% for patients beginning treatment within 18 weeks of referral.
- We saw the risk register for the outpatients and diagnostic imaging department. This had items listed with their identified initial and current risk level. The list showed the likelihood, current consequences and review date due.

Summary of findings

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient and diagnostic imaging services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.

However

- Copies of the consultant's individual notes for private patients in the outpatient department were not kept by the hospital; these were kept by the individual consultants. This is not in line with the Health and Social Care Act 2008 (regulated activities) Regulation 2014 which requires the registered person to: ' maintain securely an accurate , complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.'

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Contents

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Nuffield Health Guildford Hospital

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

Summary of this inspection

Background to Nuffield Health Guildford Hospital

Nuffield Health Guildford Hospital is operated by Nuffield Health. The hospital opened in 1999. It is a private hospital in Guildford, Surrey. The hospital primarily serves the communities of the Guildford area. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since September 2015.

The accountable officer for controlled drugs (CDs) was the registered manager.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, Sheona Keeler, other CQC inspectors, and specialist advisors with expertise in surgery, children and young people services and outpatients. The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Information about Nuffield Health Guildford Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection we visited the ward, theatres and out patients. We spoke with over 25 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, radiography staff and senior managers. We spoke with eight patients and relatives. We also received 47 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital's most recent inspection took place in February 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016, there were 11,965 inpatient and day case episodes of care recorded at the hospital; of these 0.9% were NHS funded and 99.1% were other funded.
- 66% of all NHS funded patients and 20% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 23,253 outpatient total attendances in the reporting period (July 2015 to June 2016); of these 0.1% were NHS funded and 99.9% were other funded.
- From July 2015 to June 2016, the service carried out 416 operations on children and young people. The hospital saw 2,232 children and young people for outpatient's consultation, minor procedures such as allergy testing, and imaging services such as X-ray during the same period. Of the 2,232 outpatient attendances, 245 children were aged two and under.

There were 208 consultants employed at the hospital under practising privileges and two resident medical officers (RMO) who worked on seven days on, seven days off rota. The Nuffield Health Guildford employed 89 full time equivalent (FTE) registered nurses, 33.8 care assistants and operating department practitioners, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

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Track record on safety

- There were no never events in the period from July 2015 to June 2016.
- There were a total of 517 clinical incidents in the reporting period from July 2015 to June 2016.
- Out of 517 clinical incidents 76% (393 incidents) occurred in surgery or inpatients and 11% (55 incidents) occurred in other services. The remaining 13% of all clinical incidents occurred in outpatient and DI services (69 incidents). The hospital reported 2% of all incidents as severe or death.
- Total of 52 non-clinical incidents in the reporting period from July 2015 to June 2016.
- Out of 52 non-clinical incidents 56% (29 incidents) occurred in surgery or inpatients and 37% (19 incidents) occurred in other services. The remaining 8% of all non-clinical incidents occurred in outpatient and DI services (four incidents).
- There were no serious injuries in the reporting period from July 2015 to June 2016.
- There were no incidents of MRSA in the reporting period from July 2015 to June 2016.
- There was one incident of MSSA in the period from July 2015 to June 2016 .
- There was one incident of Clostridium difficile (C.diff) in the reporting period from July 2015 to June 2016.
- Three incidents of E-Coli in the reporting period from July 2015 to June 2016.
- There were 40 complaints in the reporting period from July 2015 to June 2016.

Services accredited by a national body:

- BUPA accredited breast care centre
- BUPA accredited prostate centre
- Macmillan Quality Environment Mark
- Guildford Pathology Laboratory is CPA-UKAS accredited (CPA no 4025), and MHRA (BSQR 2005) compliant.

Services provided at the hospital under service level agreement:

- Catering
- Clinical equipment maintenance
- Facilities management
- Resident medical officer

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as Good because:

- There were systems in place to ensure good incident reporting, lessons were learnt from incidents and staff were confident to report them.
- The hospital was visibly clean and tidy, and equipment was stored appropriately.
- There had been no cases of Meticillin-resistant Staphylococcus (MRSA), one case of Meticillin – sensitive Staphylococcus aureus (MSSA), one incident ofClostridium difficile (C.diff) and three cases of Escherichia coli (E-Coli) in the reporting period (July 2015 to June 2016). There was evidence all these incidences had been investigated with no common themes found.
- Medicines were stored correctly and the hospital had a monthly medicine management forum meeting, we saw evidence of these meetings, which contained a review of any national guidance or safety alerts, and when relevant, detailed how these were actioned.
- Nuffield Healthcare has a Group Health records standards policy, which is accessible to the staff at Guildford hospital. We saw staff adhering to this policy. Patient records were managed in accordance with the Data Protection Act (DPA)1998.Records were kept securely preventing the risk of unauthorised access to patient information.
- Data showed that 11 members of staff at the hospital had level three safeguarding children's training. This included registered children's nurses, the ward manager, the theatre manager, the deputy theatre manager, the RMOs and the senior management team.
- Staff in the diagnostic imaging department had a clear understanding of what was a reportable incident. A Radiation Protection Advisor (RPA) was available for advice, by telephone if required. Staff showed us the incident reporting policy they followed for incidents where patients had received an unintended dose of radiation.
- Mandatory training was monitored and all staff expected to complete on an annual basis, the training was organised corporately by Nuffield Health. The mandatory training programme included topics such as health, safety and welfare,

Summary of this inspection

infection control, incident reporting and manual handling. Training rates for individual topics ranged from 86% to 100%.On the day of the inspection the most recent records showed an average compliance of 98%.

- We observed specific WHO checklists for different procedures including general surgery, gynaecology and ophthalmology, this ensured the most important safety factors relating to the procedure were highlighted and checked.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes post operatively. Staff told us compliance with the checklist was closely monitored and monthly audits of compliance took place on a regular basis.
- There were sufficient numbers of appropriately trained staff to meet the needs of patients.
- We saw 208 consultants had practising privileges at the hospital. Practising privileges is a term which means consultants have been granted right to practise in an independent hospital.
- The Resident Medical Officers (RMO) provides continuous medical cover and conducts regular ward rounds to ensure that all patients are appropriately treated and safe. Any change in a patient's condition is reported to the consultant and their advice was followed in respect of further treatment.
- We saw the Hospital major incident procedure/plan. This was reviewed in January 2016 and contained up to date information on who to contact and what actions to take in the case of a major incident. This incorporated information to ensure business continuity in the case of any system failures for example if the phone system was not working.

However

- Although there were many good things about the service, it breached a regulation relating to the maintenance of patient records.
- The hospital should ensure that the controlled drugs register in theatres is maintained to a high standard.

Are services effective?

Good

We rated effective as good because:

- Staff were able to access corporate and local policies via the intranet and hard copies of policies were available in departments. The policies referenced NICE/Royal College guidelines and all policies were in date.

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- Following surgery, patients were nursed in accordance with the National Institute for Health and Care Excellence (NICE) guidance CG50: Acutely ill patients in hospital: Recognition and response to acute illness in adults in hospital.
- We reviewed the hospital's policies relating to children and young people (CYP). All policies we saw were within their review date. We saw that the hospital based its CYP policies on relevant and current evidence-based guidance and standards.
- Patients received pain relief as required. Evidence was seen that a pain audit was completed annually and results were available for the audit done in July 2016. Fifty-six patients completed a specific questionnaire and 100% reported getting pain relief drugs when they requested, 95% said the staff were compassionate and responsive in managing pain. There was an action plan attached to the audit results.
- The hospital used age appropriate tools for the assessment of children's pain after surgery.
- The diagnostic imaging department had policies and procedures in place. They were in line with regulations under ionising radiation (medical exposure) regulations (IR(ME)R 2000) and in accordance with the Royal College of Radiologist's standards.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' risk of being undernourished.
- The hospital had specific menus for children. We reviewed the children's menu and saw there were a range of child-friendly choices, including options for vegetarians. The catering staff could also provide meals for children with food allergies and intolerances on request.
- National clinical audits were completed, such as Patient Reported Outcome Measures (PROMS). The hospital told us they participated in the national audit programme. All patients having hip and knee replacements, varicose vein surgery or groin hernia surgery were invited to complete a PROMs questionnaire to help measure and improve the quality of care.
- Patients undergoing hip and knee surgery consented to their data being submitted to the National Joint registry (NJR). We saw completed consent forms within the patient records. The data was submitted to enable monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and to benefit patients.
- The hospital reported no paediatric readmissions between July 2015 and June 2016. The hospital performed 416 operations on CYP under 18 years old during the same period.

Summary of this inspection

- The hospital measured performance against key indicators, including healthcare associated infections, which were benchmarked against other healthcare providers and other Nuffield Health providers. We saw the Guildford Hospital compared favourably.
- The hospital had a robust system for granting and reviewing practicing privileges in-line with the Nuffield Health practicing privileges policy. Consultants completed an extensive application form and provided evidence of adequate insurance or indemnity cover, immunisation status and an enhanced disclosure check.
- Staff had comprehensive training to ensure their competency.
- Care planning takes place at pre assessment with input from the multidisciplinary team, including doctors, nurses and allied healthcare professionals. The pre-assessment staff work closely with the ward and theatres to share information about forthcoming admissions and any special requirements. The pre-assessment team also worked closely with the physiotherapy team to plan the care for more complex patients coming into the hospital for surgery.
- We reviewed the competency folders for three registered children's nurses. We saw evidence of competency assessment in a range of areas relevant to their role. This included the use of medical devices, completion of paediatric early warning (PEWS) charts and medicines management. This provided the hospital with assurances that the registered children's nurses were competent to work unsupervised in relevant areas.
- The hospital had a consent policy in place, which was based on the guidance issued by the Department of Health. This included guidance for the staff in gaining valid consent.
- Consultants took consent, and assessed Gillick competence for children under the age of 16. This was the statutory process for assessing that children under the age of 16 were competent to make decisions about their own care and treatment.
- Training on Deprivation of liberty (DOLs) and Mental Capacity Act (2005)(MCA) was part of mandatory training and was easily accessible. We saw 96% of theatre staff and 100% of all ward staff had completed Deprivation of liberty safeguarding training. All staff had completed MCA training.

Are services caring?

We rated caring as good because:

Good

Summary of this inspection

- During our inspection the eight patients we spoke to were all very positive about the care they had received and said nurses were kind and compassionate. One patient commented that 'they had excellent treatment and care, there were no delays and staff answered all her questions'.
- We consistently saw patients being treated with respect.
- In children's services staff recognised when people who used services and those close to them needed additional support to help them understand and be involved in their care and treatment. Each patient had a named children's nurse who supported the patient and their family from pre-assessment through the care pathway. Patients met with the nurse, consultant and anaesthetist before surgery to discuss concerns.
- Surgical services had arrangements in place to provide emotional support to patients and their family when needed. Patients told us they would feel able to ask the staff for emotional support if it was needed.

Are services responsive?

Good

We rated responsive as good because:

- The majority of patients were privately funded and there were very few NHS funded patients. There were 23,235 outpatient attendances in the reporting period July 2015 to June 2016 at the hospital. Of these, 19 were NHS funded.
- Staff told us there was a flexible approach to working during busy times. There was an ability to extend clinic times and the pre assessment service if necessary. Additional cases can be added to theatre lists allowing for appropriate consent and screening times. There are few capacity issues.
- On the day of inspection we saw the blue pillow initiative was being used for a patient with dementia. The use of the blue pillow had been explained to the patient and relative and the patient had consented to this. There was a personalised plan of care and clear allocation of one nurse to provide continuity of care for this patient.
- There was a footstool in the bathroom so that children could reach the sink. Two brightly coloured, informative posters reminded children of "hand hygiene moments'" and answered the question, "what germs are on your hands?"
- Nuffield Health recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that

these could be addressed. These issues were managed through the complaints procedure. The hospital manager was responsible for the management of complaints. The personal assistant to the hospital's director was responsible for the day to day administration of the complaint management process.

- There were 40 complaints received by the hospital in the reporting period (July 2015 to June 2016). No complaints have been referred to ISCAS (Independent Healthcare sector complaints Adjudication Service) in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) is lower than the rate of other independent acute hospitals we hold this type of data for.

Are services well-led?

Good

We rated well-led as good because:

- As part of a large independent healthcare provider Nuffield Health have a corporate vision, values and beliefs which have been put in place at the Guildford Hospital. We were told that in 2015 the senior management team at the hospital ran a series of workshops to enable staff discussion and understanding.
- All staff we spoke to were aware of the vision, values and believes and could tell us what this meant to them in their departments. We were told by managers in surgery it meant 'putting patients first with a safe clinical service' , providing 'best practice evidence based care' and ensuring 'caring staff, patient safety and the right training for staff.'
- The hospital held meetings through which governance issues were addressed. The meetings included the Integrated Governance Committee/Hospital Board, the Clinical Governance Committee and the Medical Advisory Committee (MAC).
- The MAC was due to meet quarterly. The MAC meeting minutes supplied by the hospital for January, April and July 2016 demonstrated key governance areas were discussed including clinical incident reporting, complaints, risk assessments and feedback from clinical specialist groups.
- The staff we spoke to were proud to work for the organisation. One member of staff described how they were encouraged to work hard and focus on what was needed to be done to give the best care to the patient. A number of staff spoke about an open culture with good communication and stated the senior management team were accessible and visible in the clinical areas.
- The hospital had a patient feedback system that operated across the Nuffield Health group. The hospital also operated

the NHS family and friends test which was a short survey where patients were asked four questions relating to the quality of care and if they would recommend the hospital to family and friends.

- The hospital introduced a children's experience forum in July 2016. We saw the action log from the first meeting. This showed areas the service had made improvements following feedback from staff and patients. For example, one completed action was to purchase a book rack and children's books for the outpatient's waiting room. We saw the books were there during our visit.
- A member of staff wrote a book for children coming to the hospital called "Archie and Theo's Special Day Out to the Guildford Nuffield Hospital". The booklet helped educate children about the importance of hand washing. Children also performed hand hygiene audits by completing a simple form by indicating which staff groups they saw cleaning their hands.

Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Good

Surgery

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

Are surgery services safe?

Good

The main service provided by this hospital was surgery. Where our findings on surgery for example, management arrangements, also apply to other services, we do not repeat the information elsewhere but cross-refer to the surgery section. The surgical section of the report also covers the hospital's medical services such as endoscopy and pain management procedures.

For example, in this section we cover the hospital's arrangements for dealing with risks that might affect its ability to provide services (such as staffing problems, power cuts, fire and flood) in the overall safety section and the information applies to all services unless we mention an exception.

We rated safe as good

Incidents

- There have been no reported never events between July 2015 to June 2016. (Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- Reviewing incidents was a standard agenda item on the monthly clinical governance and board meetings and we saw evidence of this from meeting minutes. This ensured that any themes of incidents were highlighted and new incidents discussed.
- There were a total of 517 clinical incidents in the reporting period (July 2015 to June 2016). Out of 517 incidents, 76% (393) occurred in surgery or inpatients. For this reporting period, the assessed rate of clinical incidents for surgery or inpatients is similar to, or lower than the rate of other independent hospitals we hold this data for. The majority of the incidents were of no or low harm.
- Hospital policy stated that incidents should be reported through the electronic reporting system. All clinical and non-clinical staff we spoke to were familiar with the electronic system and are encouraged to enter incidents. We were told by one staff member that incident reporting had improved as staff have become more competent through training.
- Staff described the process for reporting incidents and told us they received feedback, which was given at ward or departmental meetings. Team meetings on all ward areas, theatres and pre assessment were held monthly. Evidence was seen of these meetings and three sets of minutes from different departments showed discussions had taken place about reported incidents.
- We were told that lessons learned from incidents would result in change of practice. One member of staff described an incident which led to the introduction of hydration charts in addition to fluid charts for ward patients to ensure that patients received adequate fluids.
- In theatre we were told by a staff member that they receive feedback on near misses and this would be for all Nuffield hospitals. The hospital director confirmed they do get learnings from near misses and serious incidents at other Nuffield sites through their integrated

governance approach. The operation board quality report showed incident comparism data across all Nuffield health hospitals which demonstrated an opportunity to learn.

- We saw root cause analysis investigations (RCA) were completed as part of the investigation of incidents. Those seen were completed for patients with surgical site infections (SSI)and were completed on a standard template. Lessons learned had been identified and action logs showed when actions were complete. Minutes of ward and theatre team meetings demonstrated learnings were then discussed at departmental level with the staff.
- The provider reported no serious incidents in the reporting period (July 2015 to June 2016).

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 was introduced in November 2014. This Regulation requires the organisation to notifying the relevant person an incident has occurred, provide reasonable support to the relevant person, in relation to the incident and offer an apology.
- We saw the hospital had a duty of candour policy and staff were aware of the terminology, the process they described in communicating with patients and their relatives reflected openness and transparency.

Clinical Quality Dashboard

- The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE).
- The hospital used the NHS safety thermometer and the pharmacy department collected data on a monthly basis. In addition the hospital used a clinical quality dashboard and a monthly operations board quality report which compared data across all Nuffield hospitals enabling the hospital to benchmark its reporting.
- Information was seen on the ward of the clinical dashboard, which showed results for the last three months prior to the inspection on the occurrence of patient falls, never events and infections such as Clostridium Difficile (C.diff). There were no occurrences of these complications.
- The VTE screening rate for the same period was 100%. This demonstrated each patient was assessed for the risk of VTE enabling preventative measures to be put in place. This was seen to be monitored by the pharmacy department where records were kept.

Cleanliness, infection control and hygiene

- There had been no cases of Methicillin-resistant Staphylococcus (MRSA), one case of Methicillin – sensitive Staphylococcus aureus (MSSA,) one incident of C.difficile and three cases of Escherichia coli (E-Coli) in the reporting period (July 2015 to June 2016). There was evidence all these incidences had been investigated with no common themes found.
- There were nine surgical site infections in the reporting period July 2015 to June 2016. The rate of infections during primary hip and knee arthroplasty procedures was above the rate of other independent acute hospitals we hold this type of data for. The rate of infections during other orthopaedic and trauma, upper gastro intestinal and colorectal, and urological procedures was similar to the rate of other independent acute hospitals we hold this data for. There were no surgical site infections resulting from other surgery.
- We saw examples of root cause analysis (RCA) that had been completed by the lead Infection prevention and control (IPC) nurse to investigate the causes of infection. The RCA was detailed and demonstrated involvement of the microbiologist. There was a completed action log. We were told that examples of learnings from the RCAs and changes to practice were the monitoring of the sepsis pathway, the development of clinical pathways detailing the management of catheters and ensuring staff were trained in asceptic non-touch technique (ANTT). IPC lead was the ANTT lead ensuring there was compliance across the hospital.
- The hospital has a service level agreement with a microbiologist from a local NHS trust. There was 24 hour cover and it was seen from the minutes that he attends the quarterly infection control and prevention (IPC) meetings.

Good

Surgery

- Patient-led assessments of the care environment (PLACE) is a system for assessing the quality of the patient environment.Patient representatives go into hospitals as part of the team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. In the PLACE audit 2016 Nuffield Health Guildford Hospital scored 100% which is better than the national average of 98% in relation to cleanliness and general building maintenance. The hospital score was the same or higher than the England average across all eight categories.
- There were IPC policies and procedures in place that were readily available to staff on the hospital intranet. Infection prevention and control was included in the mandatory training and 96% of staff had completed this training.
- The Matron was designated as the Director of infection prevention and control (DIPC). There was an IPC lead nurse who reported directly to the matron. There was corporate support with quarterly meetings which means practice could be benchmarked across the Nuffield group.
- We saw an annual IPC report 2015 which set out the plan for 2016. This was then monitored through a quarterly IPC committee meeting and was reported through to the quarterly clinical governance meeting and the Medical Advisory meeting (MAC). Minutes of both meetings demonstrated that this was happening.
- The IPC lead nurse had received appropriate training for the role and was being supported to continue studying for a masters degree. There were link nurses and staff in different departments of the hospital. We were told that there were opportunities for the link staff to undertake training relating to infection prevention and that one staff member was doing this at a local college.
- The IPC lead nurse reviews pathology results every day to monitor for any concerns. The pharmacist, IPC lead nurse and microbiologist have formed an anti-microbial group to scrutinise any concerns with the prescribing of antibiotics. Evidence of this was seen in quarterly infection prevention meeting minutes. The minutes also demonstrated that a water safety committee was established and was reviewing the corporate policy and its implications for the hospital, the actions from this group were evident in the minutes of the IPC meeting.
- Areas we visited were tidy and visibly clean. We saw evidence of interdepartmental cleaning audits and the hospital wide cleanliness score was 96%.
- All sinks in patient areas did have posters of hand washing technique displayed. We witnessed staff used a good hand washing technique which was compliant with Health Protection agency (HPA)guidelines.
- We saw records of regular IPC audits that took place to ensure all staff were compliant with hospital policies such as hand hygiene. We observed hand cleaning gel outside each patient room. On the ward we observed that staff regularly gelled their hands on entering and leaving the patient's room. This practice conforms with The National Institute for health and care Excellence (NICE) quality standard (QS)61. Statement three : people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct care and contact. Staff in theatre confirmed that results of hand hygiene audits are feedback at their team meetings and this was seen to be minuted.
- On the ward we observed all clinical staff to be bare below the elbow in line with best practice.
- Personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas. Staff were observed to be using appropriate PPE and one patient commented that the nurses always put on gloves when emptying her catheter bag.
- Equipment was marked with a sticker when it had been cleaned and ready for use. This was observed as happening on all ward areas and in theatre.
- Decontamination and sterilisation of instruments was managed externally to the hospital at a dedicated site used by Nuffield hospitals. The facility was responsible for cleaning and sterilising all reusable instruments and equipment used in operating theatres except for endoscopy which managed its own decontamination. Staff said there was a good working relationship with this external decontamination unit.
- The cleaning of the hospital was undertaken by hospital staff. Cleaning equipment was colour coded and met the national colour coding cleaning equipment guidelines. We saw evidence of cleaning rotas, checklists and the project called 'Blue Sapphire' which

was both a written and pictorial resource for housekeeping staff which aimed to standardise practice ensuring 'highest standards of common excellence, cleanliness and consistency throughout the working environment'.This was used as an induction and resource tool and was seen to be an example of outstanding practice.

- We observed sharps management complied with Health and Safety (Sharp instrument in Healthcare) regulations 2013. The sharps bins were clearly labelled and tagged to ensure correct disposal.
- We saw clinical and domestic waste bins were available and contained no inappropriate items. Staff we spoke to were aware of the correct disposal of waste.
- We spoke to five inpatients and they all commented their rooms were cleaned daily, that housekeeping staff introduced themselves before cleaning and they were satisfied with the cleanliness of their room and bathroom.
- Up to date patient information about IPC was seen to be available across the hospital.
- On the ward, one member of the catering staff was not adhering to bare below the elbows and did not clean their hands before entering the patient's room.
- One member of the theatre team was seen to be entering the ward in 'scrubs' (the uniform worn by the intra operative scrub teams)and this was seen not to be in line with the hospital IPC policy.

Environment and equipment

- General storage of equipment on the wards and in theatres was observed to be satisfactory with corridors kept free of clutter.
- Four oxygen cylinders were checked on the ward areas and they were in date and safely stored. In theatres we checked the storage of oxygen and observed all cylinders were stored safely in a cupboard that could be locked and made secure when the department was closed.
- There were arrangements to ensure endoscopes were decontaminated and the risk of infection to patients minimised. We observed the decontamination cycle and reviewed the cleaning records of the endoscopes, which were all compliant with patient traceability using the health edge system making it possible to track which endoscope was used on each patient.
- We saw records which confirmed endoscope washers were annually serviced and records were seen showing the weekly testing of water quality.
- We saw an in date spillage kit within the endoscopy washer room appropriate to use in the case of chemical spillage. The member of staff present, was aware of the purpose of this and how to use it.
- Staff told us there was good support from outside contractors should advice be required in relation to endoscopes. There was also support from the IPC lead nurse should advice about IPC be needed.
- We saw evidence staff had received appropriate training in the cleaning of endoscopes.
- We observed that equipment within the endoscopy unit was visibly clean and was marked as being annually serviced/tested which provided a visual check they had been examined and were safe to use.
- All equipment service records for endoscopy and theatre were kept in theatre and we saw an up to date list of medical devices service dates and a list of local service contracts with dates of checks and renewals. This information was in addition to the hospital equipment that was managed under a hospital wide contract.
- In theatres we saw the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic related Equipment (2009) were being adhered to with appropriate log books being kept. A sample of checks made on two anaesthetic machines showed the checks to be complete and signed by the anaesthetic practitioner.
- We saw theatres and anaesthetic rooms were generally well organised, clutter free and single use items such as syringes and needles were readily available. Random stock check were done and this showed stock to be in date.
- In theatre the difficult intubation trolley was centrally located within the department for ease of access. The equipment was the same as used at the local NHS Trust,

as some anaesthetists work in the department on an infrequent basis the use of standard equipment that the anaesthetists are familiar with would be seen to improve patient safety.

- We checked five adult resuscitation trolleys around the hospital. In all cases there was evidence of daily checks to ensure the trolley tag/seal was intact and there was a checklist to show this was done with no omissions. Staff also checked the full contents of the trolley once a week and we saw a checklist to show this was done with no omission on any of the trolleys. The staff we spoke with confirmed they had access to the equipment that they required to meet patients' care needs.
- In MRI/radiology there was clear signage above the resuscitation trolley indicating its location and on the day ward there were stickers showing portable appliance testing (PAT) testing within one year for both the defibrillator and portable suction. In theatre recovery we saw all emergency drugs were in date.
- The use of natural Rubber latex (NRL) gloves has the potential to cause asthma and urticarial (itchy rash) including more serious allergic reactions, such as anaphylaxis (extreme serious allergic reaction). The Health and Safety Executive recommends employers should carefully consider the risks when selecting gloves for the workplace. We observed that latex gloves were being used within theatres however non-latex gloves were available for staff to use. Staff were able to explain the management of a patient with a latex allergy and the correct use of non-latex gloves and equipment.
- Two empty patient rooms were checked and they were seen to be visibly clean. There was information in the room about hand hygiene. Bathrooms were clean and tidy.
- On the ward four blood pressure machines were checked and they were clean, serviced and tested, which provided a visual check that they had been examined and were safe to use.

Medicines

- The hospital had a monthly medicine management forum meeting, we saw evidence of these meetings, which contained a review of any national guidance or safety alerts, and when relevant, detailed how these were actioned. At alternate meetings safe management of medical gases was discussed. We also saw a review of any medicine management incidents recorded on the electronic reporting system and a record of actions taken with completion dates. We were told about a change of practice following a check on allergan drugs that were found to be out of date. Allergan drugs are medicines used for treating allergies. Checks were now more frequent with a regular audit of storage of these drugs.
- We were told the pharmacy manager has support from the corporate chief pharmacist and there were monthly calls/meetings to share best practice.
- Staff in the clinical departments told us drug stocks were checked weekly by pharmacy.
- We found that medicine cupboards were kept locked and on checking were orderly, neat and tidy.
- On the ward we saw robust management controls in place with drug cupboards locked within clinical utility rooms locked with a secure keypad for entry. The drug keys were kept by the senior nurse.
- We saw medicines were stored in dedicated medication fridges when applicable. We saw that temperature monitoring devices were integral to the drug fridges and these were linked to pharmacy that would be alerted if temperatures were out of recommended range and would check what action had been taken by the department. There were additional checks made at ward level and daily records were correctly kept of fridge temperatures. When asked, staff were aware of what action to take if the temperature was outside the recommended range.
- A check of five prescription charts showed prescriptions were signed and dated appropriately but on the ward in three charts the writing was not always legible. Prescriptions should be legible in line with the nursing and midwifery council (NMC) standards for medicine management.
- The pharmacist, IPC lead nurse and microbiologist have formed an anti-microbial group. We saw an anti-microbial stewardship policy to ensure appropriate prescribing of antibiotics. This complies with NICE QS61 statement one stating people should be prescribed antibiotics in accordance with local antibiotic formularies as part of anti-microbial stewardship.

- There was pharmacy support Monday to Friday 8am to 5pm and on Saturdays 8am to 12pm.Outside normal pharmacy working hours there was currently no pharmacist on call, which was seen to be on the hospital risk register. The hospital has recently piloted an on call service and it was being considered for implementation.
- Pre-packed take home medicines were available on the ward. Staff told us the Resident Medical Officer (RMO) prescribed medication to be taken home from a central cupboard. The drugs are labelled with patient details, drug and dosage. The medications were checked by a nurse to ensure they were correct. We were told that Pharmacy had produced nurse competencies to be assured of safe dispensing.
- Examples were seen of patient information given to patients. In the case of complex drug regimens the information was produced specific to the patient needs.
- We looked at controlled drugs (CDs) (medicines liable to be misused and requiring special management) in wards and theatres. On random checking all stock balances were correct. We checked CD registers and on wards these were legible and correct.
- In one theatre the controlled drug book was reviewed and we saw the administration of drugs was dated, timed and signed by two trained clinical staff in line with guidance. However on one page the doses were illegible and on the second page five entries of dosage were illegible. Staff should ensure all entries are legible in line with Nursing and midwifery council (NMC) Standards for medicine management.

Records

- Nuffield healthcare has a Group Health records standards policy, which is accessible to the staff at Guildford hospital. We saw staff adhering to this policy. Patient records were managed in accordance with the Data Protection Act (DPA) 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- Information governance and health record keeping was part of the mandatory training and compliance was noted to be 96% and 97% respectively.
- On the ward all patient health records were kept in the patient room, no patient sensitive data was seen at the nurse station.
- The surgical care pathway included pre-operative assessment such as previous medical history, anaesthetic assessment, discharge planning and allergies together with baseline observations and any investigations undertaken.
- We looked at eight medical and nursing paper records. These were generally of a good standard and demonstrated evidence of completed risk assessments, a clear plan of treatment and a signed consent form. Nursing notes were signed and dated in six sets of notes but not in the other two.
- One patient had a catheter in place, this was documented in the operation notes but not in the nursing notes. This was discussed with the ward sister at the time of inspection and we were reassured a new pathway was being introduced that would address this issue.
- There was evidence in the nursing notes of daily visits by the Consultant but in six sets of records there was no documentation by the Consultants. We were told that that the Consultants keep their own sets of records with their secretaries usually on site at the hospital. This is not in line with the Health and Social Care Act 2008 (regulated activities) Regulation 2014 which requires the registered person to: ' maintain securely an accurate , complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.' Keeping separate file notes in this manner did not meet the requirement of the regulation and because of this, our rating lowers to 'requires improvement' for safety. The way the records are were kept added to the risk that papers could be separated or misfiled, which was an unsafe practice. In addition, separating the medical records in this way made it harder for staff to monitor the results of treatments and the patient's progress.

Safeguarding

- The Nuffield Health group has a corporate Safeguarding policy dated 1st April 2016, which was available to all

staff on the intranet. There were flowcharts to guide staff in all departments on how to raise a concern and the relevant social care contacts. We saw these charts on display in all the surgical departments.

- The Matron was the designated lead for adult and child safeguarding and sits on the Surrey Safeguarding strategic board.
- There have been three safeguarding concern reported to CQC in the reporting period (July 2015 to June 2016) we reviewed these and saw investigation had been undertaken and actions taken.
- We asked three staff members separately to describe the process for raising a safeguarding concern and they were able to describe the process.
- Staff we spoke with confirmed they had received safeguarding vulnerable adult training as part of their mandatory training and records showed 98% compliance for level one. The matron and deputy had level 3 training. We saw the Mandatory training policy 2016 which stipulated what each employee should complete for mandatory training and the hospital was compliant with this training.
- We were told by staff in theatre that there was on line training in order to understand and know what to do in the case of female genital mutilation (FGM) and that they would report any concerns to their line manager.

Mandatory training

- Mandatory training was monitored and all staff expected to complete on an annual basis, the training was organised corporately by Nuffield Health. The mandatory training programme included topics such as health, safety and welfare, infection control, incident reporting and manual handling. Training rates for individual topics ranged from 86% to 100%.On the day of the inspection the most recent records showed an average compliance of 98%.This was well above the target of 90%.
- Mandatory training data for Consultants was not provided to us.
- Staff told us mandatory training was a mixture of on-line and face to face training. Staff told us that sometimes they could complete their training at work. Some staff said it was difficult to complete their on line training due to workload but they can ask for protected time and it was possible to do it remotely from home.
- Mandatory training was monitored and was seen to be discussed at the leadership team meeting with remedial action being taken if the compliance was below an acceptable level of 90%.

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

- The WHO (World Health organisation) checklist was a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic room to recovery and discharge from the theatre.
- We observed specific WHO checklists for different procedures including general surgery, gynaecology and ophthalmology, this ensured the most important safety factors relating to the procedure were highlighted and checked.
- We found evidence of staff completing WHO checklist documentation when we reviewed patients' notes post operatively. Staff told us compliance with the checklist was closely monitored and monthly audits of compliance took place on a regular basis.
- The July and August 2016 WHO safety checklists audit were seen. For July there was 100% compliance but August was not fully complete so it was not possible to calculate compliance. Following the inspection the hospital provided four months of WHO checklists which showed full compliance. Staff told us if the checklist had not been completed correctly it would be discussed at the team meeting. This was seen evidenced in the minutes of the August theatre team meeting.
- We observed three examples of the WHO checklist in use for example during orthopaedic, ophthalmic and endoscopy procedures. In all cases they followed a standardised accurate approach, were well led and had good staff engagement. This demonstrated good teamwork.

Good

Surgery

- We observed pre-operative team briefs and de-briefs took place and demonstrated good teamwork. This was in line with the 'WHO Guidelines for Safe Surgery' 2009 and Royal College of Surgeons, 'The High Performing Surgical team-best practice for Surgeons'
- We observed handovers between theatre staff to recovery staff, which were good and communicated all the relevant information.
- The hospital used a modified early warning system (MEWS) track and trigger flow chart. It is based on a simple scoring system in which a score was allocated to physiological measurements (for example blood pressure and pulse) already undertaken when patients present to, or are being monitored in hospital. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support. We reviewed five sets of notes and the MEWS chart was completed correctly.
- We were told by the staff medical support was readily available when required as the Resident Medical Officer (RMO) attended to patients quickly. One member of staff commented that this was always the case as there were always two RMOs on duty.
- The RMO was able to describe how they were able to access advice and support form consultants when patients required interventions.
- We saw patients had a VTE assessment completed. We saw completed risk assessments either integral to the pathway document or as a separate risk assessment booklet. In the records we looked at these were complete.
- In theatre we were told that moving and handling assessments are done on the ward. An example was given that if a bariatric patient was admitted then theatres are told the hover mattress was needed.
- There were three daily nursing handovers, one at the beginning of the day, one at lunchtime and one at the end of the day. We observed the midday handover and saw a risk assessment approach to giving information about each patient. At the end of report the ward sister made reference to each patient detailing what planned care should be given. This demonstrated an individualised approach to care for each patient. We saw staff discuss their allocation to patients and where possible there was continuity of care for the patients.
- We saw there were a variety of up to date clinical standard operating procedures in the management of emergency situations. We were told there were monthly scenarios for example patient cardiac arrest, massive blood loss and the management of the deteriorating patient. These ensure a standardised evidence based approach to managing emergency situations. We saw evidence of action plans of these scenarios and we saw feedback at the theatre team meeting following a massive haemorrhage scenarios. The staff said these scenarios were helpful as on one occasion this led to changes in the drugs that were kept. At the team meeting staff were asked what additional training of this sort would be beneficial for them.
- The hospital director said they had taken a decision to change their high dependency unit (HDU) from level 2 to level 1, as they were not able to achieve the standard required for level 2. They have a service level agreement (SLA) in place with the local NHS trust (on the same site) so should patients require emergency transfer or high needs they could safely transfer across.
- There were 16 cases of unplanned transfers of an inpatient to another hospital in the reporting period (July 2015 to June 2016). This rate was not high when compared to a group of independent acute hospitals, which submitted data to CQC. The Clinical Governance meeting minutes show that when patients are transferred out to the trust hospital a root cause analysis was completed.
- There were six cases of unplanned return to theatre in the reporting period (July 2015 to June 2016). These were investigated and no trends were identified.
- The hospital had a pre-assessment service and we were told they were working towards screening all patients but currently see only patients undergoing general anaesthetic. This enables an assessment to be made of the patient's suitability for surgery
- At pre-assessment the patient's previous and current health conditions were evaluated, risk assessments were completed and the results documented in the patient's care record. Risk assessments included the risk

of venous thromboembolism (VTE), falls, pressure ulcers, the patient's body mass index and malnutrition. Any concerns were documented and any discussions documented

- If the nurse at pre-assessment has any queries regarding patient's suitability we were told she would discuss this with the anaesthetist to ensure patient safety.

Nursing and support staffing

- In theatres there was a variable use of bank and agency nurses in the reporting period (July 2015 to June 2016). There was a higher than average use of bank and agency ODPs and healthcare assistants for the same period when compared to other independent acute hospitals we hold this data for.
- From data submitted, the vacancy rate for theatres currently runs at 31%, which was higher than the vacancy rate for this staff group in other independent acute hospitals we hold this type of data for. However there has been recruitment of staff from abroad and there were currently three practitioners supernumerary in the department who were undergoing training to fill three of the vacant posts.
- An active recruitment plan was in place across the hospital for all clinical staff. There has been a reduction in the use of agency staff achieved from 1947.9 hours usage in 2015 to 304.75 hours in October 2016.The highest agency use remains in theatre. The matron and hospital director said this improvement has been achieved through changing the approach to recruitment, which now focusses on recruiting for values. They have also recruited from abroad.
- Theatres used the Association for Perioperative Practice (AfPP) staffing guidelines to ensure there was an adequate number of appropriately trained staff available for each theatre.
- There was no acuity tool in use on the wards to assess staffing requirements. However the ward sister was able to describe how staffing levels were assessed using a risk based approach depending on patient numbers and acuity. Activities on the ward for that day were also taken into account. This was evidenced by looking at staffing rotas for the past two months and on average the ration of trained nurses to patients was 1 to 5.In addition there were healthcare assistants on the ward who work within the team. There was currently 1 whole time equivalent (WTE) registered nurse vacancy at ward level that had just been recruited into.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN2012).This meant one registered nurse for eight patients and the ward was compliant with this.
- The staff and patients we spoke with said there were enough nurses to provide safe compassionate care.
- Student nurses from the local university worked on the ward and we were told there is normally one on placement at a time. The student nurse on duty at the time of inspection felt well supported and had more than one mentor to support learning and to ensure practice was safe.

Medical staffing

- We saw 208 consultants had practising privileges at the hospital. Practising privileges is a term which means consultants have been granted right to practise in an independent hospital.
- The Resident Medical Officers (RMO) provided continuous medical cover and conducts regular ward rounds to ensure that all patients are appropriately treated and safe. Any change in a patient's condition is reported to the consultant and their advice was followed in respect of further treatment.
- The hospital has RMOs who are employed by an external agency and provide immediate medical support 24 hours a day seven days a week. There are two RMOs on duty at any time.
- Staff told us that a formal hand over process was undertaken between RMOs but we did not see this. We did observe both RMOs coming onto the ward in the morning to take report from the senior nurse in charge.
- Staff told us that consultants were available by telephone 24 hours a day as they maintained responsibility for the patient for the duration of the patient's stay. We were informed the anaesthetist was available via telephone for support following a patient's

procedure. Staff reported that they did not have any difficulties contacting the consultants but would let matron know if they were not contactable for any reason.

- We spoke to an RMO who confirmed that support from consultants was always available via telephone and that when consultants were unavailable they had cross cover arrangements in place.

Emergency awareness and training

- We saw the hospital major incident procedure/plan. This was reviewed in January 2016 and contained up to date information on who to contact and what actions to take in the case of a major incident. This incorporated information to ensure business continuity in the case of any system failures for example if the phone system was not working.
- We did see evidence of fire safety training which 99% of the staff had completed.
- The hospital provided emergency scenario training for situations including major haemorrhage and resuscitation. We saw that the feedback identified areas for improvement, including leadership and communication. This helped staff to refresh their skills and knowledge in this area.

Are surgery services effective?

Good

We rated effective as good

Evidence-based care and treatment

- Staff were able to access corporate and local policies via the intranet and hard copies of policies were available in departments. The policies referenced NICE/Royal College guidelines and all policies were in date.
- Care pathways were in use on the wards and were easy to follow. The care pathway referenced the guidance used in the document, for example, the oxygen use and observations was taken from the British Thoracic Society guidance.
- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance was cascaded down by the department manager and evidence of this was seen in both ward and theatre team meetings.
- Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations. For example, the ward manager gave examples of recent changes in line with guidance, which resulted in a change of recommended dressings for patients with central lines.
- Following surgery, patients were nursed in accordance with the National Institute for Health and Care Excellence (NICE) guidance CG50: Acutely ill patients in hospital: Recognition and response to acute illness in adults in hospital. Sometimes, the health of a patient in hospital may get worse suddenly (becoming acutely ill).There were certain times when this was more likely, for example after surgery. Adherence to this guidance by monitoring patients (checking them and their health) regularly after surgery and taking action if they show signs of becoming worse can help avoid serious problems.
- Within theatre, we observed that staff adhered to the NICE guidelines CG74 related to surgical site infection prevention and staff followed the recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. For example, we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic (aqueous or alcohol-based) preparation.
- We observed the endoscopy unit has not yet achieved JAG accreditation however, the department was collecting audit information and there was a plan to work towards accreditation.
- NICE guideline updates were seen to be a regular agenda item on the clinical governance committee meetings to ensure arrangements for implementation were made.
- We saw evidence of an audit calendar that demonstrated local audits taking place across all departments and when this was planned for. Evidence was seen that audit reports were discussed at the clinical governance committee and specialty meetings.

For example, the medicine management forum had a standing agenda item of audit results and actions to be taken to address noncompliance of areas of concern. The IPC committee looked at audits results and planned any actions to be taken.

- The ward manager confirmed participation inpatient notes audit quarterly. Evidence of this audit was seen and the resulting action plan dated June 2016.For example, some consultants were not sending a copy of the discharge letter to the GP through to the hospital so there was a record in the patient's notes. We saw this was reported to the MAC committee for action to be taken.

Pain relief

- Pain assessment was seen to be within the patient pathway document. In theatres whilst in the recovery area pain levels were monitored and the patient was only moved back to the ward when their pain was controlled. The pain assessment tool was seen to be part of the early warning scoring chart using a scale of one to ten .
- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief. One patient commented that they were treated with kindness when pain relief was needed. Another patient said the nurse explained what pain relief was given and the patient was told they 'could ask for pain relief at any time'.
- Another patient commented that each time the nurse checked how they were the nurse assessed pain and checked for comfort .
- Evidence was seen that a pain audit was completed annually and results were available for the audit done in July 2016. Fifty-six patients completed a specific questionnaire and 100% reported getting pain relief drugs when they requested, 95% said the staff were compassionate and responsive in managing pain. There was an action plan attached to the audit results.
- The ward manager confirmed that one change that followed the pain audit was a study day for the nurses which included the management of epidurals and methods of giving pain relieving drugs.

Nutrition and hydration

- There was a process in place to ensure patients were appropriately fasted prior to undergoing a general anaesthetic. Each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. We observed this on three different occasions for different procedures.
- The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation, this was in line with best practice guidance on fasting prior to surgery.
- The Malnutrition Universal screening tool (MUST) was used to assess patients' risk of being undernourished. The eight records we reviewed had a nutrition and hydration assessment undertaken and these were appropriately completed.
- Following surgery, fluid input and output records were kept and the patient's condition monitored until normal urinary functions resumed. Patients were offered nutrition and fluid as soon as they returned from theatre, depending on their surgery and ability to consume. If concerns were identified through routine monitoring or observation, this would be escalated to the nursing team for investigation and action as appropriate.
- Patients with specialist dietary requirements were either highlighted at pre assessment or when on the ward and the catering staff were informed. One patient told us they were on a low fat diet and was seen by the chef. They were able to choose meals from a separate menu and had a good choice of appropriate foods.
- We were told by staff they have access to a dietician if a patient is not eating or has a special dietary requirement.
- All patients we saw had access to water and patients told us they were offered a hot drink at meal times.

Patient outcomes

- National clinical audits were completed, such as Patient Reported Outcome Measures (PROMS). The hospital told us they participated in the national audit programme. All patients having hip and knee replacements, varicose vein surgery or groin hernia surgery were invited to complete a PROMs questionnaire to help measure and improve the quality of care. The hospital had a small

percentage of returns in line with the volume of NHS patients and there were insufficient records for the England PROM adjusted average health gain to be calculated.

- Patients undergoing hip and knee surgery consented to their data being submitted to the National Joint registry (NJR). We saw completed consent forms within the patient records. The data was submitted to enable monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and to benefit patients.
- There were four incidents of hospital acquired VTE or Pulmonary embolism (PE) in the reporting period July 2015 to June 2016.
- The hospital engaged with the Private Healthcare Information Network (PHIN) so that data can be submitted in accordance with legal requirements regulated by the Competition Markets Authority Engagement.
- The data submitted confirmed in the reporting period (July 2015 to June 2016) there were 6 unplanned returns to theatre. This was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the reporting period (July 2015 to June 2016) there were16 unplanned transfers of inpatients to other hospitals This was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the reporting period (July 2015 to June 2016) there were seven readmissions to surgery within 28 days. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

Competent staff

- The hospital had a robust system for granting and reviewing practicing privileges in-line with the Nuffield health practicing privileges policy. Consultants completed an extensive application form and provided evidence of adequate insurance or indemnity cover, immunisation status and an enhanced disclosure check. The hospital director and matron interviewed all new applicants. After this, the hospital's MAC reviewed all applicants before granting practicing privileges. We saw evidence of review in the MAC minutes.
- All consultant practising privileges files were complete
- The hospital only granted practising privileges for procedures or techniques that were part of the consultant's normal NHS practice. The hospital would only consider making an exception to this rule if a consultant provided evidence of adequate training and competence.
- We were told the matron meets with the Local NHS Trusts medical Director on a monthly basis to share concerns in regards to Consultant practice or incident trends within the organisation.
- The hospital had in place appropriate job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff appropriately experienced, qualified and suitable for the post
- New employees undertake a local induction programme with additional support and training when that was identified. Each new employee was allocated a mentor. Mentorship was always offered to overseas nurses who were recruited into post. This was monitored by the Clinical Practice educator.
- The Clinical practice educator(CPE) had been in post for eighteen months and supported the training for clinical staff. The CPE described introducing a clinical framework and ensuring staff work in line with evidence based practice. This was developed to ensure consistency. All clinical staff complete competencies relevant to their role, this ensures staff have been assessed as competent to undertake their role.
- We were shown evidence of healthcare assistants (HCA) competencies and how training had been managed so they were competent to bring patients back from theatre. The HCA we spoke to described support given to complete her competencies. Personal file competencies were available on the ward and showed all the training undertaken.
- In theatres, we saw evidence of training files for each member of staff, which contained their individual competencies these were seen to be in date.

Good

Surgery

- During the period January 2016 to December 2016 all inpatient, theatre and outpatient staff had an appraisal completed.
- We were told by staff that learning and development needs were identified during appraisal. Staff were supported in their learning and development by their manager and the clinical practice educator. Evidence was seen of the Nuffield health academy workbook for HCAs and how in one case this had been used to develop and extend skills in theatre.
- Evidence was seen that the nursing staff were being supported with the revalidation process. There has been a corporate training day and information days were run locally by the hospital once a month
- The hospital tried to use the same agency staff who are familiar with the environment.
- All staff who worked in surgery were expected to undertake intermediate life support (ILS) training including HCAs. We saw that 95% theatre staff were compliant with up to date ILS training and 93% of ward staff were compliant. Basic Life Support (BLS) training had been undertaken by 96% of theatre staff and 94% ward staff. This was better than the Nuffield health target of 90%.

Multidisciplinary working

- Care planning takes place at pre assessment with input from the multidisciplinary team, including doctors, nurses and allied healthcare professionals. The pre-assessment staff work closely with the ward and theatres to share information about forthcoming admissions and any special requirements. The pre-assessment team also worked closely with the physiotherapy team to plan the care for more complex patients coming into the hospital for surgery.
- The health records included multidisciplinary input where required, for example entries made by physiotherapist.
- Overall staff reported good multidisciplinary working with other services within the hospital and with external organisations such as the local NHS trust and local authorities.
- We observed good culture in multidisciplinary working and a good team ethos. We saw good interaction between physiotherapist, nurses and patients.
- We saw evidence of good internal multidisciplinary working at the midday ward handover. The pharmacist was present to enable that department to understand how they can support prescribed treatments and get drugs ready for patients planned for discharge. We were told that in the morning the physiotherapist would attend the handover to support the nursing team and help in planning the patient's care.
- There were a number of service level agreements for specialist services from the local NHS trust and staff said there was a good working relationship with the staff that supply these services.
- There are no multidisciplinary team (MDT) meetings on site but we were told these do occur at the local Trust for complex patients. We did not ask to see evidence of these meetings.

Seven-day services

- The hospital was open routinely 24 hours a day, seven days a week with no periods of closure.
- Theatres routinely open on a Saturday but were closed on Sunday except for any emergency cases. Evidence was seen of an on call theatre rota with four members of staff available if needed for emergency cases.
- Consultants provide details of cover arrangements when on leave and staff confirmed they always were able to get hold of Consultants if necessary.
- An RMO was available on site 24 hours a day, seven days a week and was always available on a bleep system. The two RMOs worked a week on / week off rota. They were available throughout the 24 hour period seven days a week. The provider agency had a standby available should the RMO need to be absent for any reason.
- Pharmacy offer a Saturday service and had an informal on call arrangement, which they are looking to formalise to ensure continuity of care.
- Imaging and physiotherapy had an on call service out of hours.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for the patients.
- There were paper based records for each patient and these were kept within the patient room.
- We saw the Group health Records standards policy, which is in place across all Nuffield Hospitals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place, which was based on the guidance issued by the Department of Health. This included guidance for the staff in gaining valid consent.
- The policy was readily available for staff to access and included guidelines for treating adults who were unable to consent due to a lack of capacity. A separate consent form was used in these instances which included the involvement of the patient's family, a capacity assessment and a declaration of best interest.
- Staff we spoke to on the wards and in theatres were aware of the policy and the correct procedures to ensure patients gave valid consent prior to any treatment or surgical procedure.
- Training on Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA), 2005 was part of mandatory training and was easily accessible. We saw 96% of theatre staff and 100% of all ward staff had completed DoLS training. All staff had completed MCA training.
- Six patient records were checked of patients that underwent surgical procedures and all had consent forms that were correctly completed with signatures of patient and consultant. They were legible and all identified all possible risks and complications that may occur.

Are surgery services caring?

Good

We rated caring as good

Compassionate care

- The Friends and Family test (FFT) is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience.
- The inpatient and day case episodes of care recorded at Nuffield health Guildford in the reporting period (July 2015 to June 2016); of these, only 0.9% was NHS funded and of this small number on average 80% of NHS funded patients would recommend or highly recommend the service.
- The Nuffield Health group used its own patient satisfaction survey where the results are compared monthly against other Nuffield health hospitals.
- On the ward we saw the local results for patient feedback displayed for September 2016. It was presented showing the overall satisfaction for each specialty. There was a section of patient verbatim feedback and what had been done to address this. 'you said..we did.' An example used was the patient saying there was no way of telling the time when in bed, as a result clocks were put into each patient room.
- We saw patient satisfaction results/actions was a standing agenda item on the clinical governance committee meeting.
- During our inspection the eight patients we spoke to were all very positive about the care they had received and said nurses were kind and compassionate. One patient commented that 'they had excellent treatment and care, there were no delays and staff answered all her questions.'
- Several other patients described the care as excellent, commenting the nurses had time to stop and talk to them. Patients also commented the nurses introduced themselves on entering the patient room. One patient commented specifically that they was very pleased with the 'very good specialist care' from the physiotherapist.
- Throughout our inspection we witnessed excellent staff interaction with the patients.
- We observed a patient being made comfortable following surgery. Pressure relieving aids were being used and this was being discussed with the patient as they were repositioned. Dignity was maintained throughout the process.

Good

Surgery

- In theatres and endoscopy we observed staff delivering care with empathy and compassion, safeguarding the patient's dignity and addressing the patient by name and putting them at ease.
- In the PLACE audit 2016 Nuffield Health Guildford Hospital scored 100%, which is better than the national average of 98% in relation to cleanliness and general building maintenance. The hospital score was the same or higher than the England average across all eight categories.
- The hospital was compliant with the government requirement to eliminate mixed sex accommodation. Patients admitted to the hospital were only admitted to single rooms and only shared facilities when clinically necessary such as in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.

Understanding and involvement of patients and those close to them

- We spoke with patients at different stages of their surgical journey and they told us they felt involved in their care and in decision making about their treatment. One patient commented the nurse in pre- assessment had been kind and 'managed his expectations well.'
- The patients we spoke with told us they were given adequate information about the specific surgical procedure and what to expect.
- Patient commented staff introduced themselves by name and this was observed on more than one occasion during the inspection.
- We observed the ward receptionist greeting relatives entering the ward and answering their questions in a professional and kind way.
- The staff supported friends and family to visit patients during the day except during 12pm to 2pm when patients were encouraged to rest. We were told visitors were able to have meals and refreshments at the hospital and if necessary arrangements could be made for them to stay overnight.

Emotional support

- Surgical services had arrangements in place to provide emotional support to patients and their family when needed. Patients told us they would feel able to ask the staff for emotional support if it was needed.
- Pre-admission staff told us where it was identified patient's required extra support this was arranged where possible before admission and discussed with the multi-disciplinary team. For example when a patient had complex needs the pre admission nurse would discuss this with the wards and theatres to minimise anxiety for the patient.
- We saw the availability of specialist services for the patient and observed the stoma nurse on the ward with a patient on the day of inspection.
- We saw a patient undergoing a procedure under sedation, a nurse supported the patient throughout the procedure who reassured and ensured her comfort.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- As an independent hospital treating mainly elective patients, the hospital was constantly looking at the services it offered in order to meet the needs of the local population. Leadership team meeting minutes showed that the hospital was committed to working closely with the NHS and commissioners to provide appropriate services.
- There were 11,965 inpatient and day case episodes of care recorded at the hospital in the reporting period (July 2015 to June 2016). This related to 2,390 inpatients and 9,575 day case patients. Of these patients 0.9% were NHS funded and 99.1% had other means of funding treatment. During the same reporting period, 66% of all NHS funded patients and 20% of all other funded patients stayed overnight at the hospital.
- Staff told us there was a flexible approach to working during busy times. There was an ability to extend clinic

times and the pre-assessment service if necessary. Additional cases could be added to theatre lists allowing for appropriate consent and screening times. There were few capacity issues.

- In theatre there was an on-call team for out of hours and all staff on the rota were within 30-minute travel time to the hospital.
- At busy times staff told us additional staff will be bought in to work and staff will extend their hours to meet the requirement of the patients.

Access and flow

- The hospital was seen to offer a flexible service, which included variable appointment times and choice regarding when patients would like their surgery, subject to consultant availability.
- Following an initial referral all patients were seen in outpatients. If the patient was being admitted for a procedure or surgery they will be seen by the pre-assessment team of nurses. We were told this service is being expanded to screen all patients undergoing general anaesthetic for surgery but they do not see patients undergoing a procedure under local anaesthetic.
- When patients arrive at the hospital for an operation or procedure they report to reception and were either directed to the day surgery ward or the inpatient ward. The patients were prepared for their operation or procedure in either location and wait to be escorted to theatre or endoscopy unit. After their operation or procedure they were transferred to the recovery room to recover and to ensure they are stable and pain free. Then they were collected and taken to either the day surgery ward and discharged home or returned to their room on the ward and for an overnight stay.
- The theatre manager or a deputy reviews the operating theatre list in advance, this ensured there was adequate time, staff and equipment available.
- Patients told us the nurses kept them informed of the approximate time of their operation. We observed the midday ward handover and saw staff being reminded to check the time of the operating lists and to keep the patients informed of any delays.
- There were adequate discharge arrangements in place and the patient record held details of who to contact in case of an emergency.
- We observed records were kept of any patients transferred out of the hospital and any operations cancelled for clinical or non-clinical reasons.
- We were told as an independent hospital there were few capacity issues and as such waiting times were minimal and often reflect patient preference rather than capacity. In the majority of cases patients would have their procedure within four weeks of the decision to operate.

Meeting people's individual needs

- Senior staff told us the hospital was generally able to meet patients' individual needs and had in place a three-year dementia strategy. Evidence was seen of this strategy and the initiative using a blue pillowcase on the bed of patients with dementia and memory problems. This was a visual aid to staff to remind them, these patients may require more help and assistance. On the ward, four of the patient rooms had been designated as dementia friendly rooms. In these rooms, there were clear notices on the bathroom and wardrobe. Evidence was seen that all staff had at least basic dementia training.
- On the day of inspection we saw the blue pillow initiative was being used for a patient with dementia. The use of the blue pillow had been explained to the patient and relative and the patient had consented to this. There was a personalised plan of care and clear allocation of one nurse to provide continuity of care for this patient. The nurse looking after the patient explained how she had ensured the theatre department was aware of this patient and a blue pillow sign was put on the door of the patient's room to ensure all other staff were aware this patient had complex needs.
- Theatre staff were aware of the blue pillow initiative and the need to be aware the patient would have complex needs. They described how this might mean careful explanation of what was happening and allowed the relatives of such patients to escort them to theatre to avoid any unnecessary anxiety for the patient.
- We were told the blue pillow case initiative was used for any patient with more complex needs including learning

disabilities. This initiative was seen as an area of outstanding practice as all the staff we spoke to had a good understanding of this initiative and were aware of the need to consider the patients' individual needs.

- We were told that patients' individual needs were assessed and documented at pre-assessment. If specialised requirements were identified these would be put in place before or on admission. For example, any specialised equipment or dietary requirement.
- In the patient-led assessments of the care environment (PLACE) audit 2016, the hospital scored 93%, which was better than the national average to care for patients living with dementia. The hospital scored 97% against a national average 81% for patients living with a disability.
- We saw good facilities for patients with a disability or in a wheelchair. Staff told us they would accommodate these patients in an appropriate room depending on the patient's individual requirement.
- We were told translation services were available but were rarely required. We were told patient's family members were not used to translate for the patient.
- There was access to patient information leaflets which were given to patients at pre assessment. This allowed time to read the information prior to their operation. This also meant that relatives had the opportunity to read the information and were well informed. We saw examples of information about procedures and infection prevention and control information.

Learning from complaints and concerns

- Nuffield Health recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be addressed. These issues were managed through the complaints procedure. The hospital manager was responsible for the management of complaints. The personal assistant to the hospital's director was responsible for the day to day administration of the complaint management process.
- Information on how to make a complaint was available in leaflet form or on the website. Staff were aware of how to direct patients who would like to raise a complaint or concern. Complaints could be made verbally or in writing directly to the organisation.
- The Nuffield Health standard operating procedure for complaints set out the relevant timeframes associated with the various parts of the complaint response process. The procedure stipulated the timescales for each stage of the complaints process, how response times were monitored and how complaints could be escalated if the complainant was not satisfied with the response.
- The hospital had a clear process in place for dealing with complaints. Patients we spoke with understood how to complain. There was information leaflets in each patient room and around the hospital informing patients of the complaint process. Staff were aware of the complaints process and were able to tell us about changes to practice as a result of complaints investigations and how this information was shared.
- All complaints were logged onto the hospital electronic reporting system. The hospital director would determine who would deal with the complaint. In the case of clinical complaints the matron would investigate. We were told all responses to complaints were signed off by the hospital director. Meetings with patients and relatives were arranged if this is thought to be helpful.
- It was observed that complaints were a standard agenda item and discussed at the clinical governance meetings and at a number of forums including the senior management team hospital board meeting. Evidence was seen of this and complaints and learnings were discussed at team meetings on the wards and in theatre.
- Staff told us there was a patient focus group which reviewed feedback such as complaints and any lessons learned.
- There were 40 complaints received by the hospital in the reporting period (July 2015 to June 2016). No complaints had been referred to ISCAS (Independent Healthcare sector complaints Adjudication Service) in the same reporting period. The assessed rate of

complaints (per 100 inpatient and day case attendances) was lower than the rate of other independent acute hospitals we hold this type of data for.

- We were given examples of changes in practice from learning from complaints, for example on the ward a patient complained the ticking clocks in the patient rooms were disturbing them. The ward manager described how a non-ticking clock was sourced and all the clocks in the patient rooms were being replaced following this feedback
- In the theatre department we were told feedback about complaints was given at staff meetings. Examples of change of practice following patient feedback were for staff to ensure they wear name badges so patients would know who they were. They had also reduced the number of people in endoscopy following a patient comment.
- Patient experience newsletter was seen which was distributed to all a staff with suggestions on how to improve care.
- Hospital managers told us that complaints were acknowledged within two working days and then a response is provided in 20 working days. If this timescale was not possible, for example because more information was required, a holding letter was sent to the complainant so they are aware their complaint had net been forgotten and was still being looked into.

Are surgery services well-led?

Good

We rated well-led as good

Vision and strategy for this this core service

- As part of a large independent healthcare provider Nuffield Health have a corporate vision, values and beliefs which have been put in place at the Guildford hospital. We were told that in 2015 the senior management team at the hospital ran a series of workshops to enable staff discussion and understanding.
- All staff we spoke to were aware of the vision, values and believes and could tell us what this meant to them in their departments. We were told by managers in surgery it meant 'putting patients first with a safe clinical service,' providing 'best practice evidence based care' and ensuring 'caring staff, patient safety and the right training for staff.'
- We observed the values and beliefs on display in the hospital and staff told us that they were proud to work there.
- We saw a clinical strategy document dated August 2016, which sets out how the values and beliefs are being put into practice.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- The hospital held meetings through which governance issues were addressed. The meetings included the Integrated Governance committee/Hospital board, the clinical governance committee and the Medical advisory committee (MAC).
- The MAC was due to meet quarterly. The MAC meeting minutes supplied by the hospital for January, April and July 2016 demonstrated key governance areas were discussed including clinical incident reporting, complaints, risk assessments and feedback from clinical specialist groups.
- We saw thorough root cause analysis (RCA) of incidents with learning.All of those submitted were related to infection prevention and control and demonstrated a good level of detail and an action plan.
- We saw quality measurements of procedures and operations were monitored and reported to the relevant agencies. However, sample sizes were small and the number of cases reported to the National Joint Agency (NJR) did not relate to a large NHS trust, which made benchmarking results difficult.We saw any operative complications were discussed at the clinical governance meetings.
- Staff told us that if they had any safety concerns they would be able to raise this either at a team meeting or directly with one of the management team.

- We reviewed the risk register and looked at the current risks, which all related directly to the hospital. There were current review dates and a commentary on actions taken demonstrating an open culture of reporting and mitigation of risk.
- We spoke to managers concerning risk management and they were able to tell us what was relevant to their department and what actions were being taken to manage the risk. For example, the pharmacy manager was aware out of hours cover was on the risk register and she was able to explain what measures had been put in place to mitigate risk.
- We were told that Nuffield Health and the hospital were supportive of (PHIN) private healthcare information network agenda and attended a monthly implementation forum. Relevant data was being collected and submitted. PHIN is an independent , not for profit organisation that publishes trustworthy , comprehensive data to help patients make informed decisions regarding their treatment options, and to help providers improve standards.
- There was a variety of service level agreements in place to support the hospital services for example the provision of critical care services and emergency medical assistance was provided by the local NHS Trust next door to the hospital under an SLA. There was a link corridor between the hospital and the Trust through which patients can be transferred and also allows the trust resuscitation team to have access to the hospital.

Leadership / culture of service related to this core service

- The clinical department lead managers reported to the matron, who reported to the hospital director.
- The staff we spoke with were proud to work for the organisation.One member of staff described how they were encouraged to work hard and focus on what needed to be done to give the best care to the patient. A number of staff spoke about an open culture with good communication and statedthe senior management team were accessible and visible in the clinical areas.
- Staff spoke aboutregular staff forums once a month. We were told that at the forums, the hospital director briefed the staff about what was happening at the hospital and staff were encouraged to contribute to the meeting.
- One member of staff said the hospital manager and matron were present at their induction and this made them feel valued. Another staff member said theyfelt they could raise concerns without being blamed.
- We spoke to a number of staff who were aware of the whistle blowing policy and we were told concerns could be raised withoutblame.
- We were told there was good teamwork and a good atmosphere in the hospital. Several staff commented on their own opportunities for development and said ‘there has been investment in training for the staff.' We saw and heard good examples of nursing leaders and managers developing others. The post of clinical practice educator had been put in role 18 months ago and staff saw this as a positive development . We saw examples of individual staff who had been encouraged to develop their skills.
- One staff member described the good team spirit saying ‘everyone works well together and the work is well organised and matron is very approachable.' They also commentedthe hospital ‘keeps going forward’ and that ‘ideas are well received.'
- We saw evidence of regular team meetings in all clinical departments that were minuted and were available for all staff.
- The rate of sickness for nurses, ODPs and healthcarein theatres and inpatient departments was lower than the average for other independent acute hospitals we hold this data for in the reporting period (July 2015 to June 2016).
- Results of a recent staff satisfaction survey indicated that 93% of staffwould recommend Nuffield Health services to family and friends. Staff were asked if they would recommend Nuffield health as a place to work. This result was shown as +30(NPS) net promoter score. The hospital directortold us this was a significant increase from a score of minus19 in 2014.

Public and staff engagement (local and service level if this is the main core service)

Good

Surgery

- The hospital had a patient feedback system that operated across the Nuffield Health group. The hospital also operated the NHS family and friends test which was a short survey where patients were asked four questions relating to the quality of care and if they would recommend the hospital to family and friends.
- The hospital told us that the Nuffield Health beliefs were delivered in staff workshops to ensure that there was a consistent message across all staff groups about their expectations in how to behave towards patients and each other.
- The hospital told us that staff welfare was also included in the Nuffield Health's caring ethos. They gave examples of the employee assistance programme that offered confidential counselling support, access to occupational health, phased return to work programmes for those returning from long term-sick, flexible working and a supportive and caring attitude according to individual needs.
- Equality responsibilities were taken seriously and where staff had an illness that incapacitated them the hospital prioritised their wellbeing over business need. The hospital told us that their charitable status allowed them to focus on the needs of the patient and staff rather than financial constraints.
- The hospital had an established system of departmental meetings where staff felt able to contribute and raise issues and concerns. Team meetings were held on a regular basis and staff told us they felt able to contribute where necessary. We saw minutes from team meetings from both the ward and theatres which included team member discussions about relevant issues such as team behaviour and concerns.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- We saw that staff wanted to develop in their roles and there was a positive response to training and extending their skills.We were told they were given time, resources and encouragement to do so.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

We rated safe as good

Incidents

- The hospital did not report any patient deaths, never events or serious incidents related to children and young people (CYP) between July 2015 and June 2016. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The occurrence of never events could indicate unsafe practice.
- The hospital used an online software system for reporting incidents and monitoring trends. Staff described the process for reporting incidents, and gave examples of times they had done this. The hospital reported four clinical incidents involving CYP between July 2015 and June 2016. All staff we spoke to had confidence in the incident reporting process. Staff told us they received email feedback following incidents they reported.
- The hospital had robust systems to ensure staff learned from incidents to improve patient safety. The matron investigated incidents involving CYP. We saw from meeting minutes that a review of adverse incidents was a standard agenda item on the clinical governance committee minutes. The minutes showed that the paediatric lead nurse represented services for CYP at monthly meetings. The paediatric nurse then fed any relevant learning back to the other paediatric nurses. We also saw from the ward meeting minutes that staff received feedback from incidents discussed at clinical governance meetings. Staff told us they signed each month to confirm they had read the meeting minutes. This provided the senior management team with assurances that all staff were aware of any learning or changes to practice.
- The paediatric lead nurse told us about a change to practice following incident learning. A child developed a pressure sore on their heel following prolonged surgery. The service subsequently introduced gel mattresses or heel pads for all operations to help prevent a recurrence of this incident. We saw documentation in 10 sets of notes, which showed staff used gel mattresses or heal pads during all 10 operations. We also saw the gel mattresses and heel pads available in theatres.
- Staff we spoke with were aware of the Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The 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" and provide them with reasonable support. Staff gave us examples of times the service had discharged DoC.
- We saw from the clinical governance committee minutes that staff received information about any alerts for sharing with their teams. This included drug alerts from the Medicines and Healthcare Products Regulatory

Agency (MHRA). The hospital also received information about incidents from other Nuffield Health hospitals. This enabled shared learning across the Nuffield Health group.

- Due to the elective nature of the CYP service, there were no regular morbidity and mortality meetings related to CYP. However, the service could review morbidity and mortality through its clinical governance committee if the need arose.

Cleanliness, infection control and hygiene

- There were no infections of meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile, meticillin-sensitive Staphylococcus aureus (MSSA) or Escherichia coli (E. coli) relating to CYP between July 2015 and June 2016.
- We saw that all clinical areas were visibly clean and tidy. We saw consulting room doors and patient rooms labelled with “I am clean stickers." This provided staff and patients with assurances rooms were clean and ready for use at the start of clinics and before patient admission.
- The hospital scored 100% for cleanliness in the national Patient Led Assessments of the Care Environment (PLACE) audit in February to June 2016. This was better than the England average score of 98% for independent hospitals during the same period. The result showed that all patients who responded to the survey were satisfied with the hospital’s cleanliness.
- We checked the toy cleaning schedule for room three in outpatients. This was one of the two outpatients consulting rooms used for CYP. We saw that staff had fully completed the checklist. This demonstrated staff had cleaned the toys after each clinic. This was in line with the hospital’s toy policy, which stated staff should clean the toys using antimicrobial wipes after use or weekly if CYP had not used them.
- All clinical staff we met were ‘bare below the elbows’ to allow effective hand washing in line with best practice guidance. We saw that staff carried alcohol hand gel clipped onto their uniform. There were also alcohol hand gel dispensers on the day ward, theatres and in the outpatients department. We observed staff appropriately using alcohol hand gel to clean their hands.
- We saw hand hygiene observation sheets for children. These were simple forms, illustrated with pictures of different staff groups. Staff asked children to indicate yes or no as to whether they saw staff clean their hands at the point of care.
- We saw results from the children’s hand hygiene audit in July 2016. Nine children took part, and the results showed 100% of staff (nine nurses and one pharmacist) cleaned their hands.
- The hospital introduced hand hygiene boards in paediatric areas in July 2016 to help educate children on the importance of good hand hygiene. We saw these boards in the outpatient waiting room and the day ward during our inspection. The boards used child-friendly pictures with monkeys to explain the importance of washing hands before eating.

Environment and equipment

- We saw paediatric resuscitation trollies in the recovery area in theatres, on the day ward and in the outpatients department. We also saw a paediatric grab bag in the radiology department, with clear signage to show staff where it was kept. Staff checked the paediatric emergency equipment daily to ensure the seals were intact and no items were missing. We saw checklists in all areas showing they had carried out daily checks with no gaps.
- We checked the emergency drugs and single use equipment in all the paediatric resuscitation trolleys. We found all single use equipment and drugs were within the recommended use by dates. Staff checked the entire contents of the trolley weekly to ensure all items were within their recommended use by dates. We saw fully completed checklists showing staff had done this in all areas. This provided the hospital with assurances all paediatric resuscitation equipment was available and safe to use.
- We saw labels providing evidence of recent electrical safety testing on the portable suction units on the paediatric resuscitation trolleys. We also saw that the defibrillator on the day unit had a label showing evidence of recent electrical safety testing. This provided the hospital with assurances around the electrical safety of these items.

- We saw labels providing evidence of recent electrical safety testing on the treatment couch and paediatric weighing scales in consulting room three. We also reviewed the outpatient's equipment folder, and saw evidence of servicing for all equipment in the rooms used by CYP. An outpatient's sister told us she checked the folder each month and arranged servicing for any items approaching the end of their service period. This provided assurances equipment was safe and fit for purpose.
- In outpatients, we saw appropriate paediatric equipment available to staff treating CYP. This included blood pressure cuffs, weighing scales, and ear nose and throat equipment.
- We saw the correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks. The sharps bin in consulting room three was raised high up off the floor. This ensured it was out of the reach of young children to prevent injury.

Medicines

- We reviewed 10 sets of notes for CYP who had surgery at the hospital. In all 10 sets of notes, we saw staff had recorded information about any allergies, as well as the child's weight. This enabled safe and appropriate prescribing.
- In the outpatients department, a doctor told us they had access to copies of the Paediatric British National Formulary (BNF). These books provided doctors with guidance on the safe prescribing of medicines for CYP. A nurse showed us the Paediatric BNFs, and we saw the service used the most up-to-date version available.
- For details of the hospital's pharmacy arrangements and information about medicines on the ward and in theatres, see information under this sub-heading in the surgery section of this report.

Records

- We reviewed 10 sets of CYP's notes and saw thorough, clear and legible documentation in all records. This was in line with General Medical Council (GMC) guidance.
- We saw the 2016 records audit for CYP. The audit looked at nurse documentation for 10 patients who had minor operations. We saw that in 100% of cases, nurses had recorded the child's height and weight. This was in line with the Royal College of Nursing (RCN) guidance, "Standards for the weighing of infants, children and young people in the acute health care setting" (2013). However, only 60% of records provided evidence a paediatric nurse attended the procedure in line with hospital policy. We saw that the lead paediatric nurse fed back to staff and reminded them of the importance of thorough documentation. In the records we reviewed, staff had signed each entry and there was a staff signature identification form present in every set of notes. This demonstrated the service had addressed the issues identified from the audit.
- The hospital stored records securely on site in their medical records department. Patient records never left the hospital to minimise the risk of confidential data loss. However, consultants kept their records in locked filing cabinets in their offices. As consultants' records were not integrated into the patient's medical notes, this may have made it difficult for all members of the multidisciplinary team to easily access all the information they needed to assist with clinical decision making. This is not in line with the Health and Social Care Act 2008 (regulated activities) Regulation 2014 which requires the registered person to: ' maintain securely an accurate , complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided'. Keeping separate file notes in this manner did not meet the requirement of the regulation and because of this, our rating lowers to 'requires improvement' for safety. The way the records were kept added to the risk that papers could be separated or misfiled, which was an unsafe practice. In addition, separating the medical records in this way made it harder for staff to monitor the results of treatments and the patient's progress.

Assessing and responding to patient risk

Good

Services for children and young people

- We saw the hospital's CYP service provision statement. This set out clear admissions criteria for surgery, as well as inclusion criteria for all outpatient and diagnostic imaging services. The hospital did not accept children under the age of three for surgery. The hospital only accepted children age three and over for elective surgery any did not accept any emergency surgery admissions. The hospital also did not admit CYP with additional pre-existing conditions, with the exception of mild respiratory or skin conditions such as asthma or eczema. This enabled the hospital to provide a safe level of service for children's surgery as it did not have level two or three critical care facilities should a child need this level of support after surgery.
- The hospital had a service-level agreement with an adjacent NHS hospital. This allowed them to transfer any patients who became unwell after surgery and needed critical care support. There was an emergency corridor linking the Nuffield Guildford theatres to the critical care unit in the NHS hospital. This enabled rapid transfer of a deteriorating patient. However, no CYP needed a transfer between July 2015 and June 2016.
- We saw a red telephone on the ward. The CYP lead told us staff could use this telephone to activate a cardiac arrest call. The line provided a direct link to the resus team at the adjoining NHS hospital to enable rapid assistance in the event of a cardiac arrest.
- All CYP had a pre-operative assessment before surgery. The service aimed to carry out face-to-face assessments for all patients. However, some children had a telephone assessment if they had difficulty attending a hospital appointment, for example, if they lived far away. The service carried out a pre-assessment audit in July 2016. We saw that 71% of patients had a face-to-face assessment and the remaining 29% had a telephone assessment. All children had their pre-operative assessment with a registered children's nurse in line with the Nuffield "children and young people in hospital" policy.
- The service used the national Paediatric Early Warning Score (PEWS) charts for all CYP admitted for surgery. PEWS is a simple scoring system of physiological measurements (for example, blood pressure and pulse) for patient monitoring. This allowed staff to identify deteriorating patients and provide them with additional support. All 10 records we reviewed showed staff had consistently completed PEWS observations and escalated for further support where appropriate.
- The service used the "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" for all children's operations. The WHO checklist was a national core set of safety checks for use in any operating theatre setting. Its purpose was to reduce the risk of preventable errors and adverse events during surgery. We saw theatre staff had fully completed the WHO checklist in the 10 sets of records we reviewed. The hospital audited compliance with the WHO checklist on 25 sets of notes every month. We saw the results for June 2016, which demonstrated an overall compliance rate of 96%. However, we were unable to observe staff completing the checklist as no children's operations took place during our visit.

Safeguarding

- Data showed that 11 members of staff at the hospital had level three safeguarding children's training. This included registered children's nurses, the ward manager, the theatre manager, the deputy theatre manager, the RMOs and the senior management team.
- The hospital had systems to ensure children were always under the care of staff who held national safeguarding children's level three training in line with the national intercollegiate guidance, "Working together to safeguard children" (March 2015). The hospital only booked surgery for CYP once the CYP lead nurse confirmed availability of a registered children's nurse to care for the child. We saw rotas showing that the CYP lead arranged bank registered children's nurse cover when needed. All consultants who carried out surgery or saw CYP in outpatients provided evidence of level three safeguarding children's training as part of their practicing privileges agreement. This was in line with the corporate Nuffield Health Safeguarding policy
- The hospital's annual safeguarding report 2015 showed 100% of required staff completed national safeguarding children level three training. This was better than the Nuffield Health mandatory training target of 85%.
- All other staff that had contact with CYP had national safeguarding children level two training. This was in line with the national intercollegiate guidance and the

corporate Nuffield Health safeguarding policy. In November 2016, hospital data showed that 151 out of 152, or 99% of required staff, had up-to-date training. This was better than the Nuffield Health mandatory training target of 85%.

- The hospital's annual safeguarding report 2015 showed the hospital made three child safeguarding referrals to the local safeguarding authority in 2015. We saw that all referrals were appropriate. A medical secretary identified one of the children at risk. The secretary had recently completed their level one safeguarding training at the time of the referral. This was an appropriate level of training for staff working in a healthcare setting who did not come into direct contact with children in accordance with the intercollegiate guidance. This demonstrated that safeguarding training enabled all staff to identify and report safeguarding concerns.
- Staff we spoke to demonstrated good awareness of how to report safeguarding concerns. We saw adult and child safeguarding flow charts displayed in the staff rooms on the day ward and in outpatients. These served to remind staff of the correct processes. Staff could identify the matron as the hospital's child safeguarding lead.
- The lead children's nurse told us the hospital issued yellow and blue wristbands to the visitors of all children admitted to the hospital for surgery. This ensured staff could easily identify children's visitors. Staff also escorted visitors to the child's room and ensured the child and parents were happy for the visitor to stay. This hospital's local abduction policy reflected the arrangements for visitors, and provided clear guidance on the supervision of children in hospital.
- Staff told us all children had a parent or guardian with them when they attended for surgery. We saw notices inside the children's bedrooms on the ward reminding parents or guardians to advise a nurse if they were leaving the room.
- Staff told us the hospital would designate a Healthcare Assistant (HCA) to stay with any child under the age of 12 at all times if their parent or guardian did not stay. We saw that this was in line with the hospital's abduction policy and the corporate Nuffield Health chaperone policy.

Mandatory training

- We reviewed mandatory training data for staff involved in the care and treatment of CYP. This showed 97% of relevant staff had up to date mandatory training in November 2016. This was better than the Nuffield Health mandatory training target of 85%.
- Please see the Surgery section of this report for the main findings relating to mandatory training topics.

Nursing and support staffing

- Children's care was planned, delivered and/or supervised by the registered children's nurses. At the time of our visit, the hospital employed one whole-time equivalent (WTE) CYP lead sister, one WTE paediatric sister in the outpatient's department, and one 0.4 WTE paediatric staff nurse on the day ward. There was also a dual-trained adult and children's nurse on the medical ward who could help care for children if needed. There were no vacancies for registered children's nurses.
- The service used a staffing ratio of one registered children's nurse to three surgical patients. The service only accepted children aged three and over for surgery in line with the hospital's CYP's service provision statement. This ratio was better than the Royal College of Nursing (RCN) recommendation of one registered children's nurse to four patients over the age of two. This was the standard for bedside, deliverable hands-on care set out in the RCN's 2013 guidance "Defining staffing levels for children and young people's services".
- The hospital ensured the service maintained its nursing staffing ratio by only booking surgery for CYP once the CYP lead nurse confirmed availability of a registered children's nurse to care for the child. We saw rotas showing that the CYP lead arranged bank registered children's nurse cover when needed. Since September 2016, the service had used a regular bank nurse. This ensured the service used bank staff that were familiar with the hospital's policies, staff and environment. Occasionally, the service used agency registered children's nurses to fill any gaps. Staffing rotas showed the service had only used an agency nurse on one occasion between September 2016 and the time of our visit to cover annual leave.
- Most CYP who had surgery at the hospital attended for a day case procedure. Hospital data showed only 35 CYP under 18 stayed overnight between July 2015 and June

2016. The CYP lead sister provided night time nursing care whenever there was a child in the hospital overnight. This meant there was access to a senior children's nurse at all times in line with RCN guidance.

- Young people aged 13 to15 attending for outpatient appointments had a risk assessment as to whether they needed an allocated paediatric nurse. This was in line with the Nuffield "children and young people in hospital" policy. We saw the risk assessment form staff used. There was clear guidance accompanying the form. This stated that any young person who was extremely anxious, under 40kg in weight, or had existing co-morbidities, learning difficulties or disabilities should have an allocated paediatric nurse for all outpatients appointments. We reviewed four weeks of minor procedures data between August and September 2016. The data showed that all young people who needed a paediatric nurse in attendance for their procedure during this period had one.
- Hospital data showed four members of staff had advanced paediatric life support training (APLS) or European advanced paediatric life support (EPALS). This included the CYP lead, and we saw the CYP lead's certificate providing evidence of up-to-date EPALS training. The CYP lead allocated rotas to ensure APLS/ EPALS trained staff were on shift on days the service scheduled children's surgery.

Medical staffing

- All paediatric patients were under the care of a named consultant. There were two consultant paediatricians with practicing privileges within the hospital. Both consultants held substantive posts within the NHS. This meant they regularly practised when not working at the Nuffield Guildford Hospital, which kept their skills current. As part of the corporate Nuffield Heath "practicing privileges policy", consultants could only carry out the same procedures they performed in their NHS role unless they could provide evidence of adequate training, competence and experience.
- Four resident medical officers (RMOs) worked at the hospital. There were always two RMOs on duty at any given time. The RMO work pattern was 24-hour cover for seven days followed by seven days' rest. Data provided by the hospital showed all RMOs had an in date APLS certificate. This ensured there were always staff with advanced paediatric life support training available in the hospital at all times.
- All patients received contact details for the ward and their consultant's secretary on discharge. CYP and their parents or guardians could contact the ward 24 hours a day with any post-operative concerns. The ward could subsequently contact the patient's consultant out-of-hours to review the patient if necessary. We saw the hospital's policy for "on call processes during off peak periods". The policy stated consultants and anaesthetists should be contactable to review recently discharged patients out-of-hours where necessary. This requirement also formed part of consultants' practicing privileges agreements. The corporate Nuffield Heath "practicing privileges policy" stated, "The admitting medical practitioner, anaesthetist or their duly nominated colleague, must be available at all times in case of emergency for all patients for whom they are responsible and be available to attend the patient within an agreed time period – usually not more than 30 minutes."
- If ward staff were unable to contact a patient's consultant in an emergency, the hospital had a service level agreement (SLA) with a local NHS trust for 24-hour access to paediatric consultant and anaesthetist cover. Staff reported good working relationships with the local NHS trust. An emergency corridor connected the Nuffield Guildford Hospital with the local NHS hospital. This allowed quick and easy medical attendance within 30 minutes in an emergency.

Emergency awareness and training

- For details of the main findings, see information under this sub-heading in the surgery section of this report.
- The hospital provided emergency scenario training for situations including major haemorrhage and resuscitation. We saw feedback given to staff following a paediatric resuscitation exercise in July 2016. We saw that the feedback identified areas for improvement, including leadership and communication. This helped staff to refresh their skills and knowledge in this area.

Good

Services for children and young people

Are services for children and young people effective?

Good

We rated effective as good

Evidence-based care and treatment

- Staff had access to hospital and corporate policies and procedures through the hospital's intranet. Staff we spoke to knew how to access the policies and procedures they needed to do their jobs.
- We reviewed the hospital's policies relating to children and young people (CYP). All policies we saw were within their review date. We saw that the hospital based its CYP policies on relevant and current evidence-based guidance and standards. These included National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) guidance. For example, the hospital's nutrition and hydration standard operating procedure (SOP) for children referred to the most recent 2014 RCN guidance on screening for malnutrition. The child resuscitation policy referred to the Resuscitation Council (UK) and the National Patient Safety Agency.
- The hospital audited compliance against local and corporate policies. We saw a 2016 audit to assess compliance against the admission criteria for tonsillectomy in children less than five years old. Tonsillectomy is an operation to remove the tonsils. The tonsillectomy audit showed all children under the age of five met the minimum weight limit for surgery of 15kg. This meant the hospital had 100% compliance with the patient admission criteria set out in the corporate SOP.
- The hospital's comprehensive audit schedule relating to CYP covered a range of areas. We also saw audit data on minor operation documentation; pain, nausea and vomiting management; pre-assessment and consent.

Pain relief

- The hospital used age appropriate tools for the assessment of children's pain after surgery. For example, with young children, staff used a chart with faces so that children could easily identify their level of pain. We reviewed 10 sets of patient notes and saw staff had consistently assessed and recorded children's pain with every set of observations.
- CYP patient satisfaction questionnaires from November 2015 to September 2016 showed 100% of patients who experienced post-operative pain felt staff did everything they could to control it. During this period, 49 patients responded to the questionnaire.

Nutrition and hydration

- The hospital's fasting policy for children's surgery was nil by mouth for six hours before admission, with the exception of clear fluids up to the child's admission time. The hospital scheduled children's operations at the start of the theatre list to avoid prolonged fasting in young children.
- The hospital had specific menus for children. We reviewed the children's menu and saw there were a range of child-friendly choices, including options for vegetarians. The catering staff could also provide meals for children with food allergies and intolerances on request.
- The hospital had a dietician who could provide additional support if needed. The dietician had a special interest in paediatric nutrition, including allergies and feeding difficulties, coeliac disease and weight management.
- The service carried out a hydration and nutrition assessment at pre-operative assessment. We saw that the assessment form included an action plan for any child identified as over or underweight. However, we reviewed 10 sets of notes and saw that most, but not all patients, had evidence of a hydration and nutrition assessment. This meant the service may not have fully identified the nutritional needs of all CYP before they were admitted for surgery.

Patient outcomes

- The hospital reported no paediatric readmissions between July 2015 and June 2016. The hospital performed 416 operations on CYP under 18 years old during the same period.
- The hospital reported no unplanned transfers to other hospitals with critical care facilities between July 2015

and June 2016. The hospital benchmarked readmission and transfer data against other hospitals in the Nuffield Health group. This allowed them to monitor their performance.

- The hospital monitored outcome data for CYP in terms of readmission, reoperations and infections as part of their standard key performance indicators (KPIs). The clinical governance team monitored KPI data and raised any concerns with the matron for further analysis.
- With the exception of readmission and transfer data, the service used patient satisfaction surveys to measure patient outcomes. The service carried out monthly patient satisfaction audits for CYP. Patient satisfaction results can be very subjective and may not always provide a robust tool for measuring outcomes.

Competent staff

- Hospital data showed 100% of relevant nurses completed up-to-date professional revalidation between July 2015 and June 2016. This meant the hospital had assurances all nurses were competent and fit to practice.
- Hospital data showed 100% of doctors working under practising privileges between July 2015 and June 2016 provided evidence of up-to-date professional revalidation. This meant the hospital had assurances all doctors were competent and fit to practice.
- Hospital data showed 100% of staff who cared for CYP had an up-to-date appraisal at the time of our visit. This meant the service regularly reviewed staff performance and held assurance around staff competencies.
- We reviewed the competency folders for three registered children's nurses. We saw evidence of competency assessment in a range of areas relevant to their role. This included the use of medical devices, completion of paediatric early warning (PEWS) charts and medicines management. This provided the hospital with assurances that the registered children's nurses were competent to work unsupervised in relevant areas.
- For the main findings relating to the granting and renewing of consultant practicing privileges, see information under this sub-heading in the surgery section of this report.

Multidisciplinary working

- The service held CYP meetings every other month. We saw meeting minutes, which showed representation from a range of staff groups. This included nurses, pharmacists, radiographers, theatre staff and housekeeping.
- The hospital had a multidisciplinary paediatric governance committee, which met quarterly. We saw meeting minutes, which demonstrated involvement from a range of staff groups including consultants of different specialties, nurses, radiographers, and allergists.
- The hospital had a physiotherapist who provided therapy to CYP where relevant. The physiotherapist attended pre-operative assessments to assess the physiotherapy needs of CYP before their surgery. This also allowed CYP to meet the physiotherapist in advance to help them feel more at ease with a familiar member of staff after their surgery.
- The hospital had a service level agreement (SLA) for access to the on-call paediatric consultant within the local NHS trust. We saw the hospital's policy for "access to a consultant paediatrician", which gave contact details so staff could access specialist paediatric support. Staff reported good working relationship with the local NHS trust and could contact consultants for support if needed.

Seven-day services

- The hospital carried out most CYP surgery as day case procedures. Between July 2015 and June 2016, 371 out of 416, or 89% of operations on CYP under 18 years old were day-case procedures. Any children who needed to stay overnight received care from a registered children's nurse throughout their hospital visit.
- For CYP who needed an overnight stay, see information under this sub-heading in the surgery section of this report for the main findings relating to access to imaging and other seven-day services.

Access to information

- See information under this sub-heading in the surgery section of this report for the main findings.
- Consultants' secretaries typed discharge letters. Staff sent one copy in the post to the child's GP and a further copy to the patient or guardian following discharge from

hospital. This allowed continuity of care in the child's community and kept the child and their parent or guardian fully informed of the next steps. Staff also contacted the child's health visitor if necessary to provide further support to the patient and family.

- A registered children's nurse described the discharge process. Consultants saw the patient along with their parent or guardian and gave verbal advice. A registered children's nurse gave additional information, including wound care and advice on medications to take out. The nurse gave all patients a 24-hour contact number at discharge. This allowed CYP or their parents or guardians to contact a nurse for advice if they developed any concerns after they went home. We saw documentation of discharge processes in the 10 sets of notes we reviewed. However, there were no CYP discharges during our visit; therefore, we were unable to observe this process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consultants took consent, and assessed Gillick competence for children under the age of 16. This was the statutory process for assessing that children under the age of 16 were competent to make decisions about their own care and treatment. We saw a copy of the hospital's SOP for the assessment of Gillick competency available to consultants taking consent in the outpatient's department. The SOP referred to the current GMC guidance for assessing capacity to consent.
- We reviewed 10 sets of notes and saw that all had a fully completed consent form for surgery. We saw that children had provided consent where a consultant had assessed them as Gillick competent. For young children, or those not deemed competent to consent, we saw that a parent or guardian had consented on their behalf. This was in line with NMC and GMC guidance on consent.
- We saw the results of a CYP consent form audit from June 2016. The service audited 12 sets of notes for children aged 12 and over. The audit showed 100% of patients had either provided consent if they were deemed Gillick competent, or co-signed the consent form along with their parent or guardian if they were not. Co-signing the form allowed children who were not Gillick competent to demonstrate involvement in decisions about their treatment. This is in line with GMC guidance, "Consent: patients and doctors making decisions together" (2008). The guidance stated, "You should involve children and young people as much as possible in discussions about their care, even if they are not able to make decisions on their own".
- The consent form audit also showed the consultant taking consent had documented the risks of surgery in 100% of cases. This demonstrated patients and their parents or guardians were fully informed of any potential risks. This allowed them to make an informed decision about whether to proceed with surgery.
- However, the consent form audit also showed staff only documented the benefits of surgery in 10 out of 12, or 83% of cases. To address this issue, the service printed up-to-date information leaflets describing the benefits and risks of different operations. Staff gave the leaflets to CYP and their parents or guardians at pre-assessment.

Are services for children and young people caring?

Good

We rated caring as good

Compassionate care

- Staff interacted with patients in a respectful and considerate way. We saw a nurse explaining the process and plan for a child's elective admission to a parent. We also saw a doctor introducing himself to a parent while nurses admired the baby.
- Staff interacted with patients in an encouraging, sensitive and supportive manner. Nurses we spoke with repeatedly cited the hospital's ethos of providing compassionate care, a Nuffield Health value. A children's nurse we spoke with explained that she had time to build a rapport with patients and families and could provide reassurance and support to patients and families. This was because the nurse-to-patient ratios were high in the department.

- We saw patients' privacy and dignity being respected. For instance, staff took patients to a consulting room to discuss their treatment. We saw no confidential or sensitive information discussed in public areas.
- The hospital audited children and young people's inpatient communications between April and June 2016.The audit reflected that in April 2016, 68% of patients were pre-assessed face to face while 15% were pre-assessed by phone. In May 2016, 100% of patients were pre-assessed face to face; and in June 2016, 85% of patients were pre-assessed face-to-face and 15% by phone. The service encouraged patients and their parents or guardians to attend in person.
- We reviewed reports from CYP's feedback forms from January to September 2016 from patients aged three to 15 years old. During this period, 65 children completed a feedback form.
- The feedback forms reflected that 100% of patients felt that they could ask questions at the pre-assessment visit. Between 95% and 100% of patients felt that they were given enough information.
- Patient feedback from June through September 2016 reflected that 45% experienced pain and 55% did not but 100% responded that the nurse helped them with their pain. One patient stated, "The nurse always asked if I had any pain".

Understanding and involvement of patients and those close to them

- Staff interacted with both patients and their families so they would understand the care, treatment and condition. This was in line with the Royal College of Surgeons "Standards for Children's surgery- Patients and Families" (2013).
- A consultant reported that he communicated with the patient and their parents or guardians about the child's illness or injury and the treatment. The consultant explained he communicated with children by bringing himself down to their level and using instructive pictures and props. He demonstrated how he used an online search engine to access explanatory pictures and showed us his cartoon stool chart, which he used to discuss bowel movements with children.
- A parent we spoke to explained that communication with them and their child was thorough. The parent explained that her child had been treated on several occasions at the hospital. The consultant always explained the child's illness and treatment to both the parent and child so that both would understand. She stated that staff were always present, available and responsive to questions.
- Staff recognised when people who used services and those close to them needed additional support to help them understand and be involved in their care and treatment. Each patient had a named children's nurse who supported the patient and their family from pre-assessment through the care pathway. Patients met with the nurse, consultant and anaesthetist before surgery to discuss concerns.
- A consultant explained that when treating adolescents, he only included parents or guardians with the young person's consent.This was in line with the accessibility criteria outlined in the Department of Health guidance, "You're welcome: Quality criteria for young people friendly health services" (2011).
- One patient, who provided feedback between June and September 2016, noted that, "I met the nurse that looked after me after my surgery at pre-assessment, this made me less anxious".
- On discharge, the service provided patients and their parents or guardians with contact information so that they could contact the nurses with any concerns. The nurses also followed up with patients after surgery by phone within 48 hours.
- However, the audit of CYP inpatient communications from April through June 2016 reflected that patients did not always speak to nurses after discharge. In April, 36% of patients received post- op phone calls, in May 40% received post- op phone calls and in June 34% received post- op phone calls. The lead children's nurse explained that all patients would have been called on two occasions but the numbers reflect only the patients who answered the calls. She advised that staff documented these calls.
- Patient feedback from January to September 2016 reflected that 100% of patients felt that they were involved with decisions about their care and treatment. This was in line with the Royal College of Surgeons "Standards for children's surgery- patients and families" (2013).

Good

Services for children and young people

Emotional support

- Staff understood the impact of their care on the CYP who they cared for as well as their families. Staff reported that they are able to spend the necessary time developing a rapport with the patients and their families. Nurses provided emotional support in their interactions with children and their families. They also supported the patients with distraction techniques whilst they were in or outpatients.
- CYP attended for pre-operative assessment on the day ward. This allowed them to familiarise themselves with the environment they would recover in after surgery. Registered children's nurses carried out the pre-operative assessment. This allowed CYP to get to know the staff that would look after them before and after their operation.
- A registered children's nurse explained that they provided a holistic service which looked after and empowered the entire family by providing them with information and reassurance tailored to the needs of the individual patient and family.
- For minor procedures, parents or guardians could remain with their child during the procedure. For major procedures, one parent or guardian was permitted in the preoperative anaesthetic room and the post-operative recovery room.
- Family were enabled to be with the patient in whatever way best suited the circumstances. There were no set visiting hours, family could visit children at whatever times suited them and could spend the night in the child's room on a bed if they chose.
- A consultant we spoke with explained the importance of children understanding their own condition. He described how he explained the patient's condition and treatment directly to the patient in an age appropriate manner. He also educated families to appreciate the significance of the child understanding his or her own condition.

Are services for children and young people responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The service was flexible in meeting the needs specific to CYP. For instance, the service offered outpatient appointments for CYP during the afternoon and weekends so that families can attend during non-school hours.
- The lead children's nurse explained that the number of surgery appointments spikes during school holiday periods. For instance, the hospital has scheduled 20 surgeries for CYP during December. This scheduling is for the patient's convenience so that CYP can be treated and recover during the school holidays.
- Where needs were identified but were not met, the service was developed to address this. One parent explained that parking at the hospital had previously been "terrible" but that a parking attendant had addressed the matter. The parking situation was still "not great" but was now better as the attendant had directed her to a parking space. The hospital had also started bussing staff from a nearby car park so that more parking spaces were available at the hospital.
- We saw that patient feedback was reviewed and actions were set to respond to the feedback. For instance when there were complaints about food options for CYP, nurses began discussing food with patients before admission.
- We observed children's rooms that were responsive to children's needs in accordance with the environmental criteria outlined in Department of Health guidance, "You're welcome: Quality criteria for young people friendly health services" (2011).
- The children's room on the ward which we saw was decorated with the 'Nuffield Monkey' motif. There was

Wi-Fi, TV and a box of books and games for children of differing ages that were clean and in good condition. Matron told us that tablets were purchased for CYP and they were awaiting delivery.

- There was a footstool in the bathroom so that children could reach the sink. Two brightly coloured, informative posters reminded children of "hand hygiene moments'" and answered the question, "what germs are on your hands?"
- Outside the children's rooms on the ward, we saw a brightly coloured hand hygiene bulletin board for children. It provided child friendly information about how, when and why to wash your hands. We also observed a variety of children's books, "Kids Change for Life" pamphlets and a monkey themed hand-washing poster on the wall outside.
- In the outpatient department, we observed a children's consultation room decorated with the "Nuffield Monkey" motif. We saw that the room had children's books for a range of ages and toys including a motorcycle, cars, dinosaurs and a rubix cube.
- We saw that literature was child-focused. For example, take home diaries included pictures for children who could not read.

Meeting people's individual needs

- CYP services were directed towards the needs of children and families. Local policy required a children's nurse to be responsible for admission, pre-operative and post-operative care of CYP.
- There were publications directed to children available at the entrance of the hospital, in the outpatient waiting room and on the ward. "A Visit to Outpatients" was a Nuffield specific leaflet explaining what a child can expect when visiting the hospital. It featured "Nuffy" the bear, child friendly language and cartoon pictures.
- "Archie and Theo's Special Day Out to the Guildford Nuffield Hospital" was a booklet for children about hand washing. The book featured child friendly language, large print and colourful art. We saw one child reading the booklet and another carrying one as she left the hospital.
- The service had access to interpreters of different languages for patients who spoke limited English. We saw posters with contact details for telephone translators, face-to-face translators, sign language interpreters and lip readers on the wall in the staff rooms in outpatients and on the ward. Staff in outpatients were able to describe the processes for booking interpreters.
- Staff provided child-friendly menus for children recovering from surgery. Patient feedback on the children's menu was largely positive. Patient satisfaction questionnaire results from November 2015 to September 2016 showed 98% of patients were happy with the quality and choice of food. The hospital also provided a meal from the adult menu for parents or guardians of children recovering on the ward after surgery.
- The hospital's standard operating procedure, "Criteria for children and young people undergoing surgery" specifically excluded patients with pre-existing conditions and emergency acute admission (except for readmissions). As a result, the department did not treat CYP with complex needs.

Access and flow

- Staff explained that pre-assessment appointments, generally with the named nurse, were tailored around the inpatient list and school needs (for instance after school appointments). One parent told us that they had been offered a 5pm appointment time which meant that the father could be present after work.
- Hospital data showed there were no cancelled paediatric operations for non-clinical reasons between July 2015 and June 2016.
- A registered children's nurse explained that the service provided more paediatric surgery in school holidays to meet the needs of families. This minimised the amount of time children needed to take off school for their operation. Staff explained that some minor procedures in outpatients took place on Saturdays.
- The service scheduled paediatric operations at the start of theatre lists. This helped minimise anxiety for children waiting for surgery. Children were recovered in an appropriate children's recovery area.

Good

Services for children and young people

- The hospital prioritised treatment for urgent cases. We spoke to one parent who explained that this was her child's first appointment at the hospital. The parent had called for an urgent appointment and been given an appointment for three days later.
- The parent told us that the receptionist had said that she would try to set up an urgent appointment and did so. The receptionist explained that had she not able to set up an urgent appointment, she would have escalated the matter to a manager. This would assure that the patient was seen as a matter of urgency.
- One parent reported that scheduling appointments was easy, she could set up appointments by phone at convenient times and that staff supported her in the process.
- The hospital's audit of outpatient paediatric waiting times for February 2016 (the most recent provided) reflects that patients waited, on average, 5.08 minutes for their appointments that month. During our visit, we witnessed patients waiting for less than five minutes for their appointments.
- The hospital performed a monthly audit measuring CYP radiology wait times on one day per month April through July. The audit reflects that across the four days, 50 CYP patients attended the radiology department; 41 waited less than five minutes and nine waited less than 10 minutes.

Learning from complaints and concerns

- People are able to complain to the hospital verbally or in writing. There is information about how to complain on the Nuffield Guildford website. On the website, there is a form for patients to use or a pamphlet called "How to Make a Comment or Formal Complaint". The pamphlet directed patients to the hospital director or general manager at the hospital where patients were treated and explained the complaints process.
- We reviewed the four complaints raised about services provided to CYP between July 2015 and September 2016. Three complaints were verbal and one was submitted in writing.
- Each of the complaints received a written response comprising recognition of the issues underlying the complaint and an apology. Where appropriate, the letter also outlined the compensation offered and the steps that the hospital was taking to share learning from the complaint.
- However, the complaints pamphlet "How to Make a Comment or Formal Complaint" stated complainants would receive a written response within 20 days. The complainant received a written response in that timeframe.
- Children were provided with child-friendly feedback forms, which invited them to describe their experience in pictures and words. This was in line with the "Young people's involvement in monitoring and evaluation of patient experience" criteria outlined in the Department of Health guidance, "You're welcome: Quality criteria for young people friendly health services" (2011). The form provided spaces to describe one positive and one negative aspect of their hospital experience. We observed three of these competed forms on the bulletin board on the ward.
- Minutes from the 10 August 2016 Patient Experience meeting reflected that learning from complaints was considered and shared. For instance, when the parent of a patient complained about the poor attitude of a secretary, the feedback was shared with the secretary and discussed at a patient experience meeting. The Hospital Director explained how this learning was shared in the response letter to the complainant.
- The hospital offered "stage three" external complaints adjudication through the Independent Sector Complaints Adjudication Service (ISCAS). ISCAS would only review a complaint after it had been through stages one and two of the hospital's internal complaints process. No complaints for CYP had escalated to ISCAS in the year before our visit. This suggested that the service was able to satisfactorily resolve complaints and concerns without the need for escalation.
- The patient experience group reviewed patient complaints. They produced a patient experience newsletter in November 2016, reflecting general themes. The newsletter reviewed positive and negative commentary, the importance of communication to the patient experience and actions taken in response to feedback.

Good

Services for children and young people

Are services for children and young people well-led?

Good

We rated well-led as good

Vision and strategy for this this core service

- See information under this sub-heading in the surgery section of this report for the main findings.
- The senior management team (SMT) told us CYP services were one of the areas they were proud of. In particular, the SMT were proud of the paediatric clinical governance committee and the dedicated children's rooms on the day ward.
- The hospital were keen to build on this success by developing and expanding the CYP service. We saw that leaders shared the vision to grow the service with staff at a paediatric governance committee meeting in October 2016. The CYP lead nurse was able to describe the vision for the service. This showed the vision was shared and understood by relevant staff.

Governance, risk management and quality measurement

- See information under this sub-heading in the surgery section of this report for the main findings.
- The service had a CYP clinical governance committee, which met every other month. We saw copies of the meeting minutes. The CYP lead nurse led the committee. A paediatric consultant and the matron attended the meetings. We also saw multidisciplinary representation from other staff groups involved in the care and treatment of CYP. This included radiology, outpatients and allergy. The CYP clinical governance committee fed into the monthly hospital clinical governance committee chaired by the matron. The clinical governance committee provided quality and safety assurances to the hospital board.
- The hospital had a medical advisory committee (MAC), which met quarterly. We saw copies of the minutes and saw that a consultant paediatrician represented CYP services on the MAC. The MAC provided the formal structure through which consultants communicated and reviewed practicing privileges. The MAC provided quality and safety assurances to the hospital board.
- There was no local risk register for CYP. However, the hospital recorded any risks relating to services for CYP on the hospital risk register. We saw the hospital recorded services for CYP as an area of moderate risk in December 2015. This was related to the service lacking a CYP lead nurse and lack of governance processes. The hospital later downgraded CYP services to a low risk following improvements to the service. During our visit, we saw that the hospital had fully addressed the areas of risk. This included appointing a permanent CYP lead nurse and a CYP outpatients' sister, the introduction of an audit schedule, and a dedicated paediatric clinical governance committee.
- We asked the CYP lead nurse about the main areas of risk for CYP services. She told us these were the environment (by having children and adult patients in the same areas) and safeguarding. We saw the service took action to mitigate these risks. For example, we saw copies of integral risk assessments for CYP carried out in November 2016. The service completed risk assessments for the inpatient rooms on the ward, the phlebotomy clinic, the paediatric waiting room and play area, the dental room, and other areas of outpatients and diagnostic imaging. The assessments identified no high risks.
- The safeguarding lead did not attend local safeguarding children's board meetings. This meant feedback of learning from serious case reviews (SCRs) in the local area was not available to staff.

Leadership / culture of service related to this core service

- See information under this sub-heading in the surgery section of this report for the main findings.
- A senior registered children's nurse led the hospital's services for CYP. The CYP lead nurse started working at the hospital in June 2016. We saw evidence of positive changes since the CYP lead nurse joined the service. This included increased audit activity. Another registered children's nurse spoke positively of the CYP lead nurse's leadership and described her as "supportive".

Good

Services for children and young people

- Staff working with CYP spoke positively of the culture. The CYP lead nurse felt adult trained staff were supportive of CYP services. Staff felt the matron offered plenty of guidance and said they received praise when things went well. This helped them to feel valued. One member of staff described the culture as a "very supportive family team".

Public and staff engagement

- The hospital public and staff engagement processes have been reported on under the surgery service within this report.
- The hospital introduced a children's experience forum in July 2016. We saw the action log from the first meeting. This showed areas the service had made improvements following feedback from staff and patients. For example, one completed action was to purchase a book rack and children's books for the outpatient's waiting room. We saw the books were there during our visit.

Innovation, improvement and sustainability

- The hospital planned to expand its range of services for CYP, as few other independent hospitals offered services for CYP in the local area. Paediatric clinical governance committee minutes from October 2016 stated the hospital planned to involve its sales and service manager to help grow the service.
- We saw that the service performed a range of audits to monitor compliance with policies and identify areas for improvements. We saw that the service took action to address any areas identified as needing improvement, such as documentation.
- The hospital recently set up a children's experience forum. The hospital also proactively sought the views of patients and their parents or guardians through monthly patient satisfaction surveys for CYP. We saw that the service considered the views of patients and staff and used this information to help improve the service. One example of this was improvements to the décor, such as the child-friendly "monkey theme" we saw on the walls in areas where children received care and treatment.
- A member of staff wrote a book for children coming to the hospital called "Archie and Theo's Special Day Out to the Guildford Nuffield Hospital." The booklet helped educate children about the importance of hand washing. Children also performed hand hygiene audits by completing a simple form by indicating which staff groups they saw cleaning their hands.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good

Incidents

- No never events related to the outpatients or diagnostic imaging departments were reported by the hospital in the period July 2015 to June 2016 as none had occurred. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital used an online software system for reporting incidents and monitoring trends. Staff described the process for reporting incidents, and gave examples of times they had done this.
- Staff demonstrated a good understanding of how to use the system. Staff told us feedback from incidents were discussed at departmental meetings. We saw minutes of meetings which confirmed this. Staff told us the hospital encouraged them to report incidents to help the whole organisation learn. Staff were able to give us examples of incidents that had been reported in the past.
- There were 69 clinical incidents reported between July 2015 and June 2016 in the outpatients and diagnostic imaging departments. The rate of incidents was higher than the other independent acute hospitals the Care Quality Commission (CQC) holds data for. However, we saw reported incidents were graded according to severity and all incidents reported were rated as either no or low harm. This is suggestive of a strong reporting culture.
- Incidents were investigated by the management team to establish the cause. The majority of incidents either related to issues with communication or post-surgical wound infections. These were then reported locally to departmental teams, the management board, the medical advisory committee (MAC).
- Staff in the diagnostic imaging department had a clear understanding of what was a reportable incident. A Radiation protection Advisor (RPA) was available for advice, by telephone if required. Staff showed us the incident reporting policy they followed for incidents where patients had received an unintended dose of radiation. Section 15 of the departments IR(ME)R 2000 medical exposures manual and standard operating procedures states: Clinical Incidents reportable under IRMER 2000: Exposures much greater than intended or unintended exposure to radiation not caused by equipment failure. It stated if a patient received a radiation dose much greater than intended or a patient is X-rayed by mistake, a report must be made to CQC.
- Staff said the dissemination of information regarding incidents and lessons learned was through electronic communications and their attendance at staff meetings. We also reviewed a sample of hospital wide clinical incidents, patient's notes and root cause analysis and saw evidence that staff had applied the duty of candour appropriately.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and

requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised and informed people of the actions they had taken.

- We saw operational staff understood their responsibilities with regard to the duty of candour legislation and we found the responsible manager ensured that the duty was considered and met when investigating safety incidents.

Cleanliness, infection control and hygiene

- There were no incidences of E-Coli, MRSA and MSSA bloodstream infections or cases of C.difficile related diarrhoea reported in the period July 2015 to June 2016 at the hospital as none had occurred.
- Patient-led assessments of the care environment (PLACE) are a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of the team to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance . In the PLACE audit 2016 Nuffield Health Guildford Hospital scored 100% which is better than the national average of 98% in relation to cleanliness and general building maintenance. The hospital score was the same or higher than the England average across all eight categories.
- The Matron was designated as the Director of infection prevention and control (DIPC). There was an IPC lead nurse who reported directly to the matron. There was corporate support with quarterly meetings which means practice can be benchmarked across the Nuffield group.
- We saw an annual IPC report 2015 which set out the plan for 2016. This was then monitored through a quarterly IPC committee meeting and was reported through to the quarterly clinical governance meeting and the Medical Advisory meeting (MAC). Minutes of both meetings demonstrated that this was happening.
- The IPC lead nurse had received appropriate training for the role and was being supported to continue studying for a master's degree. There were link nurses/staff in different departments of the hospital.
- All the areas we visited in the outpatients and diagnostic imaging departments were visibly clean and tidy and we saw there were good infection control practices. We saw the cleaning schedule for the rooms and toilets in the outpatients and diagnostic imaging departments were completed on a daily basis when the department was open.
- Staff were bare below the elbow and demonstrated an appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care.
- There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information was displayed demonstrating the 'five moments for hand hygiene' near hand washing sinks. Sanitising hand gel was readily available throughout the department.
- We saw personal protective equipment was available for all staff and observed staff use it appropriately.
- We saw disinfectant wipes were available in each room. Equipment was cleaned with these between each patient use and a green sticker placed on it to show it was. We saw equipment with green stickers on; this meant the equipment was clean and ready for use.
- We saw disposable curtains used in the treatment and consultation rooms. The dates on them indicated they had been changed within six months in line with manufacturer's guidance.
- Waste in the clinic rooms was separated and placed in different coloured bags to identify the different categories of waste. This was in accordance with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1)d. This required staff to place

secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.

- We saw the seating in the outpatients department was covered with a wipeable fabric. HBN 00-09 section 3.133 for furnishings states all seating should be covered in a material that is impermeable, easy to clean and compatible with detergents and disinfectants.

Environment and equipment

- The consultation rooms were equipped with a treatment couch and trolley for carrying the clinical equipment required. The rooms had equipment in them to provide physical measurements (blood pressure, weight and height). This was in line with HBN 12 (4.18) which recommends a space for physical measures be provided so this can be done in privacy.
- We saw equipment service records which indicated 100% of electrical equipment had been serviced in the last 12 months. Individual pieces of equipment had stickers to indicate equipment was serviced regularly and ready for use. We saw electrical testing stickers on equipment, which indicated the equipment was safe to use.
- We saw certificates to indicate staff were competent to use equipment which was in line with the hospital's medical devices policy.
- We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this a radiation protection committee reported annually on the quality of radiology equipment, which we saw. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000).
- Lead aprons were available in the diagnostic imaging department. We saw evidence which showed checks of the effectiveness of their protection occurred regularly and equipment provided adequate protection as per regulations.
- The ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000) state medical facilities operating X-ray machines are required to post 'in use' warning signs outside room doors. The diagnostic imaging department had warning signs in place to ensure patients and staff were safe.
- We saw confidential waste was managed in accordance with national regulations. Confidential waste areas were available in administration areas and we saw the certificates of destruction.
- Appropriate resuscitation equipment was available for both adults and children. In all cases there was evidence of daily checks to ensure the trolley tag/seal was intact and there was a checklist to show this was done with no omissions. Staff also checked the full contents of the trolley once a week and we saw a checklist to show this was done with no omission on any of the trolleys.
- Fire extinguishers were serviced appropriately and in prominent positions. Fire exits were clearly sign posted and exits were accessible and clear from obstructions.

Medicines

- The hospital had a monthly medicine management forum meeting, we saw evidence of these meetings, which contained a review of any national guidance or safety alerts, and when relevant, detailed how these were actioned. At alternate meetings safe management of medical gases was discussed. We also saw a review of any medicine management incidents recorded on the electronic reporting system and a record of actions taken with completion dates. We were told about a change of practice following a check on allergan drugs that were found to be out of date. Allergan drugs are medicines used for treating allergies. Checks were now more frequent with a regular audit of storage of these drugs.
- We were told the pharmacy manager has support from the corporate chief pharmacist and there were monthly calls/meetings to share best practice.
- Staff in the department told us drug stocks were checked weekly by pharmacy.
- We found that medicine cupboards were kept locked and on checking were orderly, neat and tidy.
- Staff stored prescription pads in a locked cupboard and a registered nurse held the key. We saw the register for

recording of prescription pads; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, security of prescription forms, 2013.

- In the diagnostic imaging department, medicines used to perform scans were stored in a locked cupboard with key pad access in a locked room with key pad access. Only authorised, registered professionals had access to the medicine cupboard.
- Staff monitored and recorded the minimum and maximum of the medicine refrigerator and room temperatures where medications and products were stored in the outpatients and pathology departments. We saw records which indicated this was done daily and clearly marked when the department was not open.

Records

- We saw the available paper records of patients being seen in the outpatients department were kept and stored appropriately in the department. These were sent to the medical records department when no longer required.
- We looked at ten sets of patients records for patients seen in the outpatients department. We saw records were complete, legible and signed. They contained letters, results of diagnostic tests and discharge letters.
- We saw the referrals and patients records for the physiotherapy department were received and stored electronically. No paper records were kept for patients seen in the outpatient department.
- We saw a copy of consultation notes for NHS patients was kept by the hospital. However, copies of the consultant's individual notes for private patients in the outpatient department were not kept by the hospital; these were kept by the individual consultants. This is not in line with the Health and Social Care Act 2008 (regulated activities) Regulation 2014 which requires the registered person to: ' maintain securely an accurate , complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.'
- The consultants worked under practising privileges agreements. The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. The practising privileges agreement requires consultants to abide by the rules of the hospital. One rule was the consultant complied with data protection laws and maintains complete and contemporaneous records in the outpatient department.

Safeguarding

- See the Surgery section for main findings.
- At the time of inspection the hospital offered a full service for children and young people and details of children's safeguarding is in the CYP section of this report.

Mandatory training

- Staff were required to undertake mandatory training courses which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk. Staff told us they were given protected time to complete mandatory courses.
- We saw the training records for staff (excluding medical staff) for mandatory training. The Training rates for individual topics ranged from 86% to 100%. On the day of the inspection the most recent records showed an average compliance of 98%. This was well above the target of 90%.

Assessing and responding to risk

- Medical cover was provided by two resident medical officer (RMO) who would attend to any unwell patients in the outpatient or diagnostic imaging department if required. All RMO's held a current ALS (advance life support) certificate.
- We saw records showed all nursing staff in the outpatient and diagnostic imaging departments received basic life support training. Additionally we saw relevant staff had attended paediatric basic life support training.

Good

Outpatients and diagnostic imaging

- In the event of an emergency occurring with a paediatric patient, the hospital's policy was to first stabilise and then transfer the patient to the local trust, under the paediatric support service level agreement.
- We saw there was adequate resuscitation equipment, it was accessible and staff knew where it was located.
- Signs were displayed throughout the department with the nominated first aiders and fire wardens identified.
- A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor (RPA) was contactable if required. This was in line with ionising regulations 1999 and regulations (IR (ME) R 2000). The RPA service for the diagnostic imaging department was provided by the local NHS acute trust. The hospital had annual radiation protection meetings at the hospital.
- The diagnostic imaging department had a stop buttons on the walls of the examination rooms to stop the radiation examination in an emergency. We saw the records demonstrating these were tested at the annual service.
- We saw local rules available in the diagnostic imaging room which were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff had signed them to indicate they had read them.

Nursing and diagnostic staffing

- There were sufficient staff with the qualifications, skills and experience to meet the needs of patients.
- The hospital employed 25.5 whole time equivalent (WTE) registered nurses and 10 WTE healthcare assistants. We saw the staffing rotas which indicated there was always registered staff available in each department.
- The use of bank and agency nurses in outpatient departments was similar to or lower than the average of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 to June 2016).
- The use of bank and agency health care assistants in outpatient departments was lower than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for in July 2015 to September 2015 and December 2015 when the rate was higher than the average.
- There were no agency nurses and health care assistants working in outpatient departments in the last three months of the reporting period (July 2015 to June 2016).
- The sickness rate reported for nurses in the outpatient department during the period July 2015 to June 2016 was varied when compared to the average of other independent acute providers CQC holds data for. Sickness rates were higher in July to September 2015, May 2016 and June 2016.

Medical staffing.

- Two RMOs were on duty 24 hours a day and was based on site for seven days at a time. All RMO's who worked at the hospital were registered with the General Medical Council (GMC). The RMO was provided to the hospital by an agency and we saw the hospital received assurance that all appropriate training had been undertaken.
- Guidelines state a named consultant should have access to the hospital within 30 minutes for paediatric support. The hospital had a service level agreement (SLA) for paediatric and emergency support in place with the local NHS Trust.

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Emergency awareness and training

- We saw the Hospital major incident procedure/plan. This was reviewed in January 2016 and contains up to date information on who to contact and what actions to take in the case of a major incident. This incorporated information to ensure business continuity in the case of any system failures for example if the phone system was not working.
- We did see evidence of fire safety training which 99% of the staff had completed.
- The hospital provided emergency scenario training for situations including major haemorrhage and resuscitation. We saw that the feedback identified areas for improvement, including leadership and communication. This helped staff to refresh their skills and knowledge in this area.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

We rated effective as inspected but not rated

Evidence-based care and treatment

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

Pain relief

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

Patient outcomes

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

Competent staff

- All staff had an induction programme devised by their departmental manager. This included a tour of the facilities and teams, supervised work sessions and protected time for reading the relevant policies and protocols. The induction course was written using a standard template, signed off on completion by the responsible manager and filed in the employee's personnel record. Staff showed us these records.
- We saw competency certificates for staff including nurses, radiographers, physiotherapists and pathology staff, all of whom had the relevant qualifications and

memberships appropriate to their position. There were systems which alerted managers when staff professional registrations were due and to ensure they were renewed. These were demonstrated to us.

- Nursing staff told us they had access to local and national training. This contributed to maintaining their registration with the Nursing and Midwifery Council (NMC).
- In compliance with ionising regulations 1999 and regulations (IR (ME) R 2000), we saw certificates were held for staff who were able to refer patients for diagnostic imaging tests. This gave assurance that only those qualified to request a diagnostic examination were able to do so.
- We saw the records to show 100% of outpatient staff had received an appraisal by November 2016.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured consultants who worked under practising privileges had the necessary skills and competencies. The consultants received supervision and appraisals. Senior managers ensured the relevant checks against professional registers and information from the DBS were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the MAC notes.

Multidisciplinary working

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

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nuffield Health had a policy for consent to examination or treatment, dated 2015. The policy demonstrated the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits.
- We saw signed consent forms in five medical records which showed patients had consented to treatment in line with the hospital's policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- We saw patients for the diagnostic imaging department had their identity confirmed by asking name, address and date of birth. This followed IRMER requirements. We saw the request forms and signatures of staff to identify that identities had been checked.
- Nuffield Health had a policy for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The policy set out procedures staff should follow if a person lacked capacity. Staff had access to flowcharts to prompt them of the process.
- Training on Deprivation of liberty (DOLs) and Mental Capacity act (2005)(MCA) was part of mandatory training

and was easily accessible. We saw 96% of theatre staff and 100% of all ward staff had completed Deprivation of liberty safeguarding training. All staff had completed MCA training.

- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good

Compassionate Care

- We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff always treated them with dignity and respect. We saw staff introduce themselves to patients and explain their role.
- We saw all treatment and consultation rooms had curtains to ensure patients dignity was respected if the door was open.
- Nuffield Health had a privacy and dignity policy (including chaperoning) dated 2015. We saw signs in the patient waiting areas informing patients they could have a chaperone, if required. We saw certificates which indicated staff had chaperone training. Staff would record if a chaperone had been offered and document if a patient agreed or declined. In a separate register it was recorded who had been a chaperone, the patient concerned and the day it occurred. We saw the chaperone register which indicated this was occurring. This was in line with the hospital's chaperone policy.
- We spoke with nine patients during our visit. Patients told us they felt well cared for and staff were always willing to help.

Understanding and involvement of patients and those close to them

- We observed staff discussed treatments with patients in a kind and considerate manner.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in a clear and simple style and language.

Emotional support

- We observed staff discussed treatments with patients in a kind and considerate manner.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need.
- Staff sent detailed information about the examination patients were booked in for with the appointment letter. We saw examples of this information and it was in a clear and simple style and language.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good

Service planning and delivery to meet the needs of local people

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

Good

Outpatients and diagnostic imaging

- Patients told us they had been offered a choice of times and dates for their appointments.

Access and flow

- The majority of patients were privately funded and there were very few NHS funded patients. There were 23,235 outpatient attendances in the reporting period July 2015 to June 2016 at the hospital. Of these, 19 were NHS funded.
- The hospital achieved above the national target of 95% for patients beginning treatment within 18 weeks of referral.
- The hospital had no patients waiting six weeks or longer from referral for the ultrasound scan in the same reporting period.
- The waiting times for patients on arrival to the hospital until their admission to the consultation room was audited by the hospital. The clinics we observed ran to schedule, we did not see any patients wait more than five minutes.
- Patients told us they were happy with the speed at which they had been notified of their appointments.
- We saw a radiologist provided a report within 48 hours and all reports were checked by a radiographer before they were sent.
- We saw in the pathology department they provided the results of blood tests results within 45 minutes. Certain blood tests, for example full blood count, were available within 15 minutes. The results were available on the computer system.

Meeting people's individual needs

- The waiting areas for the outpatients and diagnostic imaging departments had seating areas with refreshments and magazines available for waiting patients and their relatives. The hospital had several wheelchairs available for patients to use if required.
- Literature was available to help patients understand their care, treatment and general health issues. We saw a variety of health-education literature and leaflets in the reception area. Some of this information was general in nature while some was specific to certain conditions.
- Staff could tell us how they would access translation services for people who needed them. However, we were told these were rarely needed.
- We did not see any leaflets in any other languages apart from English. However, staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database.
- Nuffield Health had a diversity and inclusion strategy to ensure the Equality Act 2010 was embedded in the operations of the unit, and we saw an equality report was submitted to the NHS commissioner.
- The outpatient department provided a health screening service which provided an appropriate range of tests and examinations based on clinical need. Reports went to patients and their GP if further investigations were required.
- The physiotherapy department provided a wide range of exercise classes to suit the needs of the patients referred to them. They had a range of equipment to help staff deliver high quality care for patients.
- Patients who were living with a learning disability or dementia were identified by staff when the referral was received. Staff told us if applicable, the appropriate individualised care and support was provided, for example appointments to accommodate individual needs.
- The hospital had a dementia strategy. This focused on key issues such as flooring, decoration (for example contrasting colours on walls), signage, seating and availability of handrails which can prove helpful to people living with dementia. We saw the toilets in the outpatients department had hand rails in a contrasting colour.
- The hospital had allocated disabled parking bays and disabled toilets signposted in the main reception to accommodate patients living with a mobility disability.

Learning from complaints and concerns

- Nuffield Health recognised there may be occasions when the service provided fell short of the standards to which they aspired and the expectations of the patient were not met. Patients who had concerns about any aspect of the service received were encouraged to contact the hospital in order that these could be

addressed. These issues were managed through the complaints procedure. The hospital manager was responsible for the management of complaints. The personal assistant to the hospital's director was responsible for the day to day administration of the complaint management process.

- Information on how to make a complaint was available in leaflet form or on the website. Staff were aware of how to direct patients who would like to raise a complaint or concern. Complaints could be made verbally or in writing directly to the organisation.
- The Nuffield Health standard operating procedure for complaints set out the relevant timeframes associated with the various parts of the complaint response process. The procedure stipulated the timescales for each stage of the complaints process, how response times were monitored and how complaints could be escalated if the complainant was not satisfied with the response.
- The hospital had 40 complaints in the reporting period July 2015 to June 2016. No complaints had been referred to the ombudsman or an independent adjudicator. The assessed rate of complaints (per 100 inpatient and day case attendances) was lower than the rate of other independent acute hospitals CQC hold data for. CQC directly received no complaints in the reporting period.
- All complaints were recorded in the incident reporting system and were discussed at the monthly clinical governance meetings and included in the clinical governance report. We saw minutes of meetings which confirmed the nature, response and outcome of the complaint were reviewed. The reporting of complaints also formed part of the compliance agenda at the medical advisory committee (MAC) meetings. A summary of the clinical governance report was also made at each individual head of department meetings to support learning.
- Staff received feedback regarding complaints at team departmental meetings as well as on an individual basis.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good

Vision and strategy for this this core service

- See the Surgery section for main findings.
- There was no specific strategy for the outpatient and diagnostic imaging departments, however, there was a corporate level statement of purpose.

Governance, risk management and quality measurement

- See the Surgery section for main findings.
- We saw the risk register for the outpatients and diagnostic imaging department. This had items listed with their identified initial and current risk level. The list showed the likelihood, current consequences and review date due. The list was displayed in the manager's office.All staff we spoke with described how they would access the risk register and they were encouraged to report risks to their managers.

Leadership and culture of service

- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient and diagnostic imaging services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- The managers of the outpatient and diagnostic imaging departments reported to the matron, who reported to the hospital director.
- Staff saw their managers every day and told us the executive team were visible and listened to them. Staff in the focus group told us any changes made were communicated through departmental meetings, newsletters and emails.
- Staff told us the hospital was a good place to work, everyone was friendly, they had sufficient time to spend with their patients and they were proud of the work they did.

Good

Outpatients and diagnostic imaging

- The sickness rate reported for nurses in the outpatient department during the period July 2015 to June 2016 was similar when compared to the average of other independent acute providers CQC holds data for.
- The Nuffield Health leadership and appraisal system was based on six key beliefs (including 'commercial gain not coming before clinical need, being straight with people and taking care of the small stuff').
- Data received before the inspection showed in 2015/16, 100% of staff in the outpatient and diagnostic imaging department had received an appraisal.

Public and staff engagement

- See the Surgery section for main findings.
- The outpatient and diagnostic imaging departments had forums for staff communication. This included departmental meetings, bulletin boards and a monthly company newsletter which was issued following management board meetings.
- We saw managers shared information via email and newsletters. We saw noticeboards displaying information about infection prevention and control, health and safety, safeguarding and lessons learned from incidents and complaints.

Innovation, improvement and sustainability

- There were publications directed to children available at the entrance of the hospital, in the outpatient waiting room and on the ward. "A Visit to Outpatients" was a Nuffield specific leaflet explaining what a child can expect when visiting the hospital. It featured "Nuffy" the bear, child friendly language and cartoon pictures.

Outstanding practice and areas for improvement

Outstanding practice

- We saw evidence of cleaning rotas, checklists and the project called ‘Blue Sapphire’ which was both a written and pictorial resource for housekeeping staff which aimed to standardise practice ensuring ‘highest standards of common excellence, cleanliness and consistency throughout the working environment.' This was used as an induction and resource tool and was seen to be an example of outstanding practice.
- There were publications directed to children available at the entrance of the hospital, in the outpatient waiting room and on the ward. “A Visit to Outpatients” was a Nuffield Health specific leaflet explaining what a child can expect when visiting the hospital. It featured "Nuffy" the bear, child friendly language and cartoon pictures.
- We identified the hospital’s approach to educating young children about the importance of hand hygiene as an area of outstanding practice. This included child-friendly booklets called “Archie and Theo’s Special Day Out to the Guildford Nuffield Hospital”, monkey-themed posters on the walls in outpatients and on the ward, and child assessments of hand hygiene on the ward.
- The hospital had in place a three-year dementia strategy. Evidence was seen of this strategy and the initiative using a blue pillowcase on the bed of patients with dementia and memory problems. This was a visual aid to staff to remind them, these patients may require more help and assistance. On the ward , four of the patient rooms have been designated as dementia friendly rooms.

Areas for improvement

Action the provider MUST take to improve

- The provider must improve the way it manages records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Action the provider SHOULD take to improve

- Staff should ensure all entries in the theatres CD register are legible and in line with Nursing and Midwifery Council (NMC) Standards for medicine management.
- The provider should ensure that they are assured at all times that staff are complying with the bare beneath the elbows policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.** • Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. • Records must be kept secure at all times and only accessed, amended, or securely destroyed by authorised people