Nuffield Health North Staffordshire Hospital

Quality Report

Clayton Road
Newcastle Under Lyme
Staffordshire
Tel: 01782 625431
Website: www.nuffieldhealth.com/hospitals/north-staffordshire

Date of inspection visit: 9 – 10 February 2016
Date of publication: 14/06/2016

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health North Staffordshire Hospital was opened in 1978 and is one of 31 in the Nuffield Health Group. The hospital provides mostly surgical services but also carries out some chemotherapy services. We did not specifically inspect this service but have included some aspects of the service delivery in our report on outpatients and diagnostic imaging.

At the time of the inspection, the hospital was in the process of opening a new CT/MRI scanning facility, in partnership with a private diagnostics service provider. Catering and estates management services are outsourced.

We inspected this service as part of the comprehensive inspection programme and visited the hospital on 9 and 10 February 2016 as part of our announced inspection. We also visited unannounced to the hospital on 23 February 2016.

Overall, we have rated the hospital as good, with one requires improvement rating in the safe domain for surgery.

Are services safe at this hospital?

- Staff were able to demonstrate they understood their responsibilities under Duty of Candour regulations. We were provided given specific examples of where Duty of Candour had been used following incidents to be open and transparent with patients.
- There were clear policies and procedures in place in regard to safeguarding. All staff we spoke to were aware of what to do if they were concerned about a child or vulnerable adult. The outpatient sister and hospital matron were trained to level 3 in both adult and child safeguarding.
- There had been 331 clinical incidents reported between October 2014 and September 2015. We saw that staff were encouraged and supported to report incidents. All incidents were investigated and reported to the quality and safety committee so that lessons could be learnt and learning applied. Staff received feedback.
- The World Health Organisation (WHO) Five Steps to Safer Surgery checklist was not embedded in theatre daily practice and not consistently adhered to. Audit processes to confirm compliance with the checklist were not robust, observational audits were not routinely completed.

Are services effective at this hospital?

- Hospital staff followed local policies and procedures such as wound care pathways and specific consultant post-operative preferences. NICE guidelines were reviewed and discussed at the hospital quality and safety meetings and departmental meetings.
- The hospital had a well-established governance system for signing off policies and procedures. We observed that the Medical Advisory committee had clear over-sight of changes to practice and the introduction of new drugs or procedures.
- The hospital participated in patient reported outcome measures (PROMS) audits. Knee and hip replacement (primary) were both within the expected range of the England average relating to five questions about their health.
- All readmissions either to the hospital or an NHS trust were recorded on an electronic data collection system, the hospital reported six unplanned readmissions within 29 days of discharge between October 2014 and September 2015.
- There were 166 doctors working under practising privileges at the hospital The hospital used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process. We looked at nine randomly selected personnel files for medical practitioners and found all the relevant documentation in place.

Summary of findings

- Staff were aware of their responsibilities about informed consent and they were clear about the procedures to follow for those patients who lacked capacity including involvement of those close to the patient. Staff demonstrated an understanding of the mental capacity assessment process

Are services caring at this hospital?

- Patients spoke highly of staff in areas across the hospital. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to patients' individual needs. Patients told us they were given good explanations of their treatments and were given opportunity to ask questions. Survey data confirmed that patients had confidence in being treated at the hospital.

Are services responsive at this hospital?

- Services were planned and delivered in a way that took people's needs and preferences into account. There were regular monthly meetings with the local clinical commissioning group to discuss service provision for NHS patients. We saw minutes of these meetings where quality and service delivery issues were discussed.
- Patients told us they had received all the information they required prior to their procedure or surgery. They told us they understood the reason for their admission to hospital and staff had clearly explained the risks and benefits to them.
- The needs of patients living with dementia or those who had a learning disability were identified at pre-assessment. Patients with complex needs were risk assessed by physiotherapists and occupational therapists and their care plans were then based on the risk assessments and professional advice.
- There were effective systems and processes to respond to and learn from complaints

Are services well led at this hospital?

- There was a clear vision and strategy for the hospital, held by the senior management team and shared widely with the hospital staff. The hospital director used a range of mechanisms to communicate the vision and strategy to staff and keep them updated. Staff we spoke with understood the vision and their role in achieving it.
- Governance, risk management and quality measurement processes were well established. There was a clear line of sight for the senior management team from the ward to the board and the MAC were well engaged in the hospitals quality management processes. The MAC maintained oversight of the process for agreeing and reviewing practising privileges.
- The senior management team had been in post for approximately three years and provided stable and cohesive leadership at the hospital. The matron and hospital director had a clear grip on hospital issues and were well known to the staff.

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

Importantly, the provider must:

- Ensure that surgical safety procedures are consistently carried out in theatre and theatre documentation and observational audits are routinely carried out and staff are made fully aware of the findings to provide ongoing assurance.
- Ensure that all medication is secure in theatre.

In addition the provider should:

- Ensure that learning from audits is disseminated to staff including the process, outcomes and the risk register progress.
- Ensure that the findings of the privacy, dignity and well-being 2015 PLACE score are addressed.

Summary of findings

- The hospital should ensure that out of date radiology equipment is replaced as soon as possible.

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
Surgery	Good	Surgery was planned and co-ordinated effectively. Strong governance arrangements promoted safe practice. Incidents were reported, investigated, feedback given to staff and learning was applied. Patients were complimentary about the care they received pre and post-operatively and patients with complex needs were supported and their carers encouraged to attend with them. Staff felt valued and listened to. We observed inconsistent surgical safety procedures in theatres. We also found theatre refrigerator temperatures were not being recorded as per national guidance and out of date medications. Learning from audits was not widely disseminated and staff were unsure of the hospital audit process, outcomes and the risk register progress
Outpatients and diagnostic imaging	Good	Outpatients and diagnostic imaging services at this hospital had systems and processes in place to promote practices that protected patients from the risk of harm. There were sufficient numbers of trained staff to meet the needs of patients. There was an open culture where staff were encouraged to report incidents and lessons learned were shared within team meetings. Treatment and care was provided in line with national guidance. Staff were polite, courteous, friendly and responsive to patients' individual needs. There were no waiting times to access appointments which were also available in the evenings and on Saturday mornings. Staff felt supported and proud to work within the hospital.

Summary of findings

Contents

Good

Nuffield Health North Staffordshire Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Nuffield Health North Staffordshire Hospital

Nuffield Health North Staffordshire Hospital was opened in 1978, located in Newcastle Under Lyme close to the M6. The Hospital is one of 31 in the Nuffield Health Group. There are 38 individual patient bedrooms each with en-suite facilities. The hospital has three theatres two with ultra clean air flow systems and one general theatre. The outpatient department has 12 consulting rooms, a clinical room for minor procedures, a treatment room and a phlebotomy room.

At the time of the inspection, building work was taking place, including the installation of a second lift to theatres and the opening a new CT/MRI scanning facility.

The new imaging service was being provided in partnership with a private diagnostics service provider. Catering and estates management services are outsourced.

The hospital provides mostly surgical services but also carries out some medical care services, including chemotherapy services. The two most common procedures performed were therapeutic arthroscopies and total hip replacement. The hospital does not treat children under the age of 16 years. Almost half of all the activity at the hospital is NHS funded.

Our inspection team

Our inspection team was led by:

Inspection Lead: Debbie Widdowson, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a consultant surgeon, orthopaedic theatre team leader, a theatre manager, senior radiographer, a specialist physiotherapist and senior out-patients nurse.

How we carried out this inspection

We inspected this service as part of the comprehensive inspection programme and visited the hospital on 9 and 10 February 2016 as part of our announced inspection. We also visited unannounced to the hospital on Tuesday 23 February 2016.

We attended the hospitals quarterly Medical Advisory Committee (MAC) meeting on 28 January. We held a planned focus group with staff on Monday 8 February to allow staff to share their views with the inspection team. These included all of the professional clinical and non-clinical staff.

We met with the hospital senior managers, we also met with service leaders and clinical staff of all grades. We also spoke to patients and their relatives and carers we met during our inspection.

We visited all clinical areas and observed direct patient care and treatment.

The hospital also provided oncology services to patients on an out-patient basis, although this was delivered on the ward area for the comfort of patients. We did not specifically inspect this service but have included some aspects of the service delivery in our report on outpatients and diagnostic imaging.

Summary of this inspection

Information about Nuffield Health North Staffordshire Hospital

- The hospital is registered for three regulated activities; diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.
- The registered manager had been in post since June 2013, and is also the Controlled Drugs Accountable Officer.
- There are 166 doctors working under practising privileges at the hospital. There are 118 full time equivalent staff are employed, including 40.8 nurses.
- Between October 2104 and September 2015, there were 4482 inpatient episodes and 1661 day cases.
- Thirteen children between the ages of 16 and 18 years were treated as an inpatient or day case in the same period.
- The hospital provided 724 chemotherapy sessions to its patients in the same period.
- 331 clinical incidents were reported, one was considered a serious incident and reported to CQC.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Information about the service

Nuffield Health North Staffordshire Hospital provides inpatient and day care services. Between October 2014 and September 2015, there were 6,143 recorded inpatient activities. Of those, 1,661 were inpatient overnight stays, 818 NHS funded (49%) and 843 cases (51%) provided by other funding) and 4,481 were day cases; 2,056 NHS funded (46%) and 2,425 (54%) provided by other funding). In the same time frame there were 4,812 visits to theatre.

Between October 2014 and September 2015 three young people aged between 16 and 17 years had been inpatients overnight and 11 young people had been inpatient day cases. Children under the age of 16 years old were not treated at the hospital.

The hospital has 27 individual patient bedrooms each with en-suite facilities, open 24-hours per day, and nine day case beds. There are three operating theatres, two with ultra clean air-flow systems and one general theatre.

The hospital provided mostly orthopaedic surgery. The five most common procedures performed were arthroscopic operations on joints, total hip replacements, lens implants, gastroscopy procedures and prosthetic knee replacements. The hospital does not carry out emergency surgery; all operating procedures were planned.

We visited all three theatres during the inspection. We also visited the recovery area where patients were cared for after surgery. We spent time with the manager in the ward area and spoke with the theatre manager. We spoke with two consultants, eight nurses and four patients. We also spoke with other health professionals, porters and housekeeping staff. We observed care being provided and looked at four patients' records.

Summary of findings

Surgery was planned and co-ordinated effectively. Strong governance arrangements promoted safe practice. Incidents were reported, investigated, feedback given to staff and learning was applied. Patients were complimentary about the care they received pre and post-operatively and patients with complex needs were supported and their carers encouraged to attend with them. Staff felt valued and listened to.

However we also observed inconsistent surgical safety procedures in theatres. We also found poor recording of theatre refrigerator temperatures and out of date medicines. Learning from audits was not widely disseminated and staff were unsure of the hospital audit process, outcomes and the risk register progress.

Good

Surgery

Are surgery services safe?

Requires improvement

We have rated this service as requires improvement for safe. This is because:

- Surgical safety processes were not embedded in theatres
- Medicines management in theatres was inconsistent
- Refrigerator temperature recordings in theatre were checked weekly rather than daily
- The blood bank refrigerator was unreliable and inappropriately sited

However we also saw:

- Incidents were reported, investigated, feedback given and learning applied
- Infection control and prevention processes were in place and recorded rates of infection were low
- NHS Safety thermometer data was used to measure 'harm free' care
- Staffing levels were planned and implemented to keep people safe

Incidents

- Staff told us they felt supported to report incidents. When incidents needed to be reported staff were given sufficient time to complete the report, and managers gave them feedback after investigations were completed.
- Between October and December 2015, staff reported 88 clinical incidents, which had been investigated by the hospital. Sixty-three incidents were 'general' incidents of which nine were staff related, including manual handling issues and needle stick injuries. Twenty-five incidents were about pharmacy interventions. Ward staff told us they were aware of the incidents and they had been discussed at ward level. One serious incident with moderate harm was reported during December 2014. This involved a retained swab which was removed during the same theatre session.
- The hospital reported three incidents of hospital acquired venous thromboembolism (VTE), a blood clot in a vein, between July and September 2015. From October 2015 to December 2015 no VTEs had been reported.
- When necessary and depending on their nature, incidents were discussed during clinical governance meetings, heads of departments meetings and Medical Advisory Committee (MAC) meetings.
- Two cases of mortality and one unexpected death were reported between October 2015 and December 2015. Mortality and morbidity review meetings were not regularly arranged; however any unexpected deaths were discussed at the hospital integrated governance meetings. Data for the previous five years showed there had been one unexpected death (after discharge) in this time. Minutes of the hospital's integrated governance meetings showed that the incident had been discussed, and an incident report was written for the coroner.

Duty of Candour

- Staff had been given Duty of Candour information, both electronically and as a paper report. No specific classroom based or e-learning had been provided. Staff told us of incidences where Duty of Candour processes had been followed. For example, a patient's surgery was cancelled on the day of operation due to equipment not being available. The surgeon took full responsibility for the error and explained the situation to the patient.

Safety thermometer

- Safety thermometer data was recorded for NHS patients only. This applied to approximately half of the patients attending. The hospital sent its data to an analyst at Nuffield Health's head office who then submitted data for the group as a whole. Harm free days were recorded at 100% with no falls reported during 2015.
- Contracts for NHS funded care had a target of 95% for VTE screening. Throughout 2015, the hospital had achieved 100% against this target.

Cleanliness, infection control and hygiene

- Staff showed us the hospital had appropriate policies and procedures in place to manage infection prevention and control. These policies and procedures were up to date and freely available on the intranet.

- Information provided by the hospital identified that there had been no incidence of MRSA, MSSA or Clostridium difficile between October 2014 and September 2015.
- Between October and December 2015, three hospital acquired wound infections were reported. The hospital had investigated the causes of these infections and action plans had been implemented. We were told and saw the process for reporting infections to the Infection Prevention Coordinator, who completed a root cause analysis where required.
- Adequate hand-washing facilities and hand sanitising gel were available and we observed staff washing their hands and using sanitising gel. The 'bare below the elbows' policy was observed by all staff during clinical interventions and staff were seen to follow the hospital's infection prevention and control policy by washing their hands between seeing patients and wearing correct personal protective equipment, such as gloves and aprons.
- We saw that infection control audits had been undertaken in all parts of the hospital. Compliance was recorded at 100% for ward hand hygiene audits completed during November 2015; this included observation of staff hand washing. The asepsis audit for November 2015 had also recorded 100% in all areas except cannulation which scored 80%. The reasons for the low compliance score were clear and staff had received a briefing to remind them of the policy.
- Staff told us that patients who attended a pre-assessment appointment for surgery were swabbed for potential infections such as MRSA. We saw that a patient's surgery was only approved when no infection was identified. When infection was present, the surgery was rescheduled following an infection free period.

Environment and equipment

- We saw that ward equipment was visibly clean, labelled, had been regularly checked and was ready for use.
- In theatre, patient handling equipment which should be wall mounted was stored on the floor and arm supports used in theatre procedures were in a poor state of repair. During our unannounced inspection, we observed patient handling equipment placed on wall hooks and staff told us that arm support covers had been ordered.
- Theatre access was secure, with a reception area where staff working in theatre were greeted and shown to changing areas as necessary. The storage of surgical equipment and instruments was well organised with appropriate stock levels.
- The offsite hospital sterile services department ensured that appropriate equipment was available for surgeons. The system promoted the correct flow of dirty to clean equipment, which reduced the risk of contamination. Where there are issues such as torn packaging or wet equipment, these were reported as incidents and escalated to the provider of the service for immediate attention.
- Resuscitation equipment was available on the ward and in theatre. Records showed that the equipment had been checked daily and a comprehensive check performed weekly, with the seal on the trolley being broken and replaced to check the contents. We found one out of date suction tube and two items out of their sterile packaging. We brought these to the attention of staff and they were replaced immediately.
- Patient moving and handling equipment was available on the ward. This had been maintained and serviced appropriately. Staff told us that the inflatable lifting device was now used in preference to a hoist to aid patients' safety and comfort when mobility was restricted.
- Staff told us suitable and sufficient equipment was available to support the surgical procedures undertaken. However, we were told and observed that the ward electrocardiogram (ECG) machine had been faulty for over one month and labelled 'out of order'. A loan ECG had been provided, staff were trialling a new machine in anticipation of purchasing one for each area in the near future. Following the announced inspection we were sent documentation that assured us four ECG machines of the same type had been ordered. One machine would be available in recovery, one in theatre;

one on floor one and one on floor two. We were told that ECG's would remain on the risk register until the ECG machines were all on site and staff had been trained, there was a clear plan in place for this.

- Minimal storage was available around the hospital which led to some equipment being stored in corridors and unused patient rooms. We did see cleaning trolleys left unattended in the ward corridors throughout the inspection which were potential trip hazards and allowed access to hazardous substances. This was highlighted to the nurse in charge and the trolleys were made secure. Domestic trolleys in use on the ward were not risk assessed.
- Current building work was seen to be well managed. Risks to staff and patients were minimised through strict building control and robust risk assessments.
- We observed that all areas of the hospital were visibly clean and dust free, despite the ongoing building work. We saw there were cleaning schedules in place. Domestic staff told us they had the correct equipment to do their job and had received health and safety training including in relation to the Control of Substances Hazardous to Health Regulations.
- The hospital's 2015 Patient Led Assessment of the Care Environment (PLACE) audit identified a score of 98% for cleanliness, which is the same as England average for NHS hospitals.

Medicines

- On the wards, we found that medicines were stored, administered and managed safely. Medicine administration records were clear about medicines that had been prescribed and administered. The hospital had an on-site pharmacy; pharmacists visited the ward five days a week to check and re-stock the medicine supply.
- The refrigerator recordings in theatre had been checked weekly rather than daily as per national guidance. During the unannounced inspection, we saw that this had been corrected and the temperatures were being recorded daily. We were informed that audit processes had been changed to include checking the recording of refrigerator and would continue to monitor this until full assurance was gained.
- Because of their potential for misuse, controlled drugs (CDs) require special storage arrangements. We saw that there were suitable arrangements in place on the ward to store and administer CDs. Stock levels were appropriate and seen to be monitored. When a patient had their own CDs, they were stored in the CD cupboard and returned to the patient on discharge.
- In theatre, we identified inconsistencies in CD record checks. The manager confirmed CDs should be checked, in line with the hospital's policy, at the beginning and the end of each day. Between 7 January 2016 and 9 March 2016 we saw that 53 out of a possible 126 (42%) checks had not been recorded by staff. During the unannounced inspection, we saw that a new recording book was in place and the CDs had been checked twice a day, and on occasions three times.
- In theatre three, we found an unsecure box of out-of-date adrenaline on top of the anaesthetic machine. The medicine had an expiry date of January 2016, and had not been disposed of correctly. During the unannounced inspection, we saw no unsecure or out-of-date medicines.
- On the wards, patients' medicines were securely stored in one of three mobile trolleys, depending on the area in which they were being cared for. On-site emergency medicines and 'tablets to take home' were available and these were checked regularly to establish the use by date and to ensure appropriate stock control.
- We saw that medicine intervention monitoring logs were in place to record errors in medication administration and documentation along with missed dose audits. The hospital pharmacist completed a quarterly report, which was presented at quality and safety meetings. Trend analysis was completed including identification of staff involved. Staff members were invited to meetings where incidents were discussed and where necessary retraining was discussed and planned.
- While in the theatre, we were shown the refrigerator where blood was stored. The room in which it was kept was very small, without sufficient air flow or ventilation and there was no light source. A sign on the room door said 'leave open at night as machine overheats'. We were told that the machine had been faulty on several occasions including the previous weekend when the

blood had been stored in the on-site pathology laboratory due to a fluctuating temperature issues. When faulty, the machine activated an alarm on the ward, to warn staff they needed to take action to protect the blood products. We noted that this issue had been logged on the hospital risk register. The hospital manager told us that these issues would be addressed as part of a wider Nuffield Health review regarding the storage of blood products. During the unannounced inspection we saw that the door to this room had been removed to improve air-flow. This had been done as an interim measure, following a review by the regional pathology manager.

Records

- The hospital used a paper-based system to record patients' care pathways. These documents covered the patient's journey from admission through surgery to discharge. NHS medical records were not always available for patients whose treatment was funded by the NHS. This could potentially lead to a delay in gaining a patient's past medical history.
- Records we looked at were all appropriately completed. They clearly showed the patient's journey including procedures undertaken, with anaesthetists' and physiotherapists' input.
- We looked at pre-assessment information in four patient records and saw that tests and investigations were clearly documented and the patient's medical and social history had been recorded. We saw that risk assessments had been completed during the pre-assessment appointment and re-assessed on the ward. For example, we saw that VTE scores were written in patient notes. We observed one patient was fitted with compression boots in theatre to promote circulation and prevent blood clots forming while they were immobile following surgery.
- Record audits were consistently rated as green, demonstrating compliance with the Nuffield target of 90-100%. Quarter three results were 94% and quarter four results were 96%. Issues with records identified through the audit process were discussed at the hospital's integrated governance meeting. We saw meeting minutes, which recorded discussions about incidents including the wrong notes being pulled for a clinic and a letter with insurer details being sent to a patient's GP instead of the patient.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children.
- The matron and the outpatient's sister were trained at level-two adult and level-three paediatric safeguarding.
- Data provided by the hospital showed that as at February 2016, 91% of ward staff and 86% of theatre staff had completed safeguarding vulnerable adults training level-one training, against a hospital target of 85%. Data also showed that 94% of ward staff and 86% of theatre staff had completed safeguarding children and young adults training level-one.
- We were told there were plans in place for staff on the ward and in theatre to undertake the new e-learning level two safeguarding module but no dates were provided.
- We were shown a young person's risk assessment, which was completed for 16 to 18 year olds which assessed the patient's ability to understand the treatment to be given. This assessment recorded 'gaining or not gaining' their informed consent and was in place to protect them from receiving treatment which they had not consented to. It also explained that they had entered a predominantly adult area.

Mandatory training

- We reviewed the February 2016 mandatory training records for the ward staff. The hospital had a compliance target of 85%. Data showed that the target had been achieved for all mandatory training with the exception of basic life support (74%) and infection prevention (84%). The overall average was 90%.
- We also reviewed the February 2016 mandatory training records for theatre staff. Against the hospital compliance target of 85%, the average level of compliance was 82%. Data showed that the target had been achieved for training on aseptic techniques, incident reporting,

business ethics, fire safety, infection prevention, information governance, health, safety and welfare, managing stress and whistleblowing. All other training compliance was below the hospital target.

- We were told that mandatory training rates would improve when vacancies had been filled; allowing staff time to attend training sessions and complete e-learning.
- Staff we spoke with told us they felt well supported to complete their training which was either classroom based lectures or e-learning. Classroom training sessions were planned at varying times of the day to accommodate all staff. Staff told us they felt that they were given sufficient time to complete e-learning training but classroom training time was sometimes cancelled if the hospital was busier than anticipated.

Assessing and responding to patient risk

- During pre-admission patients were assessed, considering the planned procedure, for risks to their well-being. A patient would not be considered for surgery at the hospital if they had a severe illness or disease
- There was one unplanned transfer out of the hospital between October and December 2015. An anaesthetist had requested this because the patient's oxygen levels had been low after surgery. This was reported as an incident and included in the quarterly clinical governance report to the integrated governance committee and the MAC.
- The hospital had a service level agreement with the local acute NHS trust if patients needed to be transferred as an emergency. We heard of one example when this process had worked efficiently and successfully for the patient.
- We were informed and we saw that surgeons and anaesthetists had 24-hour a day responsibility for their patients until they were discharged from the hospital. Formal patient handover arrangements were arranged when consultants were on annual leave. This commitment was part of their practicing privileges arrangements, which were discussed at MAC meetings.
- We observed that the World Health Organisation (WHO) Five Steps to Safer Surgery checklist was not embedded in daily practice and not consistently adhered to. This process, recommended by the National Patient Safety Agency should be used for every patient undergoing a surgical procedure. The process involves specific safety checks before, during and after surgery.
- We observed that staff were not accurately following the WHO checklist on two occasions and it was not fully completed for each patient procedure. For example a 'sign in' occurred with the anaesthetist not present, the sign out documentation was not fully completed and the anaesthetist's mobile telephone rang several times in the anaesthetic room. We also observed the anaesthetist did not interact with the patient during 'sign in', the operating department practitioner (ODP) ticked off the WHO checklist while the anaesthetist was out of the room and again the anaesthetist was not present during 'time out' part of the WHO checklist process. During the unannounced inspection, we noted that practice had been improved. We followed a surgical patient from the anaesthetic room through to the recovery room. The WHO checklist was followed precisely, with equipment checks carried out throughout the procedure.
- Completion of the WHO surgical checklist was reviewed as part of the hospital's regular quarterly audit programme and the results were included in the quarterly clinical audit report. We identified that for the quarter October to December 2015, the records of 25 patients had been reviewed; 100% compliance was recorded in all areas including observational theatre audits. This was not supported by our observations during the inspection. We were not assured that observational audits had been carried out in theatre. When we asked the theatre manager and theatre staff they were unaware who had completed the observational audits and if anyone had visited the theatres to complete this part of the audit.
- During the unannounced inspection, we were informed that the senior management team had visited theatre twice a week since the announced inspection to complete observational audits. The findings from these audits had reflected some our findings and the observational audits would continue until full assurance was provided.
- Whilst in recovery, patients were monitored by the surgeon and anaesthetist. When the patient's condition was stable, the recovery nurses then made the decision

that they were safe to return to the ward. The ward nurse then received a handover from the recovery nurse and reassessed the patient. We saw that care records covered risk assessments such as pressure ulcers, VTE, patient handling, falls, nutrition and delirium with interventions and outcomes recorded. Nurses told us they used their clinical judgement with all post-operative patients and throughout their whole journey.

- On the wards, the National Early Warning Score (NEWS) was used to identify any deterioration in patients; this process recorded patient observations enabling early recognition of signs of deterioration which would require escalation to the medical team. The patient's consultant and the hospital matron were also informed when an escalation had occurred.
- When a patient was required to return to theatre during working hours this was facilitated by the theatre and bookings team. When required out of hours, the ward nurses would call the on call theatre team. At weekends, an on call nurse manager was available from 7pm on Friday night until 7am on Monday morning. A member of the senior management team was also on call 24-hours a day, seven days a week for advice and support. Patients' resuscitation status was recorded and monitored during consultations.
- We observed discharge information and advice was provided in a discharge pack, this included specific wound care advice. The ward sister told us that patients were contacted 48-hours after discharge, to check their progress. We saw that patients were provided with contact telephone numbers should they need to ask any advice once at home.

Nursing staffing

- During our inspection we saw that the staffing levels were sufficient to protect patients from avoidable harm. Nuffield Health had adopted the National Institute of Clinical Excellence (NICE) Safe Staffing Guidelines. The hospital used a basic staffing tool to meet patient acuity or individual dependency needs. One qualified nurse was assigned to eight inpatients or six day case patients, with the support of health care assistants. We were told that staff numbers could be increased according to the assessment of the patients and we saw a duty rota which showed an extra member of staff had worked to meet patients' needs.
- Staff told us that they felt staffing was sufficient and the skill mix was correct; on some occasions, when patients became unwell or the wards were busier; bank or agency staff could be requested.
- In theatre, during 2015, there had been little use of agency nursing staff; at any one time, the maximum of 20% of total staff was covered by agency staff. No agency care assistants worked in theatre during the same period. Between May and October 2015 no agency ODP was required to work in theatre. Theatres were staffed in line with Association For Perioperative Practice (AfPP)
- Nursing staff worked on a day/night shift rotation. Senior nursing staff were required to be on the out of hour's on-call rota. Staff told us when they worked over their scheduled hours they almost always got their time back.

Surgical staffing

- A resident medical officer (RMO) was on the hospital site 24 hours a day, seven days a week. The RMO offered medical support to the nursing staff; although nursing staff told us they had no problems contacting individual consultants for information or advice. The RMO was informed of all patient theatre lists and we saw that they were included in staff handovers. This ensued they were aware of the nature and acuity of all patients in the hospital.
- All clinical care was consultant led and consultants provided personal cover for their own patients 24 hours a day, seven days a week. They also arranged cover from another consultant with practising privileges at the hospital, in the event that they were not available. Cover arrangements were discussed and agreed at MAC meetings.

Major incident awareness and training

- Nuffield Health major incident policy was tailored to each individual service. This outlined the plan for managing a major incident with the support of the local

emergency services where necessary. Staff we spoke with were aware that the site may be used to support the local NHS trust in the case of a local major incident, including consultant cover and medical support.

- A major incident plan was accessible to staff at the main reception desk of the hospital. There were regular testing of fire alarms and fire evacuation drills were conducted four times a year. Monthly resuscitation scenarios were also carried out.

Are surgery services effective?

Good

We have rated this service as good for effective. This is because:

- The hospital had systems in place to provide care and treatment in line with national guidance
- There was effective multi-disciplinary working with informative handovers, good record keeping and communication
- An enhanced recovery programme promoted post-operative health and well-being
- Patients were complimentary about the care they received pre and post-operatively including pain relief, the quality of the meals and the information available
- All staff had appraisals and there were effective systems in place to check the qualifications, skills, competence and experience of medical practitioners with practising privileges.

However we also saw:

- Learning from audits was not widely disseminated and staff were unsure of the hospital audit process and outcomes
- We did not see any evidence of any local audits or any formal theatre audits based on national recommendations such as those made by Association for Perioperative Practice (AfPP); a registered charity working to enhance skills and knowledge within operating departments.

Evidence-based care and treatment

- Hospital staff followed local policies and procedures such as wound care pathways and specific consultant post-operative preferences.
- We saw that the hospital had systems in place to provide care and treatment in line with national guidance, such as National Institute for Health and Care Excellence (NICE) guidance, including NG24 blood transfusion and NG28 Diabetes, adult management.
- Care pathways supported surgical procedures that were undertaken, for example gynaecology, and hip and knee replacement.
- The Matron received information on NICE guidelines every month in the form of a gap analysis. Guidelines identified as relevant to the hospital were discussed at the quality and safety meeting prior to them being discussed at the departmental meetings. The quarterly governance report identified those guidelines relevant to the hospital. For example, pressure ulcer guidelines had been updated to remain compliant with the NICE pressure ulcer guideline.
- Recovery Plus, Nuffield Health's recovery programme, was available to private patients, for a number of procedures. This programme was an optional enhanced recovery pathway that started after patients had finished their post-operative physiotherapy. It enabled them to continue their recovery at their local Nuffield Fitness and Wellbeing Gym, at no extra cost. Recovery Plus brought together a range of healthcare services across Nuffield Health's Hospitals and their Fitness and Wellbeing Gyms. It provided patients with the support they needed to recover and stay healthy after their procedure.

Pain relief

- Two patients we spoke with told us that their pain management had been discussed with them during their preadmission assessment appointment. They told us their pain relief had been discussed with them prior to their surgery.
- We saw that theatre staff reviewed prescribed pain relief with the anaesthetists prior to patients being transferred to the ward. Staff told us they were encouraged to contact the anaesthetist or consultant when they felt additional pain relief was needed.
- We saw that pain relieving medicines were recorded on the patients' administration charts and given when required. We saw that pain scores were recorded to demonstrate the effectiveness of pain relief and patient comfort level.

Good

Surgery

Nutrition and hydration

- We looked at four completed fluid balance charts which recorded the times and amounts of fluid that the patient had received and their recorded urine output.
- We saw that patients had access to drinks and snacks at all times. Patients told us the quantity and quality of food was exceptional and staff had regularly offered those cold and hot drinks throughout the day and night.
- Nil by mouth' details were discussed with each patient at their pre-admission assessment and confirmed with them in writing. We saw that specific pre-operative protocols were in place for each consultant, this ensured that food and fluids were taken in line with their preferences and for the safety of the patients.
- The hospital's 2015 PLACE audit identified a score of 98% for ward food, which was above the England average of 94%.

Patient outcomes

- The hospital participated in patient reported outcome measures (PROMS) audits. Knee and hip replacement (primary) were both within the expected range of the England average relating to five questions about their health. The Oxford Knee Score was below the England average due to an increase in knee infections. Key learning and interventions had been identified as a need to ensure a well-trained cohesive team in theatre and in wound care on the wards. The infection prevention control lead (IPC) had reviewed the current building work arrangements, major decoration work and the air plant monitoring in theatres.
- PROMS data, self-reported to the Health and Social Care Information Centre (HSCIC) from April 2014 to March 2015 was available. For example, 401 groin hernia patients were eligible to give feedback of which 10 reported improvements, two reported worsening health and four reported no change in health. For knee procedures 171 patients were eligible of which 48 reported an improvement in health and one reported worsening health.
- The hospital's target for VTE screening was 95%. Throughout 2015, 100% of patients had been screened for the risk of developing VTE.
- The hospital was part of the Public Health England (PHE) surgical site surveillance programme. The hospital's infection prevention coordinator input their data into the PHE system. Staff carried out follow up telephone calls 30 days after surgery for patients who had had major surgery.
- All readmissions either to the hospital or an NHS trust were recorded on an electronic data collection system, as were patient returns to theatre. Between October and December 2015 no returns to theatre had been reported. One patient had been transferred to an NHS acute hospital at the request of their anaesthetist.
- Between October and December 2015, there were no readmissions within 28 days of surgery. During the same period, there were four recorded day case conversions to overnight stay; three of those patients were not fit for discharge due to nausea and/or immobility and one had an unexpected late return from theatre.
- There were two extended length of stay/delayed discharges recorded in the same time period, due to pain control and wound care. We were told that here had been no trends identified, relating to length of stay, throughout the last two years.
- The activity at the hospital was predominantly elective surgery. Outcome measures data from 470 completed operations was submitted to the National Joint Registry scheme (NJR). Ninety-five per cent compliance had been achieved with patient information submissions from 2015. The National Joint Registry (NJR) collects information on all hip, knee, ankle, elbow and shoulder replacement operations, to monitor the performance of joint replacement implants and the effectiveness of different types of surgery, improving clinical standards and benefiting patients, clinicians and the orthopaedic sector as a whole. This reported data was discussed at monthly governance meetings.
- We did not see any evidence of any local audits or any formal theatre audits based on national recommendations such as those made by AfPP; a registered charity working to enhance skills and knowledge within operating departments.

Competent staff

- The General Medical Council revalidation of consultants was underway where doctors were required to

demonstrate their competence in a five year cycle. NHS consultants received individual appraisal summaries and provided evidence of mandatory training from their NHS employer. Consultants who worked solely in the private sector completed the Nuffield Health mandatory training programme including an annual appraisal. The hospital used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process.

- There are 166 doctors working under practising privileges at the hospital. Practising privileges is a well-established process whereby a medical practitioner is granted permission to work in a private hospital. We looked at nine randomly selected personnel files for medical practitioners and found that seven had current appraisal information and the other two had appraisal information from 2014.All the files we looked at had up to date revalidation information.
- Staff told us and we saw that all new staff, including temporary staff, received induction training; we heard that this included a 'meet and greet' session in all departments, providing staff with an overview of all hospitals areas. Trained staff were supernumerary to the ward and theatre staffing levels during their planned induction, which was tailored to their previous experience.
- Staff told us they felt exceptionally well supported when they started to work at the hospital and soon became part of the team. Several staff told us they were able to ask for further support during their induction to assist them in their new role. Two student nurses working at the hospital, from the local university, told us they had received the same induction and had been well supported during their placement
- Ward and theatre staff confirmed that appraisals took place regularly and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in 2015, including administrative and clerical staff. We heard that the staff thought the appraisal system was effective as it formalised individual competencies achieved and identified training needs for the next year. Staff told us examples of how they had been encouraged to train in other areas or areas of interest such as other types of surgery.

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers, good record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and therapies planned.
- We saw that medical and nursing staff, therapists and pharmacist staff worked in partnership on the ward. Ward rounds took place on a daily basis.
- When patients were discharged, the hospital worked well with external services. A letter was sent to the patient's GP on discharge to inform them of the treatment and care that had been provided.

Seven-day services

- Theatres were used flexibly by all consultants within a six-day service. Theatres were open from 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday.
- Theatres were also available for emergency purposes 24-hours a day, seven days a week. To support emergency events, theatre staff were part of an 'on call rota' including a senior manager each night. Out-of-hours pharmacy advice was available.
- Consultants visited their patients daily as part of the pre and post-operative care pathway. The nursing staff told us they had no hesitation in contacting consultants at any time to discuss their patient's condition or care.

Access to information

- Policies we looked at were accessible, current and referenced good practice guidelines and made reference to professional body guidance and published research papers; for example, the safer staffing policy.
- Individual nursing records were accessible in the patient's own room. We saw that medical records were stored securely in the nursing office.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Written consent for surgical procedures was given either at pre-admission assessment or on the day of surgery. Four patients we spoke with told us the consultant had discussed the procedures during their assessment and they had been given time to consider them before consenting.

Good

Surgery

- We spoke with staff about informed consent and they were clear about the procedures to follow for those patients who lacked capacity including involvement of those close to the patient. Staff demonstrated an understanding of the mental capacity assessment process including examples whereby relatives had stayed with the patients who lived with dementia and they had been called to recovery to be with the patient when they woke from their anaesthetic. 80% of the ward staff had received Mental Capacity Act training.
- Staff clearly understood Nuffield Health's policies for the resuscitation of patients and 'Do Not Attempt cardiopulmonary Resuscitation' (DNACPR) decisions. The policy stated that unless otherwise requested, all patients that had a cardiac arrest were to be resuscitated.
- There were no 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms in place within patient's records at the time of our inspection. Staff were made aware of patients' resuscitation status during handover when necessary.

Are surgery services caring?

Good

We have rated this service as good for caring. This is because:

- Patients unanimously told us they were treated with care and compassion.
- Survey data confirmed that patients had confidence in being treated at the hospital.
- People's individual physical and emotional needs were considered and met.

Compassionate care

- Patients we spoke with told us that they had received very good care and could not fault the way they had been treated. One patient told us that they had been treated compassionately, with great respect and their dignity protected. We observed all levels of staff respectfully knocking on bedroom doors and waiting for a response before entering. Patients told us they were referred to by their name of choice. We saw was documented in care records.
- The NHS Friends and Family Test (FFT) was undertaken to record inpatient feedback. Current results demonstrated 100% of the 82 respondents would recommend the hospital. Confidence in the medical and nursing staff scored between 95% and 99%, similar to or above all Nuffield hospitals in the group.
- The hospital participated in the Friends and Family Test for the NHS patients they treated with 85% of the responses stating they would recommend the hospital to their friends and family should they need similar care and treatment (April 2015 to July 2015.)
- We looked at data from the Nuffield Health Hospitals own inpatient satisfaction survey for the period October to December 2015. Results were consistently high at 96%, higher than any other hospital in the Nuffield group.

Understanding and involvement of patients and those close to them

- The trust values stated that caring starts with listening; patients told us that staff upheld this value and they did feel they were given time to be listened to by the friendly staff. Patients told us they were fully informed to make the correct decision about their treatment.
- We saw that information was provided in a way patients understood. Patients told us they had the reason for admission, including the risks involved, explained to them during their pre-assessment appointment and again on admission. They told us the consultant ensured they fully understood the reason for the surgery or procedure. Patients followed the same admission process and received the same information for day care or inpatient care.

Emotional support

- If patients required any form of counselling, this was normally arranged as an outpatient service. We heard that religious or spiritual support could be arranged if requested by an inpatient.

Good

Surgery

- Visiting times were specified; however staff told us when necessary this could be flexible depending on the physical and emotional needs of the individual patient.

Are surgery services responsive?

Good

We have rated this service as good for responsive. This is because:

- Surgery was planned and co-ordinated in a safe way following full consultation and pre-admission assessments. Discharge arrangements were confirmed prior to leaving the hospital and a discharge pack was issued to support the patient's aftercare.
- The process was identical for private and NHS patients using the service.
- Patients with complex needs were supported and their carers encouraged to attend with them.
- Complaints and concerns were taken seriously, and responded to in a compassionate and timely way. There was evidence that lessons had been learnt and actions taken as a result.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered in a way that took people's needs and preferences into account. Admission dates for each patient were planned during consultations to include patient choice and inpatient or day case bed availability. The booking co-ordinator and theatre manager arranged the operating lists for theatre in collaboration with each consultant surgeon's secretary.
- Sufficient time was scheduled between patient admissions to enable smooth admission on to the wards, avoidance of long waits to be admitted and safe preparation of theatres.
- The physiotherapy team planned individual treatment regimes from admission to discharge. Physiotherapists attended the ward on a daily basis then, following discharge, the patient attended the Nuffield Recovery Plus programme. Rehabilitation was based on patients' assessed needs; this included support from physiotherapists, personal trainers and consultants to promoted enhanced recovery. This service was not available to NHS patients.
- The hospital did not provide emergency care and all admissions were planned and arranged in advance.

Access and flow

- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- Between October 2014 and September 2015, the hospital achieved the target of 90% of admitted patients beginning treatment within 18 weeks of referral. During the same period, the hospital met the 95% target of non-admitted patients beginning treatment within 18 weeks of referral.
- We were shown a discharge pack which included post-operative advice and guidance including a GP letter, check-up appointment, medication information and wound care advice. The ward sister showed us that additional specific wound care information had recently been incorporated in the pack to aid patients' safe recovery. The ward telephone number was included if patients needed to ask advice.
- Between October and December 2015 there were 18 'cancellations after admission' recorded. The two main reasons recorded were, infection that was not present at pre-operative assessment and patient not fit for surgery.

Meeting people's individual needs

- Patients told us they had received all the information they required prior to their procedure or surgery. They told us they understood the reason for their admission to hospital and staff had clearly explained the risks and benefits to them.
- We saw that nurses and consultants gave information leaflets to patients to ensure they were fully informed about their procedure or the surgery.
- We were told that staff were allocated their patients for each shift to ensure continuity for the patient. We observed ward nurses escorting patients to theatre and collecting them from recovery.

Good

Surgery

- Dietary preferences were noted and a choice of meals was offered. Hot and cold drinks were offered throughout the day and we heard staff asking patients if they were satisfied with their meal or required anything else before removing the serving tray.
- Interpreting services were available, when required.
- All patients had individual bedrooms, private en-suite facilities, a television and thermostatic controlled heating. We were told that should a patient require the support of a carer or a family member they were encouraged to stay at the hospital to offer familiar assurances and to assist with the rehabilitation process.
- The needs of patients living with dementia or those who had a learning disability were identified at pre-assessment. Patients with complex needs were risk assessed by physiotherapists and occupational therapists and their care plans were then based on the risk assessments and professional advice.

Learning from complaints and concerns

- We saw 'How to make a complaint' booklets around the hospital, available for patients to read.
- All formal complaints were responded to with an acknowledgement letter within two working days where possible. The hospital director offered to meet with complainants to discuss their complaint.
- Any complaints received by the hospital were reviewed at the monthly heads of departments meetings, monthly governance meetings and MAC meetings. Outcomes, lessons learnt and improvements on practice were discussed at all these meetings. Action logs were developed to ensure that improvement was monitored.
- There were 38 formal complaints to the hospital in 2014. The latest Clinical Governance report showed there had been seven formal complaints made to the hospitals between October and December 2015.
- We reviewed five randomly selected complaint files. All the complaints we looked at were investigated and responded to in a timely manner. The tone of the response letters was compassionate and appropriate. Letters of response also included changes that had been made to services in response to the complainant's feedback.

Are surgery services well-led?

Good

We have rated this service as good for well led. This is because:

- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood.
- The senior management team displayed characteristics of the hospital vision and values on a daily basis.
- The staff valued the team working ethos and stability of the professional team; they felt valued and listened to.
- Strong governance arrangements promoted safe practice supported by well risk assessed services to promote patient and staff safety.
- There were clear systems around the management of practising privileges.

Vision and strategy for this service

- There was a clear vision and strategy for the hospital. Staff throughout the service were clear on their contribution to the hospital achieving its vision. There was a clear 3-year strategy to develop services and increase activity and the hospital was achieving this. Between 2014 and 2015 there was an 11% increase in admissions. The hospital director told us they involve staff as much as possible in the development of future plans
- The hospital had a set of EPIC values (enterprising, passionate, independent and caring.)We saw that staff demonstrated these values when providing care to patients.
- Staff we spoke with told us that the hospital's values were regularly discussed during team meetings, interviews and staff appraisals. In the staff canteen we saw that staff had signed a framed 'values' poster, showing commitment and belief in what they do. This was the result of an away day event that all staff attended.

Governance, risk management and quality measurement for this service

Good

Surgery

- We saw a robust quality measurement systems in place, which were managed by the senior management team. The matron for the hospital took the lead and captured clinical data from the central database to present the clinical governance quarterly and annual reports to the senior management team. These reports identified trends and variances of all patients admitted to the hospital generating an incident report when a variance was noted. The report included complaints, incidents and patient satisfaction survey results. A comparison was made with previous reports and other hospitals in the group including readmission rates and extended lengths of stay. The clinical governance report was also shared at the Medical Advisory Committee (MAC) and Quality & Safety Committee.
- There was one risk register for the whole hospital which logged all the issues identified on site as requiring attention, replacement or review, this included a number of the issues we identified during our inspection and reflected the concerns of staff. For example, the ECG machines were listed along with the blood refrigerator facilities. Also listed was levels of agency scrub staff in orthopaedic theatre. We saw actions had been planned and implemented to mitigate some of these risks.
- Monthly business review meetings were held with the heads of each department invited. Workload and staffing were discussed along with use of agency staff and recruitment.
- Prior to the inspection, we attended a MAC meeting. Consultant surgeons and anaesthetists from each speciality were represented. The role of the committee included approval of new procedures and equipment that consultants wanted to introduce to the hospital and reviewing quality and safety issues. We heard incidents and complaints presented and discussed, surgical procedures reviewed and risks discussed. An update on the hospital development was also discussed along with clinical governance issues such as the use of certain medicines. MAC meetings were held quarterly, agendas were sent out and the previous minutes were confirmed.
- The MAC also had a key role in the oversight of practising privileges arrangements, including approval of all medical practitioners who apply to the hospital. At the meeting, we saw a recent Nuffield Health policy change on practising privileges was discussed, and that all medical practitioners should sign up to the new policy.
- There are 166 doctors working under practising privileges at the hospital. We looked at nine randomly selected personnel files for medical practitioners and found that all the files had up to date employment information references, identification and GMC check. All files also had a copy of the practising privileges contract. The hospital used an electronic database to monitor compliance, with due dates identified for doctors' appraisals, revalidation, renewal and indemnity, as a part of the practising privileges process.
- In February 2015 CQC received one whistleblowing alert about the hospital. We received documentation from the management which demonstrated that this had been fully investigated, discussed at the MAC and the issues raised were continuing to be monitored.

Leadership / culture of this service

- We heard that ward and theatre staff felt well supported, respected and listened to by their managers. They told us about the friendly, inclusive culture of feeling like one family. Many staff had worked at the hospital for over 10 years and they were proud to demonstrate their commitment to the management and patients. Eighty per cent of theatre staff and over 60% of ward staff had been at the hospital over one year. Staff turnover during 2014 was less than 20%.
- Two staff members told us that the newly appointed ward sisters had provided a focus on leadership, which the wards had lacked over the previous six months. The theatre staff told us they were confident that the leadership demonstrated professional standards and support for the whole team.
- We heard that the hospital director, senior management team and the matron were very visible, speaking with the nursing staff and ward managers when possible.
- A learning culture was described where staff development was supported and encouraged. We saw the hospital's continuing education policy was promoted.

- Student nurses told us they had been welcomed, shown around all departments and soon felt valued as part of the team. They were on placement from a local university; the hospital was part of the student nurse rotation.
- During a focus group held prior to the inspection staff unanimously told us they felt valued and respected by the hospital's managers and consultants with practising privileges. Many staff had worked at the hospital for over 10 years which demonstrated their job satisfaction.

Public and staff engagement

- We saw minutes of the patient forum group, which was held quarterly at the hospital and chaired by the hospital director. The group shared customer experience, reviewed quality and environmental issues and took a tour of the hospital. Two issues previously highlighted had been addressed which included consultant profiles on the hospital's website and wheelchair access.
- We heard many examples of how staff were engaged and informed about the hospital progress and future plans. The hospital director held monthly informal coffee mornings where all levels of staff could attend to discuss hospital issues in a relaxed atmosphere. Staff who had attended these told us they thoroughly enjoyed them and found them beneficial.
- The senior management team told us they had an open door policy which the staff we spoke with confirmed. Staff felt they could approach any of the team with confidence that their issues or concerns would be dealt with confidentially in a respectful, compassionate way.
- Monthly staff and team meetings were planned, where presentations were delivered and interactive sessions were held for staff discussions and 'hot' issues. Two each months took place during mornings and two during afternoons to ensure inclusion for all staff. Meeting minutes were stored on the hospital intranet and paper copies were placed on the notice board.
- When the hospital management received comments about patient care these were fed back to the relevant staff. Staff told us that they appreciated any positive feedback; we saw that staff whose name had been mentioned either in correspondence, verbally or in the patient satisfaction survey was listed in the monthly governance meeting minutes.

Innovation, improvement and sustainability

- Following strict processes, new surgical procedures were considered and introduced to the hospital such as 'urolift' a prostate procedure within urology. If a specific procedure was performed at a Nuffield Hospital in the group, ensuring that the surgeon provided written clinical justification for the procedure and confirming that this had been be performed or used in their NHS practice, local approval could be given. The matron and hospital director had to give approval and then it was approved at MAC. If a specific procedure was new to the Nuffield group approval from the group was required and the Matron worked with the surgeon to obtain this.

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 consisted of 12 consulting rooms, a minor operations room, a treatment room and a phlebotomy room. A range of clinics was held within outpatients including orthopaedics, gastroenterology, ophthalmology, gynaecology and pre assessment. Outpatient physiotherapy took place on the first floor in the physiotherapy gym. The radiology department provided fluoroscopy, mammography, general x-ray and ultrasound scanning. Computerised tomography (CT) and magnetic resonance imaging (MRI) were provided on site by a private company. These services were overseen by the diagnostic and imaging department.

Children were seen in the outpatient and imaging departments but only on a consultation basis or for non-interventional radiology.

The hospital had a set of EPIC values (enterprising, passionate, independent and caring.) We saw that staff demonstrated these values when providing care to patients.

The hospital also provided oncology services to patients on an out-patient basis, although this was delivered on the ward area for the comfort of patients. 762 episodes were delivered in 2015, the hospital had approximately 25 patients currently receiving chemotherapy treatment.

During our inspection we spoke with 30 staff including medical records staff, managers, nurses, health care assistants, consultants, receptionists and cleaning staff. We spoke with 16 patients and relatives to gain their views of the service received. We reviewed eight sets of patient records along with other documents supplied by the trust. Before and during our inspection we reviewed the hospital performance information.

Good

Outpatients and diagnostic imaging

Summary of findings

Outpatients and diagnostic imaging services at this hospital had systems and process in place to promote practices that protected patients from the risk of harm.

There were sufficient numbers of trained staff to meet the needs of patients. There was an open culture where staff were encouraged to report incidents and lessons learned were shared within team meetings. Treatment and care was provided in line with national guidance. Staff were polite, courteous, friendly and responsive to patients' individual needs. There were no waiting times to access appointments which were also available in the evenings and on Saturday mornings. Staff felt supported and proud to work within the hospital.

Are outpatients and diagnostic imaging services safe?

Good

We have rated this service as good for safe. This is because:

- There was an open culture where staff were encouraged to report incidents and lessons learned were shared within team meetings.
- Infection control procedures were adhered to.
- Medicines were stored appropriately.
- Staff were up-to-date with mandatory training including safeguarding of vulnerable adults and children. Staff were knowledgeable about safeguarding procedures.
- Staffing levels were up to full establishment in both outpatients and the imaging department ensuring sufficient staff to meet patients' needs.

However, we also saw that:

- As a result of the ongoing building work, radiology equipment was being stored in corridors and it had not been clear if and when it had been cleaned.
- There was no hand sanitising gel available within the outpatients and imaging department waiting areas.

Incidents

- The hospital used an electronic incident reporting system to record accidents, incidents and near misses. Staff we spoke with demonstrated knowledge and understanding of how to report incidents using this system.
- A serious incident had occurred within radiography involving a patient having a respiratory arrest. The investigation report showed that staff had followed the hospital policy, which included the need to call 999 as well as the emergency response team within the hospital. A full root cause analysis had also been carried out which had identified learning from the incident. Staff told us that learning from hospital wide incidents was shared at monthly departmental meetings. We saw minutes of these meetings confirming this.

Good

Outpatients and diagnostic imaging

- Minor incidents of overexposure within diagnostic and imaging were also reported to the Radiation Protection Adviser.
- There were 15 reported incidents within outpatients and the imaging department since October 2015.There were no identified themes.

Duty of Candour

- Staff were aware of their responsibilities under the 'Duty of Candour' and confirmed they had received guidance from the hospital management team. No specific classroom based or e-learning had been provided. We were shown an example of an incident that had been investigated and the patient involved had been offered the opportunity to have a meeting to discuss the incident.

Cleanliness, infection control and hygiene

- We observed that the waiting areas and clinic and diagnostic rooms were clean. We saw daily cleaning schedules were maintained and were up-to-date. The housekeeping team were on call to attend to any major spillage or accident with bodily fluids. Patients we spoke with said that the outpatient and imaging departments were always clean.
- We observed staff cleaning couches in clinic rooms in between patients. Daily logs were maintained of where clinical staff had cleaned clinical rooms and trolleys.
- We saw that some portable radiography equipment such as the Echo Machine and Image Intensifier Monitor was stored in corridors as result of the ongoing building work. There was no method of identifying that the equipment had been cleaned and was ready for use, furthermore, as it was in a public thoroughfare, there was a potential risk of contamination and interference. We notified the hospital of this and the Echo Machine has now been stored within the screening room until it can be rehoused once building work has been completed. 'I am clean' stickers are being used on relevant pieces of equipment when cleaned.
- Personal protective equipment (PPE) such as gloves and aprons were available in the clinic rooms within outpatients. Patients told us and we saw staff using this equipment.
- Records showed that 100% of staff within outpatients and diagnostic and imaging had received training on infection prevention and we observed that staff complied with the hospital policy of being 'bare below the elbow' and followed good hand washing technique.
- A hand hygiene audit conducted in outpatients in August 2015 showed 92% compliance and 95% for hand hygiene facilities.
- Hand gel was available at the reception desk on entering the hospital. However, there were no signs encouraging patients and visitors to use the gel. We did not observe staff reminding patients and visitors to use the gel. Hand gel and hand washing facilities were available within each clinic room with posters indicating good hand hygiene practice.

Environment and equipment

- We saw staff had access to sufficient equipment. Clinical equipment within outpatients had been labelled to indicate when it had been serviced. The physiotherapy equipment had all been PAT tested and calibrated annually. We saw that quality assurance and calibration checks on equipment were regularly completed and documented within the diagnostic and imaging department.
- We saw records that indicated the resuscitation equipment had been checked appropriately.
- There was clear signage to restrict access to imaging rooms.
- Safety equipment within the diagnostic and imaging department such as lead coats and eyeglasses were available. This was screened every six months to ensure that equipment was in good condition and we saw logs maintained.
- X-ray equipment dated 1997 was due for replacement. Equipment is usually replaced every eight to nine years. We were told a business case was to be produced to address this. This was on the hospital risk register. There was a corporate plan to roll out digital x-ray rooms and the hospital has requested that they be a priority site.

Medicines

- Medicines were stored in locked cupboards in outpatients. We observed one medicine which was out

of date by a few days. This was immediately removed by the outpatient sister. We found two oxygen cylinders which were close to empty. We informed the outpatient sister who had them replaced immediately.

- There were no controlled drugs stored within outpatients or medicines requiring refrigeration.
- Prescription pads were stored securely within a locked cabinet. Nurses signed out prescriptions.
- Contrast media was stored appropriately in the imaging department.

Records

- The medical records department ensured that records were available for outpatient clinics. Clinicians reported no problems accessing records.
- All radiology reports were available on the computerised system which was accessible to radiographers, radiologists and all consultants.
- We reviewed eight sets of patient records. The records were all complete, legible and up-to-date including signed consent forms.
- A monthly records audit was conducted. The outpatient department achieved 90% compliance in December 2015.
- We found there to be no lock on the phlebotomy room (where there was public access) where patient identifiable information was stored. We notified the outpatient sister during the inspection and a keypad was fitted to the room by the time we returned for our unannounced inspection.

Safeguarding

- Staff we spoke with demonstrated knowledge and understanding of safeguarding and of the hospital process for reporting concerns. They understood their role in protecting children and vulnerable adults.
- Staff told us that they received training in safeguarding of children and vulnerable adults.
- Records demonstrated 76% (13 out of 17) of staff had completed adult safeguarding level-one, and 94% (16 out of 17) children's safeguarding at level-one within outpatients. All (4 out of 4) of staff had completed adult safeguarding at level-one and 75% (3 out of 4) children's safeguarding at level-one within radiology. This was against a hospital target of 85%.
- We were informed that a new module on children's safeguarding at level-two had been introduced. Sixty per cent of outpatient staff and 50% of radiology staff had completed this training. The matron and the outpatient's sister were trained at level-two adult and level-three paediatric safeguarding. Female genital mutilation awareness was incorporated into the safeguarding training.
- The safeguarding policy was accessible to staff on the hospital intranet. On the outpatients staff noticeboard there was a clear flow diagram demonstrating safeguarding processes and contact numbers.

Mandatory training

- Staff told us they were able to access their mandatory training such as basic life support, infection control, safeguarding and health and safety and were kept informed by their managers if training was due.
- Records from December 2015, demonstrated that average compliance within outpatients was 94%, against a hospital target of 85%.The target compliance level had been achieved in all areas with the exception of: health and safety, information governance and manual handling.
- Records from December 2015, demonstrated that average compliance within radiology was 79%, against a hospital target of 85%.However, as there was only four staff members in the team the percentage figures were potentially misleading.

Assessing and responding to patient risk

- A pre-admission assessment was carried out on all patients undergoing procedures who needed to be admitted to the hospital. This assessment would identify any risks to the patient based on their medical history, whether these risks could be minimised and if the hospital could safely care for them. All referrals were screened, patients who had conditions such as unstable diabetes or high blood pressure had their procedures delayed until the issue was resolved.

Good

Outpatients and diagnostic imaging

- Staff told us that patient's risks were assessed and reviewed at every outpatient consultation. Procedures performed in either the treatment room or minor operation room required local anaesthetic only. Following any procedure, patients sat in the waiting areas where they would be observed by staff and have their wounds checked prior to going home. Staff told us if patients became unwell they would find them a room to lie down and recover. If necessary the consultant could review them and the patient could be admitted to the ward.
- Staff were aware of the transfer policy and actions to take should a patient become unwell and need more urgent care at another hospital. There was a transfer arrangement with the local NHS trust and patients would be transferred by ambulance in an emergency.
- World Health Organisation (WHO) Five Steps to Safer Surgery checklist was completed for all interventional radiology procedures. We saw completed checklists but did not see them in action. The use of the checklists had commenced in December 2015.There had been no audits to date; staff told us that they planned to audit the checklists from March 2016.Outpatient staff had also recently (December 2015) commenced using the checklist for patients requiring minor surgical procedures.
- Radiation regulations in the radiology department were adhered to. A Radiation Protection Adviser was appointed at the local NHS trust, who advised on radiation issues within the department. The radiology department had a current set of signed Local Rules, ensuring staff and visitors safety when entering the department. Ionising Radiation (medical exposure) Regulations (IR(ME)R) procedures were in place to ensure the safety of patients and minimise the risks of radiation exposure.

Nursing staffing

- The outpatients and radiology departments were up to full establishment. No agency staff were used in these areas. If shifts required covering for example for sickness, the service used their own staff working on the bank.
- Staffing within the outpatient department was stable with low staff turnover of 1% and low levels of sickness.69% of nursing staff and 100% of care assistants had worked within the department for longer than a year.

Medical staffing

- Consultants held regular clinics and were responsible for the care of their patients. There were four in-house medical secretaries supporting 12 consultants. The other consultants had their own private secretaries who liaised as required with the Nuffield admin team to organise clinic lists around consultant availability.
- If the consultant was delayed or unable to attend, it was their own responsibility to inform the hospital of the delay and provide cover for any clinics, with an alternative appropriately skilled consultant who also had practising privileges at the hospital.

Major incident awareness and training

- Nuffield Health major incident policy was tailored to each individual service. This outlined the plan for managing a major incident with the support of the local emergency services where necessary. Staff we spoke with were aware that the site may be used to support the local NHS trust in the case of a local major incident, including consultant cover and medical support.
- A major incident plan was accessible to staff at the main reception desk of the hospital. There were regular testing of fire alarms and fire evacuation drills were conducted four times a year. Monthly resuscitation scenarios were also carried out.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate the effectiveness of the outpatients and imaging departments.

- Treatment and care was provided in line with national guidance and processes were in place to update policies and procedures.

Good

Outpatients and diagnostic imaging

- The imaging department adhered to the Ionising Radiation (Medical Exposure) Regulations and to the Ionising Radiation Regulations 1999.
- All staff had received an annual appraisal of their performance and were supported with development opportunities.The hospital had procedures in place to monitor the competences of staff and medical practitioners.
- There was effective multi-disciplinary working in out-patients
- Staff were aware of their duty when obtaining consent, adhering to the Mental Capacity Act and consent was clearly documented in patient records.

Evidence-based care and treatment

- The National Institute for Health and Care Excellence (NICE) provides guidance on improving health and social care.NICE guidelines were reviewed monthly by the matron to ascertain which were relevant to the hospital.We saw minutes of the quality and safety meetings and departmental meetings where NICE guidelines were discussed.
- Guidance is provided by the Ionising Radiation (medical exposure) Regulations (IR(ME)R) for the safe use of radiological equipment.This includes guidance for operating procedures, incident reporting, training and equipment maintenance and medical physics' role.These IRMER procedures were accessible to staff on the hospital intranet and were reviewed annually.
- An internal quality audit had been conducted within the diagnostic and imaging department on 28 January 2015 assessing compliance with IRMER and Ionising Radiation Regulations 1999 (IRR99) and other quality measures.This was 99% compliant.
- Diagnostic reference levels had been obtained for all procedures.They were in line with national recommendations and were displayed in all imaging rooms.

Patient outcomes

- The hospital participated in the Patient Reported Outcome Measures (PROMS) data collection for hip and knee replacements, inguinal hernia repairs and surgical varicose vein removal.The hospital's adjusted average health gain for knee replacements and for hip replacement were within the expected range. Ten groin hernia patients reported improvements, two reported worsening health and four reported no change in health.
- All patients were followed up in outpatients and clinical outcomes recorded.

Competent staff

- The hospital had processes to ensure staff maintained their competencies in order to practice safely.
- The hospital had a system of monitoring staff appraisal rates and renewal of their professional registrations where required.Records demonstrated that 100% of nursing and care staff were up-to-date with appraisals.The hospital had validated 100% of nurses for their professional registration.Staff confirmed they had annual appraisals and were able to access further training.For example, staff were attending a pre-assessment course, ECG interpretation and a leadership course.
- Nursing staff told us that a journal club had recently started. 'Reflective practice' was to be discussed the following month.The club had commenced to help nurses provide evidence of ongoing learning as part of their revalidation process.
- Practising privileges and competencies of surgeons and anaesthetists were monitored using an electronic database. Medical practitioner files we reviewed confirmed that appraisal and revalidation information was available.

Multidisciplinary working

- We observed good multidisciplinary working with effective verbal and written communication between staff.Staff confirmed that there were good working relationships between physiotherapists, nurses, radiology staff and consultants.
- The imaging department had good links with the local NHS trust to provide staff with additional ongoing training.

Seven-day services

Good

Outpatients and diagnostic imaging

- The outpatients department was open Monday to Thursday between 8:30am and 9:30pm and 8:30am to 8:00pm on Fridays.The department was also open 8:30am to 1:30pm on a Saturday.
- The diagnostic and imaging department provided services 8:30 am to 9:00pm Monday to Friday.They also opened 8:30am to 1:00pm on Saturday.A radiographer was on call 24-hours a day to provide urgent services to the ward if needed.

Access to information

- Electronic access was available for pathology, microbiology and radiology results to enable timely access to diagnostic results.
- Discharge summaries from outpatient appointments were sent to GPs within 48-hours of the appointment. One patient we spoke to confirmed all follow-up letters were copied to them and their GP and were received within a couple of days. Radiology results were faxed across to GPs.
- There was a policy to report abnormal radiology findings directly to the consultants.
- The radiology department had a key performance indicator in place to produce reports within a maximum of five working days.They were meeting this target and producing reports within 48 hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duty when obtaining consent and ensured explanations were given in a way patients could understand. Patients felt they were given choice and understood the information provided for the decision-making. We saw that consent was clearly documented in the eight patient records we reviewed.

Are outpatients and diagnostic imaging services caring?

Good

We have rated this service as good for caring. This is because:

- Patients spoke highly of staff in outpatients and the imaging department.
- Patients described caring staff that were supportive and treated them with dignity and respect.
- We observed that staff were courteous, polite and friendly when responding to patients' individual needs.
- Patients told us they were given good explanations of their treatments and were given opportunity to ask questions.
- Patients spoke highly of staff in both outpatients and radiology.

Compassionate care

- We spoke with ten patients and four relatives within outpatients and the diagnostic and imaging departments.
- All the patients we spoke with were happy with the care they had received and were complimentary about the staff. One patient said, "It's brilliant here," another patient told us, "It is very good, very helpful and pleasant staff."
- All the patients told us that they were treated with dignity and respect. We observed that the reception staff maintained patient's privacy at the reception desk. Patients were greeted by the reception staff on arrival at the hospital and guided round to either outpatients or the imaging department. Patients told us they were always offered refreshments and current newspapers were available to read.
- Staff were seen to be available for patients if they needed any further support or chaperone before, during or after the consultation. We observed that there were chaperone posters displayed in reception.
- We observed that staff were polite, courteous and friendly with patients.
- The hospital participated in the Friends and Family Test for the NHS patients they treated with 85% of the responses stating they would recommend the hospital to their friends and family should they need similar care and treatment (April 2015 to July 2015.)Survey response rates were based on the hospital as a whole and outpatient survey results could not be identified.

Good

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- Patients told us that they were given clear explanations about their care and treatment. They said they did not feel rushed and were given time to ask questions. One patient said, “Any questions I asked were answered very well.”
- We observed nursing staff explaining a procedure to a patient, giving the opportunity to ask questions and offering contact numbers if they had any concerns.

Emotional support

- Patients told us they felt well cared for and supported and that staff were pleasant and friendly. One patient remarked that they were made to feel like a person, not a number.
- We observed that one patient who was distressed following their consultation was offered support by an outpatient nurse in a discreet and empathetic manner.

Are outpatients and diagnostic imaging services responsive?

Good

We have rated this service as good for responsive. This is because:

- There was timely access to appointments for patients within outpatients and radiology.
- Patients were able to choose appointment times, which were available in evenings and on Saturday mornings to enable people access out of working hours.
- Patients with special needs such as those living with dementia or with learning disabilities were fully assessed and information conveyed to ward staff to ensure their needs were met during their inpatient stay.
- Translators were booked in advance for appointments to assist patients whose first language was not English.
- Patient leaflets were available in different languages and in large print if required.
- Clinic rooms and toilets were accessible to those with mobility problems such as patients using wheelchairs.

Service planning and delivery to meet the needs of local people

- The out patient's sister met monthly with the clinical commissioning group to discuss service provision for NHS patients. We saw minutes of these meetings where quality and service deliver issues were discussed.
- The environment was appropriate and patient centred. There was sufficient seating available in the waiting areas where free drinks and newspapers were available.
- The signage to the outpatient and imaging departments was not immediately clear at the reception to the hospital. However, reception staff escorted all patients to the departments on arrival. There was no signage within the outpatient departments to assist patients to find the toilets or the way out.
- Car parking was freely available and patients told us they did not have problems finding a space. This meant if clinics were delayed parking arrangements were not effected
- Evening clinics in outpatients and the imaging department were provided Monday to Friday and Saturday morning clinics to enable patient’s access to appointments out of normal working hours.

Access and flow

- The hospital met the target of 95% of non-admitted NHS patients beginning treatment within 18 weeks of referral for each month in the reporting period October 2014 to September 2015.
- There were no waiting lists for patients to attend radiology and outpatient appointments with consultants. There was flexibility to extend clinics if consultants needed to see urgent patients.
- Both private and NHS patients were offered a choice of appointments. New patients were given 30-minute slots and follow-up appointments 15-minute slots.
- Patients told us they were mainly seen on time or within 10 to 15 minutes of their appointment. We were told that occasionally consultants were delayed in theatre at the NHS hospital where they worked. Patients were always informed of any delays and given the option to wait or re-book another appointment.

Good

Outpatients and diagnostic imaging

- Clinicians told us that the 'did not attend' (DNA) rate was very low and tended to relate to NHS patients. Patients were contacted and could rebook through the 'choose and book e-booking' system.
- The breast surgeon operated a 'one-stop clinic' whereby patients could have a consultation, mammography and aspiration during one appointment.

Meeting people's individual needs

- GPs were able to inform staff within outpatients of NHS patients with special needs, for example to be brought in on a stretcher, via the 'choose and book' online portal. A hoist was available to assist with patient transfers if required.
- Patients with special needs such as those living with dementia or patients with learning disabilities were flagged at the pre-assessment clinic. An in-depth assessment was carried, out in conjunction with the patient's family/carer, to ascertain their individual needs. This information was then conveyed to the ward staff to ensure patients' needs were met during their inpatient stay.
- Staff had access to interpreters to assist in communicating with patients whose first language was not English**.** Translators were booked in advance for appointments.
- Staff were able to print off patient education leaflets in different languages. They were also available in large print for patients with reduced vision.
- Clinic rooms and toilets were accessible to those with mobility problems such as patients using wheelchairs.

Learning from complaints and concerns

- Most patients we spoke with did not know how to make a complaint. Complaints leaflets were displayed at the reception area and the imaging department waiting areas.
- Any complaints received by the hospital were reviewed at the monthly heads of departments meetings, monthly governance meetings and MAC meetings. Outcomes, lessons learnt and improvements on practice were discussed at all these meetings. Action logs were developed to ensure that improvement was monitored.
- Records showed that there had been no complaints regarding outpatients October to December 2015.

Are outpatients and diagnostic imaging services well-led?

Good

Outpatients and diagnostic imaging services were judged to be well led.

- Both outpatients and imaging departments had a clear vision for their service.
- There were clear governance structures with evidence of incidents, complaints, the risk register and clinical outcomes being regularly reviewed.
- There was effective leadership with staff felt well supported.
- A patient focus group provided feedback on the quality of the service and facilities. We saw that the hospital was responsive and had taken actions to suggestions made.

Vision and strategy for this service

- The outpatient sister was able to describe a clear vision for the service.The outpatient department had been undertaking more procedures and had established a need for an ambulatory care centre.A business plan was currently being put together to address this.Staff were visiting other centres with ambulatory care centres to help develop their plans.
- The hospital had a set of EPIC values (enterprising, passionate, independent and caring.)We saw that staff demonstrated these values when providing care to patients.

Governance, risk management and quality measurement for this service

- There were clear governance structures within the outpatients and diagnostic imaging departments.Monthly departmental meetings and quarterly integrated governance meetings took place which fed into the medical advisory committee meetings.Minutes of these meetings showed that

incidents, complaints, the risk register and clinical outcomes such as unplanned transfers and returns to theatre and readmissions following surgery were discussed.

- There was one single hospital risk register which contain two risks pertinent to the outpatients and imaging departments.An ECG machine was broken in outpatients and they had to use one from another department.This risk has now been mitigated by trialling a new machine with plans to purchase four new machines.
- Within the imaging department the x-ray room was old and would soon require replacement.There was a corporate plan to roll out digital x-ray rooms and the hospital has requested that they be a priority site.Managers of both departments were able to articulate the risks documented on the risk register.
- The imaging department had just started working (within the past few weeks) with another organisation to provide MRI and CT services to patients.Equipment, staff and management of this service were provided to the hospital by the private organisation.We saw a service level agreement was in place which demonstrated that all of these staff would have to comply with Nuffield policies including mandatory training and reporting incidents. Monthly meetings had been arranged between the hospital and the provider to monitor the quality and delivery of this service.
- Following our announced inspection the trust forwarded an action log which identified areas for improvement, the action taken, who had responsibility, completion due date and outcome with assurance.During the unannounced inspection we met with members of the senior management team and reviewed this.We saw that actions had been taken including a new lock to the phlebotomy room and appropriate storage of radiology equipment.

Leadership / culture of this service

- All the staff we spoke with felt well supported and listened to by their managers.
- The matron visited the outpatient department on a daily basis and was accessible when needed.The matron knew the names of staff within the departments.
- The hospital director had an open door policy with monthly coffee mornings to which most staff we spoke with had attended.
- Staff talked of a supportive and caring work environment describing it as a family.Staff were motivated and were content and proud to work within the hospital.

Public and staff engagement

- The 'Friends and Family' questionnaires were handed out at reception to all NHS patients attending outpatients and the imaging department. There were no surveys for private patients who only attend for out-patient appointments.
- All patients (privately funded and NHS) who were admitted to have a procedure were given a hospital questionnaire. We saw that all feedback from the hospital patient satisfaction survey was analysed and an action plan developed to address improvements.
- A patient focus group was held quarterly throughout the year to provide feedback on the service and facilities at the hospital.Patient satisfaction surveys and quality assurance reviews were discussed at these meetings.We saw that actions had been taken by the hospital in response to feedback.For example approval had been obtained to alter the front desk at reception to ensure accessibility for wheelchair users.
- Staff engagement with the senior management team was done through a range of initiatives such as team meetings, coffee mornings and staff away days. Staff were encouraged to contribute ideas for improvements within their team meetings.For example staff had discussed which areas they required further update training and a schedule of training had been developed.

Innovation, improvement and sustainability

- As there was now a static CT and MRI scanner on site rather than mobile, the radiology service was proposing to develop services and provide procedures such as CT calcium scoring, CT guided biopsies and cardiac MRI which were previously not safe to do on a mobile scanner.

Good

Outpatients and diagnostic imaging

- The outpatient and imaging departments offered one-stop breast clinics where women saw the consultant, had their imaging and follow up on the same day (including biopsies if required.)
- When patients had prostate screening, MRI scans and biopsies were arranged on the same day.
- A CT colonoscopy service operated where patients get the results straight after the procedure.

Outstanding practice and areas for improvement

Outstanding practice

- As there was now a static CT and MRI scanner on site rather than mobile, the radiology service was proposing to develop services and provide procedures such as CT calcium scoring, CT guided biopsies and cardiac MRI that were previously not safe to do on a mobile scanner.
- The outpatient and imaging departments offered one-stop breast clinics where women saw the consultant, had their imaging and follow up on the same day (including biopsies if required.)

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that surgical safety procedures are consistently carried out in theatre and theatre documentation, observational audits are routinely carried out, and staff are made fully aware of the findings to provide ongoing assurance.
- The hospital should ensure that all medication is secure in theatre.

Action the provider SHOULD take to improve

- The hospital should ensure that learning from audits is disseminated to staff including the process, outcomes and the risk register progress.
- The hospital should ensure that the findings of the privacy, dignity and well-being 2015 PLACE score are addressed.
- The hospital should ensure that out of date radiology equipment is replaced as soon as possible.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. How the regulation was not being met: People who use services and others were not protected against potential risk as the provider was not doing all that was reasonably practical to mitigate risks. Surgical safety procedures were not being consistently carried out in theatres and theatre documentation and observational audits were not being carried out to provide assurance.