Nuffield Health Derby Hospital

Quality Report

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Date of inspection visit: 14, 15 and 28 October 2015
Date of publication: 06/05/2016

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Nuffield Health Derby Hospital on 14 and 15 October 2015 during our announced inspection. We also completed an unannounced inspection of the hospital on 28 October 2015.

The inspection was a comprehensive inspection, which was part of the CQC's programme of comprehensive, independent healthcare acute hospital inspections. We inspected medicine, surgery and outpatients and diagnostic imaging services.

Overall, we rated the hospital as 'Good.' We found surgery and outpatients and diagnostic imaging services were 'Good.' We found medicine services 'Required improvement';

Are services safe at this hospital

We found services at the hospital were safe:

- Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff were aware of Duty of Candour regulations and the requirements for them to discuss incidents where patients had been harmed in an open, honest and timely way with patients, providing explanations and apologies where required.
- Staff knew who their safeguarding lead was in the hospital; this was their matron or the deputy matron. Staff were aware of circumstances when they would need to raise safeguarding concerns and had access to contact details for local safeguarding agencies.
- Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Although there was the use of agency and bank, wherever possible the hospital used regular bank and agency staff.
- Resident Medical Officer (RMO) was available to all staff 24 hours a day, seven days a week. Consultants could be contacted for additional, specific support and advice for individual patients.
- Handover was scheduled at the end of each shift to ensure there was handover between RMO and consultants on site, as well as between medical and surgical staff and nursing staff.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.

Are services effective at this hospital

We found services at the hospital were effective:

- Care and treatments were planned and delivered in line with current evidence based guidance, standards and best practice legislation.
- New evidence-based techniques were used to support the delivery of high quality care and staff worked collaboratively to understand and meet the range of people's needs.
- We found policies and procedures were discussed by the senior management team, were progressed and ratified through the medical advisory committee (MAC) and the integrated clinical governance committee.
- Patient outcomes were audited and benchmarked within the hospital and in comparison to other hospitals in the Nuffield Health provider group.
- Where appropriate, services took part in national audits such as the national joint registry, surgical site infection rates and when appropriate the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The hospital had a formal revalidation process for doctors and nursing staff, including checks for professional registration and indemnity, training, appraisal, Disclosure and Barring Service (DBS). Doctors worked under practising privileges and had to provide information to the Hospital Director in order to maintain their privileges. The MAC provided assurance and support to individual doctors as required and identified by the hospital.

Summary of findings

- Not all staff had completed training in the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards. Staff were aware of requesting and speaking with patients about their consent for procedures, care and treatment.

Are services caring at this hospital

We found services at the hospital were caring:

- Feedback from patients was continually positive about the way staff treated people. Patients told us staff were polite, helpful and kind.
- Staff were highly motivated and cared for patients in ways which promoted their privacy and dignity.
- The hospital used a Friends and Family Test to ask patients and their families to rate the service, care and treatment they had received. This formed part of a broader Patient Satisfaction Survey which patients were asked to complete. This was audited by the hospital and compared with other hospitals in the Nuffield Health provider group.
- For outpatient and diagnostic imaging services, between May 2015 and August 2015, 95% of patients would recommend care at the hospital to others.
- For surgery services, during the period March 2015 to August 2015 between 79 and 92% of patients who responded would recommend Nuffield Health Derby Hospital to family or friends. The average percentage for other Nuffield Health hospitals was 89%.
- We were told of an example where staff had provided additional emotional support to a patient in a person centred way to ensure treatment could be given in a manner which protected the patient's dignity and privacy.

Are services responsive at this hospital

We found services at the hospital were responsive:

- The hospital planned services to meet the needs of its patients in the local area and for individual patients.
- For surgery services, the hospital had a policy which outlined the inclusion and exclusion criteria for patients. Patients with an American Society of Anaesthesiologists (ASA) physical status score of four were excluded. The patients admitted to the hospital had an ASA score of one to three. These patients were generally healthy or suffered from mild systemic disease.
- Waiting times, delays and cancellations were managed appropriately to minimise delays and waiting times for patients.
- Departments had 'dementia champions', staff who were the lead for patients living with dementia and who could provide additional information and support to colleagues.
- The Resident Medical Officer was available at all times to provide assistance and support.
- The hospital had good liaison with the neighbouring NHS trust, which provided some out of hours support.
- Complaints and concerns were taken seriously and responded to in a timely way. Feedback and learning from complaints had been shared and changes made as a result of complaints. For example, outpatients leaflets had been redesigned and reworded following a complaint.

Are services well led at this hospital

We found services at the hospital were well-led:

- The hospital had a clear vision and strategy, in line with the Nuffield Health provider values of Enterprising, Passionate, Independent, Caring (EPIC).
- The senior management team and other levels of governance within the organisation functioned effectively and interacted with each other appropriately.
- The Hospital Director and chair of the MAC worked together to ensure doctors working under practising privileges were appropriately monitored and their practising privileges to continue working at the hospital were routinely reviewed.

Summary of findings

- The service was transparent and leaders at every level prioritised high quality compassionate care. There was a positive staff culture where innovation was supported.
- The endoscopy services were working towards achieving Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) accreditation.
- Surgery services had introduced a new anaesthetic procedure, called targeted spinal anaesthesia.

Our key findings were as follows:

- The overall leadership of the hospital was good; staff felt able to discuss improvements for their patients and services, to raise concerns and felt part of the hospital team.
- We found the hospital was visibly clean. The hospital senior management team confirmed a programme of refurbishment was on-going to update areas of the hospital which had been identified as needing redecoration.
- We found staffing levels were safe and met the needs of patients. Where bank or agency staff were used, the hospital tried to ensure these staff were used on a longer term basis to provide continuity of patient care.
- We found staff cared for patients and provided them regularly with meals and drinks.

We saw several areas of outstanding practice including:

- The hospital had introduced a new anaesthetic procedure. Patients undergoing certain surgical procedures were given a short-acting spinal anaesthetic using different local anaesthetic based on the time required for the surgery this was called targeted spinal anaesthesia. The effect of this anaesthesia only lasted for the duration of the procedure which meant patients were able to start moving around immediately, were able to eat and drink immediately and could be discharged sooner. This was beneficial for patients, such as those with diabetes, who needed as short a time as possible without being able to eat and drink.
- The hospital had recently introduced "The Nuffield Health Promise" for self-funded patients. This enabled patients to have further care and follow ups at no extra cost if their expectations had not been reasonably met.
- Prior to a patient going into the anaesthetic room, patients were taken to a 'quiet room'. Patients were introduced to the surgical team. A handover of the patient from the ward nurse to the theatre staff including the patient took place in this room; the patient was involved in the whole process and put at ease.
- During the Five Steps to Safer Surgery safety checklist in the operating theatre, patients who were anesthetised were 'introduced' to the team by their full name, for example, 'team let me introduce to you', and this was respectful of the patient.
- The hospital's cancer services offered a range of therapies to cancer patients without any extra charge. Patients could have up to six treatments, such as massages or eyebrow tattooing.
- We were given a positive example of staff going out of their way to protect the dignity and privacy needs of a patient with learning disabilities. The hospital had recognised the patient needed to be brought into the hospital in a special way involving extra staff. We were told how it was dealt with in a person centred way by all staff to ensure treatment could be given in a manner, which protected their dignity and privacy.

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

Importantly, the provider MUST:

- Ensure that performance monitoring, quality dashboards and patient outcome measures are in place in endoscopy and cancer services.
- Ensure that service specific policies are fully developed and understood for cancer services.
- Ensure that patient outcomes are reported and used to inform the endoscopy and cancer services.

Additionally, the provider SHOULD:

- Ensure all staff are aware of and understand their responsibilities in relation to the hospital major incident and business continuity plans.

Summary of findings

- Review the use of the step down unit in order to comply with the clinical commissioning arrangements and Department of Health same sex accommodation guidance.
- Ensure all staff are aware of and know the requirements in relation to The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.
- Ensure staff complete all mandatory training, including in The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.
- Ensure all risk assessments in patients records are up to date and accurately reflect the patient's current condition.
- Review the arrangements for the borrowing of the defibrillator from the ward by other departments.
- Ensure local and national guidance, policies and procedures used in the delivery of care and treatment are current, especially on the step down unit.
- Increase the local understanding and routine completion of monitoring incidents in the outpatients department.
- Consider ensuring patient information leaflets are easily and readily available in languages other than English.
- Ensure the hospital's local risk register is updated and reflects risks identified by services and departments at the hospital.
- Ensure appropriate storage, management of information governance and patient confidential information is maintained when consultants remove notes from the hospital.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Requires improvement 	The environment and equipment were kept visibly clean. There were safe levels of staffing. Staff risk assessed patients to minimise harm and there were safe arrangements for medicines. Staff understood when to report incidents and the services had systems to enable them to learn when things went wrong. Not all patient outcomes in endoscopy were monitored. The staff used patient satisfaction feedback to monitor outcomes, but did not have a formal suite of performance indicators. The service had not fully developed an openly reported performance and quality dashboard for each service. Most staff we spoke with lacked awareness and understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff in cancer services and endoscopy were caring and compassionate. Services were adapted for some people, including patients with diabetes. The hospital offered free services to cancer patients, such as massages and eyebrow tattooing. The hospital's complaints procedure was clear. However, patient information was only readily available in English. The services had not fully developed some key policies, such as the overall policy for cancer services. The services had not fully developed an openly reported performance and quality dashboard for each service. Working arrangements with partner organisations were not fully formalised. Staff felt leaders were approachable and effective
Surgery	Good 	Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Systems, processes and standard operating procedures in infection control,

Summary of findings

medicines management, patient records and, the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
Care and treatments were planned and delivered in line with current evidence based guidance, standards and best practice legislation. New evidence-based techniques were used to support the delivery of high quality care and staff worked collaboratively to understand and meet the range of people's needs.
Patients were truly respected as individuals and were empowered as partners in their care.
Feedback from patients was continually positive about the way staff treated people.
The needs of different people were taken into account when planning and delivering services.
Waiting times, delays and cancellations were minimal and managed appropriately. Complaints and concerns were taken seriously and responded to in a timely way.
The leadership, governance and culture promoted delivery of high quality person centred care. There was a clear statement of vision and values. The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. There was a positive staff culture where innovation was supported.

Outpatients and diagnostic imaging

Good

There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse. Risks to patients were appropriately assessed and care and treatment was delivered following evidence based guidance.
The hospital had access to a radiation protection supervisor and radiation protection adviser in accordance with the ionising radiation (medical exposure) regulations. Practices and systems were in accordance with the legislation.
Care delivered by the hospital staff was in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Consent to care and treatment was obtained in accordance with legislation and guidance.
Patients told us that they were treated with dignity and respect and were involved in their care.

Summary of findings

Staff were appropriately qualified to provide effective care and treatment. However, we found not all staff had completed safeguarding adults (level two) training or training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
Patients had timely access to appointments and treatments. Leaflets were visible on how to make a complaint and patients felt confident that they could discuss their concerns with staff.
We witnessed supportive management and a culture of teamwork throughout the department. Staff were proud of the service that they provided and enjoyed working at the hospital.

Summary of findings

Contents

Good

Nuffield Health Derby Hospital

Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Derby Hospital

The hospital is part of the Nuffield Health provider group of independent acute hospitals. The hospital opened in October 1981. The hospital provides care and treatment to NHS funded and self-funded (insured or self-paying) patients in Derby and the surrounding areas.

There were 38 inpatient, single occupancy bedrooms and an additional four beds in a step down unit, for patients who require more observation post surgery. The hospital offers a range of surgical and medical procedures including Oncology, Diagnostic Imaging, Refractive Eye Surgery and Endoscopy.

We inspected the Nuffield Health Derby Hospital on 14 and 15 October 2015 during our announced inspection. We also completed an unannounced inspection of the hospital on 28 October 2015.

At the time of our inspection, the hospital's Registered Manager had been in post since February 2015.

Our inspection team

Our inspection team was led by:

Inspection Lead: Yin Naing, Inspection Manager, Care Quality Commission

The team included five CQC inspectors and a variety of specialists, including a radiographer, a specialist oncology nurse, a matron and a consultant anaesthetist.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the hospital.

Why we carried out this inspection

The inspection was a comprehensive inspection, which was part of the CQC's programme of comprehensive, independent healthcare acute hospital inspections. We inspected medicine, surgery and outpatients and diagnostic imaging services.

How we carried out this inspection

Before we visited, we reviewed a range of information we held about Nuffield Health Derby Hospital and asked other organisations to share what they knew. We carried out an announced visit on 14 and 15 October 2015. We carried out an unannounced visit on 28 October 2015.

During the visit we talked with staff and patients. We observed how patients were being cared for and talked with carers and/or family members and reviewed care or treatment records of patients. Patients and their families shared their views and experiences of the hospital with us.

For medicine, endoscopy and cancer services, we spoke with two patients and two accompanying relatives. We spoke with 11 staff including nurses, consultants and supporting staff.

Summary of this inspection

For Surgery, we spoke with 14 patients. We spoke with 33 staff including nurses, consultants, anaesthetists, student nurses, operating department practitioners, therapy, porters and supporting staff. We also interviewed senior managers.

For Outpatients and Diagnostic Imaging, we spoke with 11 patients and one relative. We spoke with eight staff who worked in this service.

Information about Nuffield Health Derby Hospital

The hospital had three theatres, two of them with laminar flow. All three theatres were open 8am till 8pm, Monday to Friday. Non laminar flow General Theatre and Laminar flow Orthopaedic Theatre 3 were open occasionally on Saturdays when required. Laminar flow Orthopaedic Theatre 2 was open 8am to 4pm on Saturdays.

There were 4,863 visits to the theatre between July 2014 and June 2015. The five most common procedures performed accounted for 1,748 visits to theatre, 36% of all theatre procedures. The five most common procedures were:

- Injection(s) into joint(s) without X-ray control (508)
- Primary total hip replacement with or without cement (369)
- Prosthetic replacement of knee joint, with or without cement (360)
- Phacoemulsification of lens with implant – unilateral (322)
- Arthroscopic meniscectomy (including debridement) (189).

The hospital had 4,873 episodes of inpatient activity between July 2014 and June 2015. There were a total of 1,810 overnight inpatients and 3,063 day case inpatients during this time period.

Outpatient activity between July 2014 and June 2015 was 21,097. The majority of outpatient activity was completed for self-funded patients (insured or self-paying).

The hospital provided inpatient and outpatient care and treatment for a total of 25,970 patients. The majority of these were for self-funded patients; 21,185 (82%). A total of 4,785 (18%) NHS funded patients were treated by hospital staff.

The hospital had 213 doctors working under practising privileges. The hospital employed 39.4 whole time equivalent (WTE) nurses, 10.9 WTE Operating department practitioners (theatre) and 17.2 WTE Care assistants. An additional 13.5 WTE allied health professionals were employed and a total of 52.1 WTE administrative and other staff.

The Accountable Officer for Controlled Drugs (CDs) was the Registered Manager and had been since 1 April 2015.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.
2. We have deviated from current published ratings principles for this hospital. This was because medicine services were very small compared with the other core services within the hospital.

Requires improvement

Medical care

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

Information about the service

Our inspection of medical care covered the hospital's endoscopy and cancer services.

Most endoscopy procedures performed at the hospital were completed on a day case basis. Between July 2014 and June 2015; 307 gastroscopies, 301 laryngo-pharynoscopies, 215 diagnostic colonoscopies and 203 sigmoidoscopies were completed. Most of these procedures took place in Theatre 1 of the hospital, with the exception of some sigmoidoscopies and all laryngo-pharynoscopies, which were outpatient's procedures. A team of three qualified nurses offered support to the consultant performing the endoscopy.

The cancer service was small and treated 20 patients from July 2014 to June 2015. The service treated patients with breast, bowel, upper gastrointestinal, prostate and haematology related cancers. It was based in the Bamford Suite, a day case unit with eight cubicles. The service started in 2013 and was staffed by a lead oncology nurse. Two ward nurses provided cover when necessary.

We spoke to five nurses, four managers, two consultants, two patients and two relatives of patients during our inspection.

Summary of findings

We rated the endoscopy and cancer services as good for 'safe'. Both services had a track record of safety for patients. The environment and equipment were kept visibly clean. There were safe levels of staffing. Staff risk assessed patients to minimise harm and there were safe arrangements for medicines. Staff understood when to report incidents and the services had systems to enable them to learn when things went wrong.

However, there was no safety thermometer or quality dashboard in cancer or endoscopy services. In endoscopy and cancer services, risk assessments in medical records were not always fully completed. Below management level, there was a limited understanding of what to do in an emergency.

We assessed 'effective' as requires improvement. Not all patient outcomes in endoscopy were monitored. The staff used patient satisfaction feedback to monitor outcomes, but did not have a formal suite of performance indicators. The service had not fully developed an openly reported performance and quality dashboard for each service. Most staff we spoke with lacked awareness and understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff in cancer services and endoscopy were caring and compassionate. There was a support group for cancer patients and staff offered emotional support to family members. Endoscopy patients were given privacy before their diagnostic procedures and treated with dignity and respect.

Requires improvement

Medical care

We rated the responsiveness of medical care services as 'good'. Services were planned in line with the needs of local people and were suitable for the needs of all communities. They could be accessed in a timely way. Services were adapted for some people, including patients with diabetes. The hospital offered free services to cancer patients, such as massages and eyebrow tattooing. The hospital's complaints procedure was clear. However, patient information was only readily available in English.

The leadership for these services required improvement. The services had not fully developed some key policies, such as the overall policy for cancer services. The services had not fully developed an openly reported performance and quality dashboard for each service. Working arrangements with partner organisations were not fully formalised.

Are medical care services safe?

Good

We rated the services as good for 'safe'. We found;

- Both endoscopy and cancer services had a track record of safety.
- The environment and equipment were kept visibly clean.
- There were safe levels of staffing.
- Staff risk assessed patients to minimise harm.
- There were safe arrangements for medicines.
- Staff understood when to report incidents and the services had systems to enable them to learn when things went wrong.

However we found the following;

- There was no safety thermometer or quality dashboard in cancer or endoscopy services.
- In endoscopy and cancer services, risk assessments in medical records were not always fully completed.
- Below management level, there was a limited understanding of what to do in an emergency.

Incidents

- There had been no serious incidents or Never Events for endoscopy or cancer services from July 2014 to July 2015.
- The services had processes to learn from incidents. For example, a patient had a suspected cardiac episode after a colonoscopy and had to be transferred to a neighbouring NHS trust. Staff and clinicians were investigating the incident when we inspected. Endoscopy staff told us that the immediate learning had been shared with them.
- The hospital had a standard operating procedure, updated in 2015, on the reporting and management of adverse events. This included how to investigate and how to share learning, but was not explicit about how to let the person reporting the incident know about action taken.
- Staff understood their responsibility for raising concerns, recording safety incidents and reporting them

internally and externally. All nurses and healthcare assistants in endoscopy and cancer services completed an e-learning training module to understand how to use the electronic incident reporting system.
- Staff told us that management listened if they had concerns about safety. Nurses told us that if they were concerned about staffing or bed capacity issues, then management would listen and take action.
- Staff in both services had an understanding of the ' Duty of Candour' regulation. They told us that they understood the 'Duty of Candour' as the legal requirement for health workers to be 'open and honest.' However, they did not receive formal Duty of Candour training. They could not think of an incident when they had the opportunity to apply the Duty of Candour.

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

- A safety thermometer is a tool used to record four common, and largely preventable, harms to patients: pressure ulcers, falls, urinary tract infections in patients with a catheter and new venous thromboembolisms (VTE blood clots). The safety thermometer provides information for frontline teams to monitor their performance and to make improvements to eliminate patient harms. The services did not monitor or record this data.
- Endoscopy services did not have a specific quality dashboard. Cancer services staff told us they did not have a quality dashboard.

· The hospital's VTE (blood clot) screening for all patients was consistently 100% in the reporting period July 2014 to June 2015. The NHS target for this is 95%.

Cleanliness, infection control and hygiene

- The Bamford Suite, which was used for cancer services, had its own housekeeping team. Infection control staff carried out independent audits.
- Cancer services aimed to improve infection control. Audits had shown problems with dust in air vents in the Bamford Suite. The service had worked with maintenance staff to resolve the issue and plan a cleaning routine. The service had a quality improvement action plan. This included cleanliness actions such as: finding an area for clean linen, clearing out a cluttered bay and redecorating the ward with antibacterial paint.
- Endoscopy equipment and theatres were visibly clean. Theatres and theatre equipment were cleaned between each patient. There was a system for ensuring equipment was clean and ready for use, for example 'I am clean' stickers. These were clearly visible, dated and signed appropriately. There was a deep clean in theatres twice a year.
- The hospital had modern specialist equipment to wash endoscopes. The water in the machine was tested weekly. The equipment supplier trained the endoscopy team on using the equipment and there were annual mandatory updates. The lead nurse went on a 'decontamination for managers' course, run by the equipment supplier. There was a maintenance contract for the equipment. Staff told us that the endoscopy machine was reliable but they had a reciprocal arrangement for back up with another, local Nuffield Hospital in case of breakdown.
- Endoscopy staff tagged individual endoscopes with a patient identification. This helped ensure hygiene and traceability.
- Cleansing gel was available at the entrances to each area and in each room: patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively. Staff were 'bare below the elbow' to allow effective hand washing.
- Hand hygiene was audited monthly. When we reviewed the hand hygiene audit, we found a small number of consultants in theatres were not washing their hands at important stages of patient care. The hospital was addressing this by making it a condition of practising privileges.
- For patient-led assessments of the care environment (PLACE) audits the hospital scored over 99 % for cleanliness, above the national average of 98%.
- The hospital had no incidences of Clostridium Difficile (C diff) or Methicillin Resistant Staphylococcus Aureus (MRSA) during the year up to our inspection. It screened all patients for the infections.

Environment and equipment

- The endoscopy service had high quality, high definition camera equipment installed in 2012. These machines were regularly maintained. The information captured during endoscopy enabled safe and effective management of endoscopy patients. Hospital staff were

learning how to use it to provide key clinical performance indicators as used by Global Rating Scale (GRS) and the British Society of Gastroenterologists (BSG). The reporting function provided high quality images to inform clinical decisions and could initiate follow up for patients three years in advance.
- The hospital had all necessary safety monitoring equipment in theatre including blood pressure, heart rate and pulse monitoring as well as an anaesthetic machine should the patient need it.Staff checked these daily.
- We checked the resuscitation trolley in the theatre area and it was checked and signed daily. The contents were within the date limits specified on their packaging.

Medicines

- The lead oncology nurse kept chemotherapy drugs and controlled drugs in a locked cupboard in a room with keypad entry in the Bamford Suite. Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register. There was a standard operating procedure for cancer services and a procedure for dispensing and checking drugs.
- The hospital had processes to ensure that prescribing was safe. The hospital pharmacy reported one drug related incident in the last year when a consultant prescribed a milligram extra of a chemotherapy drug. The pharmacist noticed the error and contacted the consultant to amend the dose. The patient received the correct amount of chemotherapy drug.
- In theatres, staff stored controlled drugs and those requiring cool storage appropriately. We saw records of daily checks of the fridge temperatures.

Records

- Records were not always fully completed. We reviewed three sets of endoscopy records. The drug charts, pain section and early warning scores were mostly clear and completed. However, none of the records had completed nutrition sections and two out of the three did not have completed falls and VTE sections. We highlighted this to staff, who reviewed and completed the sections straight away.
- We reviewed three patient records for cancer services. They contained completed falls, early warning systems and pain assessments, but none of the records contained details on nutrition or pressure ulcer risks. Although oncologists communicated issues back from the local NHS hospital to clinics and key people in the service by email and letter, we did not find information from the NHS acute hospital multidisciplinary team included in the patient notes.
- The hospital had a system to track patient's notes between the outpatient's department, pre-assessment and the medical records departments. Any patients who arrived via outpatients would have their notes automatically tracked. The services kept patient records securely locked in offices.

Safeguarding

- Endoscopy and cancer staff received safeguarding of vulnerable adults training (level two) as part of their mandatory training. This was updated and repeated every year. Completion rates were on average 88%. This was above the Nuffield target of 85% but below the hospital target of 90%.
- There were no safeguarding incidents reported in either cancer or endoscopy services.
- Most staff demonstrated an awareness of potential safeguarding issues and procedures to follow for suspected or alleged abuse. Staff told us who the safeguarding lead was for the hospital, so they knew where to seek advice.
- There was a safeguarding and protecting vulnerable people policy and procedure. This included guidance on safeguarding adults and a senior named nurse lead for safeguarding for adults. There were flow charts to assist staff in the safeguarding process and contact numbers for the local authority safeguarding team.

Mandatory training

- Mandatory training for cancer and endoscopy staff was wide-ranging. It included a variety of modules, including moving and handling, infection control, fire and resuscitation. The lead oncology nurse was trained on consent, the Mental Capacity Act and Deprivation of Liberty standards.
- Mandatory training data showed a varied but high completion rate of between 90% and 100% for the core modules.
- The hospital introduced a new learning management system in July 2015. When fully established this would track each staff member's training record and managers would be able to monitor training requirements and

attendance. At the time of our inspection, departments held their own training records, which provided a limited corporate organisational overview of staff mandatory training.

Assessing and responding to patient risk

- Staff told us that the hospital would only take patients if the services had the capacity to carry out their procedures safely. The hospital had a policy of not taking complex cases. However, there were no service specific risk registers for endoscopy or cancer services. There was potential for a more rigorous assessment of risks.
- Cancer and endoscopy services had a systematic approach to the response to risk. They used an early warning score system for patients whose health was deteriorating. The hospital used the Modified Early Warning System (MEWS) which records certain indicators to identify deterioration in a patient's clinical status. This helped identify when more care and treatment was needed.
- The hospital had an agreement to transfer deteriorating endoscopy patients to an alternative acute hospital. For example, if a patient had oesophageal varices (enlarged veins in the oesophagus) they would be transferred to a larger endoscopy unit within a local NHS acute trust.
- The hospital had procedures to risk assess patients for sedatives, pain relief or anaesthetic. It had a draft sedation policy which outlined responsibilities for ensuring patient's safety. They were following these procedures when we inspected.
- The cancer service used a UK Oncology Nursing Society nationally recognised traffic light triage tool to assess patients who rang them for advice. This meant that they could prioritise and risk assess patients. They referred them to the local NHS acute trust if patients were becoming seriously ill.

Nursing staffing

- Nurse staffing for cancer services delivered care for small numbers of patients. The lead oncology nurse and ward charge nurse staffed the service along with a breast care nurse and a health care assistant. They told us that two nurses would care for a maximum of two patients. They covered for each other and told us that if there were demands on the ward and in the Bamford Suite, cancer services took priority.
- The hospital provided specialist nursing for endoscopy. A team of two qualified nurses and a health care assistant supported the endoscopy service. Theatre staff were also available to help with sedation or general anaesthetic if necessary. An operating department practitioner was always available to check equipment and prepare the theatre.
- There were low levels of staff turnover for nurses and healthcare assistants in the hospital generally (14% for nurses in Inpatient departments). In cancer services and endoscopy there were no leavers between September 2014 and September 2015.

Medical staffing

- There were 213 consultants who had been granted practising privileges at the hospital. The majority of these worked at local NHS trusts. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there.
- There were four clinical oncology consultants and eight endoscopists with a further 13 consultant surgeons who undertook endoscopy as part of their practice.
- Clinicians told us they remained available and close to the unit for at least 30 minutes after endoscopy procedures.
- If further medical input was required at the hospital, for example consultants who specialised in care of patients with diabetes, this was provided by one of the other doctors with practising privileges at Nuffield Health Derby Hospital.
- Out of hours, if a patient who had been discharged following endoscopy and subsequently whose condition deteriorated, the patient would normally return to the hospital for review and further treatment where appropriate. The hospital had an out-of-hours rota for clinical staff, and consultants provided 24-hour cover for their patients post-operatively. The provider told us this may result in an additional operating theatre being opened out of hours.
- If however, a patient's condition deteriorated to the point where the most appropriate location for treatment was the local NHS trust, an agreed transfer protocol was in place between Nuffield Health Derby Hospital, the local NHS trust, local ambulance services and the Mid Trent Critical Care Network.

Requires improvement

Medical care

- Nursing staff told us consultants could be contacted if required and the Resident Medical Officer (RMO) was on site 24 hours a day, seven days a week for additional, specific advice as needed.
- There were systems, processes and standard operating procedures to support effective handover between the resident medical officer, consultants and other clinical staff. They were mostly reliable and appropriate to keep patients safe.

Major incident awareness and training

- The hospital had a major incident plan. This outlined the process for managing and coordinating the hospital's emergency response in the event of such a major external incident. Most staff we spoke with were neither familiar with these plans nor trained to respond to major incidents.
- Routine fire drills took place, this allowed staff to rehearse their response in the event of a fire.
- Monthly tests took place of the backup generator to ensure it was in working order.

Are medical care services effective?

Requires improvement

We assessed this as requires improvement. We found;

- Not all patient outcomes in endoscopy were monitored. The staff used patient satisfaction feedback to monitor outcomes, but did not have a formal suite of performance indicators.
- The service had not fully developed an openly reported performance and quality dashboard for each service.
- Most staff we spoke with lacked awareness and understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

However;

- Services were delivered around good practice guidance. The use of technology in endoscopy enhanced the effectiveness of services.
- There were good arrangements around nutrition and pain relief.
- Staff were competent to deliver care. They sought patient's consent to care and provided them with information on chemotherapy side effects and how long sedation for endoscopy would last.

Evidence-based care and treatment

- Staff delivered care and treatment and the hospital's draft endoscopy policy, were based on National Institute for Health and Care (NICE) and British Society of Gastroenterology guidelines. Medical staff told us they discussed NICE guidelines at clinical meetings; minutes of these meetings reflected this. However, the hospital recognised that there was still work to do to develop and update endoscopy specific policies. They aimed to ensure a standardised approach to endoscopy based on good practice.
- The endoscopy service used technology to enhance care and treatment. The Nuffield Group aimed to achieve JAG (Joint Advisory Group for Gastrointestinal Endoscopy) accreditation. This accreditation recognises high levels of clinical quality, training and patient experience. The hospital invested in new endoscopy camera equipment in 2012. In 2014 it installed an endoscopy image capture and reporting system. This system stored endoscopy images, patient details and collated data to inform GPs about the endoscopy. It tracked the entire patient pathway and could monitor patient outcomes. This meant that it could provide information for auditing and management of adverse events.
- The cancer service had a range of policies and procedures. It adopted some East Midlands Cancer Network arrangements such as their cytotoxic policy. It also had a policy for sepsis, cannulation, and a procedure for extravasation (accidental leakage of chemicals outside the veins.) This ensured that patients received treatment in line with good practice.
- There was no overall policy for the treatment of cancer patients, nor cancer pathways. The lead oncology nurse had started to develop the policy.
- The cancer service also sought to improve its services by comparing them to other Nuffield hospitals, for example where patients were offered an option to stay overnight in emergencies. The lead oncology nurse was interested in learning about this aspect of service because patients did not currently have the option of staying overnight at Derby.

Pain relief

- Nurses assessed patient's pain on admission, but there was no specific pain tool to help with this assessment. Nurses recorded pain relief in five out of the six sets of notes we reviewed, showing that it was recorded in most cases.
- Cancer patients told us that nurses dealt with pain quickly and effectively.
- The endoscopy service collected survey data from patients between October 2014 and June 2015, and found that 61 out of 64 patients said that they were not in any pain or that their pain was well controlled. The remaining three patients said that their pain was controlled to some extent. The service used a range of sedatives and analgesics to control pain.

Nutrition and hydration

- A dietician was available for cancer patients. Cancer patients told us catering staff offered them appetising food.
- The hospital's pharmacy gave instructions in clear English on bowel preparations before endoscopic procedures. This included how much water to drink, what type of food to eat and when to fast. They checked these instructions with endoscopy consultants. They updated the text regularly as a result of patient feedback.
- The hospital screened most patients for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).

Patient outcomes

- Not all patient outcomes in endoscopy were monitored. The service monitored colonoscopy outcomes to collect data for the colonoscopy outcomes audit, for example polyp detection. It collected data for completion rates in line with JAG standards. It reported unplanned admissions following diagnostic endoscopy to the clinical governance group However, it did notcapture and audit re-admissions or 30 day outcomes.
- The cancer service tracked outcomes through regular follow up appointments with the oncologist and scans. The staff used patient satisfaction feedback to monitor outcomes, but did not have a formal suite of performance indicators.
- The cancer service participated in local audits. The hospital audited cancer services in September 2014. This audit was used to ensure that services were at a safe level.
- In theatres, we saw a rolling audit plan, including theatre audits, information governance and medication. They used the results of these to inform areas for improvement.

Competent staff

- The services identified learning needs through the appraisal process. The percentage of staff having an appraisal in 2014 was around 96%. We reviewed three appraisal documents for nurses and found them fully completed. They contained both personal and standard corporate objectives in line with the hospitals values.
- Nurses working with patients with cancer had appropriate skills for their role. They followed accredited chemotherapy courses with relevant providers. They completed secondary training with the local NHS acute trust. The lead oncology nurse was also trained in breaking bad news. They also planned to receive training in counselling to further improve their skills.
- Both pharmacists had British Oncology Pharmacy Association (BOPA) accreditation for dispensing chemotherapy drugs. They had listed competencies for locum pharmacists who might be required to provide cover in future. They were trained in how to deal with cytotoxic spillages. The lead pharmacist was also doing a diploma in oncology.
- New staff had an induction relevant to their role. One new nurse said the induction was informative. Staff told us there was a flexible approach to the induction period and that managers negotiated the length of induction with each staff member individually.
- Consultants worked under practising privileges in the same speciality as in their NHS hospital role. There was a robust process in place for granting practising privileges, which included an interview with the hospital director. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there. In line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's name.

Multidisciplinary working (in relation to this core service)

Requires improvement

Medical care

- Multidisciplinary teams (MDTs) discussed cancer patients at the local NHS acute trust. The cancer service did not always receive the evidence and clinic letters from the MDT in a timely way. It reported that joint working was good and that communication was getting better.
- The cancer service offered referral via the local NHS acute trust to benefits, services and to Social Services for ongoing counselling, if the patient felt they needed it. They could also access psychiatric help.
- The cancer service ran a one-stop breast clinic, where patients could access medical advice and prosthesis fitting.

Seven-day services

- The hospital offered cancer services and most types of endoscopy as day procedures. Cancer services and on-call advice were available from 8am to 6pm on weekdays. A partner organisation, Healthcare at Home, or the local NHS trust assisted patients out of hours.
- If cancer patients became ill between visits to the hospital, the hospital had a day time helpline to offer advice. At night, this advice line was transferred to a partner organisation, Healthcare at Home. If the illness was serious, the patient would attend the local NHS trust. The service reported that patients used the helpline frequently.
- Routine access to endoscopy procedures was during normal theatre opening hours from 8am to 8pm, and occasionally at the weekend.
- Out of hours, if a patient who had been discharged following endoscopy and subsequently whose condition deteriorated, the patient would normally come back to the hospital for review and further treatment where appropriate. The hospital had an out-of-hours rota for clinical staff, and consultants provided 24-hour cover for their patients post-operatively. The provider told us this may result in an additional operating theatre being opened out of hours.
- If however, a patient's condition deteriorated to the point where the most appropriate location for treatment was the local NHS trust, an agreed transfer protocol was in place between Nuffield Health Derby Hospital, the local NHS trust, local ambulance services and the Mid Trent Critical Care Network.
- Drugs were available out of hours via the hospital's pharmacy, if a patient needed these.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- The endoscopy reporting system facilitated storage of patient data and collected data for the results and care plan to be sent to the patient's GP. In cancer services, the oncology secretary sent out letters to surgeries and to the local NHS acute hospital for information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff gave patients time to think about consent. Before the endoscopy procedure, a nurse took the patient to a small 'quiet room' on the way to theatre to explain the endoscopy and to ask again for their consent. The consent process included informing patients that their cognition would be impaired after sedation. It gave the patient a chance to discuss any issues in a private, calm environment.
- We reviewed cancer patient notes to see if staff had explained side effects to them. They were not explicit about which potential side effects, but just contained a comment saying 'explained.'
- Staff told us patients lacking capacity to make an informed decision about procedures were extremely rare. Staff would identify these patients at pre-admission stage. A specific consent form was available for adults who were unable to consent to investigation or treatment. In these cases, clinicians made a decision in the patient's best interests, in line with Mental Capacity Act 2005.
- Hospital data showed on average 74% of staff had received training about the Mental Capacity Act 2005 and an average of 73% in the Deprivation of Liberty Safeguards. This was significantly lower than the Nuffield target of 85% and the hospital target of 90%. Most staff we spoke with lacked awareness and understanding of the requirements of this legislation.

Are medical care services caring?

Requires improvement

Medical care

Good

We rated caring as 'good'. We found;

- Patients and those close to them were treated with dignity and compassion.
- There was a support group for chemotherapy patients and staff offered emotional support to family members.
- Endoscopy patients were given privacy before their diagnostic procedures and treated with dignity and respect.

Compassionate care

- Patients were appreciative of the cancer service and chemotherapy care. We spoke to two patients, one of whom described the cancer service in the Bamford Suite as, "very caring" and the second patient told us, "[it was] like having an arm around you." Care was tailored to meet patients' needs. The service offered continuity of staff and a drop-in service and telephone advice service if patients had any queries.
- Patients told us that cancer nurses were highly observant about symptoms when introducing chemotherapy drugs. They made necessary adjustments to ensure that patients were as comfortable as possible.
- The lead oncology nurse chaperoned patients through various stages of their treatment. She made herself available to accompany patients if they were likely to hear bad news following a diagnostic procedure or operation. She offered advice and support and patients told us that they appreciated this personalised care.
- Patient survey results for cancer services showed that patients were satisfied or very satisfied with treatment. They said that the service saw them within short timescales.
- Endoscopy services surveyed patients every six months about their experience of the service. We saw results from 64 patients surveyed from October 2014 to June 2015 and they all responded that they were always treated with dignity and respect. They responded that staff managed their pain adequately.
- For colonoscopy and sigmoidoscopy (lower bowel endoscopy) patients, staff offered them a choice of 'dignity shorts' or net underpants to wear with theatre gowns.

Understanding and involvement of patients and those close to them

- We spoke to two families at the cancer service support group, who felt involved in the care of their loved ones. They were on first name terms with the lead oncology nurse and other cancer nurses.
- Cancer patients told us staff informed their partners about likely symptoms and dealt with their emotional needs with empathy.

Emotional support

- The endoscopy and cancer services showed sensitivity when breaking bad news. They asked patients how they would like to find out about the results of their diagnostic or endoscopy, and complied with this. Individual consultants visited their own patients post endoscopy and discussed the findings with them in the presence of the ward nurses if necessary.
- The cancer service made arrangements to give patients emotional support. We observed a coffee afternoon event to support patients. This group was meeting for the third time and appeared helpful and convivial.
- The lead oncology nurse made sure that all family members had her contact number. She also rang families regularly in order to provide assistance and support.

Are medical care services responsive?

Good

We rated the responsiveness of medical care services as 'good'. We found;

- Services were planned in line with the needs of local people and were suitable for the needs of all communities. They could be accessed in a timely way.
- Services were adapted for some people, including patients with diabetes.
- The hospital offered free services to cancer patients, such as massages and eyebrow tattooing.
- The hospital's complaints procedure was clear.

However, we found;

- Patient information was only readily available in English.

Service planning and delivery to meet the needs of local people

- The hospital provided a special parking area for cancer patients within easy walking distance of the Bamford Suite.
- Cancer and endoscopy services took place in areas where individual patients could be segregated via curtains or doors to provide privacy.
- Hospital staff measured patient satisfaction informally and through patient surveys. Patients had raised the day care environment, which was in need of redecoration. The provider made any necessary changes to the service in response to the feedback, such as improving the décor.

Access and flow

- The hospital services did not accept unplanned or emergency admissions for cancer services or endoscopy.
- Cancer services were accessible. Typically, a patient could be diagnosed and have their operation the following week. Depending on medical advice, chemotherapy treatment could start a month later.
- Consultants took steps to ensure that there were no delays in cancer treatment. They filled out an information sheet when requesting a scan. This sheet informed staff and clinicians of the proposed patient pathway and remained with patient notes. It contained clinical information and included the time frame for chemotherapy treatment so everybody knew when the scan needed to be done. It also helped the lead oncology nurse plan when to be present to support patients.
- Patients had access to timely endoscopy tests. Urgent cases were normally booked within a week or two. Theatres could adjust their schedules to fit in emergencies for patients who were referred from outpatients or the ward, such as the need for a flexible sigmoidoscopy to assess severe colitis. They carried out this work at the end of the day.
- The hospital had clear vetting procedures for referrals, booking and listing arrangements set out in its policies.
- Most patients received their results at the bedside post procedure or at the outpatient visit booked to coincide with pathology result availability.

Meeting people's individual needs

- The cancer services audit in September 2014 resulted in planned actions such developing information leaflets and personalised treatment booklets for patients. Patients told us they had received personalised treatment books with dates, which they appreciated. There were regular review dates for these actions, to keep them on track.
- Information leaflets given to patients with cancer were in English only. A member of staff told us they could obtain leaflets in other languages if needed. However, these were not readily available.
- Endoscopy and cancer services were available to male and female patients and to patients from all ethnic groups. Staff had access to interpreting services if required.
- Patients whose first language was not English could access an interpreter. This was booked before arrival if needed.
- Cancer services focused on all-round patient care. The hospital offered a range of therapies to cancer patients without any extra charge. Patients could have up to six treatments, such as massages or eyebrow tattooing.
- Patients waited for endoscopy on the ward in a private room with private toilet facilities. This was helpful if patients needed to take a bowel preparation before their endoscopy.
- The pharmacy service issued patient information sheets, which they developed themselves, to endoscopy patients. This was because before colonoscopies, for example, patients needed to take a bowel preparation, drink a lot of fluid and avoid high fibre foods. There are risks to the patient if they do not follow instructions closely. The pharmacy produced a plain English version of these instructions and patient feedback was positive.
- Theatre staff told us they usually scheduled patients such as diabetic patients, who need to eat regularly, for endoscopy early in the day. This meant that these patients could start eating again as soon as possible.
- The hospital had a chaperone policy. A chaperone is a person who accompanies a patient during an examination, for example, a female would be accompanied by a female member of staff when being examined by a male member of staff. This was reassuring for the patient.
- The service used a 'hospital passport' system for patients with a learning disability. This document provided information about the individual needs of the patient so that staff or carers could support them during their appointment and treatment. So far cancer services had not had to treat a patient with these needs.

Requires improvement

Medical care

- The hospital had 'dementia champions.' They cascaded relevant information on caring for patients with dementia to other hospital staff to increase their awareness.
- The hospital had recently introduced "The Nuffield Health Promise" for self funded patients. This enabled patients to have further care and follow ups at no extra cost if their treatment had not met expectations.
- The hospital did not routinely offer a choice between a general anaesthetic and sedation for colonoscopy patients. Consultants discussed this with individual patients if they felt there was a clinical need.

Learning from complaints and concerns

- The hospital aimed to resolve complaints within 20 working days, if this was not possible; the hospital wrote a letter to the complainant. This was supported by a standard operating procedure on how to manage complaints.
- Complaints were a rolling agenda item at the monthly integrated governance and learning review group meetings. They were included in the quarterly Medical Advisory Committee (MAC) clinical governance report. Complaints involving consultants were raised with the chair of MAC and if necessary they took actions to rectify problems. This ensured that the consultants were aware of the issues.
- The senior management team (SMT) met weekly to discuss complaints. A formal learning review group met on a bi-monthly basis to look at trends and to agree lessons learned. Complaint trends and lessons learned were discussed in staff meetings.
- Complaints leaflets were available for patients to use when required. It explained the process used for complaint handling.
- The endoscopy and cancer services had not received any complaints.

Are medical care services well-led?

Requires improvement

The leadership for these services required improvement. We found;

- Working arrangements with partner organisations were not fully formalised.
- Performance monitoring was not fully developed in endoscopy or cancer services.
- There was no clinical representative from oncology attending the MAC regularly when we inspected.
- There were no risk registers specific to endoscopy or cancer services. Managers we spoke with told us about organisational risks, but there was no register of service specific risks.
- The services had not fully developed some key policies, such as the overall policy for cancer services.

However, we found;

- The vision, values and strategies for cancer and endoscopy services were clear to staff.
- Cancer services asked for patient feedback and set up a support group. The endoscopy service planned a user group.
- There was a culture of continuous improvement in both services.

Vision and strategy for this this core service

- The hospital had a long term vision of integrated cancer care. It had a strategy which aimed to improve outcomes, safety and quality for cancer patients and their carers. The hospital planned to recruit two additional nurses and a health care assistant early in 2016 to help deliver this strategy.
- Staff told us that the vision for cancer services was to provide a more comprehensive and round the clock service. They were working with the local NHS acute trust to establish this. They were also developing their skills for this vision by undertaking relevant training; for example, the pharmacists were doing a diploma in oncology.
- The vision for endoscopy was quality improvement. The Nuffield Group aimed for Joint Advisory Group on Gastro-intestinal Endoscopy (JAG) accreditation, which recognises high standards of clinical quality and patient experience.
- The hospital values were 'enterprising, passionate, independent and caring.' (EPIC). The values were displayed in various locations around the hospital. Nurses we met understood the values.

Governance, risk management and quality measurement for this core service

- The services had not fully developed some key policies, such as the overall policy for cancer services.

- The hospital had a draft cancer strategy which aimed to improve quality for those living with cancer. However the strategy had not been finalised at the time of our inspection.
- There were no risk registers specific to endoscopy or cancer services. Managers we spoke with told us about organisational risks, but there was no register of service specific risks.
- The endoscopy service reported quality measurement via the clinical governance group.
- The cancer service was small and relatively new. It lacked a performance dashboard or safety thermometer. The lead nurse surveyed patients regularly and used this as the main source for improvement and learning.
- The services were in the process of formalising working arrangements with partners. For example, cancer services' service level agreement with the local NHS acute trust was not yet ratified.
- The Nuffield Group had a corporate approach to governance, risk management and quality measurement. There was a clear governance structure in place with committees such as clinical governance, infection control and health and safety and risk management feeding into the medical advisory committee (MAC) and hospital management team.
- There was no clinical representative from oncology attending the MAC regularly when we inspected. An oncology consultant planned to attend to help provide leadership for the new cancer strategy.
- A number of different staff and management groups met to discuss issues related to incidents, risk, complaints management and clinical audits. These groups included the hospital's medical advisory committee, learning review group and the integrated clinical governance committee. All staff groups were represented at these meetings.

Leadership and culture of service

- Staff told us that the lead nurse for cancer services provided strong leadership, and influenced well across the organisation. The hospital also recognised the leadership shown by the endoscopy clinical lead and lead nurse. These leaders could identify the challenges to good quality care and develop actions to address them.
- The hospital had a matron who provided professional leadership for all nursing staff. Staff told us that the matron and hospital director were visible. They felt able to approach them for guidance and support when necessary.
- Staff were positive about working at the hospital, they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.

Public and staff engagement

- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings, but they were also able to attend other meetings within the hospital if they chose, for example governance meetings.
- The hospital held regular open events where prospective patients could come to the hospital and receive a presentation from a specialist consultant surgeon on the types of treatments available.
- The hospital showed that it was listening to patients. The cancer service was redecorating the Bamford Suite in response to patient feedback.
- The endoscopy service did not have a user group. It planned to start meetings and had discussed the agenda with stakeholders. This was an important step towards (JAG) accreditation and an important source of patient feedback.

Innovation, improvement and sustainability

- The hospital involved relevant stakeholders in planning cancer services. It began delivering cancer services in 2012. It conducted a scoping exercise and consulted surgeons and oncologists, McMillan nurses, Nuffield Health patients and Healthcare at Home staff. This resulted in a new cancer service situated in the Bamford Suite, and more choice for patients.
- The endoscopy service aimed for continuous improvement. The Nuffield group planned to achieve JAG accreditation for its endoscopy services. This means demonstrating agreed levels of clinical quality, patient experience, environmental safety and workforce training.
- The hospital evaluated its service as having some of the requirements to achieve this accreditation. There was a suitable environment, modern equipment, stable staffing, and reliable decontamination arrangements. They had a strategy to meet the other criteria, with actions such as setting up an endoscopy user group,

developing endoscopy-specific policies, such as for consent, and developing systems for patient feedback about endoscopy. They aimed to be assessed for accreditation in 2016.

Good

Surgery

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

Information about the service

Surgical services at Nuffield Health Derby hospital provided day and overnight facilities for adults undergoing a variety of procedures. The majority of patients who attended the hospital for surgery were self-funded (insured or self-paying).

Between July 2014 and June 2015, there were 4,863 visits to the theatre. These included surgical procedures for general surgery, ear, nose and throat surgery, orthopaedics and ophthalmology.

Facilities at Nuffield Health Derby include one ward with 38 individual patient rooms plus a four-bedded step down unit for patients requiring a higher level of observation post operatively, three theatres including a recovery area for patients recovering immediately post-surgery. There is also one area in the outpatients department where minor procedures are undertaken.

A Nuffield Hospital central hub provided sterile services supplies. This ensured reusable equipment was cleaned, sterilised and packed for further use at the central hub then returned to the hospital.

During our inspection, we visited the surgical ward, step down unit, operating theatres and recovery area. We observed the care of patients on the ward, in the step down unit and recovery area and during operative procedures in theatre. We spoke with 14 patients, 33 staff including nurses, student nurses, and medical staff including consultants, operating department practitioners, therapy, supporting staff, porters and senior managers. We also received 24 tell us about your care comment cards which patients had completed prior to our inspection.

Summary of findings

The overall rating for surgical services at this hospital was good.

We rated the safety of this service as good because when something went wrong, people received a sincere and timely apology. Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Performance showed a good track record and steady improvements in safety. Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Although there was the use of agency and bank, wherever possible the hospital used regular bank and agency staff. Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.

We judged the effectiveness of this service to be good because people using the service received effective care and treatment, which met their needs. Care and treatments were planned and delivered in line with current evidence based guidance, standards and best practice legislation. New evidence-based techniques were used to support the delivery of high quality care and staff worked collaboratively to understand and meet the range of people's needs.

Good

Surgery

The care provided to patients in surgical services was good. Patients were supported, treated with dignity and respect, and were involved as partners in their care. Feedback from patients was positive about the way staff treated them,

Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

We rated the responsiveness of surgical services as good. People's needs were met through the way services were organised and delivered. The needs of different people were taken into account when planning and delivering services. Waiting times, delays and cancellations were minimal and managed appropriately. Complaints and concerns were taken seriously and responded to in a timely way.

The leadership of surgical services was good. The leadership, governance and culture promoted delivery of high quality person centred care. There was a clear statement of vision and values. The board and other levels of governance within the organisation functioned effectively and interacted with each other appropriately. The service was transparent and leaders at every level prioritised high quality compassionate care. There was a positive staff culture where innovation was supported.

Are surgery services safe?

Good

The safety of this service was good. We found;

- When something went wrong, people received a sincere and timely apology; we saw this following a theatre incident.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Performance showed a good track record and steady improvements in safety for example and there had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. Difficile) or Methicillin-sensitive Staphylococcus Aureus (MSSA).
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and the monitoring and maintenance of equipment were mostly reliable and appropriate to keep patients safe.
- There were clearly defined and embedded systems and procedures to keep patients safeguarded from abuse. Staff were aware of the signs of abuse and had access to appropriate resources.
- Staffing levels and skill mix were planned and reviewed to keep patients safe at all times.
- Staff were able to respond to signs of deteriorating health and medical emergencies.

However;

- Most staff were not aware of major incident or business continuity plans therefore the risks associated with anticipated events and emergencies were not fully recognised.

Incidents

- Most staff were aware of, and appeared knowledgeable and confident about reporting incidents. Most staff had access to the online reporting system; agency and bank nurses did not have access to the computer system and told us they would report incidents to the nurse in charge. Staff gave us examples of when they might report incidents such as when operations were cancelled at the last minute. Staff said there was no blame culture in the service and they felt empowered to report incidents without fear of reprisal.

- Staff told us they did not always receive individual feedback for incidents they reported, however incidents giving cause for concern or following a specific trend were discussed in the ward meetings. We saw evidence of this in the ward meeting minutes.
- There were 394 clinical incidents reported by the hospital in the reporting period July 2014 to June 2015. The rate of clinical incidents (per 100 inpatient discharges) fell between July 2014 and September 2014 and October 2014 to December 2014, and has remained constant since this time.
- There had been one incident of surgical sepsis in the previous twelve months. Staff used a pro-forma for documenting patients' physiological signs post-operatively with a clear pathway in place if the signs were outside the normal parameters. We reviewed a root cause analysis for this case which had identified all appropriate actions had been taken.
- A root cause analysis (RCA) was conducted following a surgical site infection. It was of good quality, the root cause identified and an action plan created.
- There was evidence of learning from incidents, for example, theatres had changed the skin preparation solution used for operations. An applicator was used rather than a preparation in open pots, this followed learning from a National Patient Safety Agency (NPSA) alert.
- Following an incident, which occurred during cataract surgery, a thorough investigation was conducted, involving equipment manufacturers. This was also reported to the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA regulates medicines, medical devices and blood components for transfusion in the United Kingdom.
- The new regulation, Duty of Candour, states providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. Few staff we spoke with were aware of Duty of Candour; we escalated this to senior managers and when we returned for our unannounced visit, most of the staff we spoke with were aware of Duty of Candour. During our inspection, we saw examples where duty of candour had been applied.
- Mortality and Morbidity meetings were used to review deaths and learn from them. These meetings, when required, were included in the clinical governance report and discussed at the Medical Advisory Committee (MAC) meetings.

Safety thermometer or equivalent

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Whilst the hospital did not use this tool, they did monitor performance against the possible harms identified in the tool in the way of a local audit known as Gov 14. For example, incidents of falls, pressure ulcers, venous thromboembolism and hospital acquired infections and catheter associated urinary tract infections. Pressure ulcers are damage to the skin caused by pressure from being in the same position. A venous thromboembolism is a blood clot, which forms in a vein, often in the leg, which can cause harm to patients.
- Venous thromboembolism screening for all patients was consistently 100% in the reporting period July 2014 and June 2015; 95% is the targeted rate for NHS patients. CQC had assessed the proportion of patients risk assessed for venous thromboembolism to be 'much better than expected' compared to other acute trusts we hold this data for.
- There was one patient who had acquired a hospital provoked venous thromboembolism or pulmonary embolus in the period between July 2014 to June 2015. A pulmonary embolus is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot.

Cleanliness, infection control and hygiene

- The hospital had reported no incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C Difficile) or Methicillin-Sensitive Staphylococcus Aureus (MSSA) in the reporting period between July 2014 and June 2015. MRSA, MSSA and C.Difficile are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated. C.Difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics.

Good

Surgery

- Monthly hand hygiene audits were carried out by the hospital. In the reporting period from January 2015 to August 2015, compliance varied between 75% and 96%, action plans were in place for improvement.
- There were a low number of surgical site infections, 13 following 2792 operations, in the reporting period from July 2014 to June 2015. This was less than 1% of operations resulting in surgical site infections and is in line with other independent hospitals we hold this type of information for.
- An infection prevention programme ensured management and monitoring of infection control took place throughout the hospital. We saw staff following good practice guidelines for infection prevention and control, for example the use of gloves and aprons. This minimised the risk of infection to patients.
- Two of the three operating theatres had higher levels of air filtration (laminar flow). This was particularly important for joint surgery to reduce the risk of infection.
- In the period April 2015 to July 2015, 100% of patients admitted to the hospital had MRSA screening and were risk assessed for Carbapenemase-producing Enterobacteriaceae (CPE). Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans, if the bacteria get into the wrong place, such as the bladder or bloodstream they can cause infection. Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are resistant to the antibiotics.
- In the same period there was a 100% compliance with the minimising the risk of infection to patients undergoing surgery audit, with the exception of the indicator evidence of patients showering before surgery (93%). An example of the indicators measured were administration of antibiotics at least 60 minutes prior to surgical incision and dressings used to cover the wound after surgery.
- In the 2015, Patient-led assessments of the care environment (PLACE) the hospital scored over 99% for cleanliness, above the national average of 98%.
- Cleansing gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively.
- Staff were 'bare below the elbow' to allow effective hand washing.
- Protective equipment, such as gloves and aprons, were available and we observed staff washing their hands between patients. We observed one doctor who failed to apply gloves or wash their hands prior to inserting an intravenous cannula into a patient's hand. An intravenous cannula is a small plastic tube inserted into the patient's vein for medicines administration.
- Changing into surgical scrubs and theatre caps was a requirement of all staff and visitors to theatre.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. This minimised the infection risk.
- When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk.
- Procedures prior to surgery, for example skin preparation and the use of sterile drapes were seen in use.
- There was a system for ensuring equipment was clean, for example 'I am clean' stickers. These were clearly visible, dated and signed.
- We observed patient-care equipment to be clean and ready for use.
- All patients with the exception of those in the step down unit were cared for in individual rooms. This meant patients who may have an infection were isolated appropriately.
- The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness.
- However, we saw the ward kitchen and an item of equipment in it was dirty. We raised this with the ward sister at the time. We returned later and although some action had been taken, dirt was still visible in the same place. We raised our concern with senior managers. During our unannounced visit, we noted additional items had been added to the cleaning schedule and a deep clean of the kitchen was scheduled to take place each Sunday, records showed this had taken place on the Sunday prior to our unannounced visit. The kitchen and items of equipment in it were visibly clean during our unannounced visit.

- Deep cleaning of theatre took place twice per year.

Environment and equipment

- The theatre filtration systems had annual checks to ensure compliance.
- The resuscitation equipment and emergency transfer bag on the ward and in the operating theatres had been checked daily by staff and was safe and ready for use in an emergency. Single-use items were sealed and in date, and emergency equipment had been serviced. During our inspection, the defibrillator from the ward resuscitation trolley went to another department for a considerable length of time. There was a note on the trolley to determine its location. The ward sister informed us this had been risk assessed and it if the emergency buzzer sounded, it would be returned immediately. We were not assured this would be the case as the defibrillator was in use by another department located away from the ward.
- An onsite third party company serviced and maintained all equipment including loaned equipment.
- All patient equipment we looked at had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff were aware of the process for reporting faulty equipment.
- An operating department practitioner (ODP) checked the anaesthetic machines and equipment daily in line with The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. An anaesthetist did a final check before each patient use. Anaesthetic machines and equipment were in working order and safe to use.
- A Nuffield Hospital central hub provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if required.
- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements.
- Fire-fighting equipment had been maintained and tested.
- Equipment was available in theatres for overweight patients, for example a larger operating table.
- The theatres and recovery areas we visited were well organised and tidy. The equipment store on the ward was cluttered and some items of equipment were difficult to access, which could have resulted in staff injuring themselves. We escalated this to the ward sister at the time of our inspection and when we returned on the unannounced inspection, the room was tidy and equipment accessible.
- Registers of implants, for example hip and knee, were kept by theatres; these ensured details could be quickly provided to the health care product regulator if required.
- A step down unit within the ward provided care to patients who required a higher level of observation post operatively. This area was not compliant with Department of Health same sex accommodation guidance, which states patients should not share sleeping accommodation with patients of the opposite sex. During our inspection, there were two female and one male patient being cared for in the step down unit and on our unannounced visit we found two females and two male patients had slept in the step down unit overnight. We highlighted this with the provider during our announced and unannounced inspections.

Medicines

- Administration of medication was recorded on a prescription chart.
- We looked at the prescription and medicine administration records for five patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.
- Nurses were responsible for administering medication, including patients' own medicines brought in from home. Nurses had training and a check of their competency in the safe management of medicines every year. We observed nurses following the hospital policy when administering medicines to ensure the safety of patients. This included checking the patient's identity. There were records to show each nurse's competency to give medications had been assessed.

- Patients who wished to self-administer medication were risk assessed. This was particularly important for patients who required special medicines at a critical time, for example those patients with Parkinson's disease. However, this was still supervised by a nurse.
- Patients' own medication was stored in a lockable cupboard in the patient's bedroom and accessed by a nurse.
- Medicines on the ward and in theatre, including controlled drugs and those requiring cool storage, were stored in line with hospital policy. We saw records of daily checks of the fridge temperatures. Controlled drugs are medicines, which are stored in a designated cupboard, and their use recorded in a special register.
- Medicines for patients to take home following surgery were ordered on the day of their operation and then stored in the medicines room. This meant there were no delays waiting for medicines when patients were ready to be discharged.
- There were 22 incidents reported as medication errors between July 2014 and June 2015. The types and frequency of the errors were analysed at the learning review meeting and lessons learned were documented and discussed at ward and theatre meetings.

Records

- We reviewed 11 sets of nursing and medical records. Records were paper-based. Nursing records were stored in the patient's room. Medical notes were stored in trolleys in the main ward office.
- Patient records were multidisciplinary and we saw where nurses, doctors and allied health professionals including physiotherapists had made entries.
- Records were mostly legible, accurately completed and up to date.
- Integrated care records for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge; they included comprehensive care plans for identified care needs.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. One set of records we reviewed showed a patient with an extended length of stay had no nutritional assessment despite a documented weight loss, therefore the care plan did not accurately reflect the patient's current condition at the time. We escalated this to the ward sister and when we returned later, it was completed.
- A senior manager was the Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information sharing with other agencies.

Safeguarding

- There was a safeguarding and protecting vulnerable people policy and procedure, which included guidance on safeguarding adults and a senior named nurse lead for safeguarding for adults.
- A safeguarding resource folder was available, this included flow charts to assist staff in the safeguarding process and contact numbers for the local authority safeguarding team.
- Most staff demonstrated an awareness of potential safeguarding issues and procedures to follow for suspected or alleged abuse. All staff could tell us whom the safeguarding lead was for the hospital, so knew where to seek advice.
- Staff received safeguarding of vulnerable adults training (level two) as part of their mandatory training. Completion rates were on average 88%, this was above the Nuffield target of 85% but below the hospital target of 90%.

Mandatory training

- Mandatory training for all groups of staff was comprehensive with many modules accessed through an academy system. Mandatory training modules included moving and handling, infection control, fire and resuscitation.
- Mandatory training data showed a varied completion rate of between 90% and 100% for the core modules.
- A new learning management system had been introduced in July 2015. When fully established this would track each staff member's training record, and managers would be able to monitor training requirements and attendance. At the time of our inspection, training records were only held at department level.

Assessing and responding to patient risk

Good

Surgery

- All patients saw their named consultant at each stage of their surgical pathway.
- Anaesthetists and pre admissions nurses calculated the patient's American Society of Anesthesiologists (ASA) grade as part of their assessment of a patient about to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels, with level one being the lowest risk. The hospital only undertook procedures for patients graded as levels one to three.
- A nurse, consultant and anaesthetist assessed patients in pre assessment clinics prior to surgery. Any concerns or additional input were communicated to the ward and theatre prior to the patient's admission.
- A 'pre list brief' took place in theatres prior to the list starting, this involved discussion for each planned procedure. Notes were made and stored for future reference and could be used if any issues were raised about planning and procedures.
- The Five Steps to Safer Surgery safety checklist was embedded in daily practice and adhered to. This is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during and after surgery to avoid errors. For each patient's procedure, the checklists were followed and completed in full. We reviewed the sample audits undertaken in theatre, which included a review of the Five Steps to Safer Surgery checklist completion. Results between April 2015 and July 2015 consistently showed the checklist was completed as satisfactory in all areas, 100% of the time.
- There was a separate Five Steps to Safer Surgery safety checklist for patients undergoing cataract procedures. This was in line with NPSA guidance.
- There was the use of a step down unit within the ward; this was used for patients who required closer observation post operatively, for example patients who had undergone knee and hip surgery.
- We reviewed a standard operating procedure for the step down unit, which stated patients must be visited twice daily by the admitting consultant. We reviewed four sets of medical notes of patients who had been receiving care in the step down unit; none of the notes had documented evidence of consultant review whilst in the step down unit. This meant patients were at risk because there was no evidence their condition, care and treatment plan had been reviewed by a senior doctor.
- Processes and agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated.
- Risks relating to deteriorating patients were managed using a recognised assessment tool. The Modified Early Warning System (MEWS) records certain indicators to identify deterioration in a patient's clinical status and to identify when more care and treatment is required. Within the recovery department, MEWS commenced as the patient woke from their anaesthetic and multiple observations were undertaken before the patient returned to the ward.
- Staff in recovery recorded a minimum of two MEWS score before a patient left recovery to go back to the ward. This meant patients were stable and safe to transfer back to the ward.
- As part of the audit programme, the hospital monitored the escalation of the deteriorating patient to medical staff. Between April 2015 and July 2015, 100% of patients were escalated appropriately. We reviewed a root cause analysis in relation to a patient who had deteriorated post-operatively. We saw appropriate discussions had taken place and the patient had been treated appropriately and then transferred to a local NHS trust.
- There was a hospital policy in place for the emergency management of cardiopulmonary resuscitation.
- A resident medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have regarding a patient's clinical condition.
- An anaesthetist remained on site at all times when patients were in the recovery room post operatively.
- The skill mix and experience of staff were considered when patients were assessed as having increased risks associated with surgery. We saw a newer nurse to the ward allocated a smaller number of patients, supported by the nurse in charge.
- On discharge, patients were given the contact details for the ward so they could call if they experienced any problems. Staff maintained a record of these calls.
- Regular simulated cardiac arrest scenarios were carried out so staff were able to respond quickly and be rehearsed should a real life cardiac arrest occur.
- Access to endoscopy was available whilst theatres were open, after this time there was an agreement in place with a local trust to provide this service if required.
- A supply of blood for all blood groups was available in the hospital for use in an emergency. Special blood

products could be ordered from a centrally located Nuffield facility and could arrive on site within 45 minutes. Patients undergoing major surgery were crossed matched for patient specific blood type in pre admissions clinic so blood was available on site at all times during their stay. Systems and processes were in place with a local NHS trust if further blood was required sooner. Simulation of the major haemorrhage protocol activation took place in the theatres quarterly so staff were familiar with their responsibilities in the unlikely event of needing to use this protocol. A major haemorrhage is excessive blood loss which can be life threatening.

Nursing staffing

- The hospital's ward staffing levels were set using the guidance from the National Institute for Health and Care Excellence (NICE) Safe Staffing Recommendations July 2014 - Safe Staffing levels in Adult Inpatient Wards in Acute Hospitals.
- Staffing levels were calculated initially on a weekly basis, checked and adjusted daily as required depending on changes and or patient requirements.
- Staffing levels were calculated on a ratio of five or six patients to one registered nurse in the daytime and a maximum of one registered nurse to eight patients overnight.
- There was a lower patient to nurse ratio for those patients requiring a higher level of care; this was usually in the step down unit.
- The nurse in charge of each shift had a zero or minimal patient caseload to allow for unpredictable or unplanned events. During our inspection the ward sister took a small caseload of patients when a member of staff went home ill.
- Usage of agency nurses was minimal (less than 20%) for the year July 2014 to June 2015; wherever possible the hospital used regular bank and agency staff.
- Handovers occurred at each shift change and involved all staff on duty for the shift; this meant all staff were aware of all patients' individual needs.

Surgical staffing

- A Resident Medical Officer (RMO) provided 24-hour medical cover for patients.
- Consultants and anaesthetists could be contacted 24 hours a day and were able to return to the hospital within 30 minutes.
- If further medical input was required at the hospital, for example consultants who specialised in care of patients with diabetes, this was provided by one of the other doctors with practising privileges at Nuffield Health Derby Hospital.
- Out of hours, if a patient who had been discharged following endoscopy and subsequently whose condition deteriorated, the patient would normally return to the hospital for review and further treatment where appropriate. The hospital had an out-of-hours rota for clinical staff, and consultants provided 24-hour cover for their patients post-operatively. The provider told us this may result in an additional operating theatre being opened out of hours.
- If however, a patient's condition deteriorated to the point where the most appropriate location for treatment was the local NHS trust, an agreed transfer protocol was in place between Nuffield Health Derby Hospital, the local NHS trust, local ambulance services and the Mid Trent Critical Care Network.
- There were 213 consultants granted practicing privileges at the hospital. The majority of these worked at local NHS trusts. They included consultants with specialties such as ophthalmology and orthopaedics. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there.
- The theatre staffing rota was planned on a weekly basis and adjusted where necessary according to speciality and case mix.
- The hospital worked within the recommendations of the 'Association for Perioperative Practice' with regard to numbers of staff on duty during a standard operating list. This comprised of two nurses, an operating department practitioner (ODP), a healthcare assistant, a consultant and an anaesthetist.
- Seven surgical first assistants worked in the hospital and a further two were undergoing training. A surgical first assistant works closely with the surgeon to facilitate the procedure and process of surgery. They undertake classroom and on the job training before being deemed competent.
- Usage of agency staff in the theatre department was minimal (less than 20%) for the year July 2014 to June 2015.

Good

Surgery

- There were systems, processes and standard operating procedures to support effective handover between the RMO, consultants and other clinical staff. They were mostly reliable and appropriate to keep patients safe.

Major incident awareness and training

- We saw a major incident plan; this outlined the process for managing and coordinating the hospital's emergency response in the event of such an incident. Most staff we spoke with were not familiar with these plans or been involved in any training exercises.
- Routine fire drills took place, this allowed staff to rehearse their response in the event of a fire.
- Monthly tests took place on the backup generator.

Are surgery services effective?

Good

We judged the effectiveness of this service to be good because people using the service were receiving effective care and treatment, which met their needs. We found;

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice legislation. Patient needs were assessed throughout their care pathway in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal Colleges' guidelines. Day surgery was consistent with the 'British Association of Day Surgery (BADS).
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Staff worked collaboratively to understand and meet the range of people's needs.
- Consent to care and treatment was obtained in line with legislation and guidance. People were supported to make decisions.

However;

- Staff training numbers in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were low and many staff lacked awareness and understanding of the requirements of this legislation.

Evidence-based care and treatment

- The delivery of day surgery was consistent with the 'British Association of Day Surgery (BADS). BADS promotes excellence in day surgery and provides information to patients, relatives, carers, healthcare professionals and members of the association.
- Patient needs were assessed throughout their care pathway. Care and treatment was generally delivered in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and Royal Colleges' guidelines for example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness.
- The hospital had introduced a new anaesthetic procedure. Patients undergoing certain surgical procedures were given a short-acting spinal anaesthetic using different local anaesthetic based on the time required for the surgery; this was called targeted spinal anaesthesia. The effect of this anaesthesia only lasted for the duration of the procedure, which meant patients were able to start moving around immediately, were able to eat and drink immediately and could be discharged sooner. This was beneficial for patients, such as those with diabetes, who needed as short a time as possible without being able to eat and drink.
- Patients undergoing knee surgery were assessed using the Oxford Scale, which measures muscle strength and range of movement. These assessments were completed pre and post operatively so the rehabilitation progress could be evaluated.
- In line with professional guidance, the hospital had a process in place for the recording and management of medical device implants.
- We saw evidence of a rolling audit plan including theatre audits, information governance and medication; the results were used to inform areas for improvement.
- Medical staff told us NICE guidelines were discussed at clinical meetings; minutes of these meetings reflected this.
- During our inspection, we found there were out of date policies and procedures in a folder on the step down unit. One policy was dated January 2004 and we could not see this had been reviewed; this meant patients might not be receiving care that was evidence based or following current guidance. We escalated this to senior managers and they were removed.

Pain relief

- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery. Information about the medicine prescribed, including how to use it and any side effects was given to patients.
- Information about pain management was given to patients prior to surgery and following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- The theatre care pathway ensured staff enquired about patients' pain and adequate pain was relief given in a timely manner.
- We observed staff regularly reviewing pain in the recovery area post-surgery. If a patient had pain, they administered pain relief and checked this had the desired effect.
- Pain assessment scores used on the ward assessed the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. Nursing records we checked demonstrated staff were identifying the patient's level of pain and evaluating the effects of pain relief on a consistent basis.
- The hospital's patient satisfaction survey during the period March 2015 to August 2015 indicated 90-95 % of patients thought staff did everything they could to control their pain.
- All patients post-surgery told us they were not in any pain or distress.
- Regular and as required pain relief was prescribed on all five-prescription charts we reviewed. This meant there would be no delay in the administration of pain relief.
- We saw two patients in the step down unit who had patient controlled analgesia (PCA). A PCA is an electronically controlled infusion pump. It delivers an amount of intravenous pain relief when the patient presses a button. We saw nurses encouraging patients to remain on top of their pain by using the PCA.

Nutrition and hydration

- We saw most patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- Pre admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- Staff followed best practice guidance on fasting prior to surgery. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- If patient procedures were delayed or the surgery list order changed then anaesthetists indicated to the nursing staff new fasting time for patients. This was documented on a whiteboard in the ward office.
- After surgery, there were accurate and complete records to show fluid intake and output was monitored. Where there were concerns we saw nurses followed protocol and scanned patients' bladders, seeking medical advice as needed, to prevent post-operative urinary and kidney dysfunction.
- Most of the patients we spoke with commented positively about the food. The hospital provided three meals a day for in-patients.
- The ward kitchens had sufficient food stocks to enable staff to supply sandwiches, soup, toast and cereals if patients were hungry at any time.
- Staff told us they could refer patients to an in house dietician if this was required.

Patient outcomes

- From July 2014 to September 2015, there were eight unplanned transfers of care from this hospital to a nearby NHS trust. We are unable to say if this was higher or lower than other hospitals as we could not find more than one similar hospital providing the same services as this hospital to compare the data with.
- For the reporting period October 2013 to September 2014 the number of emergency readmissions following knee and hip replacements was similar to other independent hospitals and, for hernia and cataract procedures better than expected when compared to other independent hospitals.
- For the period November 2013 to October 2014, the hospital carried out a lower number of inguinal hernias by laparoscopic (keyhole) approach than other independent hospitals. This was for various reasons including patient choice, the suitability of patients to undergo the approach and number of surgeons trained

to carry the procedure out by laparoscopic approach. NICE guidance states specially trained surgeons who regularly carry out the procedure should only perform laparoscopic surgery for inguinal hernia repair.
- Patient reported outcome measures (PROMS) for hip replacements (NHS patients only) for the period April 2014 to March 2015 were similar to the England average.
- From July 2014 to June 2015, there were 15 cases of unplanned readmission within 30 days of discharge. This was worse than expected when compared to other independent hospitals. However, over the 12-month period readmission rates had decreased on a month-by-month basis. We reviewed the reasons for readmissions and found no specific trends.
- The hospital took part in national audits focussing on patient outcomes; these included the national joint registry, surgical site infection rates and when appropriate the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

Competent staff

- New staff had an induction relevant to their role. One new nurse said their induction was informative. Staff told us there was a flexible approach to the induction period and the length of induction was negotiated with each staff member individually.
- Agency and bank nurses told us they had received an orientation and induction to the ward area. This included use of resuscitation equipment and medicines management.
- The Resident Medical Officer (RMO) who was employed through an agency underwent an additional recruitment process before they commenced employment. This involved checking their suitability to work at the hospital and checks on their qualification. They were mentored by the chair of the Medical Advisory Committee (MAC).
- There was a robust process in place for granting practicing privileges, which included an interview with the hospital director. The term "practising privileges" refers to medical practitioners not directly employed by the hospital but who have permission to practise there. For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's (RO) name.
- Consultants worked in line with the scope of professional practice and would only carried out the same surgery at the hospital as in their substantive role.
- Competency assessment programmes were available for theatre staff, for example one extra competency was scrubbing for orthopaedic procedures in theatres. Staff were not permitted to undertake tasks until they had been deemed competent.
- Physiotherapy staff told us they had access to a set amount of funding for training each year, this was sufficient for them to access effective training.
- Most staff we spoke with said they did not have formal clinical supervision. This meant staff did not have the opportunity to reflect upon their practice. Clinical supervision aims to identify solutions to problems, improve practice and increase understanding of professional issues.
- The percentage of staff having an appraisal in 2014 was around 96%. We reviewed three appraisal documents for nurses and found them fully completed. Personal objectives had been added to standard corporate ones in line with the hospital's values.
- Information received from the provider relating to required documentation for consultants showed on 12 October 2015; 100% of consultants had received a practice appraisal, 100% had supplied evidence of their medical indemnity insurance, 97% had evidence of a Disclosure and Barring Service (DBS) check in the last three years. The hospital policy was to repeat DBS checks every three years therefore the remaining 3% were in the process of a new check. The provider told us they had started a biennial review process following the introduction of the new practice privileges policy.
- There was a system to ensure qualified doctors and nurses' registration status had been renewed on an annual basis. Data provided to us by the hospital showed a 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres. We checked three nurses' registration and found them to be in date.
- There was a process in place to ensure appropriate communication was received and passed on to the NHS trust if a consultant's clinical practice raised concerns.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings. Actions were created and completed before the consultant could practice at the hospital again.

Good

Surgery

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all of the areas we visited and was notably inclusive of managers and team leaders.
- Team briefings were held each morning for theatre staff to review the operating lists and day ahead.
- In theatres, we observed excellent communication and teamwork between staff members.
- There was an MDT approach to pre-operative assessment; this involved nursing, medical and physiotherapy staff. Physiotherapists were able to identify any equipment patients may need after discharge for example raised toilet seat, and they would issue this at the pre-operative assessment.
- A physiotherapy service was available in the hospital on the ward and following discharge through the Recovery Plus programme.
- The Recovery Plus Programme was available free of charge to self-funding patients and included health checks, exercise and diet advice plus membership at a Nuffield Health Fitness and Wellbeing Centre to enhance the recovery process following surgery.
- When patients were discharged, the hospital worked well with external services. A letter was sent the patient's GP to inform them of the treatment and care provided.

Seven-day services

- The hospital had three operating theatres open six days per week. Operating times were from 8am until 8pm weekdays and 8am until 4pm on Saturdays.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care.
- Anaesthetists retained responsibility for the anaesthetic requirements at all times during the patient's entire clinical pathway.
- Medication could be prescribed and dispensed to patients prior to their discharge. The pharmacy was open on Mondays to Fridays from 8am to 5pm. Outside these hours, the RMO or consultant and the nurse in charge could dispense drugs for patients to take home. Any items not kept in pharmacy and needed urgently could be ordered from a neighbouring hospital's pharmacy via an on-call service 24 hours, seven days per week service.
- Physiotherapy services were available to inpatients seven days per week.
- Access to x-ray was available between Monday and Friday and via an on call service at weekends.
- There was a Resident Medical Officer (RMO) in the hospital 24 hours a day with immediate telephone access to on call consultants.
- There was an on-call rota for key staff groups, including theatre staff, senior managers, and imaging staff.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were paper-based records for each patient; one for medical notes and one for nursing notes; nursing records including observation charts were accessible in the patient's room. This enabled consistency and continuity of record keeping whilst the patient was on the ward, supporting staff to deliver effective care.
- There were computers available on the wards, which gave staff access to patient and hospital information for example policies and procedures.
- We saw when patients were transferred to other hospitals for further care, transfer letters were completed.
- Staff had access to General Practitioner (GP) referral letters when patients attended pre admissions clinic.
- Diagnostic tests results carried out at neighbouring trust were available using the picture archiving and communication system (PACS). Staff told us they had the necessary access to the PACS system should this be required. This meant there would be no delay accessing test results used to assess a patient's suitability for surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for surgical procedures was obtained mostly on the day of surgery by the consultant. Two patients confirmed they discussed the procedures with their consultant during pre-admission assessment, this allowed time to consider the procedure planned before consenting to treatment the day of surgery.
- Staff were aware of the hospital policy on consent. Consent was sought from patients prior to the delivery of treatment. We looked at five consent forms during our inspection; consent was appropriately obtained in all of the forms we reviewed.

Good

Surgery

- In theatres, we observed staff checking consent forms were signed before proceeding with surgery.
- Staff told us patients who may lack capacity to make an informed decision about surgery were extremely rare. This would be identified at the pre-admission assessment and if any consideration was needed this would be undertaken at this stage. We saw a specific consent form was available for adults who were unable to consent to investigation or treatment. In these cases, a decision is made in the patient best interests, in line with Mental Capacity Act 2005.
- Hospital data showed on average 74% of staff had received training about the Mental Capacity Act 2005 and an average of 73% in the Deprivation of Liberty Safeguards; this was significantly lower than the Nuffield target of 85% and the hospital target of 90%. Most staff we spoke with lacked awareness and understanding of the requirements of this legislation.
- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were clear. Unless otherwise requested, all patients who had a cardiac arrest were to be resuscitated. No DNACPR forms were in place at the time of our inspection. Staff advised us it was rare for a DNACPR form to be in place. However, should there be one, staff were aware and this information was cascaded at handover of shifts.

Are surgery services caring?

Good

The care provided to patients in surgical services was good. Patients were supported, treated with dignity and respect, and were involved as partners in their care.

We found;

- Feedback from patients was positive about the way staff treated them. We heard an example of staff going the extra mile when planning and providing care to a patient with a learning disability.
- Patients were treated with dignity, respect and kindness during all interactions with staff. We saw during the Five Steps to Safer Surgery safety checklist process staff treated patients with dignity in the operating theatre, for example they introduced the anaesthetised patient to the team.
- Patients were involved and encouraged to be partners in their care. Staff spent time talking to patients. They empowered patients to have a voice. We saw this during the use of the 'quiet room' in theatre, when staff involved patients in the formal sign in of patients.
- Staff helped patients and those close to them cope emotionally with their care and treatment.

Compassionate care

- The NHS 'Friends and Family Test' is a survey measuring patients' satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For the period January 2015 to June 2015, 61%- 84% of patients who completed this would recommend this hospital.
- The Nuffield group carried out their own patient satisfaction monitoring. During the period March 2015 to August 2015 between 79 -92% of patients who responded would recommend Nuffield Health Derby Hospital to family or friends. This score had continued to improve over the reporting period and was similar to the average for other Nuffield Health locations at 89%.
- We spoke with 14 patients during our inspection and received completed comment cards from 24 patients. Without exception, patients reported staff were polite, friendly and approachable, always caring and respectful. Some patients welcomed the relaxed atmosphere, others praised the way staff treated them with dignity, and how nothing was too much trouble.
- We observed all staff knocking on doors and waiting for a response before entering and referring to patients by their name of choice.
- We observed patients remaining covered in the anaesthetic room, operating theatre, recovery areas and during transfers between the ward and theatre areas for their dignity.
- We saw patients' bed curtains were drawn and doors closed when staff cared for patients on the ward and in the theatre and recovery area. A light was used outside of each room when a member of staff was providing care to a patient. This was a further measure used to maintain patient's privacy and dignity and to inform other staff care was being carried out and they should not be disturbed.
- Between March 2015 and August 2015, 94-98% of patients responding to the patient satisfaction survey said they felt treated with dignity and respect whilst in hospital.

Good

Surgery

- During the Five Steps to Safer Surgery safety checklist in the operating theatre, patients who were anesthetised were 'introduced' to the team by their full name, for example, 'team let me introduce to you'. This was respectful of the patient.
- We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner.
- We were given a positive example of staff going out of their way to protect the dignity and privacy needs of a patient with learning disabilities. The hospital had recognised the patient needed to be brought into the hospital in a special way involving extra staff. We were told how it was dealt with in a person centred way by all staff to ensure treatment could be given in a manner, which protected the patient's dignity and privacy.
- During our inspection, there were two female and one male patients in the step down unit. Whilst the curtains were partially drawn to maintain privacy we were not assured patient's privacy and dignity could be maintained at all times. We spoke with three of the patients; none of them voiced any concerns that they felt their privacy and dignity had not been maintained.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they felt involved in their care. They told us they received full explanations of all procedures and the care they would need following their operation. The hospital's patient satisfaction survey, for the period between June 2015 and August 2015 showed between 90% and 95% of patients said they were involved as much as they wanted to be in decisions about their care. We observed staff explaining to patients exactly what would happen after their operation and we saw examples of written information was given to patients to take home, such as information about using eye drops following cataract surgery.
- Patient records we looked at included pre-admission and pre-operative assessments; these took into account individual patient preferences.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.
- Prior to a patient going into the anaesthetic room, patients were taken into a 'quiet room'. Patients were introduced to the surgical team. A handover of the patient from the ward nurse to the theatre staff, including the patient, took place in this room. The patient was involved in the whole process and put at ease.
- Larger patient bedrooms were available for relatives to stay with patients if they wished.

Emotional support

- We observed staff giving reassurance to patients. For example, we witnessed staff encouraging a patient as they mobilised following knee surgery.
- We saw a nurse providing extra emotional support to a patient in the step down unit.
- We saw staff providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients told us the staff were understanding, calm, reassuring and supportive and this helped them to relax prior to undergoing surgery.
- Medications to help patients with anxiety were prescribed before surgery if necessary.

Are surgery services responsive?

Good

We rated the responsiveness of medical care services as good. Services were organised and delivered to meet people's needs. We found;

- Services were planned and delivered in a way, which met the needs of the local population and individuals. The importance of flexibility, choice and continuity of care was reflected in the services.
- Access to care was managed to take account of people's needs, including those with urgent needs.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- It was easy for people to raise a concern. Complaints and concerns were always listened to taken seriously and responded to in a timely way. Process and systems were in place to agree lessons learned and for sharing of these to ensure improvements were made to care.

However;

- Information leaflets given to patients were in English only. We were told leaflets could be obtained in other languages if required, however these were not readily available nor was this made known to patients who may be using the hospital.

Service planning and delivery to meet the needs of local people

- The hospital had a policy, which outlined the inclusion and exclusion criteria for patients. Patients with an American Society of Anaesthesiologists (ASA) physical status score of four were excluded. The patients admitted to the hospital had an ASA score of one to three. These patients were generally healthy or suffered from mild systemic disease.
- When extra capacity for day case surgery was required; one of the wards had four additional beds, this would be staffed appropriately.
- The admission process and care provided was the same for self-funded patients and NHS patients.
- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital.
- The hospital had recently introduced "The Nuffield Health Promise" for self-funded patients. This enabled patients to have further care and follow ups at no extra cost if their expectations had not been reasonably met.

Access and flow

- There were 1797 overnight patients and 3066-day case patients admitted to the hospital between July 2014 and June 2015.
- The national standard for referral to treatment time (RTT) for NHS patients states 90% of patients should start consultant led treatment within 18 weeks of referral. Data showed between July 2014 and June 2015 the18 week target was met with the exception of August 2014 (79%) this was due to consultant leave.
- Hospital data showed between July 2014 and June 2015 there had been 45 operations cancelled on the day of surgery. This included 17 cancellations for clinical reasons such patients being unfit for surgery. Lack of availability of staff or equipment accounted for 28 cancellations for non-clinical reasons; an action plan was in place to reduce this.
- There were staggered admission times for surgery. This meant there was a reduction in patients waiting times for surgery.
- For unplanned returns to theatre in an emergency, the hospital operated a 24 hour on call service with a 30-minute response time.
- The inspection did not highlight any concerns relating to the admission, transfer or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Theatre staff told us patients identified as high risk, such as diabetic patients, were usually scheduled for surgery at the beginning of the theatre lists in case they developed complications during their procedure.
- All pathways stated the average length of stay a patient should experience for the procedure they had undergone. Staff told us this was generally achieved with the good care and treatment they were able to give patients. However, if complications occurred this time could be extended.
- Following a referral from a consultant, bookings for surgery were made via the central bookings team.

Meeting people's individual needs

- Patients whose first language was not English could access an interpreter. This was booked before admission if needed.
- In pre-operative assessment clinic, a physiotherapist completed assessments of patients' social and personal circumstances prior to surgery to anticipate their requirements after discharge. Physiotherapists were able to provide the patient with some single use equipment for example bath boards and raised toilet seats. This allowed patients to become familiar with the use of the equipment at home prior to surgery and helped reduce delays in patients being able to go home after surgery.
- The pre-operative assessment identified patients living with dementia or a learning disability and this allowed the staff to decide whether they could accommodate these patients or refer them to another healthcare provider who could meet their needs. Staff told us a carer would normally accompany patients living with dementia or a learning disability.
- We saw a dementia resource folder on the ward, this included information and resources to support staff care for patients living with dementia.

Good

Surgery

- A 'communication passport' was available to use when caring for patients with a learning disability. Staff gave us an example of how they had recently successfully used this to improve their understanding of a patient's needs and their ability to communicate with the patient.
- The hospital had a chaperone policy in place. A chaperone is a person who accompanies a patient during an examination for example a female would be accompanied by a female member of staff when being examined by a male member of staff .Staff we spoke with told us every time a chaperone was required they were asked to assist.
- The pre-operative assessment team could access social services support to aid patients with discharge arrangements if required.
- Patients told us they had received sufficient information prior to their planned surgery. They were provided with both verbal and written information to ensure they understood the planned procedure and had clear expectations about their admission to hospital. They told us risks were explained to them.
- Information leaflets given to patients were in English only. A member of staff told us they could obtain leaflets in other languages if required, however these were not readily available nor was this made known to patients who may be using the hospital.
- All patients with the exception of those in the step down unit were cared for in individual rooms with private ensuite facilities, which helped maintain their privacy and dignity.
- On discharge, further information was provided to patients. They could also telephone the ward with any concerns post discharge.
- The housekeeper received a daily handover from the nurses. The handover indicated patients requiring special diets and those may have food allergies. We saw the housekeeper had this documented on a specially designed sheet to avoid any confusion.

Learning from complaints and concerns

- The provider had received 45 complaints from patients or relatives between January 2014 and December 2014. They had policies and procedures in place relating to complaint handling. This included ensuring all complaints were logged and reported. A letter was sent to the complainant acknowledging the complaint within 48 hours.
- There was an expectation complaints would be resolved within 20 days, if this were not possible a letter was sent to the complainant.
- Complaints were a rolling agenda item at the monthly-integrated governance and learning review group meetings.
- Complaints were included in the quarterly MAC clinical governance report. This ensured the consultants were aware of general issues and could communicate to their colleagues.
- The senior management team (SMT) met weekly to discuss complaints and a formal learning review group met on a bimonthly basis to look at trends and to agree lessons learned. Complaint trends and lessons learned were discussed in ward and theatre staff meetings. We were told of a change in practice following a complaint. The discharge process had been updated to ensure patients own medications were returned to them from their bedside locker on discharge.
- Complaints involving consultants were raised with the chair of the Medical Advisory Committee (MAC) to take forward.
- Complaints leaflets were available for patients to use when required. It explained the process used for complaint handling. An information folder included information on how to make a complaint was available in each patient room.

Are surgery services well-led?

Good

The leadership of surgical services was good. The leadership, governance and culture promoted the delivery of high quality person-centred care. We found;

- The senior management team and other levels of governance within the organisation functioned effectively. There were clear links from ward to board and staff were encouraged to attend governance meetings.
- The leadership actively shaped the culture through effective engagement with all staff.
- There was a strong focus on continuous learning and improvement and staff innovation was supported.
- Staff were able to tell us about some risks.

- The service was transparent, collaborative and open with relevant stakeholders about performance and leaders at every level prioritised high quality compassionate care. There was a clear statement of vision and values.

However;

- Some staff were not clear about specific and individual risks.
- There was a lack of awareness of the commissioning arrangements in relation to the use of the step down unit.
- Not all staff had a good understanding of the hospital and provider's vision and values.

Vision, strategy, innovation and sustainability for this core service

- The hospital values were known and included enterprising, passionate, independent and caring (EPIC).
- The vision and values were displayed in various locations around the hospital; managers told us they had been cascaded to staff across the ward and theatre areas. Objectives were linked to the vision and values.
- Many staff could not describe the EPIC values to us, however the care delivered by staff and behaviours demonstrated were in line with the hospital values.

Governance, risk management and quality measurement for this core service

- There was a clear governance structure in place with committees such as clinical governance, infection control and health and safety / risk management feeding into the medical advisory committee (MAC) and hospital management team.
- A number of different staff groups met to discuss issues related to incidents, risk, complaints management and clinical audits. These groups included the hospital's medical advisory committee, learning review group and the integrated clinical governance committee. All staff groups were represented at these meetings.
- Managers we spoke with told us about the general risks, which related to the area they worked in but some were not clear about specific and individual risks.
- Staff carried out risk assessments where risks to the service were identified, for example, a risk assessment had been completed to minimise the risks to orthopaedic surgeons using specific equipment. This had resulted in equipment replacement.
- Team meetings were held in each department and ward including theatres. These were used for the passing of two-way information.
- A clinical governance report was compiled each quarter. This was presented and discussed at the integrated governance committee (IGC) and medical advisory committee (MAC) meetings.
- Consultant surgeons were represented on the MAC.
- Incidents, complaints and reviews of surgical procedures were presented and discussed at the MAC.
- Some senior staff were aware of the new regulation relating to Duty of Candour and their responsibilities in relation to this. Those aware were able to assure us the hospital viewed their duty seriously and were able to give examples of when they had used duty of candour.
- There was a lack of awareness from senior managers regarding the use of the beds in the step down unit. We reviewed a commissioning document about the care of patients in the step down unit. It stated patients could be nursed in the step down unit during the immediate post-operative period and once fully awake and clinically stable they should return to a single room. The commissioning arrangements are important because they determine whether patients of the opposite sex are nursed in the same area.
- During our inspection, we saw one patient in the step down unit was fully awake and appeared clinically stable. During our unannounced visit, we reviewed the observation charts, medical and nursing records for four patients who had been cared for in the step down unit overnight, all of the recorded observations indicated the patients might not have required this higher level of observation. We were not assured the service had assessed the most appropriate level of observation and which area (the ward or the step down unit) would have been most appropriate for nursing these patients.
- We looked at the operational policy for the step down unit, the discharge criteria stated patients could be discharged from the unit when they meet level zero care requirements. Level zero care is for patients whose needs can be met through normal ward care. All of the four patients we reviewed were transferred to the ward between 6am and 7am on the morning of our unannounced visit, their observations and documented clinical care overnight was consistent with level zero care. We were not assured the hospital was compliant with the Department of Health guidance in relation to

same sex accommodation or with the commissioning arrangements. No risk assessment had been undertaken in relation to the risk to patients being cared for in a mixed sex area.

Leadership of service

- Team leaders were available in all areas of the hospital and were visible to staff. Staff told us who they would approach if they had any concerns and would not hesitate to do so.
- The hospital had a matron who provided professional leadership for all clinical staff.
- Staff said the matron and hospital director were visible and they were able to approach them without question for guidance and support when necessary.
- All the staff we spoke with described immediate managers and members of the senior team as having adopted an 'open door' policy.

Culture within the service

- Staff skills and strengths were recognised. We were given examples of where staff had been given development opportunities and changed roles or responsibilities allowing them to progress in their career.
- Staff were positive about working at the hospital, they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.
- Many staff had worked at the hospital for a considerable amount of time, one member of staff told us they had been there for 17 years.
- There was a positive regard for the welfare of staff. We were told of an example where a member of staff had required support and assistance in their personal lives. The extent of the support provided to staff was exceptional and beyond what would usually have been expected from an employer.
- We spoke with bank and agency staff, all told us they were made to feel part of the team at the hospital.

Public and staff engagement

- There was an annual staff survey.
- Staff told us they received good support and regular communication from their managers.
- Staff routinely participated in team meetings across the wards and theatres we inspected, they were also able to attend other meetings within the hospital if they chose, for example governance meetings.
- The hospital director attended ward staff meetings every three months.
- The hospital held regular open events where prospective patients could come to the hospital and receive a presentation from a specialist consultant surgeon on the types of treatments available. Patients then had the opportunity to have a mini one-to-one advice session with one of the consultant surgeons. In November 2015, for example there was a planned eye care event.

Innovation, improvement and sustainability

- The hospital was the first hospital in the country to introduce a new anaesthetic procedure called targeted spinal anaesthesia. Patients undergoing certain surgical procedures were given a short-acting spinal anaesthetic using different local anaesthetic based on the time required for the surgery. The effect of this anaesthesia only lasted for the duration of the procedure, which meant patients were able to start moving around immediately, were able to eat and drink immediately and could be discharged sooner. This was beneficial for patients, such as those with diabetes, who needed as short a time as possible without being able to eat and drink. The target spinal anaesthesia procedure has since been rolled out at a neighbouring NHS trust.
- Physiotherapy staff had recently introduced an improved physiotherapy programme for patients undergoing men and women's health surgery. This involved physiotherapy in the post-operative stage and as an outpatient. Prior to this patients were seen once following surgery. Physiotherapy staff said the uptake of this service had been significant.
- There was the use of a quiet room in the theatre. Patients were involved in the pre anaesthetic stage of their journey; this was a non-clinical comfortable environment, which could help ease patient's anxiety.

Good

Outpatients and diagnostic imaging

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

Information about the service

Nuffield Health Derby Hospital provides outpatient and diagnostic imaging services to adult patients for a large number of specialities including; orthopaedic surgery, urology, ophthalmology, gastro-enterology, general surgery, ear, nose and throat (ENT), gynaecology, physiotherapy and pain management procedures.

The hospital outpatient facilities consists of 11 general consulting rooms, two ENT specialist rooms, one ophthalmology specialist room, one gynaecology room and one minor treatment room. Between July 2014 and June 2015, there were 21,097 outpatients' attendances at the hospital.

On-site diagnostic imaging is available including x-rays, magnetic resonance imaging (MRI), computerised tomography (CT) and ultrasound. CT scans use x-rays to produce cross sectional and 3D images of the body. MRI scans also produce cross sectional and 3D images of the body, using magnetic energy as opposed to x-rays.

We visited all areas of the service. We spoke with 11 patients, one relative and eight members of staff. We observed interactions between patients and members of staff.

Summary of findings

We rated outpatient and diagnostic imaging services as good. There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse. Risks to patients were appropriately assessed and care and treatment was delivered following evidence based guidance. Patient areas were visibly clean and tidy and infection prevention practices were followed. The hospital had access to a radiation protection supervisor and radiation protection adviser in accordance with the ionising radiation (medical exposure) regulations. Practices and systems were in accordance with the legislation.

Care delivered by the hospital staff was in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Consent to care and treatment was obtained in accordance with legislation and guidance.

Patients told us that they were treated with dignity and respect and were involved in their care.

Staff were appropriately qualified to provide effective care and treatment. However, we found not all staff had completed safeguarding adults (level two) training or training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Patients had timely access to appointments and treatments. Leaflets were visible on how to make a complaint and patients felt confident that they could discuss their concerns with staff.

Good

Outpatients and diagnostic imaging

We witnessed supportive management and a culture of teamwork throughout the department. Staff were proud of the service that they provided and enjoyed working at the hospital.

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatient and diagnostic imaging services at Nuffield Health Derby Hospital as good. We found;

- There were systems for reporting incidents and staff were aware of the process. Investigations into incidents took place and lessons learnt were shared with staff.
- There were sufficient staff with the appropriate skill mix to meet the needs of the patients.
- Equipment was maintained and the environment was visibly clean. Staff adhered to infection control procedures.
- Patient records were stored safely and were up to date. Staff assessed and managed risks to patients.

However;

- Heads of departments for outpatients and diagnostic imaging services did not routinely monitor their department's open incidents but relied on information from the governance teams. This meant that local knowledge of incident trends was limited.
- Eighty three percent of outpatients and diagnostic imaging staff had completed safeguarding training; this was lower than the Nuffield Health target of 85% and hospital target of 90%.

Incidents

- Staff were aware of the hospital's electronic incident reporting system, and were aware of the types of incidents that required reporting. Outpatient staff had not had recent experience of reporting incidents.
- The governance team discussed incidents and necessary actions were sent to areas via email and ward meetings.
- Heads of departments for outpatients and diagnostic imaging services did not routinely monitor their department's open incidents but relied on information from the governance teams. This meant that local knowledge of incident trends was limited.
- The hospital had a process in place to ensure radiation incidents were reported as required under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).

- There had been one incident of unnecessary radiation exposure. Staff reported the incident appropriately and managers investigated thoroughly. Additionally, we saw evidence that the patient had been informed in accordance with the Duty of Candour regulation 2015. The new regulation, Duty of Candour (DOC), states providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology.
- Diagnostics staff were aware of the Duty of Candour regulation. They gave other good examples of their responsibilities in terms of writing to and meeting with patients if harm had been caused. Staff in outpatients were aware of the regulation and described it as being open and honest, but could not relate it to clinical incidents.

Cleanliness, infection control and hygiene

- The clinics and areas we visited were visibly clean.
- Hand gel was available throughout the unit for staff and patient use. There were signs in reception and beside each bottle prompting
- Staff complied with hospital policies regarding infection prevention and control. This included 'bare below the elbow' and handwashing policies.
- Hand hygiene audits were carried out each month. The results for outpatients six months from April to September demonstrated 100% compliance apart from one month, which had 87% compliance. SMART actions were included within the audit results. These are actions that are specific, measurable, achievable, realistic and time-related. We saw evidence of actions taken to maintain a high standard, such as advising staff members that nails were becoming too long. Infection control champions challenged poor hand hygiene practice.

Environment and equipment

- There were suitable safety arrangements in place in the diagnostics area to restrict access where x-ray and imaging equipment was in use. These included warning signs for patients and staff and specialist personal protective equipment for staff available in all rooms.
- Resuscitation equipment was available in outpatients and in magnetic resonance imaging (MRI), computerised tomography (CT) scanning. Staff checked the equipment daily. Outpatients did not have a defibrillation device (used for giving an electric shock to the heart in emergency situations), since the old one had been condemned. Staff performed a risk assessment on the time taken to fetch one from the ward and the potential effect on care. They considered that the time would not have an impact on the health of the patient. During procedures such as exercise echocardiograms all resuscitation equipment, including a defibrillator were placed near to the room.
- The MRI/CT resuscitation trolley was positioned in a public corridor. The risk of tampering was high and inspectors questioned whether it would block access to the fire doors. Management addressed this and moved the resuscitation trolley into the imaging waiting area where staff had sight of it. Staff were to be informed of the change to prevent delay in responding to an emergency.
- Two external providers carried out equipment servicing and maintenance. Staff reported that they were easy to contact and attended any requests for equipment repairs. We saw evidence of the servicing staff present and a programme of work.
- An external provider performed servicing and maintenance of diagnostic and screening equipment. The department maintained an inventory of equipment including replacement dates as required by IR(ME)R.
- The radiology staff all wore individual dosimetry badges to monitor cumulative radiation. The individual dosimeters were read by an external company every month to ensure the levels were not harmful to staff.
- The décor in many of the rooms looked a little dated and the carpet appeared to have been in use for a while. Despite this, the rooms were visibly clean. The provider confirmed there was a plan to refurbish and update the old décor.

Medicines

- An onsite pharmacy was open between 8am to 5pm from Monday to Friday to provide prescribed medication for outpatients. The outpatient department kept bowel preparation medications for pre-operative patients for prescribing out of hours. The prescribing doctor dispensed these medicines.
- There were effective arrangements for managing medicines, including recording, handling, storage and safe administration.

- The radiologists prescribed all contrast media used in scanning.

Records

- All records were paper based. We reviewed eight sets of patient's records. All records were clear, up to date and stored securely within the hospital.
- A system was in place that allowed some consultants to store their own patient records. This only included information supplied by the consultant. Any documentation and inpatient records compiled by the hospital staff were kept in the hospital integrated records. Staff identified that this could lead to patients attending the outpatients' clinic without complete records if the consultant did not bring them. A one off five-day audit of 456 notes demonstrated that despite 189 sets of documents stored by consultants, all were available for clinics. At that time, consultants storing notes had not affected patient care.
- Information governance training and registration with the information commissioner's office was compulsory for all consultants. This would cover storage of records and handling confidential information. The Medical Advisory Committee (MAC) monitored this.
- There was a patient records tracking system for hospital notes that ensured records could be located at every stage of a patient's appointment or treatment.
- Radiology information was available to clinicians who needed it. All radiology images were stored on a picture archiving communication system (PACS) for easy access throughout the hospital.
- Staff scanned radiology referral forms and consent forms onto a computerised radiology information system (RIS).
- Medical records were stored in office areas with keypad entry during clinic times and locked away overnight.

Safeguarding

- The hospital had identified leads for safeguarding. Staff we spoke to had an awareness of who these leads were, how to identify safeguarding issues and what to do if they had any concerns.
- The hospital had a safeguarding policy that was being reviewed. This policy outlined the responsibilities of staff concerning safeguarding.
- Staff in outpatients told us they had not had any safeguarding alerts during the last 12 months.
- Data from the hospitals mandatory training programme demonstrated 83% of staff had completed the training; this was lower than the Nuffield Health target of 85% and hospital target of 90%.

Mandatory training

- The hospital delivered mandatory training using a combination of on-line electronic learning packages and face to face learning. The training included basic life support, infection prevention and control, manual handling, fire safety and information governance.
- There was a new learning management system that when fully established, would track each staff member's training record and managers would be able to monitor training requirements. This service was implemented in July 2015 and not all data had been transferred.
- Staff compliance with mandatory training in outpatients in 2015 was between 75% and 100%. The Nuffield target was 85% and hospital target was 90%.
- Staff in radiology and imaging all undertook role specific training such as radiographers training for undertaking injections and MRI training, and had evidence of completion.

Assessing and responding to patient risk

- There were emergency procedures in place in the outpatient department including call buzzers to alert other staff. Resuscitation equipment was available and all nursing staff had undertaken immediate life support training.
- The outpatients department did not have a designated defibrillator. In the case of an emergency, and during procedures where emergency equipment was considered necessary, staff used the ward defibrillator. A risk assessment had been performed and measures in place informing staff of the location of the defibrillator at all times.
- Resuscitation equipment was available for patients undergoing scanning procedures.
- The provider had an appointed radiation protection supervisor and a radiation protection adviser (RPA) in accordance with IR(ME)R regulations. They conducted an IR(ME)R review of radiology equipment every 12 months. The radiation protection supervisor conducted audits and produced risk assessments in accordance with IR(ME)R requirements.

Good

Outpatients and diagnostic imaging

- Staff followed a radiology 'six point' checklist before using any radiological equipment. This confirmed the correct patient, site and type of investigation.
- Female patients who were or could be pregnant were identified using the six point checklist. There were notices about being pregnant and the dangers of radiation in all waiting areas and changing rooms.

Nursing staffing

- Staff in outpatients said there were sufficient staff on duty to provide safe and effective care to patients. This was supported by consultants and patients, staff told us clinics had never been delayed or cancelled due to staff shortages.
- There was one vacancy for a registered nurse at the time of inspection due to a newly created role.
- In the outpatients department there was a total of 11.2 whole time equivalent (WTE) staff including a lead nurse, registered nurses and healthcare assistants.
- The ratio of team leader to other staff was 1 to 0.8. There had been no use of agency staff to cover nursing or healthcare assistant posts between July 2014 and June 2015.
- There was a team of eight physiotherapists, one physiotherapy assistant and one administrative member of staff who provided inpatient and outpatient care.

Medical staffing

- As required by the regulations, there was an up to date electronic list of people approved to request x-rays or MRIs. There was available guidance on appropriate requesting of radiation diagnostic tests and staff were confident to challenge inappropriate requests.
- There were 160 doctors working under practising privileges in the outpatient department. Practising privileges refers to medical practitioners being granted the right to practice within a hospital.
- Consultants covered their clinics and planned appointments with the administration staff.
- If required the other medical staff or the resident medical officer would be available in emergencies.
- Nursing staff reported a good working relationship with medical staff and all staff working as a team to provide care and treatment.

Major incident awareness and training

- The hospital had a major incident policy and staff in diagnostics had a clear understanding of their roles in the event of a major incident.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate effectiveness for this service. We found;

- Care delivered by the hospital was in accordance with the National Institute for Health and Care Excellence (NICE) guidelines.
- Consent to care and treatment was obtained in accordance with legislation and guidance.
- Staff worked together to improve the service and care received by patients.

However;

- Seventy four percent of staff had received training about the Mental Capacity Act and Deprivation of Liberty Safeguards. This was lower than the hospital target of 90%. Some staff lacked awareness and understanding of the requirements of this legislation.

Evidence-based care and treatment

- The hospital had policies and care pathways in place that were in line with national guidance. We reviewed six sets of guidelines. They were in date and version controlled. We saw eight further sets of guidelines, which had been amended and ratified recently. We saw signature evidence of staff who had signed to confirm acknowledging and reading the amended guidelines.
- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) and protecting patients from the risks of unnecessary exposure to radiation.
- The imaging service used diagnostic reference levels (DRLs) endorsed by Radiation Protection Advisory service. Both national and local DRLs were on display and used in the x-ray rooms. These levels identified

situations where it may be possible to reduce the radiation dose without compromising the quality of the image. The radiation protection supervisor audited these levels.

Pain relief

- Staff gave patients pre-operative information, including pain relief and information about managing their pain.
- Patients received pain relief medication following their procedure. To take out (TTO) pain relieving medication was also given to patients upon discharge if required.

Patient outcomes

- Staff monitored patients following their outpatient treatments, providing one to one care when required.
- Staff followed up patients in a nurse led clinic providing continuity of care for dressing changes and patient support.
- We saw evidence of telephone contact made to patients one week after procedures to check there had been no further complications, such as signs of infection.
- The outpatients department collected patient feedback every six months and they recorded comments in the hospital monthly action plans.

Competent staff

- Competency assessments were completed and available in outpatients and imaging.
- All staff had received their annual appraisal, which supported their clinical development.
- Data provided by the hospital showed that in October 2015, 100% of nursing and medical staff were appropriately registered with their professional body.
- Practising privileges refer to a medical practitioner being granted the right to practice in a hospital. Practising privileges were granted or rejected by the provider's Medical Advisory Committee. In order to assess a consultant's suitability to practice at the hospital, the provider undertook checks on qualifications, reviewed references and disclosure and barring with the Disclosure and Barring Service (DBS). All medical staff had been granted practising privileges and relevant checks had been performed.
- All new nursing staff to the hospital underwent an induction, completing competency paperwork. Induction periods were tailored to the needs of the individual and area of work. The induction pack available in the CT scanner was an excellent example of ensuring competency.
- Staff attended extra study days, such as wound management, to enhance the care given.

Multidisciplinary working

- Staff reported good multidisciplinary working with good access to other medical staff if required. Examples were given of orthopaedic patients having joint reviews with dermatologists due to problems with healing. Radiology staff were flexible to provide imaging if a doctor requested one at short notice.
- Pre-operative multidisciplinary appointments were made for inpatient operations.
- The service offered a mammography 'one stop' clinic to enable patients to see more than one speciality at a time.

Seven-day services

- Outpatient and diagnostic opening times were typically five days a week 8am to 8pm, although several staff gave examples of extra clinics or appointments at weekends to cater for particular patient needs.
- Radiology services were available 8am to 6pm Monday to Friday, with two clinics ending at 8pm during the week. On call radiology staff supplied weekend and out of hours services. A service level agreement was in place with a local NHS trust to provide out of hours computerised tomography (CT) scans.

Access to information

- X-ray and diagnostic imaging results were available electronically which made them readily available to staff in the outpatient clinics.
- Results for routine x-rays and MRIs were available within 24 hours.
- Information was exchanged via letters between GPs and hospital staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking consent from patients.

Good

Outpatients and diagnostic imaging

- Hospital data showed that 74% of staff had received training about the Mental Capacity Act and Deprivation of Liberty Safeguards. This was lower than the hospital target of 90%. Some staff lacked awareness and understanding of the requirements of this legislation.
- Consent forms were available for patients who were considered to lack the capacity to give consent. It was the consultant's responsibility to perform a mental capacity assessment.

Are outpatients and diagnostic imaging services caring?

Good

Services in outpatients, and diagnostics imaging were caring. We found;

- Patients were extremely positive about the care and treatment they were receiving.
- We saw staff treating patients with dignity and respect.
- Hospital's patient satisfaction survey showed that 95% of patients would recommend the hospital to others.

Compassionate care

- During the inspection, we saw patients being treated with respect and dignity. We saw staff speaking discreetly to patients and maintaining confidentiality.
- Without exception patients reported that, they found the staff polite, friendly and approachable. One patient described care as "brilliant, they had time for me."
- The service offered patients the support of a chaperone. This person acts as a safeguard and a witness for a patient or healthcare professional during a medical examination or procedure. For clinics that involved examinations that were more intimate, a nurse was assigned to support patients throughout.
- Reception staff described that in situations where there was a need for privacy or if a patient appeared distressed, there were areas that they could use for greater privacy.
- The hospital's patient satisfaction survey data demonstrated that in May 2015 to August 2015, 95% of patients would recommend care at the hospital to others. This was the same as the provider's expected figure.

Understanding and involvement of patients and those close to them

- All except one patient understood their care and treatment. One patient described a problem of communication concerning tests performed by a local NHS trust and the hospital. They felt it caused a short delay, but could not explain any further. They had no complaints about the final care and treatment.
- We observed staff giving patients time to ask questions and explaining risks and benefits of treatment.

Emotional support

- A patient described emotional and physical support given to them during routine surgery. This was organised after a discussion in outpatients about feeling very anxious. They described the time medical staff had spent determining likes and dislikes and even appropriate music to wake up to post procedure.
- Patients were able to contact the hospital via the booking phone line and we saw staff responding to calls.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good. We found;

- Opening hours of the outpatients department made services accessible to more patients.
- Between July 2014 and June 2015, between 93% and 95% of patients were seen within the 18 week referral to treatment time target for NHS patients.
- Facilities and the environment were appropriate including free parking.
- Patients had timely access to appointments and treatments.
- Leaflets were visible on how to make a complaint and patients felt confident that they could discuss their concerns with staff.

Service planning and delivery to meet the needs of local people

- The outpatients department was open 8am to 9pm, five days a week Monday to Friday, offering a wide variety of appointments.

Good

Outpatients and diagnostic imaging

- Staff described running additional clinics at weekends, such as optometry clinics, if patients could not drive in the evenings, or attend on weekdays.
- The hospital operated an enhanced recovery programme which aimed to help patients get better quicker. This started at pre-operative assessment. The aim was for patients to spend less time in hospital after their operation. Patients received early physiotherapy and occupational therapy support.
- Self-funded patients, who were receiving care via insurance or paying themselves, were offered a free enhanced recovery programme. This service provided a personal recovery programme, health check, exercise and diet advice and a recovery coach.
- The service offered outpatients undergoing planned inpatient surgery a 90 minute health MOT in combination with their pre-operative assessment. This included blood tests for diabetes and cholesterol levels as well as a general health and lifestyle check.
- X-ray and diagnostic imaging services were available 8am to 6pm Monday to Friday with on call services outside these hours.
- The outpatients' physiotherapy department was open 8am to 7.30pm, three days a week and 8am to 5.30pm the other two week days. The clinic was not open at weekends although inpatient on-call services were available.
- The environment in the hospital was comfortable for patients and visitors. There was sufficient seating for patients in the waiting area and drinks and snacks were available.
- Car parking on site was free. Signage throughout the hospital was clear and easy to follow.

Access and flow

- The national standard for referral to treatment time (RTT) for NHS patients states that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. Data provided by the hospital showed that between July 2014 and June 2015, 95% of patients were seen within this 18-week target for 11 out of 12 months. In December 2014 the figure was 93% of patients.
- The hospital audited patient waiting times after arrival for their appointments. They found that no patients waited more than 30 minutes, but some consultants kept patients waiting up to 30 minutes. There were action plans in place, such as extending appointment times for these consultants, and audits planned to monitor the progress.
- If clinics were delayed patients were informed and offered the opportunity to wait or reschedule the appointment.

Meeting people's individual needs

- Information leaflets were available to patients regarding their treatment. Staff either sent the leaflets in appointment letters or gave them to patients to take away.
- The online system that provided a range of leaflets had the facility for printing in any language.
- The service used a 'hospital passport' system for patients with a learning disability. This document provided information about the individual needs of the patient so that they could be supported during their appointment and treatment. Staff gave us an example of when they had used this for a patient.
- A clinic room was available for care of bariatric patients. This was a speciality offered by a consultant at the hospital for treating patients with obesity.
- There were 'dementia champions' in both outpatients and physiotherapy departments. The champions cascaded relevant information on dementia to other hospital staff to increase their awareness. Staff in radiology were aware of the need for extra support for patients living with dementia.
- Radiology staff would adapt their working hours to suit the needs of the patient, for example staying into the evening to assist in procedures in the CT department.
- An agreement was in place for patients with claustrophobia to receive MRI scans at a neighbouring Nuffield Hospital in a wide bore scanner.
- Staff described how they referred patients to colleagues during appointments if an opinion was required. This reduced the need for patients to return for other appointments.

Learning from complaints and concerns

- Notices in the department informed patients of how to complain. The patients we spoke to all said they would discuss a complaint with the consultant or nurse in charge if they needed to.

Good

Outpatients and diagnostic imaging

- Staff were aware of the complaints policy and were able to advise patients on how to complain. They would however, try to resolve a complaint at the time if appropriate.
- Staff recorded complaints on the hospital electronic reporting system. The hospital had a procedure in place for investigating complaints, responding to the complainant and learning from complaints.
- We saw evidence in minutes of meetings, of investigations and changes made to patient leaflets as a result of complaints. This demonstrated that suitable governance procedures were in place to facilitate investigating and learning from complaints.
- Staff in radiology explained that patients did not like the gowns worn for scanning procedures. As a result, patients now wear clothes similar to theatre scrubs for procedures.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led for outpatients and diagnostic imaging services as good. We found;

- A culture of teamwork and supportive management was apparent. Staff were proud to work at the hospital and enjoyed coming to work.
- Governance meetings took place at the hospital and audit work was undertaken.
- Plans were in place to improve the aesthetics of the building and increase the capacity of the services.

However;

- Few staff were fully aware of the hospital and provider's values which were enterprising, passionate, independent, caring (EPIC).

Vision and strategy for this this core service

- The provider had a vision and strategy that they referred to as EPIC values. These involved staff being enterprising, passionate, independent and caring. Senior management spoke of a culture of quality and continuous improvement in both staff and the services provided.
- We saw posters on hospital walls promoting the EPIC values.
- Staff expressed an ethos of working together for a quality service for patients but very few quoted the EPIC values.

Governance, risk management and quality measurement for this core service

- The hospital held a variety of meetings through which governance issues were addressed. The meetings included senior management, clinical governance and medical advisory committee (MAC). Other specialty group meetings took place, for example learning review meetings.
- Staff carried out a series of audits within each department. Results of the audits and action plans were reviewed at relevant meetings. Staff changed processes to address issues that had been highlighted. Example of audit topics included medical records, chaperone audits, pre-assessment tool and waiting time audit.
- We looked at a selection of clinical governance and MAC meeting minutes and saw that complaints were discussed.
- Senior staff were aware of the hospital risk register and could describe risks that were placed on it. We saw evidence of managers and clinicians discussing risks at clinical governance and MAC meetings.

Leadership

- Staff told us that the outpatient department and diagnostic imaging service were well led. All staff told us that the senior management team were approachable and supportive.
- All staff were positive about working at the hospital. The felt listened to and valued. They believed that if they raised issues they would be taken seriously.
- Management encouraged staff to develop business cases for changes such as staffing levels. We saw evidence that this had been actioned in outpatients.

Culture within the service

- Staff spoke very highly about working at the hospital; many had worked there for a long time. There had been no staff turnover for nurses and care assistants working in outpatients between July 2014 and June 2015. Staff were proud to work at the hospital and enjoyed coming to work.

Good

Outpatients and diagnostic imaging

- Staff described a supportive and positive culture that encouraged staff to learn and develop.
- Heads of department told us that they had a close working relationship with senior management.

Public and staff engagement

- The hospital performed six monthly patient surveys in addition to each inpatient completing a feedback form. As a result of feedback, changes were made in informing patients about paying for consultations and hospital charges.
- Staff held ward meetings monthly and the minutes were distributed to all staff via email and staff notice boards.
- The hospital ran free event evenings for both staff and patients that gave information on areas such as cataracts and vascular surgery.
- The hospital performed yearly staff surveys. Results and comments were positive about working at the hospital.

Innovation, improvement and sustainability

- All staff focused on continually improving the quality of care. They were all familiar and appeared involved in the planned refurbishment of the unit**.**
- Radiology staff worked towards improving the experience for patients having injections within the department. Trials of new closed injection devices were taking place to reduce blood splatter.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had introduced a new anaesthetic procedure. Patients undergoing certain surgical procedures were given a short-acting spinal anaesthetic using different local anaesthetic based on the time required for the surgery this was called targeted spinal anaesthesia. The effect of this anaesthesia only lasted for the duration of the procedure which meant patients were able to start moving around immediately, were able to eat and drink immediately and could be discharged sooner. This was beneficial for patients, such as those with diabetes, who needed as short a time as possible without being able to eat and drink.
- The hospital had recently introduced "The Nuffield Health Promise" for self-funded patients. This enabled patients to have further care and follow ups at no extra cost if their expectations had not been reasonably met.
- Prior to a patient going into the anaesthetic room, patients were taken to a 'quiet room'. Patients were introduced to the surgical team. A handover of the patient from the ward nurse to the theatre staff including the patient took place in this room; the patient was involved in the whole process and put at ease.
- During the Five Steps to Safer Surgery safety checklist in the operating theatre, patients who were anesthetised were 'introduced' to the team by their full name, for example, 'team let me introduce to you', and this was respectful of the patient.
- The hospital's cancer services offered a range of therapies to cancer patients without any extra charge. Patients could have up to six treatments, such as massages or eyebrow tattooing.
- We were given a positive example of staff going out of their way to protect the dignity and privacy needs of a patient with learning disabilities. The hospital had recognised the patient needed to be brought into the hospital in a special way involving extra staff. We were told how it was dealt with in a person centred way by all staff to ensure treatment could be given in a manner, which protected their dignity and privacy.

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that performance monitoring, quality dashboards and patient outcome measures are in place in endoscopy and cancer services.
- The hospital must ensure that service specific policies are fully developed and understood for cancer services.
- The hospital must ensure that patient outcomes are reported and used to inform the endoscopy and cancer services.

Action the provider SHOULD take to improve

- Ensure all staff are aware of and understand their responsibilities in relation to the hospital major incident and business continuity plans.
- Review the use of the step down unit in order to comply with the clinical commissioning arrangements and Department of Health same sex accommodation guidance.
- Ensure all staff are aware of and know the requirements in relation to The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.
- Ensure staff complete all mandatory training, including in The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation.
- Ensure all risk assessments in patients records are up to date and accurately reflect the patient's current condition.
- Review the arrangements for the borrowing of the defibrillator from the ward by other departments.
- Ensure local and national guidance, policies and procedures used in the delivery of care and treatment are current, especially on the step down unit.

Outstanding practice and areas for improvement

- Increase the local understanding and routine completion of monitoring incidents in the outpatients department.
- Consider ensuring patient information leaflets are easily and readily available in languages other than English.
- Ensure the hospital's local risk register is updated and reflects risks identified by services and departments at the hospital.
- Ensure appropriate storage, management of information governance and patient confidential information is maintained when consultants remove notes from the hospital.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that performance monitoring, quality dashboards and patient outcome measures were not in place, reported or used to inform endoscopy and cancer services. We also found that service specific policies were not fully developed and understood for cancer services. This was in breach of regulation 17 (1) (2) (a) (b) (c) HSCA 2008 (Regulated Activities) Regulations 2014 Good governance. The trust must operate systems and processes effectively to assess, monitor and improve the quality and safety of services provided, including the quality of experience of service users.