Nuffield Health Wessex Hospital

Quality Report

Winchester Road
Chandlers Ford
Eastleigh
SO53 2DW
Tel:023 8098 3681
Website: www.nuffieldhealth.com/hospitals/wessex

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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?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health Wessex Hospital opened in 1977 and has been upgraded and extended on several occasions since. During 2012-14 an £8 million scheme was undertaken to refurbish the hospital site.

The hospital now has 46 beds suitable for inpatient and day case care. There are two high dependency beds available for level one and two care. Admission for surgery follows strict referral criteria for people aged 18 years and over who require routine-urgent surgery.

The hospital provides elective surgery to patients who pay for themselves, are insured, or are NHS patients. Surgical specialities offered include orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery. There are four main theatres and a dedicated 7 bed recovery ward located within the main theatre complex. There is also an endoscopy unit which is separate from the theatre complex.

There is an outpatient department for routine pre and post-operative appointments. Radiology provides static MRI and CT scanners, ultrasound, x-ray, bone densitometry, mammography and fluoroscopy.

We carried out a comprehensive announced inspection of Nuffield Health Wessex Hospital on 1 and 2 December 2015, and an unannounced inspection on 3 December 2015.

We inspected the following three core services:

- medicine (endoscopy)
- surgery
- outpatients and diagnostic imaging.

The overall rating for this service was 'Good'.

The services at this hospital were mainly safe, effective, caring, responsive and well led. The hospital took into account individual patient needs and preferences when designing the delivery of well-planned services to its' patient population. There were sufficient staff, and mainly robust processes, ensuring the appropriate provision of timely and compassionate care.

Our key findings were as follows.

Are services safe?

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

- The hospital protected patients from the risk of abuse and avoidable harm. There were clear, open and transparent processes for reporting and learning from incidents. Staff reported incidents, and managers shared learning locally and within the wider organisation.
- Ionising radiation (medical exposure) regulations 2000 (IR(ME)R) incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents
- The departments were visibly clean and there were good infection prevention and control policies to reduce the risk of infection. However, some clinical practices did not consistently adhere to the organisations policies.
- While nursing staff were bare below the elbow in clinical areas, a few medical staff did not always adhere to this requirement. Nursing staff described some difficulties in ensuring some medical staff followed the policy.
- Regular infection control audits were completed. However, there was a lack of clarity regarding the benchmark for the audits and a delay in the development of action plans to address areas for improvement.
- Patients were risk assessed to ensure they were suitable for treatment and staff monitored them appropriately during their stay.

Summary of findings

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The surgical ward participated in the NHS Safety Thermometer for NHS patients.. Senior staff conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. Information about the audits was not displayed. This is not mandatory, but is considered good practice.
- The hospital maintained and tested equipment appropriately.
- Medicines were stored securely and handled correctly. The hospital also used a system to report and store patient images. Nurse staffing levels were sufficient to meet the needs of patients. Managers calculated nurse-staffing levels around the planned workload using a recognised staffing tool. Ward staff used a daily workload analysis tool which calculated staffing levels, and adapted these to meet the needs of the patients and the type of surgery they had received. Some Agency staff were used in theatres, but they were employed on block contracts to ensure the provision of on-going high quality care.
- There was good access to medical support at all times. A resident medical officer (RMO) was available 24 hours a day, and lived on-site for immediate access in an emergency.
- Staff undertook appropriate mandatory training for their role. All staff we spoke with knew where to access policies, procedures and guidance to follow in the event of a major incident. Senior staff were also aware of their individual responsibilities in the event of a serious or untoward incident on the premises.

Are services effective?

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

- Outcomes of people's care and treatment were not always monitored within endoscopy.
- The endoscopy service was progressing towards achieving Joint Advisory Group (JAG) accreditation standards. The recovery area was a small room and male and female patients were not separated; this prevented the standards being met. The hospital was planning to work through an endoscopy action plan put in place in November 2015 to improve the service.
- Surgical staff delivered care and treatment that was took account of current legislation and nationally recognised evidence based guidance. Corporate policies and guidelines were developed to reflect national guidance
- IR(ME)R audits were undertaken in line with regulatory responsibility. Copies of these audits, outcomes, actions and results were seen during our inspection and were compliant with national standards.
- Patients received appropriate pain relief during and after a procedure or investigation.
- Staff had regular appraisals and supervision, and were encouraged and supported to take part in training and development.
- Staff had attended training relating to the Mental Capacity Act best practice guidelines and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of the DoLS policies and procedures, and demonstrated appropriate understanding.
- Patients told us clinical staff had sought their consent before any examination, care or treatment.

Are services caring?

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

- In all departments, patients and relatives commented positively about the care provided by all the staff, including those who were non-clinical.
- Patients told us were treated with kindness, compassion and dignity throughout our visit.
- Patients' privacy and confidentiality was respected at all times.
- Patients told us they felt informed about their treatment and had been included in decisions about their care.

Summary of findings

- Staff on the main reception and the outpatient department reception were highly praised by patients and relatives for their welcoming attitude, discretion and attention to detail. Reception desks were a sufficient distance away from waiting areas so patients could speak to reception staff in confidence.
- Reception staff were observed to deliver excellent and timely care to a patient who had presented for an appointment, but who were in considerable pain. The actions of the reception staff contributed immediately to his wellbeing and comfort.

Are services responsive?

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

- Staff took into account the needs of different people, for example, patients living with dementia, or with a learning or physical disability. Relatives and assistance dogs were allowed into clinical areas to provide extra support to individuals.
- Surgical and outpatient services were responsive to the needs of local people. Patients were able to influence the choice of date for their surgery during outpatient consultations.
- Patient admissions for surgery were staggered throughout the day so they did not have to wait a long time after their admission.
- The NHS gastroscopy service was aimed at non-urgent (non-two week wait) referrals.
- The service provides GPs with an open access diagnostic gastroscopy service. Before their first attendance, the outpatients department sent patients appropriate information: this contained information such as the consultant or clinic they were to see, length of time for the appointment and written information on any procedures which may be performed at the first appointment, including the cost of the appointment and subsequent procedures (for self-funding patients).
- Patients could be given an outpatient appointment on the same day, but generally appointments were given within a week of contacting the hospital. The outpatient department was meeting the referral to treatment time for the incomplete pathway, with 96% of patients seen within 18 weeks.
- In diagnostic imaging, the department was meeting its target to see patients within 6 weeks. Most patients were given an appointment for x-rays, scans or ultrasounds within one week
- Patients were actively encouraged to leave comments and feedback via the patient satisfaction survey. The data was collated and results displayed in waiting areas.
- Nuffield Wessex Hospital received low numbers of formal and informal complaints: there were 35 complaints in 2014 which was a slight increase on the 33 complaints received in 2013.
- Monthly or quarterly reports had been produced to help identify any trends or issues which required further investigation. Action plans were devised to address any concerns along with lessons learnt. For example, staff told us call bell volume on the ward had been reduced after 11pm as a response to complaints from patients.

Are services well-led?

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

- The process for identifying, understanding, and monitoring risks in the endoscopy suite needed to be improved. An operational risk was created in relation to endoscopy following our inspection. An action plan had been created in November 2015, to address risk identified at local management level. This did not capture all specific local risks within the service.

Summary of findings

- The arrangements for governance, and issues with poor performance with regards to the outcome of infection control audits, were not always dealt with in a timely way. There was a lack of clarity regarding the benchmark for infection control audits and a delay in the development of action plans to address areas for improvement. This had the potential to put patients at risk of developing a hospital acquired infection.
- A systematic approach to the completion of the World Health Organisation (WHO) surgical safety checklist had not been fully embedded across all surgical specialities.
- The senior management team were highly visible across the hospital, and based their offices within the clinical environments to make them more accessible to staff. Staff described a "flat and open" culture, and said senior managers were approachable at all times.
- The Medical Advisory Committee Chair described robust governance arrangements and good leadership from the Matron and Hospital Director
- The Medical Advisory Committee met quarterly. The MAC had contributed positively to influence clinical practice where necessary. An example of this was the recent decision to stop admitting children and young people to the hospital. This was discussed at the interview with the Chair of the MAC.
- Staff spoke highly about their departmental managers, and about the support they provided to them and to patients. All staff said managers supported them to report concerns. Their managers would then act on them. They said their managers regularly updated them on issues that affected the unit and the whole hospital.
- Staff from all departments had a clear ambition for the service and were aware of the vision for the department. The vision was to provide the highest standards of care, ensuring a patient's experience was as comfortable as possible.
- There was a hospital-wide risk register. This had been created in April 2015. The register detailed nine risks which were identified as a potential risk to the hospital as a whole. Action taken to mitigate identified risks was detailed with time plans for review dates
- Governance processes at department, hospital and corporate level allowed for monitoring of the service and learning from incidents, complaints and results of audits across surgical services. There were however, delays in reporting and actioning infection control audits in the surgical service.
- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The results of the survey were used by departments to improve the service. However, although outcomes were displayed in waiting areas, actions for making improvements were not available for patients to read.

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

Action the hospital MUST take to improve

The hospital should ensure

- Patient's privacy and dignity is not compromised in the recovery area in the endoscopy unit.

Action the hospital SHOULD take to improve

The hospital should ensure

- An operational policy for the endoscopy suite is produced as per hospital action plan.
- A review of the management of the endoscopy procedure lists, in respect of male and female patients being on the same list.
- A risk assessment is undertaken regarding the movement of endoscopes from main theatres to the decontamination room in the endoscopy suite.
- Emergency medicines are always available in the endoscopy unit.
- The positioning of resuscitation equipment during endoscopy procedures is reviewed.
- Tamper evident tags are used to ensure resuscitation equipment always available for use.
- A review of pre assessment health record to include younger people who may have a dementia.
- Staff are aware of when to use an interpreter.

Summary of findings

- The hazard of trailing wires in the endoscopy treatment room risk assessment, is reviewed.
- Compliance with WHO checklist is documented.
- Cleaning schedules are displayed for public and staff.
- There is a cleaning checklist for items cleaned by theatre staff in the endoscopy unit.
- The storage of oxygen cylinder in the endoscopy unit is reviewed.
- Clinical performance outcomes are used in endoscopy.
- Local risks in the endoscopy suite are recorded on a risk register.
- Infection control audits are completed and actioned in a timely manner.
- All staff adhere to the hospital infection control policies and procedures.
- Patient consent for surgical procedures is obtained prior to the day of surgery.
- Safety thermometer audits results are displayed.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	We rated the endoscopy service as, 'requires improvement' for effective and well-led, and 'good' for safe, caring and responsive. Corporately and at hospital level senior managers had a stated aim to support the service to progress to achieving Joint Advisory Group on gastro-intestinal endoscopy guidance (JAG) accreditation. The process for identifying, understanding, and monitoring risks in the endoscopy suite needed to be improved. An operational risk was created in relation to endoscopy following our inspection. An action plan had been created in November 2015, to address risk identified at local management level. This did not capture all specific local risks within the service. The endoscopy lists had male and female patients, it could happen that a male and female patient would be in the two bedded recovery bay at the same time. A disposable curtain was available to pull between the two trolleys. This practise did not yet meet JAG standards. The endoscopy suite was visibly clean and there were good infection prevention and control practices to reduce the risk of infection. The transporting of used scopes from main theatre to the endoscopy suite needed review. Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure at the hospital. Patient risks were reviewed and patients were appropriately monitored during their stay. Staff were aware of processes to follow in the event of an emergency. Medical staff undertook the endoscopy procedures. The service adopted a flexible approach to rostering in response to scheduling of lists. Theatre staff supporting endoscopy were 97% compliant with their mandatory training. There was effective working between different staff groups employed at the hospital and other organisations that were involved in the care and treatment of the patient.

Summary of findings

Staff were supported in their role through appraisals. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Informed consent was obtained from patients immediately prior to procedures.
During the inspection, we saw and were told by patients that staff were caring and compassionate. Patients commented positively about the care provided from all of the endoscopy suite staff. Patients were treated courteously and respectfully. Patients felt well informed and involved in their procedures and care, including their care after discharge from the endoscopy suite.
The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients in the inclusion criteria, with waiting times one to four weeks
The staff we spoke with described an open culture and leaders to be visible and approachable.

Surgery

Good 

We found surgical services were good for safe, effective, caring, and responsive treatment, and the well led component required improvement. The arrangements for governance, and issues with poor performance with regards to the outcome of infection control audits, were not always dealt with in a timely way. There was a lack of clarity regarding the benchmark for infection control audits and a delay in the development of action plans to address areas for improvement. This had the potential to put patients at risk of developing a hospital acquired infection.
A systematic approach to the completion of the World Health Organisation (WHO) surgical safety checklist had not been fully embedded across all surgical specialities.
Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed. Staff were reporting incidents and appropriate actions and learning occurred as a result.. There had been one never event (a serious patient safety incident) in April

Summary of findings

2015. We saw information to support the reason for the never event had been comprehensively investigated and systems were utilised to minimise the risk of recurrence.
All areas of the service we visited were visibly clean and systems were implemented to ensure nurses, medical and domestic staff adhered to infection control policies and procedures. On the ward we observed that while nursing staff were bare below the elbow, medical staff did not consistently adhere to this policy in clinical areas. However, nurses told us they would stop medical staff from entering a patient's room if they did not follow correct infection control procedures.
Staff followed comprehensive risk assessments from the initial pre-assessment clinic through to discharge. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.
Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed to reflect national guidance.
Patients had a comprehensive assessment of their needs and access to a variety of methods for pain relief. Patients' pain levels were monitored and responded to appropriately.
Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness, compassion and dignity throughout our visit. Patients' privacy and confidentiality was respected at all times. Patients told us they felt informed about their treatment and had been included in decisions about their care. Printed information was not available in other languages or formats which meant some patients may not have full understanding about their care and treatment.
There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems were in place to share information and learning. Staff across the service described an open culture and felt well supported by their managers.

Summary of findings

Outpatients and diagnostic imaging

Good 

We found outpatients and diagnostic imaging services 'Good' for safe, caring, responsive and well led. We do not currently rate effective for this service.

Staff had a good understanding of how to report incidents and learning from incidents was shared at a departmental level. Staff undertook appropriate mandatory training for their role and were supported to keep this up-to-date. Clinical areas and waiting rooms were all visibly clean and tidy. Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers guidelines. Infection prevention and control practices were followed and these were regularly monitored, to prevent the unnecessary spread of infections. Medicines were stored securely. Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging. Nursing staff felt that the outpatient department staffing was sometimes low due to staff covering pre-assessment clinics. Agency staff were not used, however long-standing bank staff were occasionally employed to cover additional sessions. Patient records were available prior to a patient being seen. Staff received training, to ensure they could appropriately respond if a patient became unwell.

National guidelines were used, however, there was limited evidence that clinical audits were being undertaken in all outpatient areas, including recording of patient reported outcomes.

Staff were supported in their role through appraisals. All staff were appraised. Staff were encouraged to participate in training and development to enable them to deliver good quality care.

There was evidence of multidisciplinary team working in the one stop breast clinic. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Patients pain needs were met appropriately during a procedure or investigation. Clinics were held mainly during the week and evenings, with some Saturday clinics.

Summary of findings

During the inspection we observed and were told by patients that staff in the outpatient department and within diagnostic imaging were caring and compassionate. Patients and relatives commented positively about the care provided from nursing, radiography and medical staff. They were treated courteously and respectfully. Patient privacy and dignity was maintained. Patients were kept up to date with and involved in discussing and planning their care and treatment. They were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively. Emotional support was provided to patients. They commented they had been well supported emotionally by staff.

Services were planned and delivered in ways which met the needs of the local population. Clinics were generally held on weekdays and evenings with alternate Saturday clinics to accommodate patients who had commitments during the week. Patients told us there was good access to appointments and at times which suited their needs. To accommodate a patient who was too unwell to travel, the outpatient department facilitated treatment off site.

The gynaecology treatment suite was separate to the main outpatient facility which ensured patients had access to a private and comfortable treatment area. There was information on specific procedures or conditions, but this information was only in English and not in other languages or formats, such as braille or easy read. In diagnostic imaging the information leaflets were in very small print.

Interpretation services were available. However information about the interpretation service was not clearly displayed in patient waiting areas. Staff made reasonable adjustments to accommodate patients with dementia or living with a learning disability. Patients were encouraged to provide feedback after their outpatient appointment by completing a patient satisfaction survey. The results of these were displayed in waiting areas.

The Outpatient and diagnostic imaging departments were well-led. The department had a vision to provide high quality care in a timely and

Summary of findings

effective way. Staff and managers were aware of this vision. Staff felt supported, and were able to develop to improve their practice. There was an open and supportive culture.
Patients were given opportunities to provide feedback about their experiences and this was used to improve the service. Staff in all outpatient areas stated they were well supported by their immediate line managers. All staff during inspection spoke very highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.
An improvement plan has been put in place following national concerns, to ensure that radiologists are able to use all imaging equipment.

Summary of findings

Contents

Good

Nuffield Health Wessex Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Nuffield Health Wessex Hospital

Nuffield Health Wessex Hospital opened in 1977 and has been upgraded and extended on several occasions since. In 2012-14 an £8 million scheme was undertaken to refurbish the hospital site.

The hospital now has 46 beds suitable for inpatient and day case care. There are two high dependency beds available for level one and two care. Admission for surgery follows strict referral criteria for people aged 18 years and over who require routine-urgent surgery.

The hospital provides elective surgery to patients who pay for themselves, are insured, or are NHS patients. Surgical specialities offered include orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery. There are four main theatres and a dedicated 7 bed recovery ward located within the main theatre complex. There is also an endoscopy unit which is separate from the theatre complex.

There is an outpatient department for routine pre and post-operative appointments. Radiology provides static MRI and CT scanners, ultrasound, x-ray, bone densitometry, mammography and fluoroscopy.

We carried out a comprehensive announced inspection of Nuffield Health Wessex Hospital on 1 and 2 December 2015, and an unannounced inspection on 3 December 2015.

We inspected the following three core services:

- medicine (endoscopy)
- surgery
- outpatients and diagnostic imaging.

The registered manager has been in post since 2012.

Our inspection team

Our inspection team was led by:

Inspection manager: Moira Black, Care Quality Commission.

The team included CQC inspectors and four specialist advisers, including a consultant surgeon, a senior nurse, a radiographer and a governance specialist.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We invited patients to contact CQC with their feedback.

We visited the hospital to undertake an announced inspection on 1 and 2 December 2015 and undertook an unannounced inspection on 3 December 2015.

As part of the inspection process, we spoke with members of the executive management team and individual staff of all grades. We met with staff working within the surgical, endoscopy and outpatient areas.

We spoke with patients and people attending the outpatient clinics. We looked at comments made by patients when completing the hospital satisfaction survey and reviewed complaints that had been raised with the hospital.

Summary of this inspection

We inspected all areas of the treatment centre over a two-day period, looking at the endoscopy suite, outpatients and diagnostics, and surgical care.

We did not inspect the core areas of medicine, critical care, maternity, care of children and young people, or end-of-life care, as the hospital did not provide these services.

We spent time observing care in the endoscopy unit, operating theatres and the outpatients department. We reviewed policies, procedures, training and monitoring records, as well as patients' records where necessary.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experience of the quality of the care they received at Nuffield Health Wessex Hospital.

Information about Nuffield Health Wessex Hospital

- Nuffield Health Wessex Hospital was opened in 1977 and has been upgraded and extended on several occasions since. In 2012-14 an £8 million scheme was undertaken to refurbish the hospital site. This included the creation of a 4th operating theatre, the installation of an integrated digital theatre for laparoscopic surgery, a dedicated gynaecology suite including treatment room, and the creation of an extended rehabilitation gym. The hospital now has 46 beds suitable for inpatient and day case stays, two high dependency unit (HDU) beds for level 1-2 care. There are four main theatres (three laminar flow, one integrated digital theatre), ten general consulting rooms, Gynaecology suite (including two further consulting rooms and one treatment room), a dental suite (for consultation & treatment), Ophthalmology room, ENT room (including audiometry booth), phlebotomy room, two further treatment rooms. The hospital has an endoscopy unit and two recovery bays. Radiology provides Static MRI and CT scanners, ultrasound, x-ray, bone densitometry, mammography, fluoroscopy.
- The clinical staff included 45.2 whole time equivalent (WTE) nurses plus 10.2 WTE operating department staff and 14.8 WTE healthcare support workers. There were 270 doctors or dentists directly employed or working under rules or privileges.
- Inpatient activity/overnight inpatients – 5,588
- Visits to theatre – 5,546
- Outpatient activity: 18,826
- Never Events reported during the reporting period: One
- Serious Injury: One
- Clinical Incidents: 392
- Incidence of hospital acquired venous thromboembolism (VTE): Four
- Infection Control: No reported incidence of Clostridium difficile (C. diff) or Methicillin resistant Staphylococcus aureus (MRSA)
- Incidence of unexpected mortality during the reporting period NIL
- Rate of unplanned readmissions within 29 days of discharge during the reporting period:
- Number of unplanned transfers during the reporting period: eight cases of unplanned transfer of an inpatient to other hospitals in the reporting period
- NHS Friends and Family Test (FFT): This showed consistently high scores of 85-95% and with a moderate response rate.
- Completed admitted pathways – "For some reason appropriate clock pauses (adjustments applied to patient waiting times) are not taken into account for incomplete and non-admitted patients when submitting information through Unify. When legitimate clock pauses are taken into account then the hospital achieved 99.5%"
- Complaints received – 35. The hospital monitored and managed all of these within the formalised Complaints Policy timescale
- Turnover - Low staff turnover for all staff groups except for healthcare assistants.
- Sickness rate – Low sickness rates for all staff groups
- Staff stability – High levels of staff stability for Care Assistants, Allied Health, Moderate levels of staff stability for Nursing and Midwifery, Administrative & Clerical.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

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

Requires improvement

Medical care

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

Information about the service

Nuffield Health Wessex Hospital provides medical services to patients who pay for themselves, are insured, or are NHS patients. Medical services can be thought of as those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Endoscopy or chemotherapy services undertaken as a day case are also included within medical care. During the period July 2014 to June 2015, there were seven medical patients. Due to this small number, this report is focusing on the endoscopy service only.

There were 332 gastroscopies, 54 Bravo capsules (a test that allows the doctor to see if a patient's symptoms are caused by reflux into the food pipe) and 42 colonoscopies performed between July 2014 to June 2015. The majority of these were performed in the endoscopy suite. If a general anaesthetic was required, the scheduling of endoscopy procedures would be in main theatres.

The endoscopy unit access was via the ward corridor and consisted of a treatment room, a preparation room, a scope-washer room with clean and dirty processing areas, and a two-bayed recovery area.

The endoscopy suite was available 8.30am until 8.30pm Monday to Friday, for elective endoscopic procedures.

We spoke with a GP endoscopist, a consultant, endoscopy lead nurse, theatre manager, ward sister, pre-operative nurse team leader, six registered nurses, one operating department practitioner, three patients, one relative, and a member of administrative staff. Before, during and after our inspection we reviewed the provider's performance and quality information.

Summary of findings

We rated the endoscopy service as, 'requires improvement' for effective and well-led, 'good' for safe, caring and responsive.

Corporately and at hospital level senior managers had a stated aim to support the service to progress to achieving Joint Advisory Group on gastro-intestinal endoscopy guidance (JAG) accreditation. The process for identifying, understanding, and monitoring risks in the endoscopy suite needed to be improved. An operational risk was created in relation to endoscopy following our inspection. An action plan had been created in November 2015, to address risk identified at local management level. This did not capture all specific local risks within the service.

The endoscopy lists had male and female patients, it could happen that a male and female patient would be in the two bedded recovery bay at the same time. A disposable curtain was available to pull between the two trolleys. This practise did not yet meet JAG standards.

The endoscopy suite was visibly clean and there were good infection prevention and control practices to reduce the risk of infection. The transporting of used scopes from main theatre to the endoscopy suite needed review. Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure at the hospital. Patient risks were reviewed and patients were appropriately monitored during their stay. Staff were aware of processes to follow in the event of an emergency.

Requires improvement

Medical care

Medical staff undertook the endoscopy procedures. The service adopted a flexible approach to rostering in response to scheduling of lists. Theatre staff supporting endoscopy were 97% compliant with their mandatory training.

There was effective working between different staff groups employed at the hospital and other organisations that were involved in the care and treatment of the patient.

Staff were supported in their role through appraisals. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Informed consent was obtained from patients immediately prior to procedures.

During the inspection, we saw and were told by patients that staff were caring and compassionate. Patients commented positively about the care provided from all of the endoscopy suite staff. Patients were treated courteously and respectfully.

Patients felt well informed and involved in their procedures and care, including their care after discharge from the endoscopy suite.

The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients in the inclusion criteria, with waiting times one to four weeks

The staff we spoke with described an open culture and leaders to be visible and approachable.

Are medical care services safe?

Good

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

We rated safe as 'good.'

The endoscopy suite was visibly clean and there were good infection prevention and control practices to reduce the risk of infection. The transporting of used scopes from main theatre to the endoscopy suite needed review. Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure at the hospital. Patient risks were reviewed and patients were appropriately monitored during their stay. Staff were aware of processes to follow in the event of an emergency.

Equipment was well maintained and tested in line with manufacturer's guidance. Medicines were stored and handled correctly. An emergency medication that may have been required was not available in the endoscopy unit.

The recovery area was one small room within the endoscopy suite. If a patient deteriorated, the other patient in the recovery area would potentially be exposed to this situation.

Medical staff undertook the endoscopy procedures. The service adopted a flexible approach to rostering in response to scheduling of lists. Theatre staff supporting endoscopy were 97% compliant with their mandatory training.

Incidents

- Staff in the endoscopy suite were aware of their responsibly to report incidents. Staff reported incidents either via an electronic reporting system or to their manager who then logged the incident on the reporting system. Staff we spoke with were confident to report incidents and challenge poor behaviour by staff at any level, medical or nursing, if they were concerned about poor practice that could harm a person.
- Within the endoscopy unit, there were no serious incidents and no clinical incidents (July 2014 to June 2015). There were two incidents in relation to booking arrangements, which were resolved the same day. One

incident was in July 2014, the other in December 2014. Both these incidents related to scheduling. A new role of theatre scheduler was introduced in December 2014. The aim of the role was to ensure effective communication. The role has provided effective communication channels between Nuffield Hospital staff and the consultant secretaries.

- The hospital matron was aware of the duty of candour. The matron was aware of their responsibilities in terms of offering an apology to patients, meeting with, and writing to patients if harm had been caused.
- There had been no never events in the endoscopy service. Never events are serious incidents that should not occur if the available preventable measures have been implemented.

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

- The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. This enables teams to measure, assess, learn, and improve the safety of the care they provide.
- Day cases were excluded from the NHS Safety Thermometer. None of the patients undergoing an endoscopy procedure in the reporting period (July 2014 to June 2015), stayed overnight.

Cleanliness, infection control and hygiene

- The hospital had policies and procedures in place to manage infection prevention and control. Staff were able to access the policies and procedures on the hospital's intranet, and the endoscopy lead demonstrated how to do this. We saw policies for the management of waste and processes surrounding decontamination.
- In general, all areas were visibly clean.
- The surface of the hatch from endoscopy room to washing room was visibly streaked and marked. Staff told us this was thought to be due to a cleaning product. The lead for endoscopy was in the process of addressing the concern.
- In the endoscopy suite, stickers were signed and dated to indicate that items, for example patient observation machines, were clean.
- Antibacterial hand disinfectant gel was available.
- Hand wash basins were available.
- Staff adhered to the 'bare below the elbow' policy when providing care and treatment.
- Disposable aprons and gloves were readily available. Staff used them when delivering care and treatment to patients, to reduce the risk of cross infection. Staff also wore disposable gloves and aprons as personal protective equipment when undertaking endoscopy.
- For the endoscopes, there was a physical decontamination pathway. There was a pass-through hatch (one way) between the endoscopy room and dirty room. This provided one-way access to washer disinfectors. There was a drying cupboard and a storage cupboard for the endoscopes. There were also full scope-tracking and traceability records kept. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- We saw a 'dirty' scope carried from main theatres in a metal tray covered in red plastic, as clear indication that the endoscope required decontamination. The health and safety executive standards have recommended practices for endoscope reprocessing units (2012). The standards state if transferring an endoscope from one place to another, the endoscope should be placed in a solid walled leakproof container. This should have a hard lid, and transported on a trolley to the 'dirty' area. This is to protect the product and the handler from inadvertent contamination. When we spoke with the matron, she was unaware endoscopes were not being transferred down the main ward corridor (the only access) as recommended. We were told that some endoscopic procedures were undertaken in the main operating theatre. We reviewed the operating theatre schedules and saw that contaminated scopes would have regularly needed to be transferred from main theatres to the decontamination area in the endoscopy suite.
- A risk assessment had been completed for the movement of clean endoscopes from endoscopy to theatres. A risk assessment had not been completed for the movement of dirty scopes from main theatres to endoscopy.
- A cleaning schedule was available, but it was stored on the wall in the domestic cupboard. This meant the cleaning schedule was not visible to the public or staff.
- Domestic staff cleaned the endoscopy unit overnight. A cleaning checklist was completed and signed by the domestic staff for items they clean.

- We found the top of a trolley that had drawers containing medical and surgical items in the treatment room was dusty. This was discussed with the endoscopy lead, who organised for the trolley to be cleaned. There was not a cleaning checklist for items cleaned by theatre staff. There was a general checklist, including a check of fridge temperatures, room temperatures and endoscopy equipment.
- There have been no incidences of Clostridium difficile between July 2014 to June 2015.
- At the pre-operative assessment stage, staff screened all patients for methicillin-resistant Staphylococcus aureus (MRSA), a type of bacterial infection that is resistant to a number of widely used antibiotics. If a patient was positive, they received treatment for MRSA and a procedure not performed until the patient was clear of infection.
- In the treatment room a small piece of carpet with thread covered electrical leads to prevent staff tripping up. The use of carpet is not good practice, as it is difficult to clean. The endoscopy unit staff told us that an environmental risk assessment had been undertaken. This was requested at the time of our inspection, and subsequently sent following the inspection. The risk assessment did not identify that the action taken to manage the risk was an infection control risk.

Environment and equipment

- The recovery area in the endoscopy unit had two patient bed trolleys. It was possible to get behind the head of the patient bed trolley by pushing it into the access area. The two patient bed trolleys were both up against the walls. The gap between the patient bed trolleys was 1.9 metres, which was acceptable. If a patient deteriorated, the team would have needed to pull a patient bed trolley away from the wall, to be able to get to both sides of the patient. This would have meant the other patient would be potentially exposed to a patient who deteriorated. This would also be a potential privacy and dignity issue.
- The endoscopy lead said that patients were risk assessed in the treatment room. If a patient was assessed at risk of deterioration following a procedure, staff would take the patient to recovery in main theatres. There had not been any patients who had deteriorated in the endoscopy unit's recovery area.
- Resuscitation trolleys were located on the main ward. There had been some substantial recording gaps of the checking of equipment, when we checked back over the preceding months. We saw staff checks of the resuscitation equipment had improved.. The resuscitation trolleys on the ward were kept secure via a numbered keypad, however there was no tamper evident tag to further prevent access by unauthorised personnel.
- The Joint Advisory Group (JAG) accreditation standards on gastrointestinal endoscopy standard states that a resuscitation trolley should be located within the endoscopy unit during an endoscopy list. One ward resuscitation trolley was approximately 40 metres away from the endoscopy unit, the other was approximately 80 metres away. Call bells and emergency bells were accessible, so staff could call for assistance.
- Over the last year, the endoscopes were standardised, to help all staff to be familiar with the equipment.
- The number of endoscopes and size of scopes met the needs of the service. There were also a sufficient number of monitors, cameras, and printers.
- Processes were in place to ensure compliance with decontamination processes as recommended by JAG.
- Maintenance and repair contracts were in place for the endoscopes, the washer disinfector, and the drying cabinet. We saw maintenance records during our inspection.

Medicines

- Medicines were stored in locked cupboards. Medicines that required storage below a certain temperature were stored in a locked fridge, specifically for that purpose. During our inspection, we saw that the checking of minimum and maximum temperatures took place. These checks were not daily, but when there was an endoscopy list. When we checked the recordings, they were all within the acceptable range. The endoscopy lead told us staff were aware of actions to take if temperatures were not within the minimum and maximum range.
- The storage of controlled drugs (CDs) was appropriate. The CDs were checked after each endoscopy list, and reconciled against stock levels.

- We identified during our inspection that the endoscopy unit did not have a medication called naloxone. This is a medication that may be needed if a patient has a reaction to specific analgesia. When we raised this with staff, they obtained the naloxone injection.
- Oxygen cylinders, tubing and masks were available on the patient trolleys in recovery if needed.
- In the decontamination room, a single oxygen cylinder had been placed in a corner on the floor. The lead for endoscopy told us more appropriate storage for the cylinder was required. We requested risk assessments which were received after our inspection. The oxygen cylinder placement had not been identified within the risk assessments received.

Records

- During our inspection, we reviewed six patient care records. The pre-assessment questions, admission record, pre-procedure care, care during procedure, recovery, and post-procedure care were fully completed.
- There were some gaps in the documentation of the completion of the Five Steps to Safer Surgery (World Health Organisation (WHO) checklist. This is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. For the period July to September 2015, compliance of 100% had been achieved for the observational audit and between 93% and 97% for documentation.

Safeguarding

- Compliance with safeguarding training was 98%. The hospital target for attendance was above 85%. A corporate policy safeguarding and protecting vulnerable people policy was in place.
- Endoscopy staff were aware of their responsibilities and described a safeguarding concern being acted upon appropriately and in a timely manner.

Mandatory training

- Mandatory training compliance for the seven staff working in the endoscopy suite ranged from 91% to 100%.

Assessing and responding to patient risk

- Patients were asked to complete a postal pre-assessment heath check questionnaire. A registered nurse checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for endoscopy. The pre-operative assessment nurse would advise the consultant's secretary, if there were any medical risk factors that the consultant needed to be made aware of.
- If a patient was at risk of being MRSA positive, the patient would be contacted pre-procedure to attend the pre-assessment clinic for swabs.
- We were told that endoscopy list order would take account of a patient's health needs. For example, if a patient had diabetes, the patient would be listed first to prevent the possibility of low blood sugar in pre-operative starvation period. Patients were advised to bring any tablets or insulin to control their diabetes with them. The medication could then be taken after the procedure.
- The medical staff told us that at the start of each endoscopy session they led an in room briefing (not observed). This was followed by patient checks at the start of the list and a debrief after. This summarised the procedure, and medications given, in line with the WHO process.
- A modified early warning system (MEWS) is a scoring system that identifies patients at risk of deterioration, or needing urgent review. This would include observations of vital signs and the patient's wellbeing to identify whether they were at risk of deteriorating. This system was in use for patients undergoing endoscopy. Medical and nursing staff were aware of the appropriate action if a patient scored higher than expected. Of the six records reviewed, none of the patients required escalation.

Nursing staffing

- The endoscopy unit team comprised of three registered nurses, an operating department practitioner, and three health care assistants. These staff were line managed by the theatre manager.
- We observed five endoscopy staff in the treatment room during procedures, and one endoscopy staff member undertaking decontamination.
- Over the past ten endoscopy lists, 68% of staff allocated to these lists had endoscopy competencies. Four members of staff were routinely allocated to an endoscopy list. As a minimum requirement, two of the four staff would hold endoscopy competencies. Staff with endoscopy competencies undertook any endoscopy specific activities (for example assisting the endoscopist or washing of scopes). This meets with JAG guidelines.

Requires improvement

Medical care

- Staff from the endoscopy suite worked in main theatres, when there was not an endoscopy list taking place.

Medical staffing

- All endoscopies were undertaken by medical staff.
- There were three medical staff undertaking regular lists in the unit.
- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. The hospital confirmed that all medical staff undertaking endoscopies had been fully trained to perform the procedure. These medical staff also regularly performed the procedure within their NHS practice.

Major incident awareness and training

- The endoscopy staff were aware of the major incident policy at Nuffield. In the event of a major incident, they would act as part of the theatre team, with specific responsibilities allocated to them.

Are medical care services effective?

Requires improvement

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

We rated effective as 'requires improvement.'

The endoscopy service was progressing towards achieving Joint Advisory Group (JAG) accreditation standards. The recovery area was a small room and male and female patients were not separated this prevented the standards being met. The hospital was planning to work through an endoscopy action plan created in November 2015 to improve the service.

The service was taking action to progress to become compliant with nationally evidenced-based guidance. Outcomes of people's care and treatment were not always monitored.

The endoscopy service was available Monday to Friday 8:30am to 8:30pm.There was effective working between different staff groups employed at the hospital and other organisations that were involved in the care and treatment of the patient.

Staff were supported in their role through appraisals. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Informed consent was obtained from patients immediately prior to procedures.

Staff had undergone training and had understanding of the Mental Capacity Act 2005, but had not had to apply this knowledge.

Evidence-based care and treatment

- Endoscopy staff were aware of National Institute for Health and Care Excellence (NICE) guidance, but did not have Joint Advisory Group (JAG) accreditation. The service had registered with JAG and had completed an endoscopy global rating scale (GRS) self-assessment. JAG had not yet formally reviewed the Nuffield Wessex. The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation.
- The recovery area in the endoscopy suite was a small room with two trolleys. Gender separation is required in an endoscopy service whenever patients are undressed, or in sleeping areas recovering from sedation. This would require a full height fixed divider, and separate male and female access.
- There was no formal system used routinely for the monitoring and review of clinical performance data. The GP practitioner told us feedback following the gastroscopy procedures he had undertaken at the hospital, using a formal system, had been 97% positive.
- The documentation of endoscopy operational policy, to support best practice, was one of the actions identified on an endoscopy action plan. The matron and theatre manager had created the endoscopy action plan in November 2015.

Pain relief

- Patients undergoing gastroscopy were offered throat spray to numb the back of their throat, or intravenous sedation.

- Colonoscopy was undertaken under intravenous sedation.
- Both patients we saw undergoing procedures were lightly sedated. They were relaxed and aware of their surroundings, and able to converse with the consultant and nurses. They were both able to change position with assistance, as requested by the consultant during the procedure. The consultant asked how the patients were during the procedure, and they said they were fine.
- Additional analgesia was available if required.

Nutrition and hydration

- Patients having a gastroscopy were advised not to eat or drink anything for at least six hours prior to appointment time, to enable good views of the stomach.
- Patients who were due to attend for colonoscopy, were sent medication in the post. They were also sent advice on how to prepare for the procedure, and given general guidance regarding pre-operative dietary and fluid intake.
- A patient, following either a gastroscopy or a colonoscopy, was offered a drink and light snack prior to discharge
- The Patient Led Assessment of the Care Environment (PLACE) undertook an audit. During the period February to June 2015, the food on the ward at the Nuffield Wessex was rated at 96%.

Patient outcomes

- The matron and theatre manager had self-completed (GRS) using a template from JAG. This self-assessment had identified areas where improvement was needed, for example, the development of a comprehensive endoscopy operational policy. The matron, to support the hospital progressing towards accreditation, had drawn up an action plan. The matron had identified nine actions for improvement, to meet JAG standards. These all had a responsible person identified and noted, and a target date.

Competent staff

- A GP endoscopist, two consultant gastroenterologists, four consultant general and colorectal surgeons, senior lecturer and general surgeon performed endoscopy procedures. Theatre nurses supported the medical staff.
- The medical advisory committee (MAC) was responsible for granting and reviewing practising privileges for medical staff. The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies. The surgeons received supervision and appraisals. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed. The status of medical staff consultants practising privileges was recorded in the minutes of the medical advisory committee notes.
- The endoscopy lead had drawn up a set of competencies for a dedicated team of staff who supported endoscopy.
- Six of these staff had attended specific training following the standardisation of endoscope systems in September 2015.
- Staff also attended a GP open forum this year, hosted by a colorectal surgeon.
- In October 2015, some of the team attended a nurse education day in colorectal surgery.
- Two endoscopy staff attended a decontamination study day in 2015.
- A consultant surgeon had provided a two-hour gastroenterology update in July 2015 to staff working in the endoscopy suite.
- Staff appraisals were planned. Appraisal compliance was 86% at December 2015.

Multidisciplinary working (in relation to this core service)

- There was effective multidisciplinary working in the endoscopy suite. During our inspection, we saw that the administrative staff, pre-assessment staff, endoscopy staff, medical staff, and ward nursing staff worked well together to ensure the patient pathway was effective.
- We were told that the medical staff liaised with colleagues in the NHS, if the findings following procedures indicated further medical support may be required.

Seven-day services

- The endoscopy procedures were planned interventions, and performed during the hours 8.30am to 8.30pm Monday to Friday. Patients we spoke to reported good access to appointments and availability at times that suited their needs.

Access to information

Medical care

- The GP practitioner, who undertook the NHS gastroscopies, told us that the pathology laboratory was responsive with biopsy results.
- The patient, upon discharge, received a letter that included the reason for the procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. The nurse sent a copy of this letter to the GP and placed a copy in the patient's medical records at the Nuffield Wessex.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients received information prior to their endoscopy procedure. This allowed patients to read the information and, if understood, give informed consent when they came for their procedure. Consent forms appropriately detailed the risks and benefits to the procedures.
- Mental Capacity Act training was part of the mandatory training programme. Staff we spoke with had not had to apply this training. Nuffield Wessex did have a consent form for a patient who lacked capacity.
- However, during our conversations with staff it became apparent that family members or other members of staff were, at times, asked to assist with interpreting. The staff in endoscopy said this was only to fill in words within information given to assist meaning, rather than whole pieces of information. The use of family or staff members is not considered best practice because staff could not be assured that the patient had given consent for information to be shared. This practice means the patient may have given information to a relative that they may not want to share.

Are medical care services caring?

Good

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

We rated caring as 'good.'

During the inspection, we saw and were told by patients that staff were caring and compassionate. Patients commented positively about the care provided from all of the endoscopy suite staff. Patients were treated courteously and respectfully.

Patients felt well informed and involved in their procedures and care, including their care after discharge from the endoscopy suite.

People were supported to cope emotionally with their care and treatment as needed.

Compassionate care

- We witnessed attentive and compassionate care delivered by the consultant and endoscopy staff. When a patient was sedated, staff maintained dialogue throughout procedures, with explanation and reassurance.
- Between the period January to June 2015, Friends and Family Test results at the hospital were between 85% and 96%. The response rate was moderate (31%t to 60%), except June which was low at less than 30%.

Understanding and involvement of patients and those close to them

- During our inspection, we spoke with a patient who had returned from a procedure 30 minutes before. The patient was comfortable, and pleased that during the procedure they had put her glasses on at her request. This enabled her to see the procedure as it was taking place on a screen in the treatment room.
- A relative was with a patient, who felt involved in his wife's care and was very positive about the experience at Nuffield Wessex Hospital.
- A patient described being involved in the process as an individual person, and feeling very much that this was 'her procedure.'

Emotional support

- The GP practitioner described how if he found what he suspected to be cancer, this possibility was discussed with the patient following the procedure. The consultants would always go to a quiet room, with a nurse present, and discuss at the patient's pace, what follow-up would be required.

Medical care

- The GP practitioner would also personally liaise with the patient's GP and specialist cancer nurse at a local NHS district hospital to ensure there was support for the patient.

Are medical care services responsive?

Good

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

We rated responsive as 'Good.'

The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral. The service was responsive to patients in the inclusion criteria, with waiting times one to four weeks. Care and treatment was coordinated with other providers.

For patients who require information in other languages or formats at the hospital, leaflets could be requested corporately. This met with the needs of the local population. Some of the current practices compromised meeting individual needs. For example, the key health questions on admission only asked people over 65 years old about dementia.

A complaints system was in place, and advertised on the hospital website.

The endoscopy lists had male and female patients, it could happen that a male and female patient would be in the two bedded recovery bay at the same time. A disposable curtain was available to pull between the two trolleys. The patients we spoke with on inspection did not raise concerns about this system, and the hospital had not received any complaints about this arrangement.

Service planning and delivery to meet the needs of local people

- The hospital undertook NHS and private work. The hospital had agreed with the local clinical commissioning group to include the GP endoscopist undertaking NHS gastroscopies in the NHS contract. This would enable the recording and monitoring of waiting times in line with national requirements. There was not an NHS commissioned colonoscopy service; patients requiring this service were treated on a self funded or insured (private) basis.
- Gastroscopy was the most common procedure performed (332) at the hospital during the period July 2014 to June 2015, followed by Bravo capsule (54) (a test that allows the doctor to see if a patient's symptoms are caused by reflux into the food pipe) and colonoscopy (42).

Access and flow

- The NHS gastroscopy service was aimed at non-urgent (non-two week wait) referrals. The service provides GPs with an open access diagnostic gastroscopy service. Exclusions included suspected cancer, active bleeding, any condition requiring emergency gastroscopy and a defined range of complex medical conditions.
- A patient that was a non–urgent case for a gastroscopy would be seen within two to four weeks of referral. If a patient was suspected to have cancer, then there was a fast track system in place following the endoscopy. This was to ensure the patient had an urgent scan. A consultant upper gastrointestinal surgeon would then see the patient in their two-week clinic.
- For a colonoscopy procedure, a patient would be referred to a consultant endoscopist by their GP or by another consultant. The patient would be seen for an outpatient consultation. The symptoms would be assessed and they would be listed for a procedure if they fulfilled standard national guidelines. Waiting times were around one to four two weeks.
- A patient admitted for a procedure, was discharged on the same day with a letter to their GP.

Meeting people's individual needs

- To ensure privacy and dignity, a patient, was provided with a gown and shorts to wear under the gown. Male and female patients were recovered post procedure who had been sedated, in the endoscopy suite two-bedded recovery bay. A disposable curtain was available to use as a screen between the trolleys as needed, to maintain patient privacy and dignity. We discussed our concerns regarding privacy and dignity with the endoscopy lead, who advised the lists were not separated into male and female.
- Patients received appropriate information prior to their procedure. For example, the information about

gastroscopy included preparation and time to arrive, the two ways it could be performed, the examination process and after care. For a colonoscopy, the information included preparation and time to arrive, what the procedure involved, during the procedure and aftercare.

- For patients whose first language was not English, telephone translation facilities were available, but was not always used and relatives were asked to interpret at times.
- The assessment of health needs questionnaires sent to patients prior to their arrival, did contain some questions about dementia, but this only related to people over 65 years old.
- When we spoke with staff from the endoscopy suite, they were aware of the possibility of a patient having a dementia or a learning disability, but a patient had not been admitted for a procedure with these needs to the endoscopy suite.
- The Patient Led Assessment of the Care Environment (PLACE) undertook an audit. During the period February to June 2015, PLACE rated the hospital at 85% dementia friendly, compared with other independent hospitals at 81%.

Learning from complaints and concerns

- There had been no complaints related to care given in the endoscopy suite during the July 2014 to June 2015.
- Nuffield Wessex Hospital received 35 complaints in 2014 which was a slight increase on the 33 complaints received in 2013.

Are medical care services well-led?

Requires improvement

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

We rated well-led as 'requires improvement.'

Corporately and at hospital level senior managers had a stated aim to support the service to progress to achieving Joint Advisory Group on gastro-intestinal endoscopy guidance (JAG) accreditation. The process for identifying, understanding, and monitoring risks in the endoscopy suite needed to be improved. An operational risk was created in relation to endoscopy following our inspection. An action plan had been created in November 2015, to address risk identified at local management level. This did not capture all specific local risks within the service. The endoscopy lead was not aware that caring for males and females, who had been sedated and were in gowns in the endoscopy recovery bay, would not have met JAG standards.

The gaps in the documentation with the Five Steps to Safer Surgery (World Health Organisation (WHO) checklist had continued, despite the importance of compliance being documented in a meeting in September 2015

Staff were able to describe the vision of the service, which was to provide the highest standards of care, ensuring a patient's experience was as comfortable as possible.

The staff we spoke with described an open culture and leaders to be visible and approachable.

There was a strong focus on continuous learning and improvement within the organisation and the service.

Vision and strategy for this this core service

- Staff spoke passionately about the service they provided and the care they offered to patients.
- Staff had a clear ambition for the service and were aware of the vision for the department. The vision was to provide the highest standards of care, ensuring a patient's experience was as comfortable as possible. There was no documented strategy for the endoscopy service.

Governance, risk management and quality measurement for this core service

- There was a hospital-wide risk register. This had been created in April 2015. The register detailed nine risks which were identified as a potential risk to the hospital as a whole. These risks included; health and safety, NHS contract compliance and hospital capacity management. Action taken to mitigate identified risks was detailed with time plans for review dates. Following our inspection on 7 December 2015, endoscopy was identified by the management team and also added as a risk. The endoscopy risk was categorised as operational.

Requires improvement

Medical care

- The operational risk described the need to make timely progress with JAG accreditation, to ensure quality and safety of endoscopy services. Areas for improvement included, the need to document an endoscopy operational policy, audit of appropriateness of procedures and use of a clinical performance reporting system by the endoscopists. Some other areas identified on the action plan were the development of an endoscopy user group and an annual survey. The specific risks in the endoscopy suite, and the actions to manage the risks were not documented on a risk register. For example, the risk that the recovery bay would not meet JAG standards due to the layout of the endoscopy suite.
- The endoscopy lead told us that the monitoring of the progress made with JAG accreditation was monitored through the hospital quality and safety meetings, represented by the theatre manager.
- The clinical lead attended a regional meeting relating to progressing to JAG accreditation it was attended by both NHS and independent health providers.
- The staff from the endoscopy suite attended regular monthly meetings led by the theatre manager. The meeting in September 2015 included a discussion to maintain awareness, and to reinforce the need for compliance with the Five Steps to Safer Surgery (World Health Organisation (WHO) checklist).
- Minutes from the medical advisory committee were circulated to all the consultants for information.

Leadership and culture of service

- There was a manager for the four theatres and the endoscopy suite, and a clinical lead for endoscopy.
- Staff were positive about the leadership at senior management level. They told us the leadership team were visible and approachable. They felt concerns were listened to and where possible acted upon. The endoscopy lead commented about senior managers doors always being open
- Staff felt their immediate manager had the appropriate skills to be able to lead and run their department, and was supportive.
- Effective teamwork was evident, with medical, theatre, nursing staff and administration staff working together to ensure effective care for a patient.
- Staff told us they felt listened to and respected. Staff told us they felt they could raise their concerns.

Public and staff engagement

- Since January 2015, the hospitals' patient satisfaction survey had enabled patients to indicate overall satisfaction with experience by procedure. There were seven other procedures performed at the hospital, as well as the three endoscopy procedures. Since January 2015 the average 'overall satisfaction' score for endoscopy patients has been 95%. Patients had made a number of positive comments. None of the comments has necessitated a review of processes.
- The endoscopy service was planning to set up an endoscopy user group by 28 February 2016. They planned to invite a patient as a member of this user group. Other members of the group the hospital planned to invite were an endoscopist, an endoscopy nurse, endoscopy ward nurse/ outpatient department (OPD) nurse, theatre manager, matron, ward and OPD manager.
- The staff survey for 2015 had a 54 percent response rate, with 96 percent saying they would be happy to recommend Nuffield Health services to family and friends.

Innovation, improvement and sustainability

- The hospital director and matron were planning to meet with the hospital endoscopists in early January 2016. The purpose of this meeting was to discuss progress on the endoscopy unit, and compliance with JAG.

Good

Surgery

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

Information about the service

Nuffield Health Wessex Hospital provides elective surgery to patients who pay for themselves, are insured, or are NHS funded patients. Between July 2014 and June 2015, 1,929 NHS patients were treated for inpatient and day case procedures compared with 3,659 patients funded from other sources. Between July 2014 and June 2015, 5546 patients attended the hospital for a variety of surgical procedures. Surgical specialities offered include orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery. Nuffield Health Wessex hospital does not offer surgical services for children.

There are four main theatres, three of which have laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination) and one integrated digital theatre (all components of the operating theatre are fully-integrated and digitally controlled). There is a dedicated 7 bed recovery ward located within the main theatre complex.

The hospital has 46 beds suitable for inpatient and day case care. There are two high dependency beds available for level one and two care.

During our inspection we visited theatres, the ward and the pre-assessment clinic. We spoke with eight patients, one relative, and 30 members of staff. These included managers, health care assistants, registered nurses, medical staff, theatre personnel, operating department assistants and administrative staff. We looked at the patient environment and observed patient care in all areas. We reviewed 11 patients' records. Before, during and after our inspection we reviewed the provider's performance and quality information.

Summary of findings

We found surgical services were good for safe, effective, caring, and responsive treatment, the well led component required improvement.

The arrangements for governance, and issues with poor performance with regards to the outcome of infection control audits, were not always dealt with in a timely way. There was a lack of clarity regarding the benchmark for infection control audits and a delay in the development of action plans to address areas for improvement. This had the potential to put patients at risk of developing a hospital acquired infection.

A systematic approach to the completion of the World Health Organisation (WHO) surgical safety checklist had not been fully embedded across all surgical specialities.

Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed. Staff were reporting incidents and appropriate actions and learning occurred as a result. There had been one never event (a serious patient safety incident) in April 2015. We saw information to support the reason for the never event had been comprehensively investigated and systems were utilised to minimise the risk of recurrence.

All areas of the service we visited were visibly clean and systems were implemented to ensure nurses, medical and domestic staff adhered to infection control policies and procedures. On the ward we observed that whilst nursing staff were bare below the elbow, medical staff

Good

Surgery

did not consistently adhere to this policy in clinical areas. Nurses told us they would prevent medical staff from entering a patient's room if they did not follow correct infection control procedures.

Staff followed comprehensive risk assessments from the initial pre-assessment clinic through to discharge. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed to reflect national guidance.

Patients had a comprehensive assessment of their needs and access to a variety of methods for pain relief. Patients' pain levels were monitored and responded to appropriately.

Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness, compassion and dignity throughout our visit. Patients' privacy and confidentiality was respected at all times. Patients told us they felt informed about their treatment and had been included in decisions about their care. Printed information was not available in other languages or formats which meant some patients may not have full understanding about their care and treatment.

There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems were in place to share information and learning. Staff across the service described an open culture and felt well supported by their managers.

Are surgery services safe?

Good

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

We rated safe as 'good.'

Staff were reporting incidents and appropriate actions and learning occurred as a result. Staff understood their responsibilities to raise concerns and report incidents and near misses. There had been one never event in the surgery service (a serious, largely preventable patient safety incident). The never event had occurred in April 2015. We saw information to support the reason for the never event; this had been comprehensively investigated and systems were in place to minimise the risk of recurrence.

Staff we spoke with were knowledgeable about the hospital's safeguarding process and were clear about their responsibilities.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who use services.

Risks to people who use services were assessed, monitored and managed on a day-to-day basis. The modified early warning score was used to identify patients whose condition might deteriorate and there were appropriate transfer arrangements of patients to a local NHS hospital if required.

All clinical areas were appropriately equipped to provide safe care and were visibly clean. Regular infection control audits were completed. Some areas of infection control and prevention did not happen consistently, for example, medical staff were not always bare below the elbow in clinical areas and pre-operative prevention practices had decreased. This could put patients at risk of an acquired infection.

Incidents

- There had been one never event (a serious, largely preventable patient safety incident which should not

occur if the available preventative measures had been implemented) in April 2015. The never event involved a mis-match between two components required for replacement knee surgery.

- Senior medical and nursing staff had investigated the reasons why the never event had occurred and shared the results of the investigations in team meetings with all members of staff. Theatre staff told us lessons had been learnt. It was evident from information seen that documentation and further checks had been devised to minimise the risk of the never event re-occurring.
- All grades of staff we spoke with were aware of the electronic incident reporting system and told us they were encouraged to report incidents. Staff told us the system was simple to use and was accessible to all staff. Staff that did not have access to the system, for example domestic and housekeeping staff alerted the senior member of staff on duty to any areas of concern which may affect the safety of patients. One member of domestic staff told us they would report any concerns to the nurse in charge. Most staff we spoke with told us they received information via email about the outcome of the incident they had reported.
- Appropriate actions and learning were taken in relation to incidents which were regularly monitored and reviewed. For example, there had been an increase in incident reporting with regards to urine output during epidural pain management. In response, changes had been made to the monitoring of urine output. Compliance with these changes was regularly reviewed and demonstrated patients urine output was being effectively recorded.
- The hospital had reported 392 clinical incidents within the reporting period of July 2014 to June 2015. Of these clinical incidents, 209 were 'no harm' events, 170 were 'low harm' events, and 13 were 'moderate harm' events.The overall rate of clinical incidents had remained consistent. However, there was no breakdown of these figures to detail how many related to surgical services. There had been no serious incidents reported within the July 2014 to June 2015 reporting period.
- All incidents were reported at monthly hospital governance meetings which included the Medical Advisory Committee (MAC) meeting, and the quality and safety committee. We saw that action plans had been identified to address any areas of concern and nominated staff assigned to complete them.
- Healthcare organisations have a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm, this is known as Duty of Candour. All grades of staff we spoke with were aware of the principles of Duty of Candour. A senior member of staff explained how patients were informed about investigations into any incidents which related to the care they had received.

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

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. The surgical ward participated in the NHS Safety Thermometer for NHS patients. Senior staff conducted monthly audits in respect to patient falls, pressure ulcers, catheters and urinary tract infections. The audits showed that patients received predominantly 'harm free' care. However, information about the audits was not displayed. It is considered to be best practice to display the results of the Safety Thermometer audits which allows staff, patients and their relatives to assess how the ward has performed.
- The service monitored safety via the electronic incident reporting system. Information gathered through this system was reported in governance meetings and monitored through the quality dashboard.

Cleanliness, infection control and hygiene

- All clinical areas were visibly clean. Staff were seen cleaning equipment after use. Green "I am clean" stickers were consistently used on the ward to notify all staff that the equipment was ready to use..
- Daily, weekly and monthly cleaning rotas were displayed in theatres. Staff were required to sign when cleaning had taken place. Senior staff monitored the completion of the cleaning tasks and the overall cleanliness of the department.
- In the operating theatres we saw staff adhered to the infection control policy. Information was clearly displayed above most sinks to remind staff about correct handwashing procedures. We observed staff were bare below the elbow in clinical areas and were seen washing their hands and using hand gel appropriately.
- On the ward we observed that whilst nursing staff were bare below the elbow medical staff did not consistently

adhere to this policy. Nursing staff described to us some difficulties in ensuring some medical staff followed the bare below the elbow policy. Nurses told us they would prevent medical staff from entering a patient's room if they did not follow correct infection control procedures.

- Hand hygiene gel was available in each of the patients' rooms and at the entrances to the ward, and theatre department.
- Personal protective equipment was available and staff were seen changing gloves and aprons in between patients to prevent the risk of cross infection.
- Regular hygiene and infection control audits were completed which included a quarterly asepsis audit. This contained information about the insertion and management of urinary catheters, and the prevention of surgical site infections. Between July 2014 to June 2015 there had been eight surgical site infections. Results of the audits were reported to the monthly infection prevention and control meeting. However, there was a delay in the development of action plans to address areas for improvement and a lack of clarity regarding the benchmark for the audits. For example, we saw an audit, conducted in April 2015 had not been discussed until July 2015. The audit had identified areas for improvement. For example the management of peripheral devices had scored 70% and prevention of intraoperative surgical site infections had scored 57%. The audit conducted in September 2015 had not been discussed at the time of our inspection. The audit results showed a drop from 75% in April to 25% in September for pre-operative prevention of surgical site infections. Staff were unaware of the benchmark for these audit results and a delay in the production of an action plan to address this area may put patients at risk of developing a hospital acquired infection.
- The staff attendance at infection control updates did not meet the hospital target of above 85%. From information sent to us we saw 44% of staff in theatres had attended the infection prevention practical. For the ward, we saw attendance for infection prevention practical was 74%. There was a risk that not enough staff had attended training to ensure their skills and knowledge were updated.
- Yearly environmental audits were conducted across the service as a whole to ensure the environment was suitable for the delivery of care.
- There had not been any reported incidents of Methicillin resistant Staphylococcus aureus (MRSA) or Clostridium difficile infections between June 2014 and June 2015.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 100% for cleanliness which was higher than the England average of 98%.

Environment and equipment

- The ward and theatres had a portable resuscitation trolley. The trolleys contained medication which was to be used in the event of a cardiac arrest. We saw a daily check sheet which documented all trolleys had been checked to ensure equipment was available and in date. The resuscitation trolley contained in theatres had a tamper evident tag to alert staff to any potential removal of equipment. The resuscitation trolleys on the ward were kept secure via a numbered key pad, however there was no tamper evident tag, as is considered best practice, to further prevent access by unauthorised personnel.
- All surgical areas were well organised and equipment was stored appropriately.
- Equipment was visibly clean and labelled with the last service or maintenance check.
- There were four operating theatres in the theatre suite. All theatres had an adjoining anaesthetic room where patients were prepared for their operation. Separate lay-up rooms were available which enabled equipment to be prepared in advance for the next procedure.
- There was a seven bed recovery ward, equipped with appropriate facilities to care for patients in the immediate post-operative period before they returned to the ward.
- Surgical equipment was planned for in advance. Operating lists were checked six weeks ahead to ensure the availability of equipment. Further equipment could be ordered from a central supplies department that serviced Nuffield hospitals within the area.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 97% for the condition, appearance and maintenance which was better than the England average of 92%.
- Patients had access to physiotherapy equipment if required.

Good

Surgery

Medicines

- Medication was mostly stored correctly within locked cupboards and resuscitation trolleys. On the day of our inspection we noted that one treatment room on the ward was not secure, and the injectable medicines cupboard had been locked open. We bought this to the attention of ward staff who immediately ensured the room and cupboard was locked.
- Medication that required storage at low temperatures was kept in dedicated fridges. The minimum, current and maximum room temperatures were monitored and recorded. Corrective action had been undertaken and recorded when these areas were outside of their recommended temperature ranges.
- There were piped medical gases on the ward and in the theatre suite. Portable oxygen cylinders were available for the transfer of patients from the theatre suite to the ward.
- Ward staff had access to paper and web based medicines information.
- Appropriately packaged and labelled medication was available for patients to take home after their surgery.
- The hospital had links with the two lead UK medicines information acute NHS trusts. This enabled both pharmacists and medical staff to access up to date information about unusual medication or drug interactions.

Records

- There were three dedicated care records which provided a pathway for staff to follow. The care records covered the different types of admission to the hospital; Day case surgery without general anaesthetic, Day and overnight stay surgery (a stay of less than 24 hours) and long stay surgery.
- The care records contained pre-operative assessments, records from the surgical procedure, recovery observations, nursing notes and discharge checklists and assessments.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example all three care records contained risk assessments for venous thromboembolism (VTE) assessments, manual handling and pressure ulcer risk. Patients who were required to stay overnight or for longer periods also had nutritional assessments.
- We reviewed 11 patient records and saw that all relevant assessments had been completed. The entries were legible and had been signed and dated by the member of staff who had completed the assessment.

Safeguarding

- All of the staff we spoke with were clear about their roles and responsibilities and the processes and practices that were in place to keep patients safe and safeguarded from abuse.
- Ward staff described a recent experience and the process they followed when they identified a patient may have been at risk of abuse.
- Staff had attended regular safeguarding training to ensure their knowledge was up-to-date. The hospital target for attendance was above 85%. We saw that 98% of theatre staff had attended safeguarding vulnerable adults, level one and safeguarding children and young people level one training. Attendance figures for the ward were slightly lower but still within the target set by the hospital. 93% of ward staff had attended safeguarding children and young people level one training and 93% of staff had attended safeguarding vulnerable adults training.

Mandatory training

- All staff who worked at Nuffield Health Wessex Hospital were required to attend mandatory training to ensure they had suitable training to care for patients safely. The hospitals target for compliance was above 85%. Staff were provided with a monthly electronic copy of their training record. Completion of mandatory training was regularly monitored by senior staff.
- Mandatory training at the hospital included consent, fire safety, Mental Capacity Act 2005, safer blood transfusions and health record keeping. Staff were able to access training on line and face to face training was available for basic life support, intermediate life support, manual handling and aseptic technique.
- We were sent the attendance records for mandatory training prior to our inspection. We saw for both the ward and theatres that attendance at some mandatory training did not achieve the hospital target of above 85%. For example in theatres, attendance at intermediate life support training was 71%. For the ward, we saw attendance for the manual handling practical was 78%. We discussed this with senior managers in both areas. The managers told us there had

been a change to the recording system used for mandatory training and some training records had not been updated on the new system. We saw attendance records, held by senior staff that demonstrated the majority of training attendance had met with the hospital target of above 85%. Attendance at intermediate life support training had not met the target, and plans had been devised to ensure all relevant staff had attended training by January 2016.

Assessing and responding to patient risk

- Risk assessments were completed to ensure patients were suitable to receive care and treatment at Nuffield Wessex Hospital. These included pressure ulcer risk and assessments for venous thromboembolism (VTE). Rates for screening patients for the risk of VTE were between 99% and 100% for April 2015 to August 2015 which was above the target of 95%.
- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks which may compromise their treatment. The health questionnaires were discussed with patients in the pre-admission clinics. If a patient was identified as being at risk, referral was made by telephone and email to the anaesthetist responsible for the operating list.
- All patients who required surgery were assessed under the American Society of Anaesthesiologists (ASA) grading system for preoperative health of surgical patients. This is a system to record the overall health status of a patient prior to surgery. The system enabled anaesthetists to plan specific post-operative care for patients if required. For example there were two high dependency beds located on the ward. Patients identified as being at risk after surgery were allocated a high dependency bed in advance of their surgery. This was to ensure a bed and appropriate staffing levels were available to care for their needs.
- Staff used the five steps to safer surgery check list. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning of each theatre list and the World Health Organisation (WHO) surgical safety checklist. (A tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). We observed three team briefings and three WHO checklists. Whilst all checks were completed there was a lack of consistency in the team briefs regarding the process staff followed. For example one theatre team completed a thorough briefing which followed a systematic format where all areas of care and treatment were discussed. Another theatre team used a more ad-hoc informal approach. There was a potential risk that areas for discussion may be missed because a systematic approach was not consistently adhered to.
- The completion of the WHO checklist was regularly audited by staff. We saw the observational audit of the check list gained 100% and the documentation audit scored between 93% and 98% for July to September 2015. The target for completion was 95%.
- Staff completed a modified early warning score (MEWS) to assess patients observations. This was a system that enabled staff to record observations and gave protocols to follow if the observations deviated from the patients' norm.
- In the event that a patient's condition deteriorated service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. There was a file available for all staff which gave guidance about the processes to follow and a grab bag with specific equipment that may be required before and during transfer. All staff we spoke with were aware of the processes to follow. There had been eight cases of unplanned transfer of patients to other hospitals during July 2014 and June 2015. These figures are 'similar to expected' when compared to other independent hospitals.

Nursing staffing

- Ward staff used a daily workload analysis tool which calculated staffing levels. Ward staff told us staffing levels were adapted to meet the needs of the patients and the type of surgery they had received. For example extra suitably trained staff were arranged for high dependency patients or patients that required continuous bladder irrigation. All staff reported there was sufficient staff to care for patients on the ward.
- There were no vacancies for nurses and health care assistants on the ward; however agency staff had been employed at times to increase staffing numbers if there was a clinical need.

Good

Surgery

- Staffing rotas showed that staffing in theatres met the guidelines from the Association for Perioperative Practice (AfPP). In our conversations with staff and observation of rotas it was evident that there were always sufficient members of staff on duty.
- Agency staff were often employed in theatres due to the national shortage of theatre staff. Senior staff told us they often block booked staff to ensure there was continuity. Figures for July 2014 to June 2015 showed there was mixed use of agency staff in theatres throughout this period, from less than 20% to greater than 40%. Senior staff told us they tried to 'block book' agency staff to ensure continuity for the service. A member of agency staff confirmed they had been booked continuously for "the last couple of months".
- Nursing staff conducted handovers of care when new staff arrived on duty. We observed a taped handover from the night staff to day staff and a verbal handover for a change of staff during the day. Handover sheets were used and updated with any change to a patients care and plans for discharge. Ward staff told us they felt they obtained sufficient information at handovers to enable them to care for patients effectively.

Surgical staffing

- The hospital employed two Resident Medical Officers (RMO) who worked opposite each other in one week blocks, from Monday to Monday. The role of the RMO was to review patients on a daily basis, prescribe additional medication and liaise with the consultants responsible for individual patients care. The RMO was based on site and was available 24 hours a day, seven days a week. The RMO had appropriate advanced life support training and skills.
- Consultants and anaesthetists worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. Robust systems were in place which ensured consultants only completed operations they were skilled and competent to perform.
- The provider followed processes to ensure all medical staff who worked at the centre had the appropriate skills and competencies which included regular supervision and appraisals.
- All nursing staff we spoke with told us consultants were available out of hours via the telephone for further advice and support. Nurses told us consultants always visited their patients to "check they were ok" prior leaving the building. Emergency cover was provided by the RMO who told us they were always able to contact consultants if required. The Matron confirmed surgeons would return to re-assess their patient if necessary.

Major incident awareness and training

- Senior ward staff told us they had received training in the form of table top exercises which enabled them to develop contingency plans in the event of a major incident.
- All of the other staff we spoke with were aware of where to find local guidance and procedures to follow in the event of a major incident.

Are surgery services effective?

Good

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

We rated effective as "good".

Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed to reflect national guidance.

Information about patient outcomes was routinely collected and monitored. Patient Reported Outcomes Measures were within the expected range for knee replacement surgery.

Patients had access to a variety of methods for pain relief. Patients' pain levels were monitored and responded to appropriately.

People had a comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.

Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005).

Good

Surgery

Consent forms had been signed on the day of surgery. However, the Royal College of Surgeons considers it is best practice for patients to sign consent forms before the date for surgery, to allow patients a 'cooling off' period and consider further treatment options.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example the modified early warning system (MEWS) was used to assess and respond to any change in a patients' condition. This was in line with NICE guidance CG50.
- Adherence to policies and national guidelines was discussed at management and departmental meetings to ensure care and treatment offered was up to date.
- There was an ongoing audit programme to evaluate care and review clinical practice. The audits were undertaken on a monthly basis and the results were either displayed on the providers' quality dashboard or discussed at governance meetings. We saw that most of the areas audited had achieved the targets set locally or nationally. For example medicines reconciliation, completion of the WHO checklist and completion of the modified early warning score met targets set by the provider.

Pain relief

- Patients in the surgical ward reported that they received pain relief in a timely manner. One patient told us "they always ask about any pain I may have and give me painkillers straight away if I need them".
- Staff assessed patients' pain regularly and used a nationally recognised scoring system to record assessments.
- Patients had access to a variety of pain relief appropriate to their operation. This included epidural and patient controlled analgesia (PCA). Patients, who required this type of pain relief, were assessed prior to their operation and information was given to ensure they understood how the delivery of the medication worked. Regular assessments were completed when this pain relief was in situ to ensure patients pain levels were controlled, the equipment worked appropriately and to monitor for any unwanted side effects.
- Patient records showed that pre-operative assessments included details of post-operative pain relief. This ensured patients were aware of the type of medication available to them.

Nutrition and hydration

- Patients received written instructions prior to their admission which advised them about starving times. Information included when they could have their last meal and how long they were able to drink water for prior to their operation.
- For some operations fluid intake and output was monitored and recorded on a fluid balance chart. This was to ensure patients were sufficiently hydrated after their operation.
- Day surgery patients were offered drinks and snacks after their procedures prior to discharge home.
- Patients who were required to stay overnight or longer after their procedure, were given a variety of menu choices. Two patients told us the food was "lovely."
- Menu options were available for patients who required special diets for religious or cultural reasons.
- In the Patient-Led Assessments of the Care Environment (PLACE) for February to June 2015 the hospital scored 99% for organisational food and 96% for ward food.

Patient outcomes

- For the reporting period July 2014 to June 2015, there were eight unplanned readmissions to theatre within 29 days of discharge. For the time period July 2014 to September 2014 this has been assessed by the CQC as 'tending towards better than expected' compared to the other independent acute hospitals this type of data is held for.
- The standardised readmission rate for the reporting period October 2013 to September 2014 showed that readmission rates for cataract, hernia and hip replacement procedures were similar, tending towards better than expected or much better than expected. However, the readmission rates for knee replacement procedures were worse than expected.
- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint

Registry (NJR) which monitors infection and revision rates. We saw that 99% of patients had consented to participate in the register which ensured their care and joint replacements were monitored at a national level.
- Patients were offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients perspective. Between April 2014 and May 2015 data from PROMS showed the hospital was within the expected range for knee replacement surgery with regards to the oxford knee score. (A patient-reported outcome measurement which contains 12 questions on activities of daily living that assess function and pain in patients undergoing total knee replacement).

Competent staff

- Patients told us they thought the staff were "excellent" and "knew what they were doing".
- The hospital quality dashboard showed that 93% of staff had received an appraisal in September 2015. Staff confirmed they had received appraisals which enabled them to have an opportunity to discuss areas for improvement or further development of their role.
- Staff across the service told us they did not have formal supervision but felt they were able to contact senior members of staff for help and guidance at any time.
- The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies. Checks were undertaken which ensured surgeons only performed the procedures they carried out within the NHS.
- The surgeons received supervision and appraisals. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- Nursing staff undertook further competency based training to ensure they had the relevant skills to care for patients. For example, epidural and patient controlled analgesia training.
- Some nurses had undertaken further training as 'link' nurses. For example medicines management, infection control and dementia care. The nurses attended regular meetings and updated ward and theatre staff about any changes to practice that were required.
- Staff were positive about access to further training and development courses. Courses were available externally or 'online' via the Nuffield Academy.

Multidisciplinary working (in relation to this core service only)

- Our review of records confirmed there were effective multidisciplinary (MDT) working practices which involved nurses, doctors, pharmacists and physiotherapists. For example, we saw physiotherapists had followed therapy guidelines documented by consultants.
- There were service level agreements were with the local NHS trusts and ambulance service in the event a patient required rapid transportation to an NHS hospital.

Seven-day services

- The majority of surgical procedures were completed between Monday and Friday.
- A resident medical officer (RMO) was based on site 24 hours a day, seven days a week.
- Consultants were contactable by phone, out of hours. Staff reported consultants were "easy to contact" if required.
- The pharmacy was accessible out of hours. One nurse and the resident medical officer (RMO) each had a key to the pharmacy to ensure medication was available at all times with the exception of controlled medication. In the event that extra controlled medication was required, service level agreements were in place with the two local acute NHS trusts to provide controlled medication out of hours.
- Radiological services were not routinely provided out of hours. However, a radiographer was on call, at home if urgent x-rays or scans were required.

Access to information

- Staff confirmed patient records were accessible to staff across the service.
- Discharge summaries were sent electronically to GPs when patients were discharged from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

- Throughout our visit staff we spoke with were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- Attendance at the Mental Capacity Act (2005) training was mandatory. The target for attendance was over 85%. We saw that 95% of theatre staff and 93% of ward staff had attended the training.
- Surgeons gained consent from patients for surgery. Information about the procedure was given to patients at their initial visit for assessment. Once admitted, on the day of the procedure formal consent was recorded by the surgeon conducting the procedure. We saw that the consent forms had been completed correctly and detailed the risks and benefits to the procedure. However, the Royal College of Surgeons considers it is best practice for patients to sign consent forms before the date for surgery, to allow patients a 'cooling off' period and consider further treatment options.
- During our conversations with staff it became apparent that family members or other members of staff were, at times, asked to assist with interpreting. The use of family or staff members is not considered best practice because staff could not be assured that the patient had given consent for information to be shared

Are surgery services caring?

Good

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

We rated caring as "good."

Feedback from patients about their care and treatment was consistently positive. We observed patients were treated with kindness, compassion and dignity throughout our visit. Patients' privacy and confidentiality was respected at all times.

Patients told us they felt they had sufficient information to enable them to be involved with their care and had their wishes respected and understood.

Flexible visiting hours enabled patients to maintain supportive relationships with those close to them.

Compassionate care

- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received. One patient told us "I am looked after like a gold clock" another patient told us "I am super, super impressed". A third patient told us "they are really kind and reassuring."
- We observed throughout our visit that patients were treated with respect and dignity. Staff knocked on doors and waited for permission to enter and patients told us they were called by their preferred name.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 88% compared to an England average of 87%.
- The hospital participated in the Friends and Family Test. There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to the surgical services. For the reporting period January to June 2015 the hospital reported consistently high levels (between 85% and 96%) of patients would recommend the hospital to their friends and families. The amount of patients who responded to the test was moderate (between 31% to 60%).

Understanding and involvement of patients and those close to them

- Patients on the surgical ward told us they were given sufficient time to ask questions and had enough information about their care. Patients told us they felt well informed about their care.
- We observed nurses explained care and involved patients in plans for discharge during our visit.
- Information was given to patients about their procedures at their pre-admission appointments. All of the patients we spoke with told us they felt they had been given sufficient information pre-operatively to prepare them for the procedure and their post-operative requirements.

Emotional support

- There was open visiting on the surgical ward to enable patients to have support from family and friends.
- Patients were able to contact the ward, after they had been discharged for further help and advice.

Good

Surgery

- If 'sensitive' discussions were needed after the operation or procedure these were held in the patients' private room. These discussions were led by the consultant in the presence of a nurse.

Are surgery services responsive?

Good

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

We rated responsive as "good."

Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service. The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.

The needs of different people were taken into account when services were planned and delivered. There were good examples where staff adapted procedures and worked flexibly to meet individual requirements. For instance, suitably trained staff worked closely with relatives to ensure the needs of patients living with dementia were met.

Complaints and concerns were taken seriously, and responded to in a timely way. Learning from complaints was disseminated in mandatory training sessions and used to improve the quality of care.

Literature was not available to patients who may require it in other languages or formats. This meant patients for whom English was not their first language, or had difficulties with the written word, may not have full understanding about their care and treatment

Service planning and delivery to meet the needs of local people

- Surgical lists were routinely planned between Monday and Friday. Occasionally, extra operating lists ran on a Saturday to meet demand. Patients were offered a choice of dates to best suit their needs.
- Nuffield Health Wessex Hospital provided elective surgery to NHS and private patients for a variety of the specialities which included orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery.
- The hospital did not provide surgical services for children.

Access and flow

- For January 2015 to June 2015 the hospital met the target of 92% of patients waiting less than 18 weeks for treatment following referral (incomplete pathway).
- Dates for surgery were discussed with patients at their initial outpatients appointment. Patients were able to choose to have their operations at times suitable for them.
- All of the patients we spoke with told us they had short waits for their surgery.
- Consultant discharge guidelines had been devised to enable nurses to discharge patients from the ward. This meant patients did not have to wait for a consultant review and were discharged home in a timely manner.

Meeting people's individual needs

- Patients' individual requirements were identified during the pre-assessment appointment and services were planned to meet their individual needs.
- If a patient was identified as requiring high dependency care post operatively, services were planned to meet this need. Senior ward staff ensured extra nurses, with the appropriate training, were scheduled to work for the duration of the patients stay in the high dependency area.
- Staff spoke about adjustments they made to meet the needs of patients living with dementia. One room had been re-furbished with appropriate signage and clocks to enable patients' living with dementia to identify areas within their room. This room was close to the nurse base which enabled members of staff to closely observe the patient. Family members and carers were encouraged to stay and were able to be with the patient in the anaesthetic room and the recovery area to reduce the patients' anxiety. The dementia link nurse disseminated information to the rest of the ward staff and planned care to support the needs of patients. For example they ensured extra and appropriately trained staff were on duty both in theatres and recovery and during their stay on the ward.

Good

Surgery

- Patients with a learning disability, or those with physical or sensory impairment were supported in a variety of ways. One room had an adjoining room which enabled family and carers to stay close by for the duration of their stay. Assistance dogs were able to stay with patients in their bedroom. This was to enable patients' to remain as independent as possible prior to the operation.
- In the Patient-Led Assessments of the Care Environment **(**PLACE) for February to June 2015 the hospital scored 85% for the care environment for patients living with dementia. The England average was 81%.
- For patients whose first language was not English telephone translation facilities were available.
- Information that covered a wide variety of topics was displayed throughout the areas we visited. However, the information printed was only in English. The information was not available in other formats for example pictorial or other languages. This meant patients for whom English was not their first language, or had difficulties with the written word may not have full understanding about their care and treatment.

Learning from complaints and concerns

- All of the patients we spoke with told us they had received information about how to make a complaint. They told us they had no complaints about the care and treatment they had received at Nuffield Wessex hospital.
- All complaints were monitored by the hospital director and responded to in line with Nuffield hospitals policy. Complaints were investigated by the relevant head of department with involvement from consultants and nurses if required.
- We saw that monthly or quarterly reports had been produced to help identify any trends or issues which required further investigation. Action plans were devised to address any concerns along with lessons learnt. For example staff told us call bell volume on the ward had been reduced after 11pm as a response to complaints from patients. Staff confirmed that lessons learnt as a result of complaints were discussed on monthly mandatory training days.
- Nuffield Wessex hospital received 35 complaints in 2014 which was a slight increase on the 33 complaints received in 2013.

Are surgery services well-led?

Requires improvement

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

We rated well-led as "requires improvement."

Risk, quality and governance structures and systems, managed at departmental, hospital and corporate levels were in place to share information and learning. However, with regards to infection control, arrangements for governance and issues with poor performance regarding the outcome of infection control audits were not always dealt with in a timely way. There was a lack of clarity regarding the benchmark for the audits and a delay in the development of action plans to address areas for improvement. This may put patients at risk of developing a hospital acquired infection.

A systematic approach to the completion of the World Health Organisation (WHO) surgical safety checklist had not been fully embedded across all surgical specialities.There was a clear statement of values and beliefs driven by quality and safety. The recent refurbishment had enabled strategic objectives to be developed with an aim to increase the amount of operations performed at the hospital.

Staff across the service described an open culture and felt well supported by their managers.

A recent refurbishment had improved services, and seen a 35% increase in activity since completion.

Vision and strategy for this this core service

- All staff we spoke with were aware of the hospital wide values and were able to describe them to us. These were designed to form the acronym EPIC and were enterprising, passionate, independent and caring.
- Senior managers told us that since the refurbishment they had developed a strategy to increase their surgical activity. In order to achieve this they had identified they needed to grow their clinical and non-clinical teams and ensure they maintained high standards of clinical care.

- Staff were clear about the corporate vision for the service which was 'to improve the health of the nation'.
- All staff we spoke with were passionate about the service they provided and believed they consistently put the patient first.

Governance, risk management and quality measurement for this core service

- There was a three month delay in the reporting of infection control audits to the infection prevention and control meeting. Action plans for improvement were not developed in a timely manner which may put patients at risk of developing a hospital acquired infection. For example the audit conducted in September showed a significant decrease from 75% to 25% for pre-operative prevention of surgical site infections. At the time of our inspection no action plan had been produced to address this risk.
- The investigations conducted into the never event showed issues with communication had been identified as part of the contributory factors. We saw variable compliance with the completion of the World Health Organisation (WHO) surgical safety check list. Whilst the completion of the WHO check list had been monitored there was no monitoring to confirm staff followed a consistent structured format to ensure all areas for discussion were identified before the operation commenced.
- There was a clear governance structure for the surgical service. Service wide meetings were held which oversaw quality, audit and risk activity performance.
- All service wide meetings reported to the quality and safety committee and the medical advisory committee (MAC).
- Consultants from a variety of surgical specialities attended the MAC meetings on a quarterly basis. We saw from records that a variety of topics were discussed for example incidents, complaints, practising privileges, and NICE guidance. Action plans were identified and monitored at the meetings. Consultants we spoke with, and senior hospital managers, described the MAC as being "highly engaged and effective"
- There was one hospital wide risk register. The register detailed 9 risks which were identified as a potential risk to the hospital as a whole. These risks included; health and safety, NHS contract compliance and hospital capacity management. Action taken to mitigate identified risks was detailed with named individuals and time plans for review dates.
- Managers within ward and theatres were aware of the specific risks to their areas of work.

Leadership / culture of service related to this core service

- Staff felt they worked "as a team."
- All staff we spoke with were passionate about the beliefs and culture of the hospital. They told us there were five beliefs which were; being straight with people, taking care of the small stuff, caring starts with listening, and a belief in staff, that treatments should be evidence-based and commercial gain can never come before clinical need. Staff felt the beliefs were fundamental to the culture of the hospital and that patients came first.
- All of the staff we spoke with spoke positively about executive team and the senior members of staff at the hospital. They told us they were visible and approachable. One member of staff told us "they are brilliant, you can go and see them anytime if you are concerned about anything"
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- All staff were positive about their relationships with their immediate managers. Staff in all areas told us they felt they worked well as a team. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.

Public and staff engagement

- Staff asked patients to complete satisfaction surveys about the quality of care provided. Figures for December 2014 to October 2015 were positive, with ratings between 93% and 96% of patients happy with their care. The results of the surveys were discussed at governance meetings.
- The hospital asked staff to complete yearly staff surveys. The results of the hospital as a whole exceeded the Nuffield Health average. For example 96% of staff would recommend the hospital to friends and family compared to 91% for Nuffield Health as a whole.

Innovation, improvement and sustainability

Good

Surgery

- The hospital had undergone significant refurbishment between April 2012 and February 2014 to improve the services on offer. The hospital had seen a 35% expansion in activity since the refurbishment.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at the Wessex Nuffield Hospital provides a wide range of speciality appointments including gynaecology, ophthalmology, ENT, urology, dermatology, orthopaedics, maxillofacial and general surgery. The diagnostic imaging service provides access to plain film x-ray, magnetic resonance imaging (MRI), computerised tomography (CT), mammography, ultrasound, bone densitometry and fluoroscopy. Between July 2014 – June 2015, the outpatient department at the Wessex Nuffield hospital provided 10,818 new patient appointments and 8,008 follow up appointments.

The outpatient department operates between 8.30am and 9.00pm Monday to Thursday, between 8.30am and 5.00pm on Fridays, and alternate Saturdays between 8.30am and 3.00pm. The operating times within diagnostic imaging services is between 8.30am and 9.00pm Monday to Thursday and from 8.30am and 5.00pm on Fridays.

There are ten general consulting rooms, a gynaecology suite which includes two further consulting rooms and one treatment room, a dental suite for consultation and treatment, a dedicated ophthalmology room and an ENT room which incorporates an audiometry booth. Minor operations are carried out within the outpatient department and there is a dedicated room allocated for these procedures.

During the inspection we visited the outpatient department and diagnostic imaging services. We spoke with 16 patients and 14 members of staff including, nurses, consultants, radiographers, health care assistants, radiography department assistants, administrators and managers.

Throughout our inspection we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at computerised records and patient care records. We looked at the environment and at equipment being used. We observed care being provided.

Good

Outpatients and diagnostic imaging

Summary of findings

Staff had a good understanding of how to report incidents and learning from incidents was shared at a departmental level. Staff undertook appropriate mandatory training for their role and were supported to keep this up-to-date. Clinical areas and waiting rooms were all visibly clean and tidy. Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers guidelines. Infection prevention and control practices were followed and these were regularly monitored, to prevent the unnecessary spread of infections. Medicines were stored securely. Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging. Nursing staff felt that the outpatient department staffing was sometimes low due to staff covering pre-assessment clinics. Agency staff were not used, however longstanding bank staff were occasionally employed to cover additional sessions. Patient records were available prior to a patient being seen. Staff received training, to ensure they could appropriately respond if a patient became unwell.

National guidelines were used, however, there was limited evidence that clinical audits were being undertaken in all outpatient areas, including recording of patient reported outcomes. Staff were supported in their role through appraisals. All staff were appraised. Staff were encouraged to participate in training and development to enable them to deliver good quality care. There was evidence of multidisciplinary team working in the one stop breast clinic. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Patients pain needs were met appropriately during a procedure or investigation. Clinics were held mainly in the week and evenings, with some Saturday clinics.

During the inspection we observed and were told by patients that staff in the outpatient department and within diagnostic imaging were caring and compassionate. Patients and relatives commented positively about the care provided from nursing, radiography and medical staff. They were treated courteously and respectfully. Patient privacy and dignity was maintained. Patients were kept up to date with and involved in discussing and planning their care and treatment. They were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively. Emotional support was provided to patients. They commented they had been well supported emotionally by staff.

Services were planned and delivered in ways which met the needs of the local population. Clinics were generally held on weekdays and evenings with alternate Saturday clinics to accommodate patients who had commitments during the week. Patients told us there was good access to appointments and at times which suited their needs. To accommodate a patient who was too unwell to travel, the outpatient department facilitated treatment off site.

The gynaecology treatment suite was separate to the main outpatient facility which ensured patients had access to a private and comfortable treatment area. There was information on specific procedures or conditions, but this information was only in English and not in other languages or formats, such as braille or easy read. In diagnostic imaging the information leaflets were in very small print.

Interpretation services were available. However information about the interpretation service was not clearly displayed in patient waiting areas. Staff made reasonable adjustments to accommodate patients with dementia or living with a learning disability. Patients were encouraged to provide feedback after their outpatient appointment by completing a patient satisfaction survey. The results of these were displayed in waiting areas.

The Outpatient and diagnostic imaging departments were well-led. The department had a vision to provide high quality care in a timely and effective way. Staff and managers were aware of this vision. Staff felt supported, and were able to develop to improve their practice. There was an open and supportive culture.

Patients were given opportunities to provide feedback about their experiences and this was used to improve the service. Staff in all outpatient areas stated they were

Good

Outpatients and diagnostic imaging

well supported by their immediate line managers. All staff during inspection spoke very highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.

An improvement plan has been put in place following national concerns, to ensure that radiologists are able to use all imaging equipment.

Are outpatients and diagnostic imaging services safe?

Good

Patients in the outpatients and diagnostic imaging departments were protected from the risk of abuse and avoidable harm.

We rated safe as 'good.'

Staff had a good understanding of how to report incidents and learning from incidents was shared at a departmental level. Staff undertook appropriate mandatory training for their role, and were supported to keep this up-to-date.

Clinical areas and waiting rooms were all visibly clean and tidy. Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers guidelines. Hospital infection prevention and control practices were followed and these were regularly monitored, to prevent the unnecessary spread of infections. Medicines were stored securely.

Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging. Nursing staff said the outpatient department staffing was sometimes low due to staff being required to cover the pre-assessment clinics. Agency staff were not used, but longstanding bank staff were occasionally employed to cover additional sessions.

Patient records were available prior to a patient being seen.

Staff received training, to ensure they could appropriately respond if a patient became unwell.

Incidents

- In the outpatient and diagnostic imaging departments, staff were aware of their responsibility to report incidents. Staff reported these on an electronic reporting system. All of the staff we spoke with were confident in reporting incidents and told us that they were updated with the outcome of incidents during team meetings. Learning was shared at these meetings to improve patient outcomes. During our inspection we saw minutes of team meetings where incidents had been discussed and changes in practice made as a

result. Copies of the minutes were filed in the nurses' station office and all staff demonstrated knowledge of where these could be found or referred to when necessary.

- There had been one serious incident within the diagnostic imaging department during November 2015. A power surge had caused heat damage to electrical components which resulted in smoke being generated within one of the imaging rooms and the department had been successfully evacuated. There was no harm caused to any patient or member of staff. Following this incident, risk assessments had been completed to mitigate any risk, in the unlikely event that this incident should reoccur in the future. The risk assessments and action plans were seen during inspection and appeared to satisfactorily mitigate any further risk. The cause of the power surge was under investigation.
- IR(ME)R incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents.

The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient's safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred. All staff told us they had received information and training about the Duty of Candour. We observed signed training logs which confirmed this. Staff gave good examples of what Duty of Candour meant and what their roles and responsibilities were as a hospital, in line with the Duty of Candour regulation.

Cleanliness, infection control and hygiene

- All outpatient and diagnostic imaging waiting areas and clinical rooms were visibly clean and tidy. Cleaning schedules for all areas were seen and had been fully completed.
- Hand sanitizer points were available to encourage good hand hygiene practice. We observed staff adhered to the 'bare below the elbow' guidance which enabled thorough hand washing, and to prevent the spread of infection between staff and patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff used them appropriately.
- In diagnostic imaging, the lead aprons used to protect radiographers during imaging were CT scanned annually to ensure the quality of the lead. They were also visually checked (these checks were recorded) for cleanliness on a daily basis.
- Infection control practices were monitored by the infection prevention and control lead, who attended departmental meetings. Infection control action plans were produced corporately and tailor made for each department, displaying their performance and what areas should be focussed on to improve performance and provide thorough infection control processes. In outpatient clinics, each member of staff was responsible for the cleanliness of a specific area of the department, which was audited weekly by the outpatient lead. Regular infection control audits were conducted and a recent hand hygiene audit showed 96% compliance. Staff we spoke with were aware of the outcomes from audits. The infection control lead nurse shared information with staff at team meetings.
- In-line with current best practise the outpatient department had a 0% MRSA rate (June 2014 to July 2015).

Environment and equipment

- Equipment was visibly clean. During inspection, we looked at 15 pieces of equipment and all the portable appliance testing (PAT) had been undertaken and was up-to-date. Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment and whom to report this to. They ensured the item was removed from the clinical area to prevent further use until it had been repaired. We spoke to the maintenance team who confirmed that an annual audit was carried out of all the equipment requiring PAT. This ensured nothing was missed and all equipment worked correctly
- Staff did not report any concerns regarding availability or access to equipment. Senior management were reported as being supportive to requests for new equipment if it improved outcomes for patients. In the outpatient department 'Friends of Nuffield' had

purchased a new piece of equipment which enabled staff who provided phlebotomy services, to obtain samples from patients for whom venous access was difficult.
- In diagnostic imaging rooms, IR(ME)R local rules were displayed and up to date.
- In the outpatient minor operations room, single use items were stored in clearly labelled drawers and were well stocked. A sample of items within the minor procedures room was found to be in date.
- Decontamination of equipment was provided by an outsourced company. The 'dirty' equipment was taken in a sealed box from the outpatient room to the main theatres within the hospital and collected for decontamination. Most of the equipment used during minor ops were single use items.
- Rubbish disposal was well managed by the housekeeping team and nursing staff to ensure that bins never overflowed. All items were clearly separated into domestic and clinical waste bins.
- Emergency call bells were situated in the clinical rooms.
- Resuscitation equipment was maintained, in order and ready for use in an emergency. Trolleys were checked daily and records kept to demonstrate that checks had been completed. Once a month all contents in the trolley were checked and any items due to expire that month were thrown away and replaced. The trolleys were secured with tamper evident seals.

Medicines

- Medicines were stored safely. All medicines cupboards were locked and the keys held by the lead nurse on duty. Fridges were locked and temperatures checked daily and logged, to ensure medicines were stored at the correct temperature.
- In main outpatients, prescription pads were stored in lockable drawers within the nurses station office, the office was accessed securely via a door key pad.
- In diagnostic imaging non controlled drugs were stored in a drugs cupboard and access was allowed via a key pad.
- The medication cupboard was temperature controlled. Up-to-date records were seen and temperatures were within the correct range (2 – 25 degrees celsius).
- The resident medical officer (RMO) prescribed medication for the imaging department if required and in the absence of a consultant radiologist.

Records

- At the time of inspection we saw patient personal information and medical records were managed safely and securely. During clinics, all clinical notes were kept in a locked office and transferred to the consultant by the clinic nurse when the patient arrived. Staff told us that they had no difficulty in retrieving patient notes for clinic appointments.
- Patient records were held securely on site in the medical records room. There was an archive facility for patient notes that was located off site.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.
- Image transfers to other hospitals were managed electronically using the Image Exchange Portal (IEP).

Safeguarding

- Safeguarding training for vulnerable adults was mandatory for all staff. All the staff we spoke to were aware when to raise a concern and the process they should follow, but had not had to raise any recent concerns. Compliance with safeguarding training was 98% in diagnostic imaging and 90% within the outpatients department.
- During the inspection we spoke to administrators, nursing and radiography staff on several separate occasions, regarding their responsibilities to safeguard adults. When presented with a scenario, all were able to give a satisfactory response as to how a safeguarding incident should be reported. Staff knew how to locate the safeguarding flow chart, which was available as guidance for all staff and was seen by the inspection team.
- Children were not seen within the Wessex Nuffield hospital outpatient and diagnostic imaging departments and therefore, paediatric safeguarding was not included within the mandatory safeguarding training.
- The diagnostic imaging department had a 6 point patient identification check; patient name, date of birth, address, body area, justification of test and date of last x-ray. The identification policy highlighted what should be checked, but did not refer to how this was documented. Verbally, senior radiographers stated that they ticked each ID check and then initialled the form.

Approximately 12 forms were checked to establish if the ID checks had been completed. The justification criteria was not consistently checked. (i.e. the clinical criteria for the test) eight of the 12 request forms did not have the justification criteria checked. All other criteria had been checked in-line with the hospital policy.

Mandatory training

- Staff completed a number of mandatory training modules as part of their induction, and updated them in line with hospital and corporate policy. This included infection prevention and control, fire safety and basic or intermediate life support. The training was mainly via e-learning packages, with practical sessions for basic/ intermediate life support and manual handling. In diagnostic imaging compliance with mandatory training was at 98% and in the outpatient department mandatory training was 92%.
- None of the staff we spoke with reported any difficulty in finding time to complete their mandatory training.
- The medical physics team; based at a London Trust, provided radiation protection training for the Radiation Protection Supervisors (RPS) within the diagnostic imaging department. Up-to-date records were seen with good compliance for radiation protection updates.
- We spoke to a bank member of staff on duty, who confirmed that they were up to date with mandatory training and had received an appraisal. This was corroborated when we looked at bank staff training documents.

Assessing and responding to patient risk.

- In the minor operations room, a risk assessment tool had been adapted from the World Health Organisation (WHO) surgical checklist. It was specific to minor operations and was in use for all appointments where outpatient surgical procedures were being undertaken. The assessment tool was a relatively new implementation within the department, and had not yet been audited to demonstrate whether it had improved safety.
- Staff in outpatients were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. All radiographers and registered nurses in the outpatients and diagnostic imaging had received training in intermediate life support, with all other staff trained in basic life support. Any changes in a patient's condition would be documented in the patient's care record and in the outpatient day book. There was no specific assessment tool used to identify a patient who became unwell.
- Staff completed scenario based training, including resuscitation simulation, every quarter. Staff received feedback during the session about how the team responded to the situation, with learning points and actions to take away.
- There was always a registered medical officer (RMO) on duty, who was trained in advanced life support to assist if a patient became unwell. Patients who became medically unwell could be transferred to the local acute NHS Trust by ambulance if required.
- The principal function of the Radiation Safety Committee is to ensure that clinical radiation procedures and supporting activities are undertaken in compliance with ionising and non-ionising radiation legislation. The committee meets annually and minutes and actions are received by the Radiation Protection Supervisor (RPS). There were two appointed and trained RPS within the diagnostic imaging departments, whose roles were to ensure that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures. Evidence was seen that these checks and procedures were being completed correctly.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.
- The last menstrual period (LMP) policy was seen and met IR(ME)R requirements and was up to date. Examples of completed LMP forms were seen and scanned onto the radiology information system.

Nursing and radiography staffing

- Nursing and radiography cover was sufficient in outpatient and diagnostic imaging areas. However, some outpatient department nurses who had completed additional competencies, also covered the pre-assessment clinics which led to shortages within the main outpatient department. Staff had been asked to move from their role in outpatients to staff pre-assessment appointments during busy periods, or to cover staff sickness absence. Remaining outpatient

Good

Outpatients and diagnostic imaging

staff told us that, they found this difficult as they were then stretched too thinly in the main clinics. There are no set guidelines on safe staffing levels for outpatient clinics. However, the nurse in charge of outpatients from experience, was aware of how many staff were required to safely manage the capacity of each clinic.

- There were no agency staff used within outpatients or diagnostic imaging. There were three radiographers who were permanent bank staff; they supported the department when staffing levels were low; e.g. to cover leave. Bank staff were also used to support the outpatients department when necessary.
- There were no current vacancies in diagnostic imaging and one health care assistant vacancy in outpatients. In Diagnostic imaging there were 11 radiographers and three radiography department assistants (RDA). In the outpatients department there were nine registered nurses and five health care assistants.
- Nurses from the ward supported the consultant radiologist when required, for interventional procedures.

Medical staffing

- There were 22 radiology consultants; there were no difficulties with availability of consultants in the imaging department. Within the outpatient department, consultants covered all specialities for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.
- Practising privileges is an authority granted to a doctor, by a hospital board, to provide patient care within the hospital. The practising privileges for the outpatient doctors were checked during inspection, these were all up-to-date.
- There was a resident medical officer (RMO) based within the hospital that could be called upon by diagnostic imaging and outpatients when required. Staff reported no concerns in being able to reach the RMO when required.

Major incident awareness and training

- There was a member of the senior management team on duty each day responsible operationally for any major incident affecting the hospital. Staff did not know of their individual responsibilities within a major incident, but were aware who to contact if an incident should arise.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

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

National guidelines were used, but there was limited evidence that clinical audits were being undertaken in outpatients, including recording of patient reported outcomes.

Staff were supported in their role through appraisals. All staff were appraised. Staff were encouraged to participate in training and development to enable them to deliver good quality care.

There was evidence of multidisciplinary team working in the one stop breast clinic. The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Patients pain needs were met appropriately during a procedure or investigation. Clinics were held mainly in the week, with some Saturday clinics.

Evidence-based care and treatment

- Radiation Exposure/diagnostic reference levels (DRL) were audited regularly and evidence of these were seen during inspection. They were within expected ranges.
- Clinical audits were undertaken in diagnostic imaging. An audit plan and the results of these were observed during inspection. For example, the audit of the pregnancy status checklist completion had revealed that 100% compliance had been achieved in radiographers signing to confirm that they had discussed this with their patients.
- IR(ME)R audits were undertaken in line with regulatory responsibility, copies of these audits, outcomes, actions and results were seen during our inspection.
- Staff in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.

Good

Outpatients and diagnostic imaging

Pain relief

- Options for pain relief were discussed with patients prior to any procedure being performed. Many procedures were undertaken with the use of local anaesthetic, which enabled patients to go home the same day. Patients were given written advice on any pain relief medications they may need to use during their recovery at home.

Patient outcomes

- In diagnostic imaging the computerised tomography (CT) team were participating in a clinical research scans trial for patients who were receiving palliative care from a local NHS Trust. Protocols for research were agreed and seen before a patient commenced treatment. Patients had to consent to the trial and were informed prior to the research scans commencing that the scans were for research purposes only, which enabled the department to meet their requirements under IR(ME)R.
- There was limited evidence that clinical audits were being undertaken in outpatients, including recording of patient reported outcomes

Competent staff

- Patients told us they felt staff were appropriately trained and competent to provide the care they needed. This was confirmed by staff who felt well supported to maintain and further develop their professional skills and experience.
- In the period June 2014 to July 2015, 98% of outpatient nursing staff and healthcare assistants had received an appraisal. In the same period, 99% of radiographers and radiography department assistants had received an appraisal.
- Practicing privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection.
- Nursing staff within the outpatient department told us that the hospital provided a revalidation study day to ensure that registered nurses were all aware of the revalidation process and what their responsibilities were in relation to this. All nurses were familiar with revalidation and felt well supported by their manager in obtaining this status.

Multidisciplinary working (related to this core service)

- There was evidence of effective multidisciplinary team (MDT) working within the one stop breast clinics. Patients saw a radiologist, outpatient consultant and nurse which ensured efficient delivery of care and treatment to patients attending the clinic. If there was a cancer diagnosis, patients were referred to the breast clinic MDT meetings at the local acute NHS trust.
- We observed, there was effective team working, with particularly strong working relationships between consultants, nursing staff and radiographers.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday, with clinics running from 8.30am to 9.00pm Monday – Thursday, and between 8.30am to 7.00pm on Fridays. Clinics were also held on alternate Saturdays between 8.30 and 3.00pm. Patients we spoke to reported good access to appointments and at times which suited their needs.
- In diagnostic imaging, scans, x-rays and ultrasounds were available between 8.30am and 9.00pm Monday to Thursday and between 8.30 and 5.00pm on a Friday. During the weekend and overnight, radiographers were on call from home. There was support from radiologists out of hours if required.

Access to information

- Staff we spoke with reported timely access to blood test results and diagnostic imaging. Results were available for the next appointment or for certain clinics, during that visit. This enabled prompt discussion with the patient on the findings and treatment plan.
- Diagnostic imaging results were available electronically, accessible by the clinician during clinic appointments.
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for their treatment.
- Patient notes were always available to ensure continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of general x-ray procedures were carried out using implied consent from the patient.

Good

Outpatients and diagnostic imaging

- Consent forms were well completed for interventional procedures e.g. facet joint injections.
- All staff were aware of the the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff knew what their responsibilities were in relation to the MCA and DoLS and how to apply this within everyday practice. Staff received mandatory training in relation to this.

Are outpatients and diagnostic imaging services caring?

Good

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

We rated 'caring' as good.

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

During the inspection we observed and were told by patients that staff in the outpatient department and within diagnostic imaging were caring and compassionate. Patients and relatives commented positively about the care provided from nursing, radiography and medical staff. They were treated courteously and respectfully.

Patient's privacy and dignity was maintained. Patients were kept up to date with and involved in discussing and planning their care and treatment. They were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively.

Emotional support was provided to patients. Patients commented that they had been well supported emotionally by staff.

Compassionate care

- All of the patients spoken with during our inspection, were positive about the care they had received. We received comments such as; 'excellent service', 'polite caring staff', 'polite and friendly', 'cannot fault the services from start to end' were made. There were no negative comments from any patients within outpatients and diagnostic imaging.
- We observed that patients' dignity was maintained and they were afforded privacy at all times. The main outpatient reception desk and diagnostic imaging reception were sufficiently distant from waiting areas so patients could speak to reception staff confidentially, without their conversation being overheard. We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- We observed an incident of care provided to an outpatient by a member of the reception staff. The patient was in obvious discomfort .They were quickly assessed and moved to an area to be seen by the consultant without any delay. This provided comfort not just to the patient, but also to his wife.
- Many clinics provided chaperones for clinics. In Gynaecology, all patients received a chaperone. Nursing staff were observed asking patients if they would like a chaperone when arriving for appointments.
- Throughout the inspection, we saw that staff spoke in a calm and relaxed way to patients. All the patients we spoke with told us that staff were friendly, helpful and caring. They told us staff always showed concern and understanding for their situation and were sensitive to any needs or worries they had.
- We saw staff were kind and considerate to patients – in particular the care and compassion given to a cancer patient who was undergoing a scan within the CT department.

Understanding and involvement of patients and those close to them

- All the patients we spoke with, told us they had been provided with relevant information, both verbal and written, to make an informed decision about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- In diagnostic imaging, the department actively encouraged patient feedback. Outcomes of bi-monthly patient satisfaction surveys were displayed in the waiting area. All with excellent results.

Emotional support

- Patients commented that they had been well supported emotionally by staff, particularly if they have received upsetting or difficult news at their appointment.
- During our conversations with staff it was clear they were passionate about caring for patients and clearly put the patient's needs first.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

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

We rated 'responsive' as good.

Services were planned and delivered in way which met the needs of the local population. Clinics were generally held on weekdays and evenings with alternate Saturday clinics to accommodate patients who had commitments during the week. Patients told us there was good access to appointments and at times which suited their needs.

To accommodate a patient who was too unwell to travel, the outpatient department facilitated treatment off site.

The gynaecology treatment suite was separate to the main outpatients facility which ensured patients had access to a private and comfortable treatment area.

There was information on specific procedures or conditions, but this information was only in English and not in other languages or formats, such as braille or easy read. In diagnostic imaging the information leaflets were in very small print. Interpretation services were available, but information on this was not clearly displayed in waiting areas. Staff made reasonable adjustments to accommodate patients with a dementia or living with a learning disability.

Patients were encouraged to complete a patient satisfaction survey which provided feedback after their outpatient appointment. The results of which were displayed in waiting areas.

Service planning and delivery to meet the needs of local people

- Services were well planned and the facilities appropriate to support the running of clinics. Clinics were held Monday to Friday until 9.00pm in the evening and alternate Saturdays to accommodate patients with commitments during the working week.

Access and flow

- The majority of patients seen in the outpatient department were self-funded, or funded by other means. A small minority of NHS patients were seen within the hospital using the 'choose and book' system. Patients could book their appointment online, visit or ring the booking office, which enabled them to choose an appointment time which suited their needs.
- All patients we spoke with felt the availability of appointments was good and appointments were provided at times that fitted in with their needs. The majority of patients left with their next appointment date or if appropriate, an admission date for surgery. Patients were very complimentary about the efficiency of the service as a whole.
- The clinics we observed mostly ran to schedule, but patients could wait up to 30 minutes to see their consultant. Staff told us if there were delays, they would speak to patients and keep them informed. During our inspection we observed staff updating patients when delays occurred. There were no delays in waiting for appointments within diagnostic imaging upon arrival at the hospital.
- Patients could be given an outpatient appointment on the same day, but generally appointments were given within a week of contacting the hospital. The outpatient department was meeting its referral to treatment time (non-admitted) pathway and 96% of patients were seen within 18 weeks. In diagnostic imaging, the department was meeting its target to see patients within 6 weeks. Most patients were given an appointment for x-rays, scans or ultrasounds within one week.

Meeting people's individual needs

- Staff told us about a patient who had been too unwell to attend for an outpatient appointment to have a capsule endoscopy. The patient lived some distance away. It was agreed by senior management, that an outpatient nurse would travel to the patient with the equipment necessary to perform the procedure to ensure that the appointment went ahead as planned. This was a good example of a responsive service.
- The gynaecology suite within the outpatient department demonstrated a responsive service for women undergoing intimate examinations and procedures. The waiting area was separated from the main waiting area, with the main suite separated again. There was a room to undress, a bathroom and the

examination room all with connecting doors which ensured patients privacy was protected during their appointment. Staff recognised the need for supporting people with complex or additional needs such as people living with dementia or a learning disability. Nurses gave examples of bringing appointments forward during clinics, to accommodate patients living with dementia who may be distressed.

- There was ample seating in waiting areas. All consulting rooms and communal spaces were wheelchair accessible.
- There was complimentary refreshment facilities provided in the waiting areas.
- All written information and signage, including pre-appointment information was provided in English only. There was a telephone interpreting service provided by language line, but not all staff were aware of it.
- Information leaflets were not provided in easy-read format. There was no information on display to advise patients how to access information in large font, braille or audio, nor was this printed on any leaflets.
- In diagnostic imaging, patient information leaflets were available for all tests except for ultrasound. Instructions for ultrasound patients were given over the phone. Some of the leaflets provided for other tests appeared to be commercially provided with clear text and supporting pictorial information. Others were too complex, with small text and no supporting diagrams.
- Patients were sent appropriate information prior to their first attendance, this contained information such as the consultant or clinic they were to see, length of time for the appointment and written information on any procedures which may be performed at the first appointment, including the cost of the appointment and subsequent procedures (for self-funding patients).

Learning from complaints and concerns

- Patients were actively encouraged to leave comments and feedback via the patient satisfaction survey. The data was collated and results displayed in waiting areas. Patient feedback was included on the displays but there was no written response to these comments to indicate any changes that had been made in light of comments from patients. Complaints leaflets were available in the waiting areas for patients who wished to make a formal complaint.
- If a patient wanted to make a complaint, staff told us they would ask their immediate line manager/service manager to speak to the patient. Most complaints were resolved locally. The outpatient and diagnostic imaging teams had not received any written complaints during the year preceding our inspection. Generally, staff felt that if there were any issues raised by patients, it was usually concerns about the 30 minute wait to see a consultant.

Are outpatients and diagnostic imaging services well-led?

Good

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

We rated 'well-led' as good.

Outpatient and diagnostic imaging departments were well-led. The department had a vision to provide high quality care in a timely and effective way. Staff and managers were aware of this vision. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture.

Patients were given opportunities to provide feedback about their experiences and this was used to improve the service. The learning and changes as a result of feedback were not visibly shared with patients.

Staff in all areas stated they were well supported by their immediate line managers. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital.

An improvement plan has been put in place following national concerns, to ensure that radiologists are able to use all imaging equipment.

Vision and strategy for this this core service

- Staff spoke enthusiastically about the service they provided and were proud of the facilities they worked in and the care they could offer to patients.

Good

Outpatients and diagnostic imaging

- Staff had a clear vision for the service and were aware of the overall vision for the hospital. The vision was to provide high quality care in a timely and effective way.

Governance, risk management and quality measurement for this core service

- There was a hospital wide risk register which was updated regularly. The outpatient and diagnostic imaging departments held their own departmental risk register which identified specific risks in that area which may affect staff, patients and visitors. The risk register also reflected what action was to be taken to mitigate these risks. The departments provided the senior management team (SMT) with a weekly report, which effectively updated them with operational information from that week. This included any risk issues.
- We saw minutes of the Medical Advisory Committee (MAC) meeting which covered areas of good practice and risk and included outpatients. Minutes from the MAC meeting were circulated to all the consultants for information.
- The outpatient department had its own risk folder, which identified risks, the people who could be affected by the risk, assessment of risk and controls to reduce the level of risk. These risks did not appear on the hospital risk register, but the departmental leads were clear about their key risks and how to mitigate the risks to patients.

Leadership / culture of service

- Front line staff were very positive about the leadership at departmental and senior management level. They told us the leadership team were visible and approachable and if they had any concerns, these were listened to and were acted upon. Staff felt their immediate manager had the appropriate skills to lead and run their department and was supportive.
- Unit leads told us they were able to identify constraints to their services and suggest changes which could be made, to maintain the standard of care provided to patients. They felt that the senior management team were very focussed on patient care as their main priority and could be relied upon to action, wherever possible, any issues that improved the patient experience. They were given regular feedback from the senior management team on how well the service was performing.
- Staff reported an open and transparent culture which was apparent during our inspection.

Public and staff engagement

- Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The results of the survey were used by departments to improve the service. However, although outcomes were displayed in waiting areas, actions for making improvements were not available for patients to read.
- The outpatient and diagnostic imaging departments sought staff engagement through monthly meetings between where staff opinions were discussed and updates given. Meeting minutes were seen during our inspection.

Innovation, improvement and sustainability

- It was reported as a national concern within the NHS that radiologists were not being trained how to use some imaging equipment. In response to this, the radiology manager had introduced an induction programme for the consultant group. All had received formal training which was documented for each individual with competencies signed off. Records were seen during our inspection for all of the consultants. The induction programme also included the radiographers.

Outstanding practice and areas for improvement

Outstanding practice

Staff told us about a patient who had been too unwell to attend for an outpatient appointment to have a capsule endoscopy. The patient lived some distance away. It was agreed by senior management, that an outpatient nurse would travel to the patient with the equipment necessary to perform the procedure to ensure that the appointment went ahead as planned. This was a good example of a responsive service.

Areas for improvement

Action the provider MUST take to improve

- Review the use of the recovery area in the endoscopy unit, to ensure a patient's privacy and dignity is not compromised.

Action the provider SHOULD take to improve

- An operational policy for the endoscopy suite is produced as per hospital action plan.
- A review of the management of the endoscopy procedure lists, in respect of male and female patients being on the same list.
- A risk assessment regarding the movement of endoscopes from main theatres to the decontamination room in the endoscopy suite needs to take place.
- A system in place that emergency medicines are always available in the endoscopy unit.
- A review of the positioning of resuscitation equipment during endoscopy procedures.
- Ensure tamper evident tags are used to ensure resuscitation equipment always available for use.
- A review of pre assessment health record to include younger people who may have a dementia.
- Awareness is raised of when to use an interpreter.
- A review of the risk assessment to manage the hazard of trailing wires in the endoscopy treatment room.
- Continued work to ensure compliance with WHO checklist is documented.
- Cleaning schedules need to be displayed for public and staff.
- A cleaning checklist for items cleaned by theatre staff in the endoscopy unit.
- A review of the oxygen cylinder storage in the endoscopy unit.
- A formal system in place to capture endoscopists clinical performance outcomes.
- Cleaning schedules are placed where they are visible to the public and staff
- Local risks to the endoscopy suite are recorded on a risk register.
- Infection control audits are completed and actioned in a timely manner.
- All staff adhere to the hospital infection control policies and procedures.
- Consent for surgical procedures is obtained prior to the day of surgery.
- Safety thermometer audits results are displayed.