Tetbury Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a comprehensive announced inspection of Tetbury Hospital as part of our programme of independent healthcare inspections under our new methodology. The inspection was carried out through announced visits on 13 and 14 September 2016 and an unannounced visit on 21 September 2016.

We inspected and reported on the following three core services:

- Emergency and urgent care
- Outpatients and diagnostic imaging
- Urgent and emergency services

Third party providers used some facilities at the hospital for example, Tetbury Hospital owned the X-ray equipment but did not perform or report on the X-rays. Other providers ran clinics from the outpatient and diagnostic imaging department and used the day surgery unit. We did not inspect their practice as part of this inspection.

Our key findings were as follows:

The overall rating for Tetbury Hospital was requires improvement.

Emergency and urgent care was rated as requires improvement overall. In the safe and effective domains it was rated as requires improvement and the caring, responsive and well led domains were rated as good.

Surgery was rated as good overall. The safe domain was rated as requires improvement and the caring, effective, responsive and well led domains were rated as good.

The outpatient and diagnostic imaging department was rated as good overall. In all domains except for effective the department was rated good. We do not rate effectiveness in outpatients and diagnostic imaging due to insufficient evidence being available.

Are services safe at this hospital?

We rated safety as requires improvement:

- Cleaning schedules, fridge temperatures and daily checks of theatre equipment were not always recorded as complete.
- Emergency drugs were not tamper-evident.
- Patient allergies were not always recorded on prescription charts.
- The hospital did not have a policy or guidance on quality standards for sepsis screening and management.
- The hospital did not have a supply of blood products for use in an emergency.
- There was poor compliance with some areas of mandatory training.
- Safeguarding processes for children and young people attending the minor injury unit (MIU) were not robust. Emergency Nurse Practitioners were not adhering to the safeguarding arrangements in MIU, which required every child and young person to undergo a safeguarding assessment.
- The resuscitation trolley and portable resuscitation equipment (grab bag) in MIU did not hold all the appropriate equipment for the resuscitation of children and young people.
- Monthly hand hygiene audits were not completed regularly in MIU.

Summary of findings

However:

- From April 2015 to March 2016 the hospital reported no never events, deaths or serious incidents. There were no cases of hospital-acquired infection.
- Staff were clear about the process for reporting incidents and were encouraged to report incidents and concerns. There was evidence of learning and improvement following incidents.
- Although the hospital did not provide specific training in the duty of candour staff were aware of the principles of this. They were open and honest and apologised to patients when things went wrong.
- The hospital maintained good levels of cleanliness and hygiene and staff mostly took appropriate precautions to prevent and control the spread of infection. Staff were seen to adhere to the hospital's cross infection policy
- The hospital had a lead for safeguarding and from April 2015 to March 2016 the hospital reported no safeguarding incidents.
- The hospital reported minimal use of agency staff and had a team of bank staff who already worked in the hospital to fill vacant shifts.
- Sufficient staff were available to treat and care for patients who attended the MIU.

Are services effective at this hospital?

We rated effectiveness as requires improvement:

- Analysis of national guideline updates did not always identify changes relevant to the hospital.
- There were no mechanisms in place to ensure ready access to professional children's nursing leadership within the service.
- Competency assessments and peer review were not in place to support shared learning between staff on a continual basis.

However:

- Care and treatment was evidence-based and hospital policies followed guidance from the Department of Health and the National Institute for Health and Care Excellence (NICE).
- New and updated policies and guidelines were discussed and approved at the monthly medical advisory committee (MAC) and the hospital quality committee (HQC) meetings.
- The hospital had a low rate of unplanned transfers to other hospitals and from April 2015 to March 2016, there were no unplanned patient readmissions.
- Staff received clinical supervision and all had appraisals completed within the last year. The hospital had systems to monitor and supervise staff.
- The hospital collected information from patients on various aspects of their experience in the hospital and reported this annually.
- The hospital monitored staff employed under practising privileges. There was an electronic system that flagged when appraisals or Disclosure and Barring Service (DBS) checks were due. These were up-to-date at the time of our inspection.
- People's consent to care and treatment was sought in line with legislation and guidance. Written consent was taken and forms were filed in patients' records. Staff were knowledgeable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The hospital provided training on these subjects.

Summary of findings

- There was good evidence of multidisciplinary working between staff in the hospital, GPs and outside organisations.
- Parents said the management of their own and relatives' pain in the MIU was effective. They praised the sensitivity of the Emergency Nurse Practitioners.
- Staff actively involved patients, relatives, parents, children and young people in consent processes in MIU and outpatients.

Are services caring at this hospital?

We rated caring as good:

- There was a high level of patient satisfaction with the service. All the feedback we received from patients regarding their care and treatment was positive and complimentary. The hospital had good results from the NHS Friends and Family Test.
- We observed staff treating patients with kindness, dignity and respect.
- Staff recognised when patients were anxious and provided them with reassurance.
- Patients and their relatives or those close to them were encouraged to be involved in all stages of their treatment.
- Parents said staff would go the "extra mile" to care for their relatives and they would highly recommend the MIU to their friends and family.
- Patients and relatives said they were treated with dignity and respect in MIU and outpatients and they were always listened to and felt able to raise concerns.

However:

- There was a lack of privacy for patients when discussing their operation and condition.
- The response rate to the NHS Friends and Family Test was low.

Are services responsive at this hospital?

We rated responsiveness as good:

- Services were planned to meet the needs of the local population. They provided timely and convenient care to NHS and private patients.
- Referral to treatment (RTT) times were consistently below (better than) the NHS England target.
- Patients with complex needs were assessed and plans made for them prior to their admission. There was good access and facilities at the hospital for people with a disability. The hospital had a Dementia Strategy policy and a lead for dementia services. Staff also received training in dementia.
- Staff managed admissions to reduce waiting times for patients.
- The hospital had strict admission criteria. Staff were knowledgeable about this and knew when and how to take action if they were unsure whether a patient was suitable for a procedure at the hospital.
- Clear information was provided to patients about how to make a complaint or raise a concern. The hospital received few complaints. The hospital took actions to resolve complaints and lessons were learned and shared with staff.
- For the reporting period April 2016 to June 2016 following improvements to the triage arrangements, patients were triaged in the MIU within 15 minutes of arrival at reception.

Summary of findings

- A review of children and young people's experiences of health services was captured as part of a service development review of Tetbury Hospital in 2016.
- Staff were aware of the complaints policy and procedure and supported patients and relatives to raise issues and concerns.

However:

- There was no policy or lead for children and young people with a learning disability.
- Feedback from parents, children and young people was not captured in the Tetbury Hospital patient survey and the friends and family test to support the development of child friendly services at the hospital.
- There were limited printed information leaflets available about the care for children who had attended outpatients and the MIU. Information was not child friendly and often only given verbally.

Are services well-led at this hospital?

We rated well-led as good because:

- The hospital had a clear vision and strategy and this was understood by staff. Staff were aware of the organisation's values and the commitment to providing a quality and responsive service to patients.
- There was an effective governance structure to support the delivery of good quality care. Staff were aware of their roles and responsibilities and what they were accountable for. There was a strong culture of delivering kind and compassionate patient-centred care.
- We saw evidence of incidents and complaints discussed at governance meetings and information was shared at staff meetings.
- Leaders were visible and approachable and had open door policies. Staff said leaders were accessible and they did not have any problems in raising concerns with them.
- The hospital actively sought the views of patients, people close to them and staff about the service they provided. People were actively engaged and involved in decision-making.
- Services which were not provided locally were identified and implemented at the hospital.

However:

- Not all risks were included in the hospital risk register including the lack of piped oxygen and blood supplies.
- There were no mechanisms in place to ensure ready access to professional children's nursing leadership within the service.
- There was no nursing representation at board level or above matron level within the hospital

There were a number of areas where the provider needs to make improvements. Importantly, the provider must:

- Adapt guidance for adults, children and young people on quality standards for sepsis screening and management.
- Review oxygen provision to ensure patient risk is minimised.
- Ensure theatre daily equipment checks are completed.
- Ensure all emergency resuscitation drugs are tamper-evident.
- Review their policies, processes and systems for obtaining blood products in an emergency.

Summary of findings

- Ensure robust safeguarding arrangements in line with hospital policy are in place for children and young people attending the minor injury unit (MIU).
- Ensure all equipment in the MIU is in date and correctly labelled.

In addition the provider should:

- Ensure all bins used for disposing of clinical waste are appropriate.
- Review arrangements in respect of storing contaminated equipment for sterilisation.
- Ensure patient allergies are recorded on prescription charts.
- Consider following the guidance of the National Early Warning System (NEWS) to identify and respond to deteriorating patients.
- Consider providing more privacy for patients when discussing their operation and condition.
- Consider providing separate areas for male and female patients.
- Develop a tool to obtain feedback from children, young people and their families.
- Develop clinical outcomes and performance indicators patients attending the Minor Injuries Unit.
- Ensure there are robust arrangements in place for the provision of professional children's nursing leadership.
- Take steps so that patients seated in minor injuries unit waiting areas can be observed by staff.

Ensure hand hygiene audits are completed monthly in MIU in line with hospital policy.

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
Urgent and emergency services	Requires improvement 	We rated urgent and emergency care in the minor injury unit as requires improvement overall because: • The resuscitation trolley drugs were not tamper evident. • The resuscitation trolley and portable resuscitation equipment (grab bag) in the unit did not hold all the appropriate equipment for the resuscitation of adults and children and young people. We raised this with the nursing staff at the time of our announced inspection and improvements were immediately made. • The grab bag contained out of date swabs and gauze. This was raised at the time of our announced inspection, however out of date swabs and gauze was still present at the time of our unannounced inspection. After raising this again it was immediately addressed. • Staff were not fully adhering to safeguarding arrangements for children and young people, meaning they were not always protected from abuse or avoidable harm • The emergency drug box was not sealed. • The unit did not have a sepsis screening tool or sepsis policy to help identify those patients at risk of sepsis and ensure correct and timely intervention. • Patient clinical outcomes were not monitored regularly or robustly. • There was a lack of clarity around the mechanisms in place to ensure ready access to professional children's nursing leadership which was not in line with national guidance, Royal College of Nursing (RCN 2014) • Limited printed information was available for children and young people attending outpatients and MIU at Tetbury Hospital • Competency assessments and peer review were not in place to support shared learning between staff on a continual basis.

Summary of findings

- There was a lack of opportunity for staff to review each other's clinical practice and learn from each other
  - Whilst there was evidence of multidisciplinary team working and learning needs were up to date there were concerns expressed about staff learning from each other and receiving supervision.
  - There was no assurance that clinical procedures undertaken on children and young people in the unit and outpatients were in line with current standards.

However:

- Clear information was provided to patients about how to make a complaint or raise a concern. There was evidence of learning from incidents and complaints. Staff were aware of their responsibilities in regards to this.
- Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely and safe arrangements were in place to ensure agency staff had knowledge of the unit.
- There was good evidence of multidisciplinary working between staff in the hospital and outside organisations.

- Learning needs of staff were up to date
  - We received positive feedback about staff from all of the patients we spoke with. Patients were treated with respect by staff when they visited the minor injuries unit.
  - The unit was achieving all national indicators for the assessment, treatment and discharge of patients.

Surgery

Good

We rated surgery as good overall because:

- There were no surgical site infections from April 2015 to March 2016. During the same period there were no incidences of methicillin resistant Staphylococcus aureus (MRSA) or clostridium difficile.
- The hospital reported no never events or serious untoward incidents.

Summary of findings

- There were low levels of staff sickness and staff turnover.
- The hospital reported no safeguarding concerns.
- The hospital had a low rate of unplanned patient transfers to other hospitals and there were no unplanned patient readmissions.
- Medical staff were checked for their fitness to practise.
- Staff were encouraged and supported to undertake training relevant to their role.
- Staff worked together to assess, plan and deliver care and treatment. They treated patients with kindness, dignity and respect and recognised when patients were anxious and provided them with reassurance.
- Patients with complex needs were assessed and plans were made for them prior to their admission.
- Patient care records were always available.
- Care was responsive and met the needs of the local population. Information about the local population was used to inform how services were planned and delivered.
- Targets for referral to treatment times for NHS patients were always met from April 2015 to March 2016. Staff managed admission times to ensure patient waiting times were kept to a minimum.
- There was a programme of clinical audit and governance.
- Complaints were investigated. Actions were taken and lessons learned as a result of complaints.
- Leaders were approachable and visible.
- The hospital had a clear vision and set of values.

However:

- Cleaning schedules, fridge temperature and daily equipment checks were not always recorded as complete.
- Emergency drugs were not tamper-evident.
- The day surgery unit did not have piped oxygen.

Summary of findings

- The hospital did not participate in national audits regarding patient outcomes.
- The hospital had not adapted guidance on quality standards for sepsis screening and management. There was no policy regarding sepsis.
- Patient allergies were not always recorded on prescription charts.
- There was poor compliance with some mandatory training.
- The hospital did not have a supply of blood products for use in an emergency.
- Not all risks were identified on the risk register such as such as the lack of piped oxygen and emergency blood provision.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging as good overall because:

- People were protected from avoidable harm. The trust had a range of safety measures in place and there were systems to report concerns or incidents and learn from them.
- There were reliable systems, practices and processes to keep people safe and safeguard them from abuse.
- Training was provided for all staff to ensure they were competent and effective in their roles. Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely.
- The outpatient and diagnostic imaging services incorporated relevant and current evidence-based best practice guidance and standards. Any new procedures or treatments to be delivered had to be agreed by the medical advisory committee.
- People's consent to care and treatment was sought in line with legislation and guidance. We observed written consent was sought, and records placed in patients' records.
- We received positive feedback about staff and services from all of the patients we spoke with. Patients were treated with respect and shown kindness by all staff when they visited the outpatient clinics.

Summary of findings

- The needs of the local population were considered in the development of services provided by Tetbury Hospital. The hospital worked in collaboration with the commissioning groups and liaised with the NHS trusts that provided services to the local community.
- People had timely access to initial assessment and diagnosis and waiting times for referral to treatment were consistently below the NHS England target of 18 weeks. The hospital was achieving 100% compliance with the government target of 31 days for patients, from having a cancer diagnosis until the start of their treatment.
- Clear information was provided to patients about how to make a complaint or raise a concern. The hospital had received few complaints but had responded to them all within their given timescale.
- There was an effective governance structure in place to support the delivery of good quality care in the outpatients department. Staff were aware of their responsibilities and their roles and who they were accountable to.
- The hospital had reviewed and rewritten all its policies since 2013, with many being reviewed annually since then.
- There were effective arrangements for identifying recording and managing risks. There was a risk register in place for the outpatient department area which was maintained and updated by the manager.
- The hospital actively sought the views of patients and staff about the quality of the service provided. Opportunities were available for patients and staff to comment on all aspects of the care and treatment provided.

Summary of findings

Contents

Requires improvement

Tetbury Hospital

Services we looked at

< Urgent and emergency services; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Tetbury Hospital

Tetbury Hospital Trust Limited is a charitable company limited by guarantee, incorporated on 28 January 1992 and registered as a charity on 27 February 1992. The charity's patron is HRH The Prince of Wales. Prior to the formation of the charity the hospital was owned by the NHS and has been delivering care to the local community for over 50 years.

The hospital provided care to both NHS and privately funded patients. From April 2015 to March 2016 the majority of patients treated at the hospital (98%) were NHS funded.

The minor injury unit (MIU) is nurse led and comprises of one room for patients to be seen and treated. Nurses in the hospital had been trained in triage so they could assist the MIU staff if required. The day surgery unit has one theatre and two recovery areas. The first recovery area is located next door to the theatre and can accommodate up to two patients. The second recovery area is in the main ward and has recliner chairs for up to eight patients. The hospital provides emergency and urgent care and outpatient and diagnostic imaging services for children and young people. The hospital does not operate on children. The outpatient and diagnostic imaging department has seven multifunctional consulting rooms and provides X-ray equipment. The hospital does not have any overnight patient beds.

Surgeons from NHS trusts use the day surgery unit under service level agreements. The X-ray services are also staffed through service level agreements with NHS trusts. Therefore, we did not inspect the practice of staff working under these service level agreements.

The registered manager and accountable officer for controlled drugs is Zena Dalton, the hospital chief executive officer, who has been in post since January 2014.

During this inspection we reviewed emergency and urgent care, the day surgery unit, services for children and young people and the outpatients and diagnostic imaging service. Services for children and young people have been reported within the other three core services. We carried out a comprehensive announced inspection on 13 and 14 September and an unannounced inspection on 21 September 2016.

We inspected the hospital as part of our routine comprehensive inspection programme for independent healthcare services.

Our inspection team

Our inspection team was led by:

Inspection Manager: Amanda Eddington, Inspection Manager, Care Quality Commission

Inspection Lead: Diane Humphries, Inspector, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: a consultant surgeon, two senior NHS nurses specialising in surgery and urgent and emergency care and a trained children's nurse. We also took advice from the CQC medicines management team where required.

How we carried out this inspection

To carry out this inspection, we used a variety of sources for information.

We requested information, statements and evidence from the hospital prior to the inspection. We requested feedback from local organisations involved with the hospital such as Healthwatch and Clinical Commissioning Groups. We provided the hospital with comment cards prior to the inspection for patients receiving care and their relatives or those close to them to complete.

Summary of this inspection

We carried out an announced visit to the hospital on 13 and 14 September and returned on 21 September for an unannounced visit. We met and spoke with 35 patients and their relatives or those close to them during the inspection. We spoke with a range of staff including the chief executive, medical director, matron, heads of departments, nursing and administration staff and surgeons and anaesthetists working under practising privileges. We also held two focus groups for all members of staff to attend.

We inspected urgent and emergency care, surgery, and the outpatients and diagnostic imaging department. We also observed care delivered to children and young people. We observed care in the operating theatre, day surgery unit, outpatients department and the minor injury unit. We reviewed various files including complaints received by the hospital, incident reports, patient care records, hospital policies and staff training records.

Information about Tetbury Hospital

From 21 January 2011 Tetbury Hospital provides the following regulated activities:

- Diagnostic and screening procedures.
- Surgical procedures.
- Treatment of disease, disorder, or injury.

No additional conditions apply to the registration of all the regulated activities above.

The minor injury unit (MIU) at Tetbury Hospital provides care to patients on a walk-in basis for treatment of minor injuries such as cuts and wounds, burns and scalds, strains, sprains and simple fractures. The minor injury unit sees an average of 3,000 patients a year. From January to June 2016 the unit saw 1,313 patients.

The day surgery unit offers procedures in gynaecology, maxillofacial, ophthalmology, orthopaedics, pain management, plastic surgery (excluding cosmetic) and vein surgery. There were 1,068 day surgery unit attendances recorded by Tetbury Hospital from April 2015 to March 2016, of which 98% were NHS funded and 2% were other funded. The most commonly performed surgical procedures were skin therapy level three plastics, which accounted for 38% of all procedures and cataract removal, which accounted for 22% of all procedures.

The hospital provides services for children and young people in the minor injury unit and the outpatient and diagnostic imaging department only. The hospital does not operate on children and young people.

The hospital provides outpatient consultations in cardiology, dermatology, ear nose and throat, gastroenterology, general surgery (including vascular), gynaecology, maxillofacial, ophthalmology, orthopaedics, pain management, thoracic medicine and urology. The hospital also has consultants from other trusts who offer outpatient services in podiatric surgery, rheumatology and diagnostic imaging.

There were 7,015 attendances at outpatient clinics from March 2015 to April 2016. These figures were for clinics run by Tetbury Hospital trust and do not include patients attending GP consultations or clinics run by other providers. The largest clinics were ophthalmology and dermatology, making up 22% and 30% respectively of the total number of attendances.

The hospital has outsourced services for equipment sterilisation, histology, laboratory services, medical engineering, pharmacy, medical records and electronic patient administration system support.

The nominated individual from 5 June 2014 is Zena Dalton who is also the registered manager and controlled drugs accountable officer.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

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

Requires improvement

Urgent and emergency services

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

Information about the service

Tetbury Hospital minor injuries unit (MIU) provides a walk in service for patients with minor injuries such as minor cuts and wounds, minor burns and scalds, strains, sprains and simple fractures. The service is open Monday to Friday (excluding bank holidays) from 8am, with the last walk in patient being accepted at 4pm to allow closure at 5pm. Patients who present with serious illnesses or injuries are stabilised where appropriate and then transferred to the nearest and most appropriate acute hospital. The minor injuries unit sees an average of 3000 patients a year. During the period from January 2016 to June 2016 the unit saw 1313 people, of which 406 were children (aged 17 and under).

Emergency Nurse Practitioners (ENPs) led the unit. ENPs are nurses specially trained who are able to assess, treat and discharge patients.

We carried out the announced period of our inspection over two weekdays with a further weekday afternoon also spent inspecting as part of our unannounced inspection. We observed care and treatment and looked at records of care. We reviewed information relating to performance about the hospital prior to and following our inspection. We also received feedback via comment cards from patients.

Summary of findings

We rated urgent and emergency care in the minor injury unit as requires improvement overall because:

- The resuscitation trolley drugs were not tamper evident.
- The resuscitation trolley and portable resuscitation equipment (grab bag) in the unit did not hold all the appropriate equipment for the resuscitation of adults and children and young people. We raised this with the nursing staff at the time of our announced inspection and improvements were immediately made.
- The grab bag contained out of date swabs and gauze. This was raised at the time of our announced inspection, however out of date swabs and gauze was still present at the time of our unannounced inspection. After raising this again it was immediately addressed.
- Staff were not fully adhering to safeguarding arrangements for children and young people, meaning they were not always protected from abuse or avoidable harm
- The emergency drug box was not sealed.
- The unit did not have a sepsis screening tool or sepsis policy to help identify those patients at risk of sepsis and ensure correct and timely intervention.
- Patient clinical outcomes were not monitored regularly or robustly.

Requires improvement

Urgent and emergency services

- There was a lack of clarity around the mechanisms in place to ensure ready access to professional children's nursing leadership which was not in line with national guidance, Royal College of Nursing (RCN 2014)
- Limited printed information was available for children and young people attending outpatients and MIU at Tetbury Hospital
- Competency assessments and peer review were not in place to support shared learning between staff on a continual basis.
- There was a lack of opportunity for staff to review each other's clinical practice and learn from each other
- There was no assurance that clinical procedures undertaken on children and young people in the unit and outpatients were in line with current standards.

However:

- There was good evidence of multidisciplinary working between staff in the hospital and outside organisations.
- Learning needs of staff were up to date.
- We received positive feedback about staff from all of the patients we spoke with. Patients were treated with respect by staff when they visited the minor injuries unit.
- The unit was achieving all national indicators for the assessment, treatment and discharge of patients.
- Clear information was provided to patients about how to make a complaint or raise a concern. Responses were completed within the organisations timescale and there was evidence of learning from incidents and complaints. Staff were aware of their responsibilities in regards to this.
- Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely and safe arrangements were in place to ensure agency staff had knowledge of the unit.

Are urgent and emergency services safe?

Requires improvement

We rated safety as requires improvement because:

- The unit did not have a sepsis screening tool or sepsis policy to help identify those patients at risk of sepsis to ensure correct and timely intervention.
- Safeguarding arrangements for children were not fully adhered, to meaning they were not always protected from abuse or avoidable harm
- The resuscitation trolley drugs were not tamper evident and the emergency drug box was not secured.
- The 'grab bag' did not contain the appropriate equipment to carry out basic life support.
- The grab bag contained out of date swabs and gauze. This was raised at the time of our announced inspection, however out of date swabs and gauze was still present at the time of our unannounced inspection. After raising this again it was immediately addressed.
- Monthly hand hygiene audits were not being completed regularly.
- The design of the Minor injuries unit (MIU) meant patients within the waiting room could not be viewed or monitored.

However:

- There was evidence of learning from incidents, staff were aware of their responsibilities in regards to this, and lessons learnt were communicated widely to support improvement.
- There were clear systems and processes in place to ensure medical records were kept secure and confidentiality protected.
- Patients were triaged within 15 minutes of arrival at the minor injuries unit and the most recent results showed they were now better than the national target.
- Staff were seen to adhere to the hospital's infection control policy.
- Staff were up to date with mandatory training.

- Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely and safe arrangements were in place to ensure agency staff had knowledge of the unit.

Incidents

- The unit had a range of safety measures and systems in place to report concerns or incidents.
- There were appropriate systems in place to ensure incidents were reported and investigated properly. Staff told us they received feedback after reporting an incident and senior managers reviewed all reported incidents weekly.
- All staff we spoke with were aware of their responsibilities in reporting incidents and said they were encouraged to do so. Staff said there was a 'no blame' culture surrounding incidents and they were encouraged to view them as a learning opportunity.
- Previous incidents had been raised surrounding the delayed reporting of X-rays following assessment by a radiographer. Learning from these incidents had occurred and checking the returned X-ray reports was now part of the ENP's (Emergency Nurse Practitioners) daily actions. We saw a reminder of this above the ENP's workspace to ensure this was completed.
- Learning from incidents was discussed and recorded at governance meetings and the matrons meetings with information then being shared with all staff in team meetings.
- We were advised there were no incidents involving children and young people in the reporting period April 2015 to March 2016. However, during the inspection we sought clarification around the management of missed fractures in children and young people in the MIU and identified three missed fractures had been reported. After the inspection we were advised the hospital monitored the number of missed fractures in children and young people, but no additional evidence of this was provided. Staff had used the hospital electronic incident reporting process correctly, which had identified the age of patients on the incident reporting form.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the hospital to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds.
- Staff we spoke with had varying levels of understanding of this regulation. However, they all knew that if a patient was harmed they were required to be open and honest about what had happened.

Cleanliness, infection control and hygiene

- The minor injuries unit, including the waiting room, appeared clean, tidy and dust free. Equipment that had been cleaned was identifiable by the use of 'I am clean' stickers. This included the play area for children, which was clean and tidy to help minimise the risk of infection to children who regularly played with toys.
- Hand gel facilities were available in reception and before entering the clinical area. They were clearly signposted to be used prior to entering the department.
- In the unit we saw staff were bare below the elbow. Staff used aprons and gloves correctly to prevent the spread of infections. We saw that all staff were washing their hands or using sanitiser gel immediately before and after patient contact, which was in line with the National Institute for Health and Care Excellence (NICE) Quality Statement 61 (Statement 3).
- The organisation requested hand hygiene audits to be carried out monthly. We saw records showing only two audits having been carried out since February. Both audits undertaken reported 100% compliance. Staff were unaware of the reason for these audits not being carried out, however a senior member of staff reported they would address this issue immediately.
- Yearly infection control audits were carried out by an external source. The last audit showed compliance within an accepted limit in all areas within the minor injuries unit. Actions were put in place to address areas where improvement could be made.
- We saw completed cleaning schedules for the unit. However, these were not displayed in clinical or public areas.

Requires improvement

Urgent and emergency services

Environment and equipment

- The design and use of facilities did not always keep patients safe.

  The minor injuries unit was located within an old building which was well maintained. However, the design of the building meant that patients within the unit's waiting room could not be observed. Although the waiting area was situated in a place which staff accessed and walked through, we sat for a period of ten minutes within the waiting room and observed no staff members walk through. This could mean a patient's condition could deteriorate without staff being aware.

- Children and young people shared the minor injuries waiting area with adults, as there was no dedicated waiting area for children within MIU. However, there was a dedicated waiting area for children in the outpatients department which children could be directed to in line with hospital policy.

- Equipment was serviced and maintained. Stickers were present on equipment to show when they were last serviced and when the next service was due. All equipment we looked at was within the servicing date.

- We saw records of daily and weekly equipment checks being carried out. However, records showed that the weekly check of the emergency alarm bell was not always being undertaken, which meant there was a risk that staff would not be aware if the emergency bell to summon help was faulty.

- The resuscitation trolley drugs within the unit were not tamper-evident and emergency drugs were not secured. This meant there was no assurance that the trolley had not had equipment removed and not replaced. This could lead to equipment not being available in an emergency situation.

- Resuscitation trolleys and portable resuscitation equipment (grab bag) for adults and children within the minor injuries unit did not hold all appropriate equipment for the resuscitation of patients. It did not contain a bag valve mask which is required to provide basic life support. It also contained out of date gauze and swabs. We brought this to the attention of the unit at the time of our announced inspection. During our unannounced inspection we reviewed the grab bag. Although it now contained a bag valve mask, the gauze and swabs were still out of date. We raised this with senior staff who immediately removed the out of date stock and replaced it with in date items.

- The resuscitation trolley contained an opened tube of lubricant used with nasal airways; this should be in single use sachets to prevent cross infection.

Medicines

- There were safe procedures for the prescription of medicines, however there were issues with the storage of some medication.

- Pharmacy services were outsourced to a local acute NHS trust. Tetbury Hospital complied with the local acute hospital's policy for the management, ordering, prescribing and administering of medicines (2012). Patient Group Directions (PGDs) policy (2014) and a Cold Chain policy (2015) for the cold storage of medicines.

- One emergency nurse practitioner had recently undertaken training to be able to supply and administer certain medication. However, they were awaiting delivery of their certification before they could undertake this. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw evidence that staff had been appropriately assessed and signed off as competent to use PGDs.

- Medicines were mostly stored correctly in locked cupboards or fridges. Fridge temperatures were regularly checked by staff working in the department and seen to be within required parameters. A medicines management re-audit undertaken in 2015 identified 100% compliance for the monitoring of fridge temperatures in the department.

- However, the emergency drugs box was not sealed. This was not in accordance with the hospital's patient group direction for the administration of adrenaline, which stated it should be stored in a sealed container.

- One needle and a syringe stored in a separate emergency drugs box for use in an allergic reaction were

out of date and the box was not secured. This was brought to the attention of staff at the time of the announced inspection and had been replaced at the time of our unannounced inspection.

- There were incidences where the drug stock check was also not completed. This could lead to a shortage in availability of certain drugs.
- We looked at 10 patients' records, of which nine had their allergies recorded or documented that there were no known allergies. One had no documentation as to whether the patient had any known drug allergies.

Records

- Records were maintained accurately and stored securely to ensure patient confidentiality. Patient notes were recorded and stored electronically and previous records were easily accessible when required.
- Computers could easily be locked and access to the system was controlled by individual passwords. This also helped to ensure that the name of the practitioner and the time that they saw each patient was accurately recorded.
- We looked at 13 patients' records, all were clear legible. However, a large number of acronyms were used which may lead to confusion if being read by another clinician. There were also multiple spelling mistakes noted.
- Risk assessments for items such as allergies were an integral part of records. We looked at 10 patients' records and found that risk assessments had been completed where appropriate, although one patient record did not have the patient's allergies recorded.

Safeguarding

- There were systems and processes in place to safeguard people from abuse, however staff did not always comply with the processes established to safeguard children and young people.
- Staff were aware of the processes for the identification and management of adults and children at risk of abuse. They understood their responsibilities to report concerns, were aware of who the safeguarding lead was and felt supported in raising any issues or concerns with them.
- We reviewed the training records for the emergency nurse practitioners. Both had received level three children's safeguarding training which was in line with the hospital's safeguarding policy. One had also undertaken level three safeguarding adults training, with the other having undertaken level two safeguarding adults training.
- The trust had a safeguarding team (for children), which included the location lead who was the accountable officer (chief executive) a designated executive lead and a safeguarding named nurse (matron). The team were involved in safeguarding referrals and serious incident reviews, which included safeguarding issues. The team provided support to staff around safeguarding concerns, sat on internal groups and committees, and liaised with external providers. For example, the relevant Safeguarding Children's Board, to ensure working relationships were developed and maintained.
- Policies and procedures for safeguarding children were in place supported by a rolling programme of safeguarding children's training: Royal College of Paediatrics and Child Health Intercollegiate Document (2014).
- The clinical computer system prompted staff to ask about safeguarding when completing a child's assessment. The child's attendance record could not be completed until consideration had been given to safeguarding issues. However,emergency nurse practitioners were not fully adhering to safeguarding arrangements. We observed four safeguarding assessments and during each of them the staff member failed to ask the seven assessment questions set out in their safeguarding policy. We reviewed three sets of children's records. All safeguarding assessments were incomplete. This was raised with staff at the time of the announced inspection. The matron for children's safeguarding told us an enhanced patient record system was being implemented and had electronic safeguards in place to ensure every field of a safeguarding assessment was completed.
- Staff we spoke with were aware of the procedures surrounding the reporting of female genital mutilation. There had good knowledge of when and who to contact if they had any concerns.

Mandatory training

- Mandatory training systems were in place to ensure staff were up to date in safety systems, processes and practices or essential training such as resuscitation. Staff reported they were given time to attend training within working hours.
- Mandatory training within the hospital included a wide range of topics. For example, manual handling, information governance, consent and equality and diversity.
- Most mandatory training was delivered by E-learning with fire, manual handling and life support training being delivered in a classroom. Staff reported they found the training engaging and enjoyable, although some stated they would prefer more classroom based learning.
- All mandatory training at the time of inspection was up to date apart from one member of staff who was overdue an update covering patient group directives.
- All staff within the department had been trained to deliver immediate life support (ILS) to both adults and children, and were also up to date with advanced adult life support training (ALS).

Assessing and responding to patient risk

- There were systems in place within the minor injury unit to ensure staff were able to assess and respond to patient risk.
- Guidance from the Royal College of Emergency Medicine and Royal College of Nursing states that patients should be rapidly assessed on arrival in order to identify or rule out life/limb threatening conditions and ensure patient safety (Triage Position Statement, April 2011). This assessment/triage should be carried out face to face by a trained clinician within 15 minutes of a patient arriving.
- Emergency Nurse Practitioners in the minor injury unit used a nationally recognised assessment tool (Manchester triage tool) to risk asses each person's clinical condition to enable the appropriate treatment/ interventions to be undertaken.
- During the 12 month period of April 2015 to April 2016 the minor injuries unit was averaging 29 minutes before triaging. This delay could pose a risk to patients as threatening conditions may not be identified or ruled out quickly. However, the unit had identified this risk and addressed it by training other members of staff in the triaging system used in the unit. During busy times, where it became apparent a patient was unlikely to be triaged within 15 minutes, trained staff working in other areas were called to undertake the initial assessment. As a result, data provided showed that in April 2016 the trust was meeting the 15 minute target and for May and June 2016 triage was being carried out within 14 minutes of patients arriving in the department.
- We observed the triage of three patients, with their consent. The process was carried out in a thorough, effective and sympathetic manner to ensure their presenting complaint and risks were identified.
- Patients who were deemed too seriously ill or injured to be treated within the unit were transferred by ambulance to the emergency department at a nearby acute NHS trust.
- The emergency nurse practitioners were able to describe the signs and symptoms that would lead them to suspect sepsis and what they would do to escalate the issue. However, the unit did not have a sepsis screening tool or sepsis policy to help identify those patients at risk of sepsis and ensure correct and timely intervention.
- Protocols and guidelines detailing the correct assessment and treatment pathways for burns, needle stick injuries and chest pain could be found on the walls of the minor injuries unit.

Nursing and medical staffing

- Staffing levels were adequate and filled to establishment to ensure patients received safe care and treatment, however staff had little time to carry out administrative tasks.
- In the 12 month period of April 2015 to March 2016 all emergency nurse practitioners shifts were filled. To ensure these shifts were filled there was a high use of agency staff, between the period of April 2016 to October 2016 agency staff were used 25% of the time. We were informed this high level was due to a member of staff being on long-term sick leave. We were informed

that the potential risks of using agency staff was mitigated by using staff who had previously worked at, or been employed in the unit and were aware of all the systems and protocols in place.

- A specific agency was used which provided them with the agency staff's qualifications and clearance. The use of agency staff had meant that the minor injuries unit had not had to close due to staff shortages in the last year.
- There were no qualified children's nurses in the minor injuries unit and no lead children's nurse within the hospital. However, all nurse practitioners had been trained to assess children and to decide which services would best meet their needs. Also all emergency nurse practitioners were trained in paediatric immediate life support.
- The emergency nurse practitioners worked alone within the clinic room, and although there were two sets of doors between the clinic room and reception desk staff had access to a panic cord to raise an alarm as well as a three point entry/exit system. We were also informed that lone working dongles were available, although staff we spoke with were unaware of these.
- There was no named consultant paediatrician at Tetbury Hospital. The MIU had access to on-call paediatric consultants for advice, support and onward referral to local NHS providers who provided emergency care and support for children and young people.

Major incident awareness and training

- A major incident policy had been approved and put into place in July 2016. This plan related to the whole hospital and there was not a separate major incident plan for the minor injury unit. The policy was supported by the business continuity plan. The plan had been written in accordance with the NHS England Emergency Preparedness Framework. The plan covered three levels of response, business continuity incident, critical incident and major incident.
- The plan was written with reference to the Civil Contingencies Act 2014 which requires NHS providers to support local commissioning groups and NHS England to discharge their Emergency Preparedness Resilience and Response Functions (EPRRF) responsibilities.
- The plans detailed the action the hospital would take and the expectations placed on the staff team. The senior management team were planning a table top training exercise for staff for October 2016.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Systems were not in place to ensure that staff had their clinical decision making reviewed regularly.
- Competency assessments and peer review were not in place to support shared learning between staff on a continual basis.
- Information about patients' outcomes were not routinely collected in the minor injuries unit.

  There was a lack of opportunity for staff to review each other's clinical practice and learn from each other.
- Staff reported the model of clinical supervision was not meeting all their needs as the current model provided an opportunity for emotional debrief but did not look at clinical practice.
- In house training specific to competencies within the minor injuries unit was not being carried out and there was no simulation or practice of emergency situations.

However:

- Treatment guidance for children was evidence based, for example in the management of head injuries and meningitis and burns protocols was based on guidance from the National Institute for Health and Care Excellence (NICE).
- The unit had unplanned re-attendances of 4% which was better than the national average of 5%.
- Staff were trained to meet the care needs of children and young people.
- Staff had access to the information required to assess and treat patients appropriately.

Learning needs of staff were up to date.

- There was good evidence of multidisciplinary working between staff in the hospital and outside organisations.
- Staff had a good understanding of consent and the Mental Capacity Act.

Evidence-based care and treatment

- The minor injury unit used treatment guidelines based on guidance from the National Institute for Health and Care Excellence (NICE). For example, development of head injury advice for carers of children based on the National Institute for Health and Care Excellence (NICE) for the early management of head injuries in children. NICE guidance for PGDs (for children and young people) was evident and meningitis and burns protocols for children and were clearly displayed in the MIU.
- The unit had recently audited their compliance with NICE head injury guidelines. This had shown poor compliance in documentation. As a result staff had introduced a checklist for head injuries which was due to be re audited. Staff members reported that they felt it had improved their clinical practice. Staff were familiar with the use of NICE guidelines and audit results. Any changes were discussed at governance meetings and updated as necessary.
- Policies, procedures and guidelines were available to staff via the trust's intranet. Staff we spoke with knew how to access them when necessary.

Pain relief

- We looked at 10 patient records. Each had a pain score calculated and recorded and appropriate pain relief had been administered. This was in line with Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine 2015) 6.4 Standard 2.
- We saw pain being assessed during triage and the administration of appropriate pain relief. Pain relief staff were able to prescribe was paracetamol and ibuprofen. We were informed by the organisation the ENPs also had access to diazepam, rectal diclofenac, nitrous oxide and co-codamol (30/500).
- When pain relief was prescribed we saw that the name, dose, route, expiry date and batch number recorded in the patient record.

Nutrition and hydration

- The average length of stay in the unit was less than 40 minutes so food was not provided however, patients had access to a vending machine which was situated in the outpatients department and clearly signposted in the minor injuries unit waiting room. The food and snacks available from the vending machine had been altered following patient feedback.

Patient outcomes

- Information about patients' outcomes were not routinely collected in the minor injuries unit.
- The minor injuries unit undertook regular monthly audits which included the auditing of notes and X-rays. These checked for compliance against policy and procedure, however we saw no evidence decision-making was audited in these areas.
- Although there was some assurance surrounding best practice relating to NICE head injury guidelines and antimicrobial stewardship, other audits undertaken focused on administration compliance rather than clinical decision making.
- The minor injuries unit was not involved in any national audits specific to minor injuries but was due to take part in a national audit on the prescription of antibiotics.
- An indicator of good patient outcomes often used is the rate of unplanned re-attendances within seven days. The lower the rate the better the patient outcomes. For the 12 month period of April 2015 to April 2016, Tetbury Hospital had unplanned re-attendances of 4% which was better than the national average of 5%. However, for two months of this 12 month unplanned re-attendances were slightly greater than the national average.

Competent staff

- Systems were not in place to ensure that staff had their clinical decision making reviewed regularly. Staff did not undertake clinical assessments, peer review or spend time observing each other's clinical practice meaning there was no assurance that on a continual basis they had the knowledge to undertake their job role.
- The hospital had recently introduced a clinical supervision programme which staff could attend once a month. This provided a platform for staff to reflect on

aspects of their job. However, staff in the unit said the clinical supervision model was not meeting their needs, as it could not provide assurance around clinical decision-making and assessment abilities in the minor injuries unit. Peer review could be offered but staff informed us this did not happen in practice.

- In house training specific to competencies within the minor injuries unit was not being carried out and there was no simulation or practice of emergency situations.
- One emergency nurse practitioner had undertaken extra training which would enable her to prescribe certain medication. They were currently awaiting completion of their registration before they could start practising.
- Specific learning needs for all staff were identified at a yearly appraisal meeting. Records showed that all staff had received an appraisal in the last year.
- Children and young people were cared by staff who were competent in meeting their needs. Although there was no registered nurse trained in the care of children employed by the trust, the ENPs were registered nurses with additional training in emergency care who had completed child competencies. This was in line with national guidance (RCN 2014) for registered nurses working in ambulatory care settings, which require ENPs to have undertaken training in paediatric immediate life support, safeguarding children to Level 3 as identified by the intercollegiate framework, effective communication with children and parents and pain management and recognition of the sick child.
- The hospital was in the process of developing a set of Standard Operating Procedures for the minor injuries unit. This would act as a reference for staff detailing the agreed treatment protocols for certain clinical situations. They would range from treatment of head injuries to eye injuries and bites.

Multidisciplinary working

- There were good working relationships with community services, GPs and the local NHS hospitals.
- Staff were able to refer patients to the physiotherapy service within Tetbury Hospital when required.
- On occasions when nursing staff required clinical advice relating to complicated injuries or X-rays, they were able to discuss with senior doctors at multiple emergency departments.
- There were good working relationships with the local GP practices and the nursing staff reported being able to ring local GPs for advice. This included when there were issues with the administration of medicines covered by patient group directions. For example, where there were contraindications to administration, such as known allergies.
- Contact numbers for social services were clearly displayed and staff had a good knowledge of who to contact and when.

Seven-day services

- The minor injuries unit was open Monday to Friday from 8.30am with the last patient attendance accepted at 4pm. If patients required access to accident and emergency services then there were four NHS accident and emergency departments within 20 miles of the hospital. The nearest accident and emergency department address was clearly signposted on the main hospital signs.
- There had been no incidents when the unit had to close within the last year. In the event of unexpected closure patients would be redirected to the closest accident and emergency department.

Access to information

- Staff had access to the information required to assess and treat patients appropriately.
- Medical records were stored and recorded on the computer system meaning they were always accessible.
- Advice leaflets which were clearly displayed and available within the unit were clear, informative and were in line with the National Institute for Health and Care Excellence guidelines.
- Emergency nurse practitioners generated discharge summaries from the electronic patient record system and these were then sent to the patient's GP. This ensured the patient's GP was informed of the attendance.

Requires improvement

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had good knowledge of mental capacity and consent.
- We observed that consent was obtained for any procedures undertaken by the staff. In all cases this was verbal consent; this was not documented in patient records. Staff informed us they did not use consent forms but relied on verbal consent for all procedures.
- The staff we spoke with had a good knowledge of the guidance for gaining valid consent from a child. Staff were aware of Gillick competence which means children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so. Where children were not able to provide consent, this was obtained from the child's parent or guardian. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult before undertaking the procedure. If staff were unable to contact a parent or guardian they understood that decisions could be made when in the patients' best interest.
- Staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to explain to us in detail what they would if they felt someone did not have the capacity to consent to treatment.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Feedback from patients and relatives confirmed that staff were caring.
- People were kept informed and given information about their condition and were involved in their care and treatment.
- Staff adapted to meet the needs of the individual.
- Patients received care from staff who treated them with respect.

However:

- Patient privacy and confidentiality was not always maintained at reception or in treatment rooms.

Compassionate care

- Whilst compassionate care was witnessed, at times, patient privacy could be compromised. There were no signs asking people to stand back from the reception desk when someone was being registered. This could lead to members of public overhearing confidential information when the reception area was busy.
- 100% of people, who responded in the Tetbury Hospital Patient Survey 2015, said they had enough privacy when discussing treatments and their condition in the minor injuries unit. However, during our inspection we observed the door to the clinic room not always being shut during assessment and treatment. This meant conversation between staff members and patients could be overheard by members of the public sat in the minor injuries unit waiting room.
- The unit consisted of a single room used to treat and assess patients. Staff reported if this room was occupied and another patient needed to be assessed they would use rooms in the outpatients or day surgery department to ensure privacy was maintained.
- Staff introduced themselves to patients by name and ensured the patients understood who they were and what their job was.
- Patients we spoke with told us when they experienced physical pain, discomfort staff responded in a compassionate, timely and appropriate way. One patient told us pain was not an issue as it was very well controlled by the staff.
- A relative said, "My daughter was very frightened of attending the minor injury service and I was impressed at how much time the staff (ENP) took to explain how my child was to be treated. What could have been a frightening experience for my child became a very positive experience. "
- We witnessed examples of patients being treated with compassion, dignity and respect. Staff spoke in a friendly, compassionate and respectful manner and gave patients time and comfort when they became upset.

Requires improvement

Urgent and emergency services

- We were shown cards of appreciation from patients. All commented how thankful they were for the care and treatment they had received.

Understanding and involvement of patients and those close to them

- Eighty seven percent of the people who responded to the Tetbury Hospital Patient Survey 2015 felt they were involved as much as they wanted to be in their care. We also spoke with five patients during our inspection who all reported they felt involved in any decisions that were made, were given the time to ask questions and staff responded in a way in which they could understand.
- Results from the patient survey 2015 showed that 86% of people were extremely likely to recommend the minor injuries unit to friends or family and the remaining other 14% likely to recommend the unit.
- One patient reported, "If you need it, they give it", "nothing is too much trouble".
- We heard of adaptations that had been made for a patient who had complex needs to prevent them undue distress. A patient who found clinical environments upsetting and stressful was seen in a non-clinical setting which was appropriate for their psychological and medical needs.
- During our inspection a patient returned to the hospital and mentioned difficulty in getting a prescription. The emergency nurse practitioner took the time to reassure the patient and arranged for the prescription to be collected at a time and place convenient for the patient.

Emotional support

- We observed staff adapt their communication to individuals. Communication with children was thoughtful and age appropriate.
- Staff were heard to provide emotional support to a young patient who had become distressed during treatment.
- We heard a staff member spend time providing emotional support to a family member who was unable to attend the appointment with their relative. They spent time ensuring the family member felt happy and reassured and that they had no other questions.
- Staff provided patients with information leaflets and written information to explain their condition and treatment plan which included aftercare, which patients said was thoroughly explained to them.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good

We rated responsiveness as good because:

- The unit was achieving all national indicators for the assessment, treatment and discharge of patients including patients waiting no more than four hours from arrival to discharge and an average time to treatment of 39 minutes.
- Staff were aware of the complaints policy and provided clear information to patients about how to make a complaint or raise a concern. Improvements were made to the quality of care as a result of complaints and concerns.
- The needs of patients were taken into account when planning and delivering services.

However:

- The hospital did not provide any training or guidance for staff surrounding the assessment of treatment of patients with learning difficulties to ensure the needs of people with learning disabilities who attended were adequately met.
- There were limited printed information leaflets available about the care for children who had attended MIU. Information was not child friendly and often given verbally.
- The doors into the main reception and outpatient area presented difficulties for people with a physical disability as they were manually operated and heavy to open. A plan was in place (2016) for automatic doors to be installed.

Service planning and delivery to meet the needs of local people

Requires improvement

Urgent and emergency services

- The minor injury unit was well signposted and easy to access. There was a drop off point close to the front door for people with mobility problems, as well as disabled parking spaces. The unit was based on the ground floor meaning it was easily accessible.
- There were on site X-ray facilities which were open Monday to Friday 9am to 5pm, with the exception of one day each week where X-ray closed at 2pm. In the event of x-rays being required outside these times, staff referred patients to a local minor injuries unit which was open and had access to X-ray facilities 24 hours a day.
- The waiting room was shared with the X-ray department and was situated at the bottom of a stairwell and corridor that was used by staff to access other areas of the hospital. It had sufficient space and had useful health and information leaflets, as well as magazines for people to pass the time. Friends and family test questionnaires were also clearly displayed in the waiting room.
- All patients we spoke with said that they were very grateful to have a local minor injuries unit with such short waiting times in comparison to the time taken to travel and wait at the closest accident and emergency departments.

Meeting people's individual needs

- The hospital did not provide any training or guidance for staff surrounding the assessment of treatment of patients with learning difficulties. However, the staff we spoke with demonstrated a good understanding of the requirements and adaptations they would make for patients with complex needs.
- The hospital had a dementia strategy and staff had undertaken training in the needs of people living with dementia.
- The doors into the main reception and outpatient area presented difficulties for people with a physical disability as they were manually operated and heavy to open. A plan was in place (2016) for automatic doors to be installed.
- Translators could be accessed via a telephone translation system if required, however information leaflets were only available in English.
- A visual impairment assessment of the hospital was undertaken in 2013 and a hearing loop was in place to support people with hearing aids.
- Staff informed us that patients were given the choice of which hospital they would like to be referred to if it was deemed that a non-urgent referral was required. This enabled patients to attend the hospital that was most convenient to them.
- There was no specific waiting area for children within the Minor Injuries Unit and play equipment was also limited to two children's books suitable for young children only. However, there was a dedicated waiting area for children in the outpatients department where toys and games were available. Although this is not a requirement, the hospital had incorporated a designated children's waiting area in the development of outpatient services planned for 2018.
- 'You're Welcome', the Department of Health's quality criteria for young people friendly services, was not in place. However, the trust had undertaken a review of all children and young people's services in 2016 with the aim of making them more child-friendly. A paediatric-trained nurse from a local NHS trust undertook the review and recommendations had been implemented. For example, a diversion box for younger children had been introduced to help distract them whilst attending MIU.
- There was one information leaflet (in MIU) available to parents around the specific care needs of children and young people. The ENPs told us this was being addressed (by the matron) and parents would be given verbal advice and written information from NHS websites about their child's condition and how to respond if their condition deteriorated.

Access and flow

- Patients received timely assessment, treatment and discharge within the minor injuries unit.
- Waiting no more than four hours from arrival to discharge and how long patients wait for treatment are important indicators in minor injury unit performance. A short wait will reduce patient risk and discomfort. The national target is a wait of below 60 minutes and Tetbury Hospital consistently achieved this target with an average time to treatment of 39 minutes and average

total time spent in the minor injury unit as 2 hours 21 minutes. The MIU achieved 100% of patients being admitted, transferred or discharged within four hours of their arrival between April 2015 and April 2016. This was against a national standard of 95%.

- The percentage of patients who leave the unit without being seen can be an indicator of the responsiveness of a unit. The lower the percentage the greater the responsiveness. An average of 0.5 % of patients left without being seen in the 12 month period between April 2015 and April 2016. This compared well to the national rate of 5%.
- There were processes in place to ensure waiting times were not lengthy. If waiting times were increasing MIU staff would often ask for another member of staff from another department to help.

Learning from complaints and concerns

- Information about how patients could make a complaint was displayed in the minor injuries unit waiting room.
- The unit had received one complaint in the last year. We observed the records and found it had been investigated by senior staff and all staff members involved were contacted and involved in the complaints procedure. Replies to the complainant were courteous, within an agreed time frame and in line with trust policy.
- We saw evidence of the issues raised in the complaint discussed at governance and management meetings with information disseminated to all staff in team meetings.
- We were told of the learning that had occurred following the formal complaint and the changes that had been made to all the emergency nurse practitioners practice.

Are urgent and emergency services well-led?

Good

We rated well led as good because:

- There was an effective governance framework in place. We saw evidence of issues within the minor injuries unit being discussed at medical advisory committee (MAC) meetings and HQC meetings
- We saw evidence of incidents and complaints being discussed in governance meetings and this information being shared amongst all members of staff.
- The lines of accountability within the minor injuries unit were clear, with day to day management sitting with ENPs.

However:

- There was little evidence of the effects of change and development within the service. Changes and strategic direction were decided at a senior level in the organisation.
- There were no mechanisms in place to ensure ready access to professional children's nursing leadership within the service.
- There were no formal routine risk assessments but when risks were identified and were deemed to be high they were incorporated into the hospital's risk register.

Leadership / culture of service

- Although there was a system-wide approach to gaining clinical support for individual clinical issues; the hospital medical director who would be able to provide the ENPs with leadership and support to help develop the service was not always on site and staff reported often it was difficult to contact him. Leadership advice for service development could not always be gained from other senior staff who managed the department as they did not have experience in working in an accident or emergency department. One of the matron positions had previously been filled by someone with ENP experience; however at the time of our inspection this position was vacant.
- The lines of accountability within the minor injuries unit were clear, with day to day management sitting with ENPs. However, there was little evidence of the effects of change and development within the service. Changes and strategic direction were decided at a senior level in the organisation.

- There was a lack of evidence that emergency nurse practitioners were empowered to lead and manage change. We saw no evidence of change brought about by ENPs.
- Although ENPs were able to seek support and guidance from local trusts concerning the treatment and care of adults and children and young people, they were unable to access professional nursing leadership for children and young people in the hospital.
- The senior clinical leader worked across two sites and as a result was not always visible at a clinical level. However, when contacted they were approachable and listened to staff concerns.
- Leaders and staff we spoke with understood the value of raising concerns and were open to staff comments.
- Staff reported that there was flexibility amongst staff within the hospital and that other departments were always willing to help when required.
- We heard from staff members that patient care was always at the forefront of what they did and improving patient care was the main vision of all within the service. One nurse said, "We all work hard to give the best care to all our patients and are very proud of what we do". Staff talked positively about a no blame culture.

Vision and strategy for this this core service

- There was a county-wide clinical commissioning group vision and strategy for the minor injury unit which was to extend its opening hours in order to meet the needs of the local population
- There was no organisation-led strategy to achieve this at the time of our inspection because the hospital was awaiting feedback from the clinical commissioning group. Staff were aware of the vision, however did not always feel involved in its development.
- The hospital's plan was to move the minor injuries unit to a purpose-built building in the next three years with a child-friendly environment.

  There was also a local vision to deliver the best care. Staff had good awareness of this vision.
- The staff we spoke with were aware of the hospital's values and these could be found displayed on posters in the unit.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework in place. Monthly meetings were held within the minor injuries unit where issues were discussed and reported. Issues could then be reported to the hospital board who met ten times throughout the year as well as the MAC who met quarterly and were responsible for advising the hospital on clinical matters. We saw evidence in the minutes from the board meetings we were provided with that issues within the minor injuries unit were discussed. This included discussion around action plans to ensure the minor injuries unit achieved the 15 minute triage time.
- Information from the board meeting was shared with the hospital committees who then passed relevant information to the hospital departments. We saw evidence of action plans relating to the minor injuries unit and heard how these were shared with staff from all departments at team meetings. Staff also had an opportunity to forward items to the HQC through a feedback sheet attached to the HQC minutes. We saw evidence in the minutes of the HQC meetings that issues within the minor injuries unit were discussed, this included, missed fractures, triage times, arrangement of the resus trolley, complaints received and learning from these as well as any risks that may be on the risk register.
- Information surrounding governance and risk management could be found on a shared computer drive and staff were invited to attend governance meetings.
- There were no formal routine risk assessments but when risks were identified and were deemed to be high they were incorporated into the hospital's risk register. The risk register was reviewed at monthly meetings. We saw that action had taken place to try and mitigate these risks, for example the training of additional staff in triage to mitigate the risk of patients waiting longer than 15 minutes.
- The ENPs were responsible for assessing risk within their department and for adding and removing risks from the risk register. However, the risks recorded did not align with all the concerns expressed by staff and there was little more senior challenge of what was included. For example, the risk register did not include the concerns staff had surrounding lack of clinical oversight.

- Peer review within the unit did not take place and the emergency nurse practitioners did not spend any time reviewing each other's clinical practice. This could lead to discrepancies in consistency of practice and issues with assuring quality of practice.
- We saw evidence of meeting minutes where complaints were reviewed and discussed. This was then presented at the matrons' meeting and team meetings.
- In April and September 2015 the hospital was inspected for against the ISO 9001 and ISO 14001 standards. These are the internationally recognised standard for Quality Management Systems (QMS). ISO 9001 provides a management framework and set of principles for an organisation to consistently satisfy patients and other stakeholders. It aims to provide the basis for effective processes to deliver a service. ISO 14001 is the Environmental Management Standard helping organisations become more environmentally friendly, reducing their consumption, waste and costs. The hospital was meeting the standards.
- The hospital had been producing quality accounts for the last two years. These provided the latest information on the progress towards the various objectives and targets the senior management had set. The trust had set out an annual operational plan which had been developed by the senior management team. Part of the plan for 2015/16 included the development of improved clinical effectiveness by the introduction of electronic records. This would also provide improved output data for the benefit of patients' choice. Other improvements that were identified and put into place included an improvement to the hospital website to provide clearer information for patients about the location of clinics and services and where various tests could be undertaken.

Public and staff engagement

- The hospital conducted patient surveys and the NHS friends and family test to understand people's views and experiences and to help shape and improve services. The unit had clearly displayed patient feedback forms which could be found in the waiting room. However, feedback from parents, children and young people was not being received. The matron told us the hospital board was considering a more child-friendly approach to obtaining patient feedback.
- There was evidence that feedback from patients and the public was acted upon. For example, the unit had received feedback about the lack of signs detailing the availability of a vending machine in the outpatients department. The hospital responded to this and a sign was now clearly displayed in the unit's waiting room. Another issue raised from patient feedback was that patients did not always feel fully informed. Following this an action was put in place to ensure leaflets were given to help explain information. We did not see these given during our inspection; however the unit had a wide range of information leaflets clearly displayed within the department

  Monthly team meetings were held between the staff of the minor injury unit. They also attended a monthly meeting with the heads of other departments within the hospital. Staff reported that they felt happy to raise issues and concerns about the unit with senior members of staff.

Innovation, improvement and sustainability.

- There was little and limited innovation within the unit to drive improvement.

Good

Surgery

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

Information about the service

Tetbury Hospital provided day case elective surgery services for a number of specialities including orthopaedics, ophthalmology, dermatology, pain injections, gynaecology, podiatry, vascular (veins) and maxillofacial. The hospital did not operate on children and there were no overnight patient beds. Patients were either NHS or privately-funded.

Services were provided by consultant surgeons and anaesthetists working under practising privileges, operating theatre teams and day surgery staff.

From April 2015 to March 2016, the hospital carried out 1,068 surgical procedures. The NHS funded approximately 98% (1,046) of the treatments.

The hospital had one theatre with non-laminar flow (laminar flow is a system of airflow used to reduce the risk of airborne contamination) an anaesthetic room and two recovery areas. The initial recovery area patients were transferred to following surgery could accommodate two patients and the second recovery area could accommodate eight patients.

During our inspection, we visited the operating theatre, recovery areas and day case ward. We reviewed 11 patient records and spoke with seven patients and members of their family or friends. We spoke with 16 members of staff including administration staff, consultants, anaesthetists, nurses, operating department practitioners and health care assistants.

Summary of findings

We rated surgery services overall as good because:

- There were no surgical site infections from April 2015 to March 2016. During the same period there were no incidences of methicillin resistant Staphylococcus aureus (MRSA) or clostridium difficile.
- The hospital reported no never events or serious untoward incidents.
- There were low levels of staff sickness and staff turnover.
- The hospital reported no safeguarding concerns.
- The hospital had a low rate of unplanned patient transfers to other hospitals and there were no unplanned patient readmissions.
- Medical staff were checked for their fitness to practise.
- Staff were encouraged and supported to undertake training relevant to their role.
- Staff worked together to assess, plan and deliver care and treatment. They treated patients with kindness, dignity and respect and recognised when patients were anxious and provided them with reassurance.
- Patients with complex needs were assessed and plans were made for them prior to their admission.
- Patient care records were always available.
- Care was responsive and met the needs of the local population. Information about the needs of the local

Good

Surgery

population was used to inform how services were planned and delivered. Services which were not provided locally were identified and implemented at the hospital.

- Targets for referral to treatment times for NHS patients were always met from April 2015 to March 2016. Staff managed admission times to ensure patient waiting times were kept to a minimum.
- There was a programme of clinical audit and governance.
- Complaints were investigated. Actions were taken and lessons learned as a result of complaints.
- Leaders were approachable and visible.
- The hospital had a clear vision and set of values.

However:

- Cleaning schedules, fridge temperature and daily equipment checks were not always recorded as complete.
- Emergency equipment and drugs were not tamper-evident.
- The day surgery unit did not have piped oxygen.
- The hospital had not adapted guidance on quality standards for sepsis screening and management. There was no policy regarding sepsis.
- The hospital did not have a supply of blood products for use in an emergency.
- Patients' allergies were not always recorded on prescription charts.
- There was poor compliance with some mandatory training
- Not all identified risks were included on the risk register.

Are surgery services safe?

Requires improvement

We rated safety as requiring improvement because:

- Emergency equipment and drugs were not tamper-evident.
- Patients' allergies were not always recorded on prescription charts.
- Cleaning schedules, fridge temperature and theatre equipment daily checks were not always recorded as complete.
- The day surgery unit did not have piped oxygen.
- There was no policy regarding sepsis.
- The hospital did not have a supply of blood products for use in an emergency.
- Bins in theatre were not appropriate for the disposal of clinical waste.
- There was poor compliance with some mandatory training.

However:

- There were no surgical site infections from April 2015 to March 2016.
- There were low levels of staff sickness and staff turnover.
- Patient care records were always available.

Incidents

- From April 2015 to March 2016 the hospital reported no never events or serious untoward incidents. A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death. There were 37 clinical incidents reported in the hospital during this period. Of these incidents, 32 were categorised as no harm and five were categorised as low harm. None were categorised as moderate, severe or death. The hospital reported 86.5% of incidents had resulted in no harm. Other independent hospitals we have information for reported 61.5% of incidents resulted in no harm. Incidents with low, moderate, severe harm or death reported by Tetbury Hospital were lower than other hospitals we have information for.

Good

Surgery

- From April 2015 to March 2016, the day surgery unit reported 23 clinical incidents and 18 non-clinical incidents. Two of these involved patients who required an overnight stay or further assessment following day case surgery. The hospital classified these as unplanned events which they reported to enable them to be tracked and monitored.
- There was a policy and systems for staff to report incidents. The reporting system was paper-based requiring staff to complete a form and the information was transferred onto an electronic system. The hospital did not report incidents to the national reporting and learning system. The chief executive had oversight of all incidents and identified themes from reported incidents.
- All incidents were reported to the trust board each month. The Hospital Quality Committee (HQC) and Medical Advisory Committee (MAC) discussed incidents in their meetings. We saw evidence that discussions had taken place regarding incidents in the minutes from these meetings.
- Incidents were investigated within the department. Staff we spoke with were able to explain the procedures for investigating incidents and said they received feedback from incidents they were involved in or had reported.
- Feedback and learning from incidents was discussed at team meetings and staff we spoke with said they were involved in these discussions. Minutes from the HQC were also available in staff areas outlining incidents and outcomes.
- Staff were able to describe learning from incidents. An incident had occurred regarding oxygen cylinders in the department and as a result of this, further training had been provided to staff and more oxygen cylinders were made available at the hospital.
- The hospital did not hold morbidity and mortality meetings. There were no deaths at the hospital from April 2015 to March 2016.

Duty of Candour

- There was knowledge among staff of when to apply duty of candour and the hospital was open and honest, and apologised to people when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This regulation requires the hospital to be open and transparent when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Staff were aware of their responsibility regarding the duty of candour. Not all staff could initially explain what the duty of candour was as they were unfamiliar with the term. However staff could describe the actions they would take if something had gone wrong which was in accordance with the duty of candour regulation. The hospital did not provide any specific training for the duty of candour.

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

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This covers areas including falls, pressure damage, infection control, venous thromboembolism (VTE) and catheter associated urinary tract infections. Hospitals submit this data each month so it is available to the public on the Health and Social Care (HSC) Information Website. Although the hospital collected this data monthly as they did not have any inpatient beds they were not required to submit it to the HSC.
- From April 2015 to March 2016 the percentage of patients assessed for risk of VTE was 93%. This was below (worse than) the target of 95% compliance. However, there were no recorded incidents of hospital acquired VTE or pulmonary embolism. Staff were reminded to complete the VTE risk assessment in the day surgery team meeting and we read this in the meeting minutes. In the patient care records we reviewed we saw completed VTE risk assessments. Staff we spoke with were aware of the requirement to complete VTE risk assessments and could describe the actions they would take if a patient was at risk.

Cleanliness, infection control and hygiene

- The day surgery unit was visibly clean and cleaning schedules were in place. However, when we reviewed the schedules, there were dates when they were not signed off as completed including on the first day of our inspection. In July 2016, the cleaning schedule had been

signed as completed in eight out of 21 working days (38% compliance) and in August 2016, it had been signed as completed in 14 out of 22 working days (64% compliance).

- An annual infection prevention and control audit was carried out by a local NHS acute hospital. The audit was completed in October 2015 and overall, the day surgery unit was 83% compliant. The unit scored 100% for compliance with linen management, handling of specimens and the management of peripheral intravenous lines. However, the unit kitchen was 67% compliant. In the audit concerns were raised regarding lack of food labelling to identify whether it was staff or patient food and the lack of use of personal protective equipment (PPE) by staff when preparing or serving food. These concerns had been addressed and staff were storing their food in the staff room and during our inspection, we observed staff using PPE when preparing food for patients.
- Disposable curtains were used in the day surgery unit. During our inspection, we observed these to be clean and in good condition. Dates when they were last changed were documented and all were within their date for being replaced.
- Patients in line with hospital policy attending the day surgery unit were screened for methicillin-resistant Staphylococcus aureus (MRSA) as part of their pre-op assessment. During the period from April 2015 to March 2016 there were no incidences of MRSA or clostridium difficile reported.
- From April 2015 to March 2016, the hospital reported there had been no surgical site infections.
- Staff we met and observed followed infection prevention and control policies. Staff in the day surgery unit wore uniforms and we observed these to be clean and well maintained.
- There was a policy for infection prevention and control. Staff we spoke with said they were able to access this policy on the hospital intranet system.
- We observed good handwashing and decontamination practices. In May and June 2016, the day surgery unit scored 100% in their monthly hand hygiene audit. Staff we spoke with could identify when it was appropriate to use hand gel and when they should wash their hands. We observed staff using a recognised technique for handwashing and decontamination. The hospital policy was for staff to be bare below the elbow, however during our inspection we saw a member of staff who was not bare below the elbow.
- Personal protective equipment (gloves and aprons) was available in the day surgery unit. We observed staff using this equipment appropriately when required.
- There were bins available for clinical and non-clinical waste. However, some of the bins were not appropriate for the disposal of waste in a clinical area as they did not have lids. We also saw a clinical waste bin liner attached to the anaesthetic equipment in theatre.
- Sharps bins were available for staff to use to dispose of used needles and syringes. These were visibly clean, not overfilled and the safety mechanisms were in use to prevent items falling out. However, staff had not completed the labels on some of the sharps bins labels indicating who had assembled them, the date of assembly and the department.

Environment and equipment

- Adult resuscitation equipment was available in the day surgery unit. We observed there was good access to the resuscitation equipment. The resuscitation trolleys were checked daily and we saw these checks had been completed. However, the resuscitation trolley was not tamper-evident. This was highlighted to staff at the time of our inspection.
- Adult resuscitation equipment was being standardised to correspond with equipment used in the local NHS acute hospital. The majority of doctors who worked in the day surgery unit were employed at the local NHS acute hospital so emergency equipment was arranged the same to avoid delays in an emergency.
- There was a schedule for daily checks to be carried out on anaesthetic equipment in theatre. However, we reviewed the schedule and found there were numerous days when this had not been signed off as completed.
- Reusable medical equipment was decontaminated at the local NHS acute hospital. This included the scopes used for hysteroscopy and nasal endoscopes. There were processes for handling the equipment before transportation to the decontamination facility. Used devices and equipment were placed in bags in the dirty utility area of the theatre. However, they were not stored for collection in this area and were in an open plastic box on the floor in a patient recovery area.

- Equipment was serviced, maintained and tested for electrical safety. Most of the equipment we checked had an in-date electrical safety test sticker. The hospital had a medical appliance asset register showing when equipment had last been serviced and when the next service was due. Servicing and maintenance of equipment was provided by the local NHS trust.
- The chairs used in the recovery areas of the day surgery unit were made of a wipe clean material and were visibly clean and in good condition at the time of the inspection. We observed staff cleaning the chairs between patients using appropriate equipment.
- The flooring in the day surgery unit was in good condition and visibly clean. It was made of a hard-wearing material which enhanced effective cleaning and decontamination.
- The day surgery unit performed laser treatment for some vascular patients but this procedure was not performed during the inspection. We were informed local rules had been provided for the safe use of laser which were to be displayed in theatre when the laser was in use. Personal protective equipment for laser treatment such as protective eyewear was supplied. The use of laser equipment was audited by a third party provider. We reviewed the recent audit which highlighted the training records for the use of laser equipment for one member of staff were not available.

Medicines

- The hospital did not have a pharmacy department. Medicines including packs for patients to take away (TTA) post operatively were provided by a local NHS acute hospital. Staff we spoke with reported the system worked well and we saw there was an up-to-date service level agreement (SLA) for the provision of medicines. As part of the SLA the local NHS hospital also carried out monthly audits on the management of controlled drugs such as morphine and pethidine and yearly medicine audits. We saw evidence of these and where re-audits had taken place to ensure recommendations were followed.
- Controlled drugs were stored in accordance with the Misuse of Drugs Act 1971 and associated regulations. The day surgery unit had suitable locked cupboards for the storage of these medicines.
- The hospital was in the process of changing medicines used for pain relief and the prescription chart. This was because there was a potential risk for groups of patients with pre-existing conditions such as ischaemic heart disease. For example, codeine and paracetamol could then be given separately instead of in a single tablet such as co-codamol for a patients who cannot tolerate codeine.During the inspection we carried out a check on the medicines. Those we checked were in date and although there were daily check sheets for recording medicine fridge temperatures these were incomplete. In July and August 2016 the fridge temperature records were 49% incomplete.
- Medicines including audits, incidents, safety alerts and clinical policies were discussed at the trust board and hospital quality committee (HQC) meetings. We saw evidence discussions had taken place in the minutes of both these meetings. Following an incident involving controlled drugs an action plan was discussed during one of the HQC meetings and completed to prevent the incident reoccurring. At the time of our inspection, this was being monitored.
- Hospital clinical staff undertook medicines management training. Compliance with this training in August 2016 was 84%. Some staff were also attending training for an update on administering intravenous (IV) medicines.
- Emergency drugs were available. We saw first line emergency drugs in the resuscitation trolley and second line emergency drugs were stored in a locked cupboard in the day surgery unit. Storage of emergency drugs had been discussed and agreed at the medical advisory committee (MAC) and HQC meetings. Policies had been updated to reflect the changes in emergency drug storage.
- The hospital policy stated that emergency drugs should be checked daily but it was decided at one of the HQC meetings this could be changed to weekly as the drugs were sealed. However, during our inspection the emergency drugs were not tamper-evident or sealed. This was highlighted to the hospital at the time of our inspection.
- The day surgery unit was proposing to introduce a different form of post-operative analgesia. Staff were unfamiliar with the administration and doses for the medicine. Their concerns had been raised with the doctors and training sessions were planned to ensure staff would be competent to give it safely before being introduced.
- The hospital used cylinders for the administration of medical gases such as oxygen. An incident had occurred

where the oxygen cylinders had been incorrectly checked and the cylinders were empty when they were needed. The hospital had addressed this by increasing their stock levels of oxygen cylinders and carrying out further staff training. However, the National Patient Safety Agency (NPSA) put an alert on oxygen in hospital settings in 2010 which states 'The use of oxygen cylinders is minimised and, where necessary, a business case for increased piped oxygen provision is developed'. This guidance was issued by the Department of Health, Estates and Facilities Division on medical gases. The guidance given in this document should be followed for all new installations and refurbishment or upgrading of existing installations. Existing installations should be assessed for compliance and a plan for upgrading the system should be prepared with the priority of patient safety. This was not on the hospital risk register and was not mentioned in the hospital business plan for 2015-2018.

- The hospital did not store blood products for use in case of emergencies. We were informed there was a policy for managing major blood loss and we saw a flowchart in recovery for staff to follow if this happened. Staff we spoke with were aware of the flowchart. We were informed if a patient experienced major blood loss, the hospital would dial 999 and request for emergency blood to be sent urgently and arrange for transfer of the patient to an acute NHS hospital by emergency ambulance. A service level agreement (SLA) for providing emergency blood products had been agreed in 2015 with the NHS ambulance service. We were informed as part of this SLA that due to the rural location of the hospital the air ambulance or an emergency vehicle would attend the hospital with emergency blood products. However, the lack of emergency blood on the hospital site would cause a delay in the treatment. The NPSA had put an alert on the transfusion of blood and blood components in an emergency in 2010 which states 'The urgent provision of blood for life threatening haemorrhages requires a rapid, focused approach as excessive blood loss can jeopardise the survival of patients. Early recognition of major blood loss and immediate effective interventions are vital to avoid hypovolaemic shock and its consequences.' One of the doctors we spoke with said the major blood loss policy was being reviewed and a simulation exercise for staff in the case of major blood loss was to take place in October this year. This was not on the hospital or day surgery unit risk register.

Records

- The patient care records we reviewed had diagnoses and clear management plans documented but completion of other information and the legibility of handwriting varied. The name and grade of the staff reviewing the patient was not always clear and patient observations were not always recorded.
- The day surgery unit used a pre-printed general anaesthetic and sedation booklet for recording patient care. This booklet included pre-operative assessments, results of investigations such as blood results and X-rays, admission information, pre-operative checklists, VTE assessments and post-operative care. Patient consent forms and prescription charts were separate to the booklet.
- The hospital had recently employed an additional nurse to carry out pre-operative assessments. They were due to commence employment in the week following our inspection. At the time of our inspection, initial pre-operative assessments were carried out by appropriately trained staff weekly in the outpatient department. Pre-operative assessments were documented in the day surgery unit general anaesthetic and sedation booklet.
- We reviewed sets of patient care records during our inspection and found that pre-operative assessments had been completed and escalated to the lead anaesthetist appropriately. However, during our inspection patient care records awaiting review were kept in an office and the door to it was not locked when unattended. This meant patients and visitors could potentially access care records.
- Medicine prescription charts were used for dispensing TTA packs. Those we reviewed were signed enabling appropriately trained staff to dispense these to patients. However, the area on the prescription chart for documenting allergies was not completed in any of the charts we reviewed despite some patients having drug allergies.

- Staff we spoke with said patient care records were always available and they had not seen any patients without their care record. The hospital confirmed that 0% of patients in the day surgery unit had been seen without their full care record.
- The hospital provided training to all staff in respect of information governance. The compliance rate in August 2016 was 68%. Training was discussed at the day surgery unit meetings but in only one of the two sets of minutes from the meetings we were provided with were staff reminded to complete their training and information governance was not mentioned specifically.

Safeguarding

- The hospital reported no safeguarding incidents from April 2015 to March 2016. Staff we spoke with were aware of their responsibilities to report suspicions of abuse. There were policies and procedures to support staff and these included flow charts to assist in the hospital safeguarding processes.
- The hospital had a senior member of staff who was the lead for safeguarding. Staff we spoke with could identify the safeguarding lead.
- Safeguarding training was available to all staff. This was provided by a third party and comprised an e-learning package. We were provided with safeguarding training figures for the hospital from August 2016. Managers were trained to adult safeguarding level two and 91% of all managers in the hospital were compliant with this training. Other staff were trained to adult safeguarding level one with 96% of all hospital staff compliant.
- Although the hospital did not operate on children, staff in the day surgery unit were trained to provide care to patients attending the minor injury unit in the hospital. This meant they could come into contact with children. All clinical staff who cared for children were trained to level two in safeguarding children which is the minimum requirement for staff with contact with children. The training figures we were provided with for June 2016 showed 100% compliance. However, from August 2016 compliance was 64%. The hospital did not provide us with information on their target for compliance in this training or how this was being addressed.

Mandatory training

- Mandatory training included life support, fire safety, moving and handling and infection prevention and control.
- The day surgery unit managers monitored mandatory training compliance rates and identified staff who were out of date. The information supplied by the hospital did not provide an overall percentage of staff who had completed their mandatory training although in the board meeting minutes from June 2016, it stated 20% of mandatory training was outstanding. We were provided with a mandatory training report for the hospital quality committee (HQC) from August 2016 showing compliance for the whole hospital. The report did not state the hospital target for compliance with mandatory training and the levels of compliance ranged from 29% to 100%. Some of the levels of compliance recorded for staff in the August mandatory training report were:
  - Basic life support 29%. This training had been completed by 11 of the 38 members of staff required to complete it.
  - Immediate life support 63%. This training had been completed by 12 of the 19 members of staff required to complete it.
  - Fire 79%. This training had been completed by 44 of the 56 members of staff required to complete it.
  - Equality and diversity 100%.
- Although the hospital reported mandatory training compliance at each HQC meeting, in the minutes we were provided with an action plan to address the levels of compliance was not discussed. In the minutes we read from March 2016 to June 2016, the action to address non-compliance was for managers to remind staff to complete their mandatory training. In the two sets of day surgery unit meeting minutes we were provided with mandatory training was mentioned in one meeting only. Overall compliance rates had reduced from 82% in March 2016 to 80% in June 2016.

Assessing and responding to patient risk

- Risk assessments were carried out prior to elective surgery. A nurse led clinic was held weekly in the outpatient department for pre-operative assessments and risk assessments were completed as part of this. The hospital followed strict criteria to assess the suitability of patients for surgery. Where risks were identified the patient was discussed with an anaesthetist and the notes were reviewed. If the patient

did not meet the hospital criteria, they were referred back to their GP. We saw this system in progress during our inspection and saw evidence the notes had been reviewed and recommendations made.

- The hospital did not follow the guidance of the National Early Warning Score (NEWS) to identify and respond to deteriorating patients. This system is used to detect patients who may be at risk by allocating scores according to observations such as blood pressure, pulse rate and temperature. If the scores trigger concerns, depending on what the concerns are, there are different protocols to follow. This system assists staff in recognising unwell or deteriorating patients. Instead the hospital used a chart each patient is observed against normal parameters for each domain. If a patient shows signs of deteriorating the orgainsations escalation process is to contact the consultant surgeon and Anaesthetist or 999. Staff we spoke with said they would rely on their clinical skills and judgements to assess patients and if they had any concerns they would escalate these to the doctor or anaesthetist. The Royal College of Physicians recommend NEWS are adopted in hospitals. Since the inspection the hospital has advised us they are reviewing their forms to develop a modified NEWS. The hospital did not have a policy for sepsis and there was no evidence of the sepsis toolkit being used. The hospital did not provide any mandatory training on sepsis. There was not a policy or protocol for sepsis management. Staff we spoke with confirmed they had not received training in screening for or managing sepsis. The hospital had received and reviewed guidance from the National Institute for Health and Care Excellence (NICE) in July 2016 called 'Sepsis: recognition, diagnosis and early management'. From the guidance they had identified that a standard operating procedure (SOP) for sepsis should be introduced in another department and this was to be discussed at the Medical Advisory Committee (MAC) meeting in September. However, there was no reference to the introduction of a SOP or policy for sepsis in the day surgery unit. Sepsis is a potentially life-threatening condition triggered by an infection or injury and patients who have undergone surgery are more at risk of developing it. Staff we spoke with said they did not admit patients who had a high temperature or were unwell so there was minimal risk of sepsis. However, the signs and symptoms of sepsis can vary and may be subtle which can lead to it being overlooked.
- There were arrangements for transferring patients to emergency care. Staff we spoke with said if a patient required transfer to a nearby NHS acute hospital with an emergency department, they would call for an emergency ambulance. The hospital did not have a service level agreement with the local NHS acute trust or ambulance service for the transfer of patients aside from the standard NHS contract which would not include patients receiving privately funded care. However, they said they had not experienced any problems with the current system.
- The theatre staff followed the five steps to safer surgery. This involved following the World Health Organisation (WHO) surgical safety checklist before, during and after each surgical procedure. The checklist forms part of a procedure to oversee the safety elements of pre and post-operative care. In the minutes from the MAC meeting in March 2016, a discussion around ensuring the WHO checklist was completed had been minuted. A policy had been written and actions to improve completion of the checklist had been proposed. These included agreement on the best time to complete the checklist, further staff training and audit. However, in the minutes from the day surgery unit meeting in April 2016, it was documented that seven WHO checklists had not been completed. All staff were reminded at this meeting to ensure the checklists were completed. During the inspection we witnessed the WHO surgical safety checklist being completed appropriately.

Nursing staffing

- The day surgery unit reported they had no unfilled shifts from April 2015 to March 2016. In the same period, they reported no use of agency staff.
- The day surgery unit used its own bank of staff to cover unfilled shifts. From April 2015 to March 2016, the use of bank staff in the unit was below 30%. Bank staff were closely monitored by the unit managers. If they had not worked a shift in the unit for over six months, they were removed from the bank or updated before they worked another shift.
- Sickness rates in the day surgery unit were low. From April 2015 to March 2016, sickness levels for registered nurses were 0% except for in three months when the rates were below 20%. Sickness rates for health care assistants during the same period were 0% except for in three months when they were below 5%.

- There were low levels of staff turnover. There were no full time vacant posts in the day surgery unit on 1st April 2016. From April 2015 to March 2016 there was no staff turnover in the day surgery unit.
- An electronic staffing planning tool was not used in the day surgery unit. However, as this was a small department all staff were well known to the unit managers who said this enabled them to plan staffing safely according to their skills.
- Staff in the day surgery unit worked in different areas of the unit. The managers said this helped them to maintain their skills and meant they were competent to work in the different areas of the unit such as recovery and theatre. Staff were provided with training as required to work in the different areas of the unit however, there were no specific competencies for staff to complete.
- Staff were encouraged to keep up-to-date with practice. Some staff from the day surgery unit reported working with the local NHS trust to update their skills.
- The day surgery unit managers planned the staff rotas according to the hospital guidelines. The hospital had one scrub practitioner for each theatre list. We highlighted the Association for Perioperative Practice (AfPP) guidelines to staff at the time of our inspection. The AfPP recommends two scrub practitioners as the basic requirement for each theatre list of minor surgery that demands a quick throughput or has several cases on it such as for elective day surgery. The AfPP also recommend there should be one circulating member of staff and a registered anaesthetic assistant practitioner including for cases where local sedation or anaesthesia was used. We were informed that some of the staff allocated to the role of anaesthetic assistant were not registered. The unit managers said they were looking into staff achieving anaesthetic competencies but we were not provided with any evidence of this at the time of our inspection. The hospital as since informed us this relates to one member of staff who is currently undergoing re registration following a return to work. We were not provided with a risk assessment regarding theatre staffing and it was not on the hospital or day surgery unit risk register.

Surgical staffing

- There were 72 doctors at Tetbury Hospital employed under practising privileges. We were provided with the hospital policy regarding practising privileges. Doctors were approved by the medical advisory committee who granted them practising privileges. Most of the staff working under practising privileges were employed in the NHS and their revalidation and appraisals were carried out by their NHS employer. This information was provided to Tetbury Hospital. Of the 72 doctors employed under practising privileges, 18 (25%) had provided no episodes of care from April 2015 to March 2016 and 18 (25%) had provided over 100 episodes of care.
- The hospital did not provide a 24 hour service. The hospital closed overnight from 7pm unless non-clinical reasons prevented this such as patients waiting for transport. If a patient was not fit for discharge when the hospital closed they were transferred to another NHS hospital. This had occurred twice between April 2015 and March 2016.
- There were processes to ensure patients were safe following surgery. Each patient was seen by their consultant and anaesthetist pre and post-operatively who were available until the patient left the hospital. The surgeon and anaesthetist checked with the member of staff in charge it was safe for them to leave the hospital. If staff had any concerns about a patient, the surgeon or anaesthetist stayed until these were addressed and staff were reassured.
- Patients were provided with out of hours contact numbers for local NHS hospitals so they could access healthcare advice if they had any concerns. These had recently been updated following a patient comment.

Major incident awareness and training

- There was a major incident policy that had been approved and put into place in July 2016. This plan related to the whole hospital and was supported by the business continuity plan. The plan had been written in accordance with the NHS England Emergency Preparedness Framework. The plan covered three levels of response, business continuity incident, critical incident and major incident.
- The plan was written with reference to the Civil Contingencies Act 2014 which requires NHS providers to support local commissioning groups and NHS England to discharge their Emergency Preparedness Resilience and Response Functions (EPRRF) responsibilities.

- The plans detailed the action the hospital would take and the expectations placed on the staff team. The senior management team were planning a table top training exercise for staff for October 2016.

Are surgery services effective?

Good

We rated effectiveness as good because:

- The hospital provided evidence based care, treatment and support.
- The hospital had a low rate of unplanned patient transfers to other hospitals and there were no unplanned patient readmissions.
- Staff were encouraged and supported to undertake training relevant to their role.
- Staff worked together to assess, plan and deliver care and treatment.
- The hospital submitted HSCIC national audit data which included data relating to cataract removal, carpel tunnel procedures, hysteroscopy and wisdom teeth removal.

However:

- The hospital did not participate in national audits regarding patient outcomes though were about to commence participation in the Private Healthcare Information Network (PHIN.)
- The hospital had not adapted guidance on quality standards for sepsis screening and management or National Early Warning Score (NEWS).

Evidence-based care and treatment

- The hospital provided evidence based care, treatment and support. Some guidelines and policies were provided by a local NHS trust and were based on guidance from organisations such as the National Institute for Health and Care Excellence (NICE) the Department of Health (DoH) and other professional bodies for example, the General Medical Council (GMC). Tetbury hospital policies were also written according to guidance from professional bodies such as NICE, the GMC and the DoH. However, the hospital had not adapted guidance on quality standards for sepsis screening and management and patients were not reviewed specifically regarding sepsis post operatively. The hospital also did not use the National Early Warning Score (NEWS) system to identify patients at risk of deterioration.
- Guidelines and policies were followed to assess patient suitability for surgery at the hospital. Patients were referred to the hospital by their GP who completed a standard form outlining their reason for referral, medical history, general health and medications. This was assessed by a member of the day surgery unit staff and using the hospital policy 'criteria for selection of patient into the day surgery unit'. They would then decide whether the patient was eligible to have surgery in the hospital or if they needed further assessment. The guideline was evidence based using information from a local NHS trust policy and NICE clinical guidelines. The policy was approved by the hospital medical advisory committee (MAC).
- Policies and guidelines were discussed at the monthly MAC meeting and the hospital quality committee (HQC) meeting. Updates to policies and approvals were discussed and minuted. The HQC meeting minutes were available to all staff. New or approved policies were also highlighted to staff at monthly unit meetings.
- Changes to guidelines and policies were made following a monthly analysis by the hospital of reports from NICE and the Medicines and Healthcare Products Regulatory Agency (MHRA). Updates to guidelines and policies were made according to those identified as relevant in the reports. These were discussed at the HQC and approved by the MAC before put into use and communicated to staff.
- There was effective traceability for medical device implants. There was an implant book where all implants were recorded and a traceability sticker from the implant was stuck into this. Details and stickers from the implants were also recorded in the patient and surgery notes. Staff we spoke with were able to describe the procedure for recording and managing implants. When lenses were used, a consignment sheet is faxed to the company after the list for the replenishment of stock

Pain relief

- In the hospital patient survey 2015, 82% of patients reported they were not in pain during their visit to the day surgery unit. The percentage of patients who reported staff "definitely" and "to some extent" did everything they could to control their pain was 100%.
- Staff assessed patients for pain. Staff we spoke with said if a patient was in discomfort they would inform the anaesthetist who would give them further pain relief. They reported anaesthetists were quick to respond and administer pain relief when required. The hospital did not have a dedicated pain team.
- Patients were discharged with pain relief and advice on pain management. The hospital was reviewing post-operative pain relief for patients at the time of our inspection and training on the drugs to be introduced had been arranged.

Nutrition and hydration

- Following surgery patients were offered a light diet and drinks. The hospital did not have a catering department. Staff prepared basic food and drinks for patients in the day surgery unit kitchen which had recently undergone refurbishment.

Patient outcomes

- The hospital did not participate in national audits regarding patient outcomes such as the Private Healthcare Information Network (PHIN). However, there was a plan to undertake this. PHIN is an independent organisation that publishes information to assist patients in making decisions about their care and treatment options. PHIN also helps hospitals improve their standards. Mandatory reporting into PHIN did not come into place until after the inspection.
- The hospital submitted HSCIC national audit data which included data relating to cataract removal, carpel tunnel procedures, hysteroscopy and wisdom teeth removal.
- The hospital participated in patient satisfaction audits and the NHS patient-led assessment of the care environment (PLACE) audit. However, PLACE scores from February to June 2015 for the hospital were not available at the time of our inspection.
- The hospital collected information from patients on various aspects of their experience in the day surgery unit both in the pre and post-operative period and reported this annually. Some of the questions asked in the patient survey were:
  - Were you given enough privacy when discussing your condition or operation?
  - Were you involved as much as you wanted to be in decisions about your care and treatment?
  - Beforehand, did a member of staff explain what would be done during the operation?
  - Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?
- The day surgery unit scored consistently good results in all of the questions patients were asked in the survey. Action plans were written to improve results where satisfaction levels were lower.
- The hospital had a low rate of unplanned transfers to other hospitals. From April 2015 to March 2016, the hospital reported two unplanned patient transfers to other hospitals. This represented 0.2% of all day case attendances.
- There were no cases of unplanned readmissions to the hospital within 28 days of discharge and there were no unplanned returns to the hospital operating theatre from April 2015 to March 2016.

Competent staff

- Staff employed by the hospital had employment checks. This included references, Disclosure and Barring Service (DBS) checks, proof of identity, and a check of any relevant professional registration. The hospital policy was for DBS disclosure checks to be repeated every three years. In August 2016, 89% of all hospital staff had a DBS check and 100% of all clinical staff had up-to-date professional registration.
- Practising privileges is an authority granted to a physician by a hospital governing body to allow them to provide patient care within that hospital. There were appropriate systems to ensure all doctors' practising privileges were kept up-to-date. This was carried out manually and a member of staff ensured all updates to documents were collected. If up-to-date documents were not provided, this was escalated to the medical director and chief executive who would formally request them from the member of staff. If they were not provided, action was taken following the hospital policy on practising privileges. The hospital was planning to change the current system to an electronic database.
- Day surgery unit staff informed us on-going training was provided. Staff we spoke with said they were

encouraged and given opportunities to develop. Members of staff informed the inspection team of role specific training they had completed and how this had assisted them to develop the service.

- In August 2016, the hospital reported that 95% of all staff had received an annual appraisal. All staff we spoke with confirmed their appraisal was up-to-date.
- Bank staff received an appraisal, induction and mandatory training. Staff we spoke with said bank staff also attended role specific training provided by the hospital.
- Some training was outsourced to third party providers such as basic and immediate life support. Training for specific equipment or procedures was provided by hospital staff or company representatives who provided the hospital with the equipment. Some of the day surgery unit staff were link staff for topics such as infection prevention and control, recovery, post-operative advice and discharge. As part of their link role, they provided training to their colleagues in the area they had specialised in. Training sessions were advertised on the staff notice board in the day surgery unit.
- Staff involved in laser treatment in the day surgery unit had received training from a third party provider. The hospital had laser protection supervisors and a laser protection adviser was available through a third party provider.

Multidisciplinary working (in relation to this core service only)

- Staff worked together to assess, plan and deliver care and treatment. We observed good multidisciplinary working between the day surgery unit staff and doctors working under practising privileges. Before doctors left the hospital they checked with the member of staff in charge of the day surgery unit they were not required before leaving. Staff reported this system worked well and doctors always checked with them before they left the premises.
- Patients were discharged at an appropriate time. The hospital closed overnight from 7pm and staff said they would stay on if a patient was unable to leave due to non-clinical reasons such as waiting for transport. If a patient was clinically not fit for discharge when the hospital closed, they were reviewed by a doctor and arrangements were made for them to be transferred to another hospital however, this rarely happened.
- The hospital ensured relevant information was shared with the patients GP's. Patients were discharged with a copy of the letter sent to their GP outlining the procedure they had and any change in medication or follow up required.

Seven-day services

- The hospital did not offer seven-day services. The hospital was open from 7am to 7pm Monday to Friday. Day surgery lists ran Monday to Friday 9.30 am to 12.30pm and from 2pm to 5.30pm. Evening lists from 6.00pm to 9.00pm were carried out by prior arrangement but were not regularly held.

Access to information

- The day surgery unit reported from April 2015 to March 2016 they had not seen a patient without access to their full care record. The unit used a general anaesthetic and sedation booklet which contained patient information received from the GP, the patient themselves and members of the day surgery unit team. The booklet was used from the pre-operative stage through to discharge and all members of the team documented the care they had given in this. Details of any implants used were also recorded in the booklet. We reviewed sets of care records and found these to be mostly complete. The care records we reviewed were well organised and in good condition.
- The hospital aimed to send letters to GP's with 24 hours of an elective admission to the day surgery unit. From April 2015 to March 2016, they achieved this target 99% of the time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In August 2016, 84% of staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff we spoke with were knowledgeable about the MCA and DoLS. They reported they had received training in this and were able to describe relevant aspects of the MCA.
- Staff we spoke with informed us that patients who did not have the mental capacity to make a decision were not treated at the hospital and were referred to their GP at the pre-operative stage.
- Consent was gained before carrying out any treatments. Staff informed us they explained procedures to patients

in the pre-operative assessment; they also provided them with a leaflet explaining consent. We saw written consent forms in the care records we reviewed. One of the patients we spoke with said they had all the risks explained to them prior to surgery and were given a leaflet to take home explaining consent.

- Staff we spoke with had knowledge of DoLS although it was unlikely to apply in this hospital. A person can be deprived of their liberty if they do not have the capacity to make their own decisions, and need treatment, care or safety to protect them or others. An application to deprive a person of their liberty to receive care and treatment was unlikely to be required for a patient treated at this hospital.

Are surgery services caring?

Good

We rated caring as good because:

- Patients were treated with kindness, dignity and respect.
- The hospital had good results from the NHS Friends and Family Test (NHS FFT).
- Staff recognised when patients were anxious and provided them with reassurance.
- Patients reported they were given enough information about their condition and treatment.

However:

- There was a lack of privacy for patients when discussing their operation and condition.

Compassionate care

- Patients were treated with dignity, kindness, compassion and respect. All the patients we spoke with in the day surgery unit were highly complementary of the care they had received. Quotes from the patients we met included:
  - "I'm very happy with the hospital."
  - "Everyone tries their best."
  - "So relaxed but caring and friendly."
- Some of the comments the day surgery unit received from the NHS FFT were:
  - "Very convenient."
  - "Small and personal."
  - "I have been treated with dignity, respect, professionalism and efficiency."
  - "Quiet and reassuring environment."
- The patient survey had been carried out in October 2015 and some of the comments patients had made were:
  - "Cannot fault the care received. Nothing was too much trouble and everyone was polite and understanding."
  - "Everything was perfect apart from our initial discussions weren't very private. Otherwise the whole process was perfect."
  - "All staff were lovely and treated me great."
  - "The care and treatment was very good I would like to thank Tetbury Hospital."
  - "Very friendly staff made me feel at ease."
- The hospital had written an action plan as a result of the patient survey however, the comments and scores regarding privacy were not mentioned or addressed in this. It had been an item on the hospital risk register since March 2014 and on the day surgery unit risk register since June 2015.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so they understood their care and treatment and how it was going to be provided. This was reflected in the results from the patient survey where 100% of respondents said they were given the right amount of information about their condition and treatment.
- Staff recognised when patients needed additional support. We observed staff reassuring an anxious patient who told the inspection team after their surgery they had appreciated this.
- People close to patients were involved in treatment and care. Patients were encouraged to bring a friend or relative with them to the day surgery unit. The bays in the main recovery area were large enough for relatives or friends to be accommodated comfortably. In the 2015 patient survey, 96% of respondents said they were involved in decisions about their care and treatment.
- The day surgery unit team was small and patients were cared for by the same members of staff pre and post operatively providing them with continuity of care. Staff we spoke with said they usually saw the same patient throughout their visit to the unit. In the 2015 patient survey, 92% of respondents said all the staff introduced themselves to them.

Good

Surgery

Emotional support

- Staff had a good understanding of the impact a person's care treatment or condition would have on their wellbeing and those close to them. In the 2015 patient survey, 98% of patients said they definitely received answers they could understand when they asked nurses questions. In the same survey, 88% of patients said their friends, carers or relatives had enough opportunity to talk with a doctor about their care and treatment. Ninety eight per cent of respondents said they received the same information from different members of staff.
- Patients were well informed regarding their surgery. They said they were told how they could expect to feel following their operation and 91% said they found someone at the hospital to talk with about their worries and fears.
- Patients had their emotional and physical needs met. Staff ensured their pain was managed and they had adequate nutrition and hydration although this was limited. Patients were given time to recover from their operation and ask any questions. Staff provided patients with information prior to discharge and ensured patients and their relatives knew who to contact if they had any concerns.

Are surgery services responsive?

Good

We rated responsiveness as good because:

- Information about the needs of the local population were used to inform how services were planned and delivered.
- Staff managed admissions to reduce waiting times for patients.
- National indicators for referral to treatment times for NHS patients were always met from April 2015 to March 2016.
- Patients with complex needs were assessed and plans were made for them prior to their admission.
- Complaints were investigated. Actions were taken and lessons learned as a result of complaints.

However:

- The day surgery unit did not have separate areas for male and female patients.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population were used to inform how services were planned and delivered. There were close links between the hospital and the local community as the hospital was a charity and owned by the local community. An annual general meeting was held yearly and the hospital reported these were well attended by the local community.
- Where people's needs were not being met, this was identified and used to inform how services were planned and developed. Stakeholders and other providers were involved in planning services. Where waiting lists for some procedures were identified as being longer the hospital considered providing the service to reduce waiting times. For example, staff we spoke with informed us referral to treatment times for gynaecology services locally were long (approximately 35 weeks). Tetbury Hospital was able to offer this service to patients and their referral to treatment time was approximately eight weeks.
- Services provided reflected the needs of the population served ensuring continuity of care. Comments from patients through the Friends and Family Test, the hospital patient survey and from CQC comment cards given out prior to our inspection showed that patients returned to the hospital for different procedures and were very pleased with the continuity of the care they had received.
- The hospital recognised the challenges of working in and maintaining an older building but the facilities and premises were appropriate for the services they provided.
- In the day surgery unit patients arrived at different times. This enabled staff to manage their admissions and reduce waiting times for patients.

Access and flow

- Services were planned and delivered to take account of the needs of different people. The day surgery unit did not operate on children under the age of 18. There was no upper age limit for people to attend the day surgery unit for procedures. Due to the lack of separate areas for male and female patients, the hospital tried to organise single sex lists to avoid male and female patients sharing the main recovery area.

Good

Surgery

- Services were planned, delivered and coordinated to take account of people with complex needs. During the pre-operative assessment patients with complex needs such as learning disabilities or dementia were identified. Plans were made so they could be treated at the hospital and staff were aware of their needs prior to admission and made adjustments as required.
- The hospital had a member of staff who was the lead for dementia. All staff were offered dementia training and this was optional for non-clinical staff. In August 2016, 66% of all hospital staff had completed dementia training. Of those who had not completed dementia training only one was a clinical member of staff.
- Reasonable adjustments were made so disabled people could access and use services on an equal basis to others. There were disabled parking bays close to the hospital entrance which were easily accessible for people with a disability. In the day surgery unit, services were arranged so disabled people could easily access it.
- Services engaged with people in vulnerable circumstances. Actions were taken to remove barriers when people found it hard to access or use services. The hospital was able to use translation services for people where English was not their first language and staff were able to explain how the system worked.
- The day surgery unit had admission processes including exclusion and inclusion criteria. The hospital had a policy outlining criteria for patients having surgery in the unit. Staff we spoke with were knowledgeable regarding the policy and were able to describe the action they would take if they were unsure whether a patient met the criteria.
- The discharge of patients was nurse-led. Patients were assessed by their doctor following surgery and when they were clinically well the day surgery unit staff would manage their discharge. A letter would be sent to their GP outlining the treatment they had received and whether any follow up or further treatment was recommended. This letter was sent within 24 hours of discharge or the next working day. Patients were also given contact numbers for advice if required. Patients were contacted the following working day after discharge to ensure they had not experienced complications or had further questions to ask.

Meeting people's individual needs

- People had timely access to initial assessment, diagnosis or treatment. The hospital reported that from April 2015 to March 2016 100% of non-admitted patients referred to the day surgery unit started their treatment within 18 weeks of referral.
- Actions were taken to minimise the time people had to wait for care or treatment. These waiting times were audited. All patient details were entered onto the hospital patient administration system (PAS) and information on waiting times was extracted and analysed. Waiting times for patients in the hospital were not audited however, if a clinic was running late, patients were informed of the delay.
- People were able to access care and treatment at a time to suit them. Private patients were offered a choice of appointments which were dependant on when the surgeon was next working at the hospital. NHS patients were not always offered a choice of appointment. In the 2015 hospital patient survey 33% of respondents said they were offered a choice of appointment, 63% said they did not need or want a choice of appointment and 4% said they would have liked to been offered a choice of appointments in the day surgery unit. Patients were offered appointments in chronological order in line with national guidance for NHS patients.
- Care and treatment was only cancelled or delayed when absolutely necessary. Cancellation rates in the hospital were low. From April 2015 to March 2016 the hospital reported no procedures were cancelled for a non-clinical reason.
- Services ran on time in the day surgery unit. During our inspection, the operating list we saw that was provided by Tetbury Hospital ran on time and patients did not experience delays.
- The day surgery unit did not have separate areas for male and female patients. The unit tried to overcome this by ensuring all theatre lists were single sex. However, in the 2015 hospital patient survey 41% of respondents said they had shared the area with patients of the opposite sex. However, in the same survey, 95% of patients said they had not minded sharing the area with patients of the opposite sex.
- Staff had access to interpretation services. Although this service was rarely required staff we spoke with were able to explain how they would access an interpreter using a telephone system. The hospital had a conference telephone which staff could use for this purpose.

Good

Surgery

- The hospital did not have a learning disability policy or learning disability lead and staff did not undergo any training in this area. However, the staff we spoke with demonstrated a good understanding of the requirements and adaptations they would make for patients with complex needs.
- Hot and cold drinks were available but food provision in the day surgery unit was limited. However, patients with different dietary requirements for example, patients with a wheat or gluten intolerance were catered for. Patients were informed during their pre-operative assessment that only basic food would be provided while they were in the hospital.

Learning from complaints and concerns

- From April 2015 to March 2016, the hospital received five complaints which was similar to other independent acute hospitals the CQC hold this type of information for. No complaints in this period had been referred to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service.
- People who used the service were helped and supported if they wanted to make a complaint. We saw leaflets about how to make a complaint prominently displayed in the main reception of the hospital and in the day surgery unit waiting room.
- Complaints were handled effectively and confidentially. One member of staff in the day surgery unit told us about a verbal complaint a patient they were caring for had made. They took steps to address and resolve the complaint immediately including apologising to the patient. They said the patient was satisfied with the action taken and this had not reoccurred.
- Complainants were regularly updated and a formal record was kept. We reviewed the records of five complaints and found the hospital gave good support to people making a complaint. There was clear evidence the complaint had been investigated thoroughly. The complaints had been formally recorded with accurate information and there was evidence that people felt their complaint had made a difference.
- Action was taken as a result of complaints and concerns to improve the quality of care and lessons were shared throughout the hospital. Complaints were reviewed at the monthly hospital quality committee meeting, the monthly board meeting and at the medical advisory committee meeting. Complaints were also discussed at the monthly day surgery unit meeting. We saw evidence of this in the minutes from the meetings we were provided with. We were informed that an annual complaints report was shared with the hospital local Clinical Commissioning Groups.

Are surgery services well-led?

Good

We rated well-led as good because:

- The hospital had a clear vision and set of values with quality and safety a priority. Openness and honesty was encouraged.
- There was an effective governance framework in place.
- Leaders were visible and approachable and had undertaken additional training courses to enhance leadership skills.
- People's views and experiences were gathered and acted on to shape and improve the services and culture.

However:

- Not all risks were included on the risk register, although the hospital stated the board did have oversight of all known risks.
- Concerns surrounding privacy had been on the risk register since March 2014 and had not been addressed

Leadership / culture of service related to this core service

- The day surgery unit was overseen by two managers who provided leadership to the nurses and healthcare staff. Staff we spoke with said the managers were visible and approachable, they were able to raise concerns with them and access them when they needed to. The unit managers had completed training courses to enhance their leadership skills and told us of changes they had made as a result of the training.
- Managers were able to update their knowledge and skills. Staff we spoke with said they were encouraged to work with local NHS trusts to assist them in refreshing and keeping their skills up to date. Managers encouraged staff to take training opportunities, these were usually funded by the hospital, and time was given to attend them.
- The day surgery unit culture was centred on the needs and experience of people who used the service. Some of the comments we received from staff were:

- "We work as part of a small team and can give excellent care."
- "I have job satisfaction."
- "We like doing what we do as we do things well."

- The hospital encouraged openness and honesty. The senior management teams had open door policies and staff said they were approachable. Staff we spoke with said they did not have any problems about raising concerns with their managers.
- There was an on-call duty rota for senior staff who could be contacted for advice. We saw an up to date rota displayed on one of the notice boards in the hospital.

Vision and strategy for this core service

- The hospital had a clear vision and set of values with quality and safety as a priority. The hospital vision was to be 'the best in care' and this was supported by their values, some of which were to be efficient and effective in everything they do, accountable for their actions, embrace diversity and deliver services to meet individual needs. All staff we spoke with were aware of the hospital values and visions and were able to describe them to us.
- There were realistic strategies for delivering good quality care. The hospital was keen to improve the services it provided and informed us of the new equipment which had been purchased for use in the day surgery unit. Staff in the unit knew about the new equipment and explained how it would improve care and benefit patients.
- The hospital was keen to expand the services they provided and the senior managers spoke enthusiastically about the different options they were looking into to achieve this.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework to support the delivery of the strategy and good quality care. The day surgery unit held monthly team meetings which were reported to various hospital committees including information governance, audit and risk, health and safety and the medical advisory committee (MAC). The committees reported directly to the hospital board who met ten times throughout the year. We saw evidence in the minutes from the board meetings we were provided with that the hospital committees minutes were available to the board members and were discussed. Information from the board meeting was shared with the hospital committees who then passed relevant information to the hospital departments. We saw copies of the hospital quality committee (HQC) meeting minutes on a noticeboard in the day surgery unit with actions specific to the unit highlighted. Staff we spoke with said actions were discussed at the day surgery unit team meetings. Staff also had an opportunity to forward items to the HQC through a feedback sheet attached to the HQC minutes.
- The MAC met quarterly and was responsible for advising the hospital on clinical matters. The MAC was also responsible for approving new consultants under practising privileges and approving hospital policies. The lead anaesthetist for the day surgery unit was a member of the MAC and we saw evidence of their attendance at the meetings. The clinical audit and HQC meeting minutes were available at the MAC meetings and we saw evidence discussions had taken place regarding these in the minutes we were provided with. The MAC also discussed surgical procedures the hospital currently undertook and reviewed proposals for expanding the service to include other procedures. The MAC meetings followed an agenda and some of the other items discussed were the hospital risk register, infection control and incidents.
- The hospital had an overall risk register that was divided into different sections for each department and a hospital wide section. The hospital also had a policy for the risk register and board assurance which outlined how risks were identified, reported, scored and addressed. Staff we spoke with were aware of their roles and responsibilities in identifying and reporting risks in their department. The risk register was available to all staff and was displayed on noticeboards in the hospital. Some of the items identified as a risk to the day surgery unit were equipment failure, adverse drug reactions and alarm systems. The risks had all been rated and actions were in place to mitigate the impact of the risk. However, not all risks such as the lack of piped oxygen and emergency blood provision were on the risk register and there was a lack of clarity around the management of these issues.
- Working arrangements with third party providers were managed. Although the hospital provided care to their own patients, other surgeons working under practising privileges were able to use the facilities for their patients. The day surgery unit staff we spoke with

reported they had a good working relationship with the surgeons and would raise any issues or concerns with the unit managers who would then escalate concerns to the matron and hospital committees.

- There was a systematic programme of internal clinical audit which was used to monitor quality and systems where actions to take were identified. The hospital had an internal clinical audit programme outlining the audits that were taking place and their progress. We saw evidence of internal audit reviews and action plans in the hospital quality committee meeting minutes. In the day surgery unit changes and improvements had been made as a result of the audits.
- In April and September 2015 the hospital was inspected against the ISO 9001 and ISO 14001 standards. These are the internationally recognised standards for Quality Management Systems (QMS). ISO 9001 provides a management framework and set of principles for an organisation to consistently satisfy patients and other stakeholders. It aims to provide the basis for effective processes to deliver a service. ISO 14001 is the Environmental Management Standard helping organisations become more environmentally friendly, reducing their consumption, waste and costs. The hospital was meeting the standards.
- The hospital had been producing quality accounts for the last two years. These provided the latest information on the progress towards the various objectives and targets the senior management had set. The trust had set out an annual operational plan which had been developed by the senior management team. Part of the plan for 2015/16 included the development of improved clinical effectiveness by the introduction of electronic records. This would also provide improved output data for the benefit of patients' choice. Other improvements that were identified and put into place included an improvement to the hospital website to provide clearer information for patients about the location of clinics and services and where various tests could be undertaken.

Public and staff engagement

- The hospital had good results from the 2015-2016 NHS Friends and Family Test (NHS FFT). The response rate was 43% which was higher than the NHS average of 28%. Of those patients who responded, 98% (882) said they would be extremely likely or likely to recommend the hospital for care or treatment to their family and friends. A total of 18 patients (2%) said they were unlikely or extremely unlikely to recommend the hospital to their family and friends. The hospital had written an action plan from the comments received in the NHS FFT called 'Areas for improvement' and we saw some of these had already been completed before our inspection.
- People's views and experiences were gathered and acted on to shape and improve the services and culture. The hospital carried out an annual patient survey and the response rate for this in the day surgery unit was 51%. The survey asked patients about various aspects of their experience from their initial contact with the hospital prior to their appointment through to their discharge. The day surgery unit scored 100% in this survey for questions regarding respect and dignity, cleanliness of the toilets and confidence and trust in the doctor treating them. The question with the lowest score was regarding privacy as 75% of patients said they definitely did not have enough privacy when discussing their operation or condition. This had not been addressed in the hospital action plan and had been an item on the hospital risk register since March 2014. However, overall care in the day surgery unit was rated as excellent by 96% of respondents. An example of a change the hospital had made in response to the 2015 patient was following comments regarding the lack of a bicycle storage area. The hospital had acted on this and a bicycle rack had been purchased and installed in the hospital grounds for patient and staff use.
- People who used services and those close to them and their representatives were actively engaged and involved in decision-making. The hospital was a charity and funding was raised by the local community. Their opinions and ideas on ways to improve how the hospital served the community were considered by the trustees of the hospital and put forward to the hospital board.
- Patients, relatives and staff were actively engaged in the service. Prior to our inspection, we provided comment cards to the hospital for patients to complete informing us of their experiences. The day surgery unit staff had been proactive in asking patients to complete the cards. As a result, we received a high volume of positive feedback from patients who had used the service in the weeks prior to our inspection.
- There was a range of meetings for staff to attend. All staff were able to attend the hospital annual general

meeting. The management team ensured staff were informed of the items to be discussed at this prior to the meeting. The day surgery unit held a monthly staff meeting where minutes from managers meetings such as the hospital quality committee were reported. Incidents, complaints, concerns and training were discussed along with staff suggestions for improvements.

- When concerns were raised in the day surgery unit, appropriate action was taken. We saw in the minutes we reviewed concerns had been highlighted by staff and ideas had been put forward to resolve them.

Innovation, improvement and sustainability

- The hospital was considering developing their day surgery unit services to provide for the local community. This involved extending their surgical services to deliver a wider range of procedures. They had assessed the impact of this and had planned training sessions for staff who would be involved.
- Staff were focussed on improving the quality of care. Staff we spoke with had attended training to improve their knowledge and skills. The hospital had recently purchased new equipment for use in the day surgery unit and staff could not give any examples of where financial pressures had compromised care. Some of the comments we received from staff we spoke with were:
  - "If I need new equipment here, it is obtained."
  - "It is never difficult to get new equipment."

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 outpatients department at Tetbury Hospital Trust is located on the ground floor of the hospital in one central area. There are seven multifunctional consulting rooms which are arranged around a central waiting area for patients. The trust provides outpatients consultations in cardiology, dermatology, ENT, general surgery, gastroenterology, gynaecology, maxillofacial, ophthalmology, orthopaedics, thoracic medicine, pain management and urology. A clinic for phototherapy is due to be started in January 2017.

The consulting rooms are also used, through service level agreements, at various times by local GPs. They are also used for some regulated activities run by other registered providers, including NHS trusts. Services provided by these NHS trusts include consultations in podiatric surgery and rheumatology.

The diagnostic and imaging services are staffed through service level agreements with a NHS trust. Tetbury Hospital Trust has purchased the equipment and retains responsibility for the maintenance and service of this and for the maintenance of the environment. The department provides plain film X-ray and there is also a mobile C-arm medical imaging device which is used in the day surgery unit. The X-ray room is located adjacent to the outpatient waiting area.

The outpatient department is led by a nurse manager and is staffed by registered nurses and health care assistants.

There were 7,015 attendances at outpatient clinics for the twelve month period March 2015 to April 2016. These figures were for clinics run by Tetbury Hospital trust and do not include patients attending GP consultations or clinics run by other providers. The largest clinics were ophthalmology and dermatology, making up 22% and 30% respectfully of the total number of attendances.

During our inspection we spoke with the manager of the outpatients department and nursing staff and healthcare assistants who worked in the department and in other areas of the hospital. We spoke with staff from the estates management team, the appointments booking team and reception, administration staff and two consultants. We also spoke with volunteers. We spoke with five patients who were attending the hospital and also received information via comment cards that had been completed. We reviewed information supplied by the trust and looked at various records, including patients' records and hospital audits. We spoke with staff from two external providers who were working in the outpatient area and also members of the radiology team from the trust that operated the diagnostic imaging service.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall we rated the outpatients and diagnostic imaging service as good.

- People were protected from avoidable harm. The trust had a range of safety measures in place and there were systems in place to report concerns or incidents and learn from them.
- There were reliable systems, practices and processes in place to keep people safe and safeguard them from abuse.
- Training was provided for all staff to ensure they were competent and effective in their roles. Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely.
- The outpatient and diagnostic imaging services incorporated relevant and current evidence-based best practice guidance and standards. Any new procedures or treatments to be delivered had to be agreed by the medical advisory committee.
- People's consent to care and treatment was sought in line with legislation and guidance. We observed written consent was sought and documented in patients' records.
- We received positive feedback about staff and services from all of the patients we spoke with. Patients were treated with respect and shown kindness by all staff when they visited the outpatient clinics.
- The needs of the local population were considered in the development of services provided by Tetbury Hospital. The hospital worked in collaboration with the commissioning groups and liaised with the NHS trusts that provided services to the local community.
- People had timely access to initial assessment and diagnosis and waiting times for referral to treatment were consistently below the NHS England target of 18 weeks. The hospital was achieving 100% compliance with the government target of 31 days for patients, from having a cancer diagnosis until the start of their treatment.
- Clear information was provided to patients about how to make a complaint or raise a concern. The hospital had received few complaints but had responded to them all within their given timescale.
- There was an effective governance structure in place to support the delivery of good quality care in the outpatients department. Staff were aware of their responsibilities and their roles and who they were accountable to.
- The hospital had reviewed and rewritten all its policies since 2013, with many being reviewed annually since then.
- There were effective arrangements for identifying recording and managing risks. There was a risk register in place for the outpatient department area which was maintained and updated by the manager.
- The hospital actively sought the views of patients and staff about the quality of the service provided. Opportunities were available for patients and staff to comment on all aspects of the care and treatment provided.
- Parents said staff were caring and responsive to the needs of their child or young person.
- A review of children and young people's experiences of health services was captured as part of a service development review at Tetbury Hospital in 2016. Waiting times in outpatient clinics were kept to a minimum for children and young people who were seen at the beginning of ENT and dermatology clinics.
- A vision and service strategy for children and young people was in place, supported by an action plan, which was up to date.
- Staff told us they received feedback and support when they reported issues or concerns to their line manager.
- Plans to provide child friendly outpatient services designed around the needs of children and young people were in place, and the build was planned for 2018.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated the safety of the outpatient and diagnostic imaging services as good. This was because;

- We judged that overall harm free care was being provided. The trust had a range of safety measures in place and there were systems in place to report concerns or incidents. We saw evidence that learning was taken from incidents and action taken to address identified concerns.
- Standards of cleanliness and hygiene were maintained. Staff and patients we spoke with told us they felt the standard of cleanliness was consistently maintained by the cleaning team.
- The design, use and maintenance of equipment and facilities kept patients and staff safe. There were well organised systems and checks in place to ensure that all equipment was correctly maintained and serviced at the appropriate intervals.
- There were clear systems and processes in place to ensure medical records were kept secure and confidentiality protected. Medical records were kept securely and were not visible to patients, protecting their confidentiality.
- There were reliable systems, practices and processes in place to keep people safe and safeguard them from abuse. The hospital had a designated safeguarding lead who was responsible for producing an annual report for the board and the local commissioning services. The hospital had made no adult safeguarding referrals between March 2015 and April 2016.
- Training was provided for all staff to ensure they were competent in their roles. There were systems in place to monitor and remind staff when training was due. There was a designated list of mandatory training. At the time of the inspection all staff working in the outpatient department were up to date with this.
- Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely. The appropriate level of nursing staff was available, with additional support being provided from elsewhere in the hospital when required.

Incidents

- We judged that overall harm free care was being provided. The trust had a range of safety measures in place and there were systems in place to report concerns or incidents.
- There was a manual paper system in place for the recording of incidents. Over the twelve month period between March 2015 and April 2016 there were 78 incidents reported. Of these, 40 were deemed clinical. There were no serious incidents or never events reported. In the outpatient department there had been three clinical and four non-clinical incidents reported. Both figures were lower than the national average reported figures for acute independent hospitals. Staff we spoke with were clear about the process for reporting incidents and the paperwork to use. Healthcare assistants explained how they would seek clarification from a registered nurse who would then generally complete the paperwork. We saw the minutes from the monthly hospital quality meetings which reviewed all incidents reported over the previous month.
- We saw evidence that learning was taken from incidents and action taken to address identified concerns. One example related to the clarity of information contained in appointment letters to patients. An explanation and further information was provided to the patient and the matter discussed with the booking team.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires a provider to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The hospital had a policy in place, Being Open and Duty of Candour Policy and Procedure, which had been approved in December 2014.

Good

Outpatients and diagnostic imaging

- The manager of the outpatient department was aware of this regulation. Whilst no specific training had been undertaken on the regulation we saw the minutes from the department meetings which recorded that it had been discussed with the staff team.

Cleanliness, infection control and hygiene

- The hospital maintained good standards of cleanliness and hygiene in patient areas, including waiting areas and in the rooms used for diagnostic imaging.
- Staff and patients we spoke with told us they felt the standard of cleanliness was consistently maintained by the cleaning team. The cleaning staff, who were appropriately trained and provided with the correct equipment and protective clothing, were supervised by the manager of the department. Staff in the imaging department and a consultant we spoke with told us the rooms were always clean and ready for use when they arrived to run clinics. They told us that high standards of cleanliness and hygiene were maintained
- All staff completed training in infection prevention and control and had completed hand-washing training. There were hand cleaning gel dispensers available throughout the department and all were clearly signposted. We observed staff washing their hands and wearing the appropriate protective clothing when required.
- The hospital had low recorded rates of and Clostridium difficile. As well as internal infection control audits and handwashing audits, which were done quarterly, there was an external annual audit of infection control done by a professional from an NHS trust. A report was provided to the hospital. No serious concerns were identified in the latest audit report.
- Patients we spoke with commented on the cleanliness of the hospital and the outpatient areas. One patient told us “we have been many times over the past two years and its always clean and tidy” and another commented, “it makes such a difference to come to such a clean and pleasant environment”.
- We observed staff at all levels caring for children and young people, washing their hands and using gel sanitizer according to trust policy. We observed the appropriate use of personal protective equipment such as gloves and aprons.

Environment and equipment

- The design, use and maintenance of equipment and facilities kept patients and staff safe. There were well organised systems and checks in place to ensure that all equipment was correctly maintained and serviced at the appropriate intervals. Staff reported faults and repairs were carried out promptly.
- The hospital had monthly visits from an external health and safety consultant who worked closely with the estates department. They provided advice and guidance on all aspects of health and safety. This included reviewing risks and producing reports for the hospital board.
- The outpatients department had a health and safety manual. This included quarterly audits that a designated staff member in the department was required to complete. The department also had its own risk assessment. This was up to date and had been reviewed within the required timescales.
- Some equipment in certain clinics was the property of external providers using the clinic rooms. It was clearly recorded who was responsible for the different items and we saw that all equipment had stickers recording when the most recent safety check had been completed. The equipment owned and serviced by the hospital was also logged in the service records held by the hospital estates team.
- The X-ray equipment was all owned by the hospital, although the staffing for the service was provided by another provider. The hospital had a servicing and maintenance agreement with the company the equipment had been purchased from. Details about the servicing records were held by the staff running the X-ray department. The estates team could also access these records. We saw that all the recent servicing and testing had been completed and recorded. The staff in the X-ray department confirmed that any concerns with the equipment were responded to quickly by the servicing company. We saw that the room had been risk assessed prior to the installation of the new equipment and the required warning lights and notices were all in place.

Good

Outpatients and diagnostic imaging

- The hospital provided all the equipment that was used in the X-ray department and also the C-Arm which was used in the theatres. A C-arm is The company that had supplied the X-ray equipment had a servicing contract with the hospital.
- We saw that the consulting rooms were well equipped and maintained. Staff we spoke with told us that repairs or issues were addressed quickly.
- There were appropriate waste disposal facilities in each room. There was a contract with an external provider for the collection and disposal of hazardous waste. There were clear warning signs in place regarding hazardous waste. The trust had been improving its performance in relation to the recycling of waste and was working towards achieving the ISO (The International Organisation for Standardisation) 14001. The ISO standards provide a guideline or framework for organisations to help them become more environmentally friendly, reducing their consumption, waste and costs.
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Medicines

- There were safe procedures for the prescribing of medicines if this was required at outpatient appointments. Medicines were stored securely and the correct recording protocols were being followed. No controlled medicines were stored in the outpatient's medication storage facility.
- The registered manager was the accountable officer for medicines within the hospital which meant they had the
- We saw that medicines were correctly stored and that there were procedures in place for the return of unused or out of date medicines. All medicines we looked at were in date and there were no inappropriate medicines being stored. There was no on site pharmacy and the trust had a working arrangement with the pharmacy from an NHS trust. A pharmacy technician from the local acute trust also visited quarterly to audit the medicines and discuss any trust-wide issues or concerns.
- Patients we spoke with told us they were given clear guidance and information about medication following their appointment, either from the consultant or the nurse on duty.

Records

- There were clear systems and processes in place to ensure medical records were kept safe and confidentiality protected.
- We saw that medical records were delivered securely by courier and then kept safely in the department. The medical records were transported in a sealed bag and fitted with a tamper proof seal. Records were stored near the clinics after the notes had been prepared. Records were kept securely and were not visible to patients, protecting their confidentiality. If the notes were not available this was because they had not been delivered from a trust or GP surgery. We were told these occurrences were rare and when this happened a temporary set of notes would be prepared. We spoke with two consultants who told us that the system for the delivering and preparing of notes was efficient and reliable.
- A patient record audit had been completed in the month prior to our visit but the results were not available at the time of the inspection.
- The role of the hospital's Caldicott guardian was undertaken by the medical director. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information sharing. NHS organisations that access patient records are required to have a Caldicott Guardian. We were told there had only been one incident in relation to this role. The appropriate action had been taken by the hospital.

Safeguarding

- There were reliable systems, practices and processes in place to keep people safe and safeguard them from abuse.
- The hospital had a designated safeguarding lead. They were responsible for producing an annual report for the board, which also went to the local commissioning services. The hospital had made no adult safeguarding referrals between March 2015 and April 2016. There had also been none reported up to the time of our inspection. The annual safeguarding report provided details of the training completed or required in the hospital. All managers were required to complete safeguarding level 2 and other staff level 1. Within the

outpatients department all staff had complied with this and it was planned for the manager to undertake level 3 training later in the year. Training was provided online and monitored through the staff appraisal system.

- The hospital had a safeguarding policy in place that had been reviewed, updated and approved in March 2015.
- Staff we spoke with were confident in the processes for reporting alerts to the safeguarding lead. Clear information was provided to the staff with regard to the process to be followed and who was to be contacted. Information was displayed in the outpatient department about the referral process and contact details were clearly displayed.

Mandatory training

- Training was provided for all staff to ensure they were competent to perform in their roles. There were systems in place to monitor and remind staff when training was due. Training was provided promptly when required.
- There was a designated list of mandatory training. At the time of our inspection all staff working in the outpatient department were up to date with this. The training included fire safety, health and safety, infection control and safeguarding. The manager of the outpatient department checked that mandatory training was up to date as part of the annual appraisal process for staff.

Assessing and responding to patient risk

- If a patient became unwell whilst attending the outpatient department staff were able to call for assistance from other areas of the hospital. The waiting room was fully visible to the department's reception desk. There were also generally nursing and healthcare assistants in attendance in the area, moving between the consulting rooms. The X-ray imaging room was also directly adjacent to the waiting area. Within each consulting room there was an emergency call bell which could be used to alert other staff that assistance was needed. Staff had the option of using the minor injuries unit for assistance and would also, if required, arrange for an ambulance to attend.
- Resuscitation equipment was located in the day surgery unit and also in the minor injuries unit, both of which were a short distance from the patients' waiting area. This equipment was maintained and checked by the staff working in these areas.
- The X-ray department was clearly signposted with appropriate warnings displayed to staff and patients when it was in use. The imaging service ensured women who were, or may be pregnant, always informed a member of staff before they were exposed to any radiation. We saw signs which advised patients to do this on the waiting room walls and X-ray room doors.

Nursing staffing

- Sufficient numbers of nursing staff were provided and maintained to ensure that the department operated smoothly and safely. The appropriate level of nursing staff was available, with additional support being provided from elsewhere in the hospital when required. It was rare for agency staff to be deployed as absence would invariably be covered from within the team by the part time staff increasing their hours. The department was covered by 1.2 full time equivalent registered nurses, with additional cover available at times from the hospital matron. During the period March 2015 to April 2016 the department had covered between 2% and 3% of the weekly hours with bank staff.
- Other staff working in the department, including healthcare assistants and professionals from other service providers, told us that there was never a problem finding a nurse for advice or information.

Medical staffing

- The hospital did not directly employ medical staff and the consultants who carried out clinics in the outpatients department had substantive NHS contracts elsewhere. The consultants worked under practicing privileges arrangements.
- The clinics were booked and coordinated by the hospital booking team. They worked in conjunction with the relevant consultant and liaised with the outpatient's department manager and also communicated any changed arrangements with the patients. Over the previous twelve months there had been only one short notice cancellation of a clinic, which had been due to illness.

Major incident awareness and training

- There was a major incident policy that had been approved and put into place in July 2016. This plan related to the whole hospital and there was not a separate major incident plan for the outpatient

department. The policy was supported by the business continuity plan. The plan had been written in accordance with the NHS England Emergency Preparedness Framework. The plan covered three levels of response, business continuity incident, critical incident and major incident.

- The plan was written with reference to the Civil Contingencies Act 2014 which requires NHS providers to support local commissioning groups and NHS England to discharge their Emergency Preparedness Resilience and Response Functions (EPRRF) responsibilities.
- The plans detailed the action the hospital would take and the expectations placed on the staff team. The senior management team was planning a table top training exercise for staff for October 2016.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic imaging was inspected but not rated.

- The outpatient and diagnostic imaging services incorporated relevant and current evidence-based best practice guidance and standards. Any new procedures or treatments to be delivered had to be agreed by the medical advisory committee. These were used to develop how services, care and treatment were delivered.
- The outpatients department was able to show evidence that they used NICE guidelines to identify and implement best practice.
- Staff working in the outpatients department had the right qualifications, skills and knowledge to do their jobs effectively. Nursing staff received clinical supervision and all had appraisals completed within the previous twelve months. There were systems in place to monitor and supervise staff. Healthcare assistants received regular supervision.
- People's consent to care and treatment was sought in line with legislation and guidance. We observed written consent was sought records placed in patients' records. Patients we spoke with confirmed that their consent to any treatment had been sought by their consultant.

Evidence-based care and treatment

- The outpatient and diagnostic imaging services incorporated relevant and current evidence-based best practice guidance and standards. The outpatient manager attended the hospital's monthly quality meetings and any new procedures or treatments that were to be delivered had to be agreed by the medical advisory committee. These were used to develop how services, care and treatment were delivered.
- The outpatients department was able to show evidence that they used NICE guidelines to identify and implement best practice. For example in the pre-operative assessment clinic, staff were using the latest NICE guidelines for preoperative tests for elective surgery and the clinic guidelines had been updated to reflect this.
- At the time of the inspection all the SUS (Secondary Uses Service) data extracts and external reporting was completed under a contract with an NHS trust, as the electronic system in place lacked functionality. SUS is the single comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. However the hospital planned to implement the use of a new electronic system from October 2016 and it was anticipated that this data extraction and reporting would be undertaken in-house.
- At the time of our inspection an audit was being undertaken of antibiotic prescribing. This was checking that patients were being prescribed antibiotics in accordance with local antibiotic formularies as part of antimicrobial stewardship, in accordance with the NICE quality standard QS6.

Pain relief

- It was not usual for the nursing staff to manage a patient's pain whilst they were attending an outpatient

clinic. If a patient was in pain or suffering discomfort due to their condition, this would be discussed as part of their consultation. Nursing staff told us they would ensure that patients were as comfortable as possible.

Patient outcomes

- Information about patient's outcomes and satisfaction with their treatments were not routinely collected across all the services provided in the outpatients department. However general feedback about the patient's experience of the department was collected through the hospital survey. This provided very positive feedback from patients. Comments included "my treatment was excellent on both occasions I have used the service" and another was "I have been here twice in last six months; the service I have received has been outstanding".
- Some specific audits were being carried out. For example the department was conducting an audit of patients who had undergone an endometrial ablation procedure. Endometrial ablationThe audit was being undertaken six months after the procedure had been completed and was yet to be completed at the time of our inspection.

Competent staff

- Staff working in the outpatients department had the right qualifications, skills and knowledge to do their jobs effectively. Nursing staff received clinical supervision and all had appraisals completed within the previous twelve months. There were systems in place to monitor and supervise staff. Healthcare assistants received regular supervision.
- Patients we spoke with talked positively about the staff. They told us, "the staff are excellent, always professional and helpful" and also "we were most impressed with all the staff they were cheerful helpful and efficient".
- Staff employed by the hospital had pre-employment checks. This included references, Disclosure and Barring Service (DBS) checks, proof of identity, and a check of any relevant professional registration. The DBS disclosure checks were repeated every three years. In August 2016, 89% of all hospital staff had an up-to-date DBS check and 100% of all clinical staff had up-to-date professional registration.
- The majority of consultants working in the hospital had substantive NHS contracts at other NHS trusts and worked at Tetbury Hospital under the practicing privileges arrangement. This system is a term that is used in legislation and defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as: 'the grant, by a person managing a hospital, to a medical practitioner of permission to practise as a medical practitioner in that hospital'. The medical director of the trust had oversight of these arrangements. There was an electronic system that flagged when new appraisals or DBS check were due and this would be followed up with the individual consultant. Consultants were requested to sign a copy of the terms and conditions of the practising privileges policy and were required to provide up to date copies of their appraisal summary, indemnity insurance and registration with the General Medical Council (GMC). We looked at a sample of these records and found they were all up to date.

Multidisciplinary working (related to this core service)

- We saw evidence that staff worked well together across the different departments. Nursing staff said they communicated effectively with the booking team and administrators. Two consultants we spoke with told us they felt the outpatients department worked well as a team.
- We spoke with staff from external providers who were using the consulting rooms and they told us that the communication between themselves and the hospital staff worked well. They felt this helped all the clinics run efficiently as different staff from different areas worked well together.
- The staff from an NHS trust who worked in the X-ray department said they worked as a team with the rest of the outpatient staff and communicated professionally and effectively over any patient issues or concerns. The X-ray department was located adjacent to the outpatient waiting area which helped with multidisciplinary working.
- Children and young people were able to access diagnostic services (plain x-rays) either through their GP or following a referral by the emergency nurse

practitioner (ENP). The imaging department worked closely with the hospitals minor injuries unit (MIU) to ensure waiting times for children and young people were kept to a minimum.

- The outpatient manager told us the department had good links with all the local GPs and could phone for additional information or clarification about patients when this was required. Letters from the department to GPs following clinic appointments were all sent out within five working days. Local GPs were represented on the hospital's medical advisory committee.
- **Seven-day services**
- The hospital did not offer seven-day services. The hospital was open Monday to Friday and closed every evening at 7pm. There were no plans to offer seven-day services.

Access to information

- Staff had access to all the relevant information that was required to plan and meet the care needs of patients. Staff had access to patients' medical records and to the hospital intranet system. This provided information about policies and procedures.
- The diagnostic imaging service had electronic access to diagnostic results for X-rays on the computer system. Results were processed off site at a local NHS trust, and sent back to the hospital via a computer system. Diagnostic imaging results were provided promptly to consultants.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- People's consent to care and treatment was sought in line with legislation and guidance. Nursing staff in the outpatient clinic explained how they checked that consent to treatment was recorded.
- We observed written consent was sought and records placed in patients' records. Patients we spoke with confirmed that their consent to any treatment had been sought by the consultant they saw. Staff informed us they explained procedures to patients in the pre-operative assessment clinic; they also provided them with a leaflet explaining consent.
- Patients we spoke with all said they had been supported appropriately by nursing and medical staff in making decisions about their treatment.
- In August 2016, 84% of all hospital staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The outpatient manager had completed training in DoLS and was aware of the relevant aspects of the MCA.
- Staff we spoke with informed us that patients who did not have the mental capacity to make a decision were not treated at the hospital and were referred back to their GP at the pre-operative stage.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring in the outpatient and diagnostic imaging services at Tetbury Hospital as good. This was because:

- We received positive feedback about staff and services from all of the patients we spoke with and from the comment cards that were completed. Staff treated patients with respect and showed them kindness when they visited the outpatient clinics.
- Patients told us they were well informed by the staff and had everything explained thoroughly.
- Patients and their relatives were encouraged to be part of the decision-making process around their treatment options. All patients we spoke with said they were involved in discussions in relation to treatment options and any surgical procedures that were being considered.

Compassionate care

- Staff interacted with and responded to patients in a respectful and caring manner. We observed nursing staff, healthcare assistants and reception staff treating patients and their relatives with a professional and considerate approach. Patients we spoke with, the feedback from comment cards and the results of the hospital's patients' survey, provided positive evidence of the compassionate care that was provided.

Good

Outpatients and diagnostic imaging

- One patient we spoke with explained that staff were always helpful which helped him and his partner "manage the worry of the appointment better." Other comments we received included, "staff have always been respectful and friendly, many appointments over the years", "excellent service always been treated with care and sympathy" and "staff are always friendly and helpful, patients' welfare always seems to be their main concern."
- Patients' privacy and dignity were promoted and supported if they required a personal or intimate examination. Patients were provided with the option of having a chaperone for their appointment if they wished. There were notices explaining this in the department and the staff told us they would also ensure verbally that patients were aware of this option.
- Patients' confidentiality was respected when discussing their care or treatments. If a further discussion was required with a patient after they had left the consulting room the nursing staff explained how there was normally a vacant room in which they could talk through any further concerns with patients or their relatives.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in an effective manner that helped them to understand their care, treatment and condition.
- Patients told us they were well informed by the staff in the outpatient department about their treatments. As well as answering questions they could be provided with additional written information about various treatments and conditions. Comments from patients included, "it's an excellent service, the procedures are always fully explained with whatever time this took," and "Excellent service, the nurse was clear and courteous and gave me a clear explanation of everything I needed to know".

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing. Staff told us how important it was for them to reassure patients about their treatments or if they were possibly considering a surgical procedure and attending a pre-operative assessment clinic. Staff would talk to patients while they waited for their consultation and this enabled them to provide support if required. One patient commented that the staff provided the "best care and consideration in everything, I would recommend this hospital to anyone".
- Staff discussed treatment options with patients and supported them to be part of the decision- making process. All patients we spoke with said they were involved in discussions around their treatment options or any surgical procedures that were being considered.
- The Friends and Family test (FFT) was in place a Tetbury Hospital but no outcomes were recorded for children and young people. The matron told us the comment cards would be made more child friendly to encourage feedback from children and young people.
- Children and young people were involved in the trust's patient survey undertaken in 2015. Two respondents (2%) aged 0-15 years participated in the patient survey but there were no outcomes for children and young people's services identified in the report.

Are outpatients and diagnostic imaging services responsive?

Good

We rated the responsiveness of the outpatient and diagnostic imaging services as good. This was because:

- The needs of the local population were considered in the development of services provided by Tetbury Hospital. The hospital worked in collaboration with the clinical commissioning groups and liaised with NHS trusts that provided services to the local community.
- People had timely access to initial assessment and diagnosis and waiting times for referral to treatment were consistently below the NHS England target of 18 weeks. The hospital was achieving 100% compliance with the government target of 31 days for patients, from having a cancer diagnosis until the start of their treatment. The hospital audits showed that all patients

who chose the hospital through the online E-Booking system service received appointments and all patients received their appointment letters within five days of their appointment.

- Waiting times in outpatient clinics were kept to a minimum for children and young people who were seen at the beginning of ear nose and throat (ENT) and dermatology clinics.
- A review of children and young people's experiences of health services was captured as part of a service development review of Tetbury Hospital in 2016.
- X-ray services were available to children and young people at Tetbury Hospital from Monday to Friday.
- The outpatient staff were flexible in their approach to meeting the individual needs of patients where possible. Efforts had been made to make the area more user-friendly to people who were living with dementia and there was a designated staff dementia champion. There were accessible services for wheelchair users.
- The hospital provided clear information to patients about how to make a complaint or raise a concern. The hospital had received few complaints and had responded to them all within their given timescale.

Service planning and delivery to meet the needs of local people

- The needs of the local population were considered in the development of services provided by Tetbury Hospital. The hospital worked in collaboration with the clinical commissioning groups and liaised with the NHS trusts that provided services to the local community. While the hospital was available to NHS patients through the E-Booking system the focus of the provision was on the needs of the people from the local area. The registered manager and medical director explained how this was a major consideration when they considered proposals for services, treatments or surgery that could be offered in the hospital, including the outpatient department. The hospital's medical advisory committee included representatives from local GP services and a local pharmacist. The medical director told us it was important to the hospital to ensure that there was a mix of primary care professionals on the committee to help represent the needs of the local community.
- In 2016, a review of children and young people's experience of health services was captured as part of a service development review undertaken by a children's trained nurse from a local NHS Trust. A dedicated children's waiting area with toys for younger children had been implemented.
- Helium balloons and bubbles were being sourced for younger children. A mural for the children's play area in outpatients had been commissioned from a local school. The outpatient manager told us there were no diversion facilities for older children and access to WI FI was being explored.
- Tetbury Hospital had on site X-ray facilities, which were open Monday to Friday 9am to 5pm. On a Friday when the X-ray department closed at 2pm, staff would refer patients to a local MIU, which was open and had access to X-ray facilities 24 hours a day.
- All the clinics provided by the hospital were commissioned through the local clinical commissioning groups. The hospital met regularly, on a quarterly and a six monthly basis, with the two commissioning groups it worked with to discuss service provision and delivery. The commissioning groups monitored the hospital's quality and access standards through information supplied by the hospital.
- The facilities and premises used for the outpatients department were located within the main hospital and were suitable and adequate. The designated area was well signposted and provided wheelchair access. The waiting area was spacious with enough seating and had a small designated area for children's outpatient appointments. The area was clean and well maintained.
- Patients were able to use the public parking at the hospital, which was free, but there was limited public transport available from the local town. The hospital did not provide a patient transport service but the reception would help arrange taxis for patients if required. Toilet facilities were clearly signposted. There was a drinks and snack machine available in the waiting area. The hospital did not have a café or refreshment area for patients or staff.

Access and flow

Good

Outpatients and diagnostic imaging

- People had timely access to initial assessment and diagnosis and waiting times for referral to treatment (RTT) were consistently below the NHS England target of 18 weeks.
- In the reporting period April 2015 to March 2016 there were 7,015 total outpatient attendances at the hospital and 30% of outpatient attendances were children and young people. 116 (2%) children aged 0-17years attended ENT and dermatology clinics. 0- 2years (values too small to provide percentage), 64 (1%) aged three to 15 years and 51 (1%) aged 16 and 17 years.
- Children and young people accessed outpatient clinics through their GP who used the referral to treatment time (RTT) booking system. A parent told us they had waited 12 weeks for their first appointment to attend the ENT clinic system. The hospital was meeting the RTT target of 18 weeks (100%) which included outpatient clinics for children and young people.
- The RTT waiting times for admitted patients being treated within 18 weeks of referral was measured at 97% over the previous twelve months. During this period 100% of non-admitted patients began treatment within 18 weeks of referral. The hospital also achieved 100% of incomplete patients beginning treatment within 18 weeks of referral. Patients were recorded on an electronic tracking system for each speciality and their position on the pathway was visible to the booking team at all times. The booking team explained that when potential delays were identified with a clinic they would notify the outpatient manager and consultant. Additional clinics could be arranged and the booking team would contact the individual patients. The booking manager met weekly with the registered manager where any issues around additional clinics could be discussed and action planned. In the twelve months prior to our inspection there had been only one clinic cancelled at short notice, which had been due to illness.
- The national target of patients waiting less than six weeks for diagnostic tests was measured at 97% over the previous twelve monthsThe reasons for occasional delays were recorded as being due to patients changing their appointment times. The X-ray service was run by another provider under a service level agreement. We spoke with the staff working who explained that the numbers of patients seen varied from day to day. Over the previous week, for example, it had been between six and thirty-two in a day. All patients referred for an X-ray following an outpatient appointment were seen on the same day, generally with little waiting time. Patients we spoke with commented upon the efficiency of the process.
- The hospital was achieving 100% compliance with the government target of 31 days for patients, from having a cancer diagnosis until the start of their treatment.
- The hospital audits showed that all patients who chose the hospital through the online E-Booking system service received appointments and all patients received their appointment letters within five days of their appointment.
- The department did not audit the running times of clinics but staff and patients we spoke with told us they usually started on time. Any delays were explained to patients when they arrived at reception and there was also a notice board which gave information about anticipated delays when clinics were running late. None of the patients we had contact with raised any issues about the late running of clinics. One patient told us they thought the system was “very efficient” and they understood that some consultations took longer than others. Other comments from patients referred to them being pleased that the consultations were not rushed and afforded them the time to ask questions if they needed to. The results from the hospital patients’ survey recorded out of 100 patients, 63 had been seen on time or earlier.

Meeting people’s individual needs

- The outpatient staff were flexible in their approach to meeting the individual needs of patients where possible.
- Staff had access to a telephone translation service and could order information leaflets and forms in different languages if required.
- The hospital had a Dementia Strategy policy in place which had been reviewed and updated in July 2016. This had identified key objectives for the hospital and also a specific objective for the outpatient department. This was to ensure a calm environment and the provision of a quiet room for any patients who may become confused or distressed. They had also ordered

some new signs which provided clearer information to patients including pictorial information. All staff had completed dementia awareness training as part of the trust's aim to provide an improved 'dementia friendly' environment. The hospital had designated a nurse as a "dementia champion". Feedback we received from one relative was positive about their relative's experience in the outpatient department. They told us "the staff were wonderfully caring and treated my relative with dignity and respect and an understanding of her special needs and difficulties". Nursing and healthcare staff told us how they would speak with carers to ensure they knew they were available for support if required.

- Members of the booking team explained how they would help some elderly patients with their appointment booking as they could have trouble understanding the online booking system. They would answer phone calls in relation to a booking and then take the person through the process on the phone.
- The hospital did not have a designated lead person for learning disabilities or a policy on how patients would be supported. Staff explained they would liaise with carers or support workers and seek advice from the hospital matron if additional help or advice was required.
- The outpatient department was accessible to wheelchair users and provided a designated parking space for them to use if they wished. In 2013 the hospital had undergone a visual impairment assessment which had resulted in some changes to the signage and layout of certain areas. They now also had hearing loops in place.
- Appointments for children and young people took account of schooling requirements. A parent told us "The first appointment my child was given was not convenient so I spoke to the receptionist in outpatients and they immediately gave me another appointment. The receptionist was very accommodating to my child's needs and made the appointment at the end of the school day".
- The service took into account the needs of children and young people but there were no local policies or guidance for staff on how to manage children with a learning disability and long-term health conditions. The matron told us the doors in main reception and outpatients presented difficulties for people with a physical disability. A plan was in place (2016) for automatic doors to be installed in November 2016.
- 116 children and young people were seen in outpatients in the reporting period April 2015 to March 2016. Whenever possible children were allocated the first appointment for ENT and dermatology clinics.
- A parent of a young person said, "This was our first appointment (ENT) at the hospital and we waited less than five minutes to see the doctor". This demonstrated that waiting times in outpatient services were kept to a minimum for children and young people.
- There was access to translation and interpretation services via the telephone. Staff said the system worked well. A visual impairment assessment of the hospital was undertaken in 2013 and a hearing loop was in place to support people with hearing aids.
- You're Welcome', the Department of Health's quality criteria for young people friendly services was not in place. However, the trust had undertaken a review of all children and young people's services in 2016 with the aim of making them more child friendly. A paediatric-trained nurse from a local NHS trust undertook the review and recommendations had been implemented.

Learning from complaints and concerns

- The hospital provided clear information to patients about how to make a complaint or raise a concern. A complaints leaflet was available which explained the process for patients to follow. Patients we spoke with were aware of how to make a complaint.
- Staff were aware of any complaints made about their service and the learning resulting from them. There had been one complaint concerning a child attending the dermatology outpatient clinic in the reporting period April 2015 to March 2016. The complaints process had been followed appropriately and learning had been shared with the relevant staff.
- The hospital complaints policy had been reviewed and updated in March 2015 and the registered manager for the trust produced an annual complaints report for the board. The trust received few formal complaints. The latest report recorded there had been five over the

previous twelve months. These were classified as four being communication issues and one relating to a clinical matter. All complaints had been responded to within 25 days and resolved. Patients who were unhappy with any aspect of their communication, care or treatment were offered apologies.

- Reception staff in the outpatient department explained how they would listen to concerns and explain as best they could any delays or concerns that patients wished to discuss. If necessary, they would ask for a nurse or the outpatient manager to speak with the patient. Information about making a complaint was clearly displayed and the appropriate forms were available. The complaints leaflet had been reviewed and updated in December 2015. The leaflet provided information to patients about the alternatives avenues they could progress a complaint and also gave information about advocacy services which would support patients making complaints.

Are outpatients and diagnostic imaging services well-led?

Good

We rated the leadership of the outpatient and diagnostic imaging services as good. This was because:

- The hospital had a clear vision and strategy for their service and this was understood by staff. Staff were aware of the services values and the commitment to providing a quality and responsive service to patients.
- A vision and service strategy for children and young people was in place, supported by an action plan. The strategy aimed to deliver services that met the health needs of children and young people through appropriately trained and skilled staff working in a child friendly and safe environment.
- There was an effective governance structure in place to support the delivery of good quality care. Staff were aware of their responsibilities and their roles and who they were accountable to.
- The hospital had reviewed and rewritten all its policies since 2013, with many being reviewed annually since then.
- There were effective arrangements for identifying recording and managing risks. There was a risk register in place for the outpatient department area which was maintained and updated by the manager.
- The hospital actively sought the views of patients and staff about the quality of the service provided. Opportunities were available for patients and staff to comment on all aspects of the care and treatment provided. People who used services and those close to them and their representatives were actively engaged and involved in decision-making.

Leadership / culture of service

- The manager oversaw the outpatient department and provided leadership to the nurses and healthcare staff. The administration and booking team was managed separately. All staff we spoke with spoke of a positive culture that enabled them to work well with, and communicate effectively, with their managers.
- Staff told us they were provided with clear direction and were aware of the aims and objectives of the hospital senior management team and the hospital board. Staff we spoke with told us they worked as a team and took pride in the work they did and the service they provided to the patients and the local community.

Vision and strategy for this this core service

- There was not a specific vision or strategy for the outpatients department but the hospital had an overall vision and set of values, with quality and safety as priorities. The hospital vision was called “We Care” and was supported by a set of values, including to be efficient and effective in everything they do, accountable for their actions, embrace diversity, be welcoming respectful and charitable. Staff we spoke with were aware of the hospital’s vision and values and able to describe them.

Governance, risk management and quality measurement for this core service

- There was an effective governance structure in place to support the delivery of good quality care. The outpatient staff were aware of their responsibilities and their roles and who they were accountable to.
- There were regular meetings of the outpatient team and the manager of the department also attended the

hospital quality meetings. The manager had daily contact with the hospital matron and the registered manager. This ensured that all areas of the department could be discussed and action taken if required. We saw examples of the minutes from the outpatient meetings which showed a full range of issues were discussed, including patient concerns and any policy or procedure issues that were being disseminated through the team. The outpatient meetings were reported to various hospital committees, including information governance, audit and risk, health and safety and the medical advisory committee (MAC). The committees reported directly to the hospital board which met ten times throughout the year.

- The MAC met quarterly and was responsible for advising the hospital on clinical matters. The MAC was responsible for approving new consultants under practising privileges, approving hospital policies and any new procedures to be undertaken in the hospital run outpatient clinics.
- In April and September 2015 the hospital was inspected for its ISO 9001 and ISO 14001. This is the internationally recognised standard for Quality Management Systems (QMS) and is the most widely used QMS standard in the world, with over 1.1 million certificates issued to organisations in 178 countries. ISO 9001 provides a management framework and set of principles for an organisation to consistently satisfy patients and other stakeholders. It aims to provide the basis for effective processes to deliver a service. ISO 14001 is the Environmental Management Standard helping organisations become more environmentally friendly, reducing their consumption, waste and costs. The hospital was meeting the standards.
- The hospital had been producing quality accounts for the last two years. These provided the latest updated information on the progress towards the various objectives and targets that the senior management had set. The trust had set out an annual operational plan which had been developed by the senior management team. Part of the plan for 20152016 included the development of improved clinical effectiveness by the introduction of electronic records. This would also provide improved output data for the benefit of patients' choice. Other improvements that were identified and put into place included an improvement to the hospital website to provide clearer information for patients about the location of clinics and services and where various tests could be undertaken. Improved leaflets had been produced providing better information for patients attending outpatient appointments.
- The hospital had achieved compliance with the NHS Information Governance Toolkit (IGT) level 2. This was the first time it was compliant as it had failed to achieve this the previous year. The IGT is a performance tool produced by the Health and Social Care Information Centre for the Department of Health. Organisations are required to carry out self-assessments of their compliance against the information governance requirements. Organisations have to assess themselves against various requirements for management structures and responsibilities, and confidentiality and data protection.
- The hospital had reviewed and rewritten all its policies since 2013, with many being reviewed annually since then.
- There was a risk register in place for the outpatient department area which was maintained and updated by the manager. There were no major risks identified on this register at the time of our inspection. The hospital employed a health and safety consultant who worked at the hospital for an average of 1.5 days a month and they worked mainly in conjunction with the estates department. They were available to the outpatient manager for advice if required. The hospital risk register was reviewed and actions taken to address and reduce risks. There were no risks associated with children and young people recorded on the risk register. For example, risks associated with the critically ill child. However, the care of children hospital policy and the young people and children strategy, refer to the escalation arrangements required for the sick child in conjunction with local NHS providers.
- Incident reporting and lessons learnt were part of the formal governance arrangements for Tetbury Hospital. However, incidents involving children were not separated out to identify specific concerns or trends.

Public and staff engagement

- The hospital actively sought the views of patients and staff about the quality of the service provided.

Opportunities were available for patients and staff to comment on all aspects of the care and treatment provided. Feedback forms were available to all patients who attended the outpatient clinic. The hospital conducted patient surveys and the Friends and Family Test to understand people's views and experiences and to help shape and improve services. However feedback from parents, children and young people was very limited. The matron told us the hospital board was considering a more child friendly approach to obtaining patient feedback.

- The matron told us about the opportunities to engage with children and young people in local schools and colleges had enabled the new build strategy to address the needs of children, young people and their parents. A mural for the designated children's waiting area in outpatients had been commissioned from a local school. The trust had not received any complaints from children their families or GPs about the hospital environment.
- People who used services and those close to them and their representatives were actively engaged and involved in decision-making. The hospital was run by a charity and funding was raised by the local community. Their opinions and ideas on ways to improve how the hospital served the community were considered by the trustees of the hospital and put forward to the hospital board.
- The hospital participated in the NHS friends and family test and carried out an annual patient survey. The results and comments from these were used to improve the service. In the most recent survey 91% of patients thought the outpatient area was "very clean" and 97% were happy with the information they were given about their treatment. 100% of patients thought they were treated with dignity and respect. However 77% said they were not told how long they would have to wait for their appointment once they were in the department. An action plan was put into place to improve this outcome, with clearer information being given to patients about any delays to the clinics.
- The survey asked staff if they would recommend the hospital as a place to have treatment, to which 89% replied "very likely", and 94% said they would "very likely" recommend the hospital as place to work.
- Staff we spoke with all said they would be happy and confident to make suggestions or raise concerns about any aspect of the care and treatment in the outpatient department if they felt there was a need. Staff told us that managers listened to ideas and suggestions and would take them forward if asked.

Innovation, improvement and sustainability

- Some new clinic services were being planned**.** A business case to provide phototherapy had been approved and it was planned for this service to begin in January 2017. This involves the use of light in the treatment of dermatological conditions. The hospital was in the process of considering whether to purchase blood testing equipment, with the major consideration being what benefits this would bring to patients.
- The hospital had recently appointed their first clinical lead in anaesthesia, to work with the medical director with one objective being an improvement in clinical governance. The hospital had also employed an external consultant who was available for clinical supervision of staff.
- Additional funds were being spent on more modern equipment for the dermatology clinic.
- The hospital was considering a case to provide therapeutic venesection. This is the removal of a volume of blood as a treatment for certain conditions. This would require a nurse or phlebotomist trained in the procedure to carry out the procedure.

Outstanding practice and areas for improvement

Outstanding practice

- The provider had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Information was used to improve care. The hospital had identified that endometrial ablation (an operation to thin or remove the lining of the uterus or womb to treat heavy periods) was not being provided by local NHS trusts and in response they had recently introduced this procedure.

Areas for improvement

Action the provider MUST take to improve

- Adapt guidance for adults, children and young people on quality standards for sepsis screening and management.
- The provider must review their oxygen provision to ensure patient risk is minimised.
- Ensure theatre daily equipment checks are completed.
- Ensure all emergency resuscitation equipment and drugs are tamper-evident.
- Review their policies, processes and systems for obtaining blood products in an emergency.
- Ensure robust safeguarding arrangements in line with hospital policy are in place for children and young people attending the minor injury unit (MIU).
- Ensure all equipment and medication in the MIU is in date and correctly labelled.

Action the provider SHOULD take to improve

- The provider should ensure all bins used for disposing of clinical waste are appropriate.
- The provider should review their arrangements in respect of storing contaminated equipment for sterilisation.
- The provider should ensure patient allergies are recorded on prescription charts.
- The provider should consider following the guidance of the National Early Warning System (NEWS) to identify and respond to deteriorating patients.
- The provider should ensure staffing levels in theatre follow the Association for Perioperative Practice (AfPP) guidelines and if they do not a risk assessment should be in place.
- The provider should consider providing more privacy for patients when discussing their operation and condition.
- The provider should consider providing separate areas for male and female patients.
- The provider should develop a tool to obtain feedback from children, young people and their families.
- The provider should develop clinical outcomes and performance indicators patients attending the Minor Injuries Unit.
- The provider should ensure the incident-reporting pathway identifies all reported incidents for children and young people.
- The provider should ensure there are robust arrangements in place for the provision of professional children's nursing leadership.
- The provider should take steps so that patients seated in minor injuries unit waiting areas can be observed by staff.
- The provider should ensure advanced life support training is available to staff.
- The provider should ensure hand hygiene audits are completed monthly in MIU in line with hospital policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- a. assessing the risks to the health and safety of service users of receiving the care or treatment; b. doing all that is reasonably practicable to mitigate any such risks; e. ensuring that the equipment used by the service provider for providing care or treatment is safe for use and is used in a safe way; g. the proper and safe management of medicines; The provider did not have a policy or guidance on quality standards for sepsis screening and management. The provider must review their oxygen provision to ensure patient risk is minimised. Theatre anaesthetic equipment was not always documented as being checked and safe for use. Clinical equipment in the minor injury unit was out of date and incorrectly labelled. The emergency resuscitation equipment and drugs were not tamper-evident. The provider did not store any blood for emergency use.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2) Systems and processes must be established and operated effectively to prevent the abuse of service users. Staff were not following safeguarding processes for children and young people attending the minor injury unit.
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1) The provider must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they can meet peoples care and treatment needs and therefore meet the requirements of section 2 of these regulations. 18 (2) Persons employed by the service provider in the provision of a regulated activity must- 1. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Not all staff regularly received supervision of practice.