Nuffield Health Haywards Heath Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health Haywards Heath Hospital is operated by Nuffield Health. The hospital has 27 beds. Facilities include three operating theatres, including one with laminar flow, a two-bedded area for closer post-operative observation, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected all four core services. Because of the low numbers of patients receiving medical care at this service, we have reported this under the surgery section.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 07 – 09 November 2016.

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

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

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

We rated this hospital as good overall because:

- Staff confidently escalated any risks that could affect patient safety and we saw effective systems for reporting, investigating and learning from incidents.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training for their roles. Completion rates for mandatory training including key topics such as safeguarding were better than the target set by the Nuffield Group.
- The hospital was visibly clean and there were appropriate systems to prevent and control healthcare associated infections. We saw that rooms were equipped with sufficient equipment and consumable items for their intended purpose. The waiting areas were spacious and well-appointed with amenities for refreshments and comfortable seating, including a variety of seat heights available to assist those recovering from surgery.
- Medicines were managed safely in accordance with legal requirements and checks on emergency resuscitation equipment were performed routinely.
- Staff responded compassionately when people needed help and support to meet their basic personal needs. Staff also respected people's privacy and confidentiality at all times. Patients' feedback through interviews and comment cards was positive.
- People were always made aware of waiting times and meals were offered to those delayed or in clinic over meal times. Any concerns or complaints were listened and responded to and feedback was used to improve the quality of care.
- We saw strong leadership at the location with an open and transparent culture. The hospital director used the Heads of Departments forum as a governance and performance management tool to maintain and improve the quality of the service. There was a clear vision and focused strategy to deliver good quality care.
- The governance framework ensured staff responsibilities were clear and that quality, performance and risks were all understood and managed. Services continuously sought to improve and develop novel approaches to enhancing care, such as exercise courses offered to the public.

Summary of findings

- Staff were overwhelmingly positive about their experience of working at the hospital and showed commitment to achieving the provider's strategic aims and demonstrating their stated values. Staff told us they were supported by the hospital director and the new matron, both of whom were visible and approachable.
- We found evidence of multidisciplinary team (MDT) working across all of the areas we visited and we saw good collaborative working and communication amongst all staff in and outside the department. Staff frequently reported they worked well as a team and liked the "family" feel of the organisation.
- There were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems. The hospital offered rapid access to diagnostic imaging and physiotherapy services, usually within a week. The hospital was above the 90% national referral to treatment (RTT) waiting time target for the majority of the year.

However, we found an area of practice that requires improvement in outpatients and children and young people's services:

- During our inspection, we observed a number of outpatient records kept in a lockable filing cabinet in a utility room. We saw that these folders contained care notes for patients attending the clinic for dressings or other interventions. These records were stored separately from medical files we had previously viewed and were treatment notes held loosely in clear plastic wallets. Some had been labelled with a patient's name and all were stored in an alphabetic filing system.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 201417 (2) (c)states the provider must "maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided."
- Keeping separate file notes in this manner did not meet the requirement of the regulation and because of this, our rating lowers to 'requires improvement' for safety. The way the records were kept added to the risk that papers could be separated or misfiled, which was an unsafe practice. We noted that this had occurred in a file our colleagues from the children's team viewed. In addition, separating the medical records in this way made it harder for the consultant to monitor the results of treatments and the patient's progress.

We found an area of practice that requires improvement in services for children and young people:

- Services did not meet the needs of their young patients fully because many facilities were shared inappropriately with adults, resulting in a lack of privacy and dignity for young patients, and there was a lack of resources available for this patient group.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected outpatients and children and young people's services. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive to people's needs and well-led. Incidents, accidents and near misses were recorded and investigated appropriately. Incidents were discussed during departmental meetings and at handover, so shared learning could take place. Staff were familiar with the process for duty of candour and carried it out in practice. • Risk assessments were completed at each stage of the patient journey from admission to discharge, with an early warning scoring system used for the management of deteriorating patients. The Five Steps to Safer Surgery checklist was completed and monitored appropriately. • Although the hospital did not use a recognised staffing acuity tool, there were processes to ensure safe nurse staffing levels. All departments were appropriately staffed. Staff were flexible in working patterns to meet the needs of the service and patient requests. Staff turnover and sickness rates were low. • Patients received care and treatment in line with national guidelines such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. The hospital participated in national audit programmes including performance related outcome measures (PROMS) and the National Joint Registry. Results showed patient outcomes were within expected levels when compared to national averages. • Results from the Friends and Family test showed 99% of patients attending for surgery would be extremely likely to recommend the service to friends and family.

Summary of findings

However,

- There was no compartmentalization in the roof space above the theatres. This meant in the event of a fire all theatres would need to be evacuated immediately rather than isolating the individual theatre.

Services for children and young people

Requires improvement 

Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement because we found the way records were kept was insufficient and staffing levels and safeguarding training for all HCAs did not meet intercollegiate guidance.

- Health Care Assistants were only mandated to train to level one in child safeguarding, despite intercollegiate guidance recommending that level two is the minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/ carers.
- Although nurses working with children had experience, there were no paediatric nurses employed at the hospital.
- A Children and Young People's Committee had been established with nine members but had yet to formally agree their terms of reference.
- The resuscitation trolleys were not equipped with a paediatric blood pressure cuff.
- Paediatric equipment kept on the resuscitation trolley was stored in an unsealed rucksack.
- There was little to do for children waiting for appointments other than use the colouring pencils that were kept behind the reception. There were no toys available for younger children.

However,

- We found that processes and protocols around child safeguarding were well embedded. All staff we spoke with had a good understanding of what they needed to do in

Summary of findings

the event of a safeguarding concern. This knowledge was further reinforced through clear flow charts being placed in prominent positions across the hospital. Furthermore, all staff received level one child safeguarding training annually.

- Mandatory training compliance was above 90% in all but one area and reached 100% in some key areas including safeguarding children at level two and three.
- The hospital was able to tailor care to the individual needs of the patient they were seeing. This was particularly evident in the way they worked to manage patients with special needs to attend dental appointments.
- The hospital had access to telephone interpreters if a patient or parent required it. Although this facility was available, no staff we spoke with had had cause to use it.
- The introduction of the children's and young people's (CYP) committee, which included staff from across the hospital, and the appointment of a CYP lead nurse, had given the services offered to children and young people a sharper focus.

Outpatients and diagnostic imaging

Good

Outpatients and diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

We rated this service as good because it was caring, responsive and well led, although we found the way records were kept requires improvement.

- Overall, patients were protected from the risk of abuse and avoidable harm. Staff could confidently escalate risks that could affect patient safety and we saw effective systems for reporting, investigating and learning from incidents, which included the duty of candour if necessary.
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and

Summary of findings

additional training for their roles. Completion rates for mandatory training including key topics such as safeguarding were better than targets set by the Nuffield Group

- Staff in all areas had a good awareness of Nuffield Health policies, which were based National Institute for Health and Care Excellence (NICE) guidelines and other national standards, such as the imaging practices agreed by the College of Radiology.
- Staff had undertaken local and national audits to monitor the quality, safety and effectiveness of care. Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as required.
- We saw a variety of processes described to measure and audit patient outcomes in physiotherapy and radiology. For example, these included the use of patient-reported outcome measures (PROMs), a method of capturing the patient's opinion on the impact of their disease or disorder and the effect of the treatment.
- We found evidence of multidisciplinary team (MDT) working across all of the areas we visited and we saw good collaborative working and communication amongst all staff in and outside the department. Staff frequently reported they worked well as a team and liked the “family” feel of the organisation.
- For NHS patients, referral to treatment times were better than the England average. Outpatient and physiotherapy services offered extended hours during the week and outpatients also ran clinics on Saturdays if needed. Evening and weekend appointments allowed patients who worked to access healthcare that suited their circumstances
- People’s concerns and complaints were listened and responded to and feedback was used to improve the quality of care. There was an effective system for capturing learning

Summary of findings

from complaints and incidents, and there was good local ownership of any problems with teams working together to resolve issues that arose.

Summary of findings

Contents

Good

Nuffield Health Haywards Heath Hospital

Services we looked at

Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Nuffield Health Haywards Heath Hospital

Nuffield Health Haywards Heath Hospital is operated by Nuffield Health. The hospital opened in 1993 as The Ashdown Hospital and was acquired by Nuffield Health in 1997, when it was renamed. It is a private hospital in Haywards Heath, West Sussex. The hospital primarily serves the communities of mid Sussex. It also accepts patient referrals from outside this area.

The registered manager had been in post since October 2014. He was also the Controlled Drugs Accountable Officer.

The hospital also offers a Magnetic Resonance Imaging (MRI) service using a new 3.0 Tesla MRI. We did not inspect this service as it is provided by a third party, which is registered separately with the Care Quality Commission.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, four CQC inspectors, and five specialist advisors with expertise in radiography, governance, safeguarding children and young people, theatre nursing and senior nurse management. Elizabeth Kershaw, Inspection Manager, oversaw the inspection team.

Information about Nuffield Health Haywards Heath Hospital

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

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

During the inspection, we visited all the clinical areas. The hospital is set over three floors and has 27 beds, and a two-bedded area for closer post-operative observation. There are two main theatres (one with laminar flow) and a third theatre used for endoscopy and pain procedures without anaesthetic. There are six consulting rooms in the outpatient department and facilities for ophthalmology, gynaecology and urology on the top floor.

We spoke with 49 staff including registered nurses, health care assistants, technicians, reception staff, administrative and housekeeping staff, medical staff, operating department practitioners and senior managers. We spoke with 16 patients and four relatives. We also received 48 'tell us about your care' comment cards which patients had completed prior to our inspection.

During our inspection, we reviewed 39 sets of patient records. We looked at policies and procedures, staff training and appraisal records along with meeting notes, audit reports, the environment and equipment used.

There were no special reviews or investigations of the hospital on-going by the CQC at any time during the 12 months before this inspection.

Between July 2015 and June 2016, 147 doctors worked at the hospital under practising privileges. The hospital told us that 68% of these had carried out no episodes of care, but this figure included anaesthetists and radiologists who had nevertheless participated in the care of patients. Apart from these, 9% carried out between one and nine episodes of care, 17% carried out between 10 and 99, and 5% carried out more than 100 episodes of patient care. Three consultants had been suspended in this time, two for not meeting a deadline for providing information relating to the CMA remedy and one for contravening the Practising Privileges Policy. A resident medical officer (RMO) provided by a third party agency worked on a rota of one week on, one week off.

The hospital employed 26.9 whole time equivalent (WTE) registered nurses, 11.3 WTE care assistants and 37.7 WTE

Summary of this inspection

other hospital staff. The use of bank and agency staff in inpatients, theatre and outpatients was lower than the average of other independent acute hospitals we hold this type of data for. Staff turnover and sickness rates were lower than the average.

Between July 2015 and June 2016, there were 4,203 inpatient and day case episodes of care, 17% of which were NHS funded and 83% other funded. There were 6,941 outpatient attendances, of which 27% were NHS funded and 73% other funded. Outpatient activity comprised 62% of the total activity with inpatients and day cases comprising 38%. The majority (84%) of patients were adults aged 18 -74, with 15% adults aged over 75 and 1% children and young people.

Services for children and young people at Nuffield Health Haywards Heath consisted of outpatient appointments for children aged between three and 15. There were no inpatient stays for this age group. Patients aged 16 and 17 who attended the hospital were cared for under the adult pathway.

In the quarter from July 2016 to September 2016, there were 155 outpatient attendances for children aged three to 15. From January 2016 to October 2016 there had been six inpatient attendances for young people aged 16 and 17.The majority of patients accessed the service through a referral from their general practitioner and were funded through insurance policies held by their parents. The hospital did not see NHS patients except for a small number of dental patients with special needs.

In this time period, the most common medical procedures were endoscopic laryngo-pharynoscopy (214), facet joint injections (157) and diagnostic gastroscopy (143). The most common surgical procedures included cataract surgery (159) and total hip replacements (112).

There were no reported cases of serious infections such as MRSA, MSSA, E-Coli or C-diff in this time frame. There were no deaths, never events or serious injuries. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were 241 clinical incidents, of which 66% occurred in surgery. The level of harm associated with the incident was mostly none (71.8%) with 21.2% rated as low harm and 7.1% as moderate harm. In addition, there were 44 non-clinical incidents. There were four incidents of hospital acquired VTE (venous thromboembolism). No safeguarding concerns were reported to the CQC in the reporting period.

The hospital received 29 complaints from July 2015 – June 2016 which is similar to the rate of other independent acute hospitals we hold this type of data for. During this time period, we did not receive any direct complaints or whistleblowing concerns.

The hospital operates a 3.0 Tesla magnet MRI in partnership with an external organisation. This was not included in the inspection as the organisation is registered separately with the CQC.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Although there were many good things about the service, it breached a regulation relating to the maintenance of patient records, which means we cannot give a rating higher than requires improvement.
- We observed a number of patient care notes filed separately from medical record folders. Although secured in a locked cabinet, keeping separate notes in this manner did not meet the requirement of a complete and contemporaneous record and the way the notes were kept added to the risk that papers could be lost or misfiled.
- In addition, filing care records in this way made it harder for the consultant to monitor the results of dressing treatments or other interventions undertaken.
- The hospital had taken the decision to stop surgery on children aged 3-15, and so children's and young people's services were limited to outpatients and surgery for young people aged 16-17. However, the absence of dedicated paediatric nurses meant we did not have assurance that their specific needs were effectively managed.

However,

- Overall, patients were protected from the risk of abuse and avoidable harm. Staff could confidently escalate risks that could affect patient safety and we saw effective systems for reporting, investigating and learning from incidents, which included the duty of candour if necessary.
- There were effective systems in place to manage safeguarding concerns. The hospital matron was the designated lead for safeguarding and had completed level three safeguarding training. Staff were aware of their roles and responsibilities for safeguarding and could describe what types of concerns they would report and the system for doing so.
- The hospital had arrangements in place to support the management of infection prevention and control. The hospital reported no Surgical Site Infections (SSIs) resulting from hip operations or knee operations or incidents of hospital acquired infections in the reporting period (July 2015 to June 2016).
- There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training for their roles. Completion

Summary of this inspection

rates for mandatory training including key topics such as safeguarding were better than targets set by the Nuffield Group. Two resident medical officers (RMO) on duty were advanced life support trained and available for assistance 24 hours a day seven days a week.

Are services effective?

Good

We rated effective as good because:

- There were effective systems in place to manage patients' pain.
- The establishment of a children and young people's committee had allowed all parts of the hospital to come together as part of a multi-disciplinary group to discuss matters relating to the care of children and young people.
- Nursing staff worked closely with carers attending the hospital with patients with special needs and challenging behaviour. This allowed the hospital to provide a service that was right for the patient and would achieve a positive outcome for them.
- Consent forms for all surgical patients, aged 16 and 17 were clear, with guidance for clinical staff as to how to take consent and complete the forms appropriately.
- Staff in all areas had a good awareness of Nuffield Health policies, which were based on National Institute for Health and Care Excellence (NICE) guidelines and other national standards, such as the imaging practices agreed by the College of Radiology.
- Staff had undertaken local and national audits to monitor the quality, safety and effectiveness of care. Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as required.

Are services caring?

Good

We rated caring as good because:

- We observed patients being treated with compassion, dignity and respect throughout our inspection. Staff were courteous and helpful in all roles. All staff we met during inspection were approachable and friendly.
- All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- We saw that people were treated with kindness, respect and compassion whilst they received care at the hospital. Patients told us they felt supported and informed at all stages of their

treatment and commented positively about the care provided to them by the staff from all the clinics we visited. Patients liked the fact that their consultant had the time to explain things in detail and allowed time for any questions.

- Consulting and clinical treatment room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. All clinic room doors had 'free/busy' signs and we observed staff using these.
- We saw an up-to-date privacy and dignity policy which staff were aware of and in the radiology department, there were curtained sections to promote dignity when patients changed into hospital gowns.

Are services responsive?

Good

We rated responsive as good because:

- The hospital worked in partnership with the NHS and other organisations to respond to the pressures within the local healthcare community. There were contractual agreements with clinical commissioning groups to provide elective surgical care. Private patients did not receive priority over NHS patients and staff confirmed there was no difference in the way staff treated patients.
- The hospital had taken action to improve the facilities and care for patients living with dementia. All staff had undertaken dementia training and reasonable adjustments had been made to the environment.
- Patients admitted to the hospital were assessed for admission suitability by their consultant using selected risk criteria in line with local and national guidelines. This meant that the majority of patients treated at the hospital were considered as 'low risk'.
- The senior management team (SMT) discussed complaints on a weekly basis. Information was shared through the clinical heads of department, integrated governance and MAC meetings. Heads of department provided feedback to staff on outcomes and lessons learned from complaints.
- For NHS patients, referral to treatment times were better than the England average. Outpatient and physiotherapy offered extended hours during the week and outpatients also ran clinics on Saturdays if needed. Evening and weekend appointments allowed patients who worked to access healthcare that suited their circumstances.

Summary of this inspection

- The environment provided was appropriate and patient centred, with comfortable and sufficient seating, toilet and refreshment facilities. Facilities for patients and their families were enhanced by free car parking and internet connectivity (Wi-Fi).

Are services well-led?

Good

We rated well-led as good because:

- There was an open and honest culture, which was reinforced through the hospital's values and behaviours. Staff were confident in the leadership and management of their department and the hospital as a whole.
- The hospital had an integrated governance framework to support the delivery of clinical excellence and patient satisfaction. The minutes of senior management team minutes such as the heads of department, MAC and governance group meetings all demonstrated good clinical governance and consideration of safety, quality, performance and finance.
- There were assurance systems in place to monitor compliance and performance. The hospital produced monthly quality and safety dashboard data. These included indicators covering safety thermometer variables, readmission rates, patient satisfaction data and departmental key performance indicators.
- The roles and responsibilities of the MAC were well defined with good oversight of practising privileges and clinical governance issues.
- There was a clear vision and strategy for the hospital, which staff understood.
- The hospital was clear about what services it was able to offer children and young people. They had a clear vision of what the service should be and had no plans to reverse the decision not to offer surgical procedures to children aged between three and 15. They were also looking to develop their physiotherapy service to children. However, the inclusion of the children's and young people's service within the outpatient department did not give assurance that the specific needs of this patient group were being identified and addressed.
- There had been positive changes in culture and further work was planned to embed a new culture where staff had more autonomy and personal responsibility.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Not rated	Not rated	Not rated	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

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

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

We rated safe as good.

Incidents

- The hospital had systems in place for dealing with untoward incidents. This included the corporate policies and procedures that were readily available for staff to access on the hospital's intranet. The electronic reporting system was accessible on every computer on the hospital's intranet. All staff had access to the system including housekeeping and ancillary staff.
- In the reporting period July 2015 to June 2016, 66% of clinical incidents in the hospital (158 incidents) occurred in surgery or inpatients. The assessed rate of clinical incidents in surgery, inpatients or other services (per 100 bed days) was higher than the rate of other independent acute hospitals we hold this type of data for.
- Of all the incidents reported in the hospital, the majority (71.8%) resulted in no harm to the patient, with 21.2% resulting in low harm and 7.1% moderate harm. No incidents resulted in severe harm or death.
- There were 10 non-clinical incidents reported in the same period. The rate of non-clinical incidents was similar to the rate of other independent acute hospitals.
- The hospital reported no serious injuries occurred from July 2015 to June 2016.
- There were no reported never events from July 2015 to June 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We noted the hospital had a positive reporting culture. All staff were encouraged to report any incident or concern through the electronic reporting system. The staff we spoke with confirmed they were encouraged to report all incidents, near misses or concerns. They told us the hospital had a no blame culture and encouraged reporting concerns.
- We saw from the training records that staff received training on incident reporting at induction and updates as part of their mandatory training.
- Investigating incidents was a new responsibility for the heads of department since the new matron had been appointed. Incidents were now investigated by the appropriate head of department with a root cause analysis (RCA) being carried out for all incidents graded as moderate or above. Managers had received incident investigation training and had attended a group teleconference to discuss the new ways of working and incident investigation. The matron told us she was

sourcing additional investigation training for those managers who wished to develop their investigation skills further. Managers told us they now felt more involved in the investigation process and had responsibility for ensuring that any actions identified were put in place.

- Reviewing any incidents was a standard agenda item on the quality and safety committee meetings and we saw evidence of this from meeting minutes. This ensured that any identified themes were highlighted and new incidents discussed.
- Learning from Incidents was shared between all the hospitals in the group as part of the quarterly matrons' cluster meetings and cascaded back through clinical department meetings.
- Staff confirmed they received feedback from incidents. We saw from team meeting minutes, bulletins and email updates that there was shared learning following any incident. For example the theatre manager told us of a recent never event at another hospital which occurred the day before the inspection. An email was sent to all the hospitals in the group and we saw details were on the theatre notice board to ensure practice was amended to prevent a similar incident occurring elsewhere. This demonstrated there was a learning culture within the group and information was disseminated quickly to reduce the risk to patients.
- We were told that any serious incident that resulted in mortality or morbidity would be investigated using the serious incident policy and procedure. This included discussing the findings at the quality and safety meetings, heads of department and medical advisory committee (MAC).
- The hospital had a duty of candour policy available on the intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- The staff we spoke with were aware of the duty of candour terminology and could describe the process of communicating openly and honestly with patients and their relatives. This included theatre staff who told us there were lots of discussions with patients and their relatives and the hospital made a point of always being open and honest.
- The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken. Duty of candour was routinely monitored as part of the adverse incident process. The senior management team reviewed all incident logs on a daily basis which included compliance with duty of candour.
- We reviewed some examples of RCAs and noted that lessons learned had been identified. The RCA was used as evidence to monitor the quality of the investigation process, any contributing factors, analysis and the lessons learnt. The RCA reports we reviewed demonstrated critical analysis, where the investigator examined facts in an open and transparent manner, which included duty of candour.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital used the NHS Safety Thermometer and a clinical quality dashboard. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm and the proportion of patients that experience 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE). The hospital was required to submit this monthly data to the NHS as this was part of the information required when treating NHS patients.
- However, day case patients were excluded from the NHS Safety Thermometer. None of the patients undergoing an endoscopic procedure in the reporting period (April 2015 to March 2016) stayed overnight.
- The VTE screening rates in the reporting period (July 2015 to June 2016) were below 90% from July 2015 to September 2015 and from April 2016 to June 2016. The remainder of the year the screening rate was 100%.
- There were four incidents of hospital acquired VTE or pulmonary embolism (PE) in the reporting period (July 2015 to June 2016). There were no new pressure ulcers, catheter or urinary tract infections.
- We noted that the hospital had taken action to improve the VTE screening rates such as reminding staff of the importance of completing the assessments, changing the forms used in the pre-assessment clinic and appointing a nurse with overall responsibility for monitoring VTE compliance and ensuring the screening was completed.

Cleanliness, infection control and hygiene

Good

Surgery

- The hospital had corporate Nuffield Health infection prevention and control policies and procedures that were available to all staff on the hospital's intranet. The Nuffield Health corporate infection prevention and control lead was available for further support and guidance if required.
- We observed staff following the hospital's infection control policies. For example, staff segregated waste and disposed of it appropriately according to the waste management policy. There were instructions for labelling and disposing of both clinical and domestic waste on display and we saw staff following this guidance. Disposable sharps were managed and disposed of safely. Spillage kits for the safe disposal of body fluids, chemical fluids and cytotoxic waste were provided and were all in date. Staff knew where to locate them, and correctly described the procedure for managing each situation in accordance with the local policy.
- The hospital had local antibiotic guidelines in place to help control increasing antibiotic resistance by limiting inappropriate and/or prolonged use. Antibiotic use was monitored through the hospital's antibiotic stewardship forum that met quarterly. The results were fed into the infection prevention expert advisory committee (IP-EAC) and the infection prevention team (IPT) and surgical site infection surveillance committee (SSISC) which met monthly. We saw when the results fell below 95% there were detailed actions in place to resolve the issues. For example, in April 2016 compliance fell to 69%. Action was identified to include review dates in the notes to use the prescriber's checklist. A reminder was sent to all prescribers. The minutes from the SSISC indicated that compliance had improved to 100% by July 2016.
- The hospital had arrangements in place to support the management of infection prevention and control. These included an infection prevention team, which included the matron as director of infection prevention and control, an infection prevention and control co-ordinator and link nurses in each department. The link nurses were given protected time to undertake infection prevention and surveillance. We saw minutes from the infection prevention committee meetings where audit results, policies and training requirements were discussed.
- Nuffield Health Haywards Heath hospital had a small pathology department on site which was used for haematology and biochemistry tests. The hospital acted as a hub for another Nuffield Health hospital which provided a microbiology service. There was a named consultant microbiologist from a nearby NHS trust who provided infection prevention and clinical advice when needed.
- The infection prevention and control team undertook regular audits and monitored infection prevention and control across the hospital. We noted that healthcare-associated infections (HCAI) were monitored by the infection prevention committee which undertook investigations of any HCAI and disseminated any learning required. For example, the April 2016 IP-EAC minutes documented two HCAI infection investigation reports. Both investigations did not identify any need for a change in practice as the contamination occurred prior to the surgery. All results were monitored by the infection prevention committee which met quarterly and fed into the hospital's quarterly quality and safety committee meetings.
- Infection prevention and control was included in the hospital's mandatory training programme. The hospital provided training data which confirmed that the 76% of all eligible staff in the hospital had attended infection prevention and control training which included asepsis training for the nurses. Overall infection prevention and control training for surgical staff was 88%. This was better than the Nuffield Health group target of above 85%. Those staff we spoke with all confirmed they had completed this training.
- The infection prevention and control link nurses undertook additional training and met regularly to share information and support each other.
- The hospital submitted monthly healthcare associated infections (HCAI) surveillance data for hip and knee patients to Public Health England. This included MSSA, MRSA and E-Coli blood stream infections, and C Difficile toxin, surgical site infections for all hip/knee patients, catheter related urinary tract infections and any other infections. These are all potentially serious infections that could cause harm to patients.
- In the reporting period July 2015 to June 2016, the hospital reported four surgical site infections. This was higher per 100 surgeries performed than the rate of other independent acute hospitals we hold this type of data for.
- In the reporting period July 2015 to June 2016, there were no surgical site infections (SSIs) resulting from hip operations or knee operations.

Good

Surgery

- In the reporting period July 2015 to June 2016, there were no reported incidences of hospital acquired MRSA, MSSA, C.diff. or hospital acquired E-Coli.
- The hospital had a contract with an external provider for the decontamination of reusable medical devices. Routine auditing of this arrangement ensured that decontamination was undertaken in accordance with national guidance. We spoke with the theatre manager who told us that theatre staff had visited the decontamination facility and that regular communication, auditing and monitoring of the service took place. We noted that any decontamination anomaly was raised as an incident and investigated accordingly.
- There was an endoscopy decontamination area attached to theatre three. The area was small and did not have separate clean and dirty utility areas to facilitate the flow of equipment from clean to dirty areas. This did not meet the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope Reprocessing Units, QPSD-D-005-2.2.
- There were not separate sinks for clean and dirty in the endoscopy dirty utility room. This risk had been identified, as the hospital was planning to move to full JAG accreditation and was aware that this is a requirement. This had been risk assessed and theatre staff were aware of the actions to take to reduce the risk of contamination. To mitigate the risk, the sink was thoroughly cleaned and decontaminated after being used for manual cleaning of endoscopes and before the rinsing process commenced, and this process was reflected in the local risk assessment. The theatre manager told us the hospital was planning to move their decontamination process to a facility off site.
- Staff kept full scope-tracking and traceability records. This indicated each stage of the decontamination process and followed national guidance (British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy 2014). An external company audited the traceability of records and in the last audit in January 2016, the department had achieved 100%. This indicated all stages of the decontamination process were occurring.
- Weekly water sampling was undertaken from the final rinse cycle to test microbiological quality. This was compliant with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. When the microbiological quality exceeded a certain number, all the filters on the machine were changed and the quality was retested to ensure the necessary levels were achieved.
- All areas of the hospital we visited appeared visibly clean and tidy. For example, surgical supplies were in date and stored tidily in appropriately labelled drawers and cupboards. This helped to ensure that stocks were used in rotation and a good standard of hygiene was maintained. The sluice and dirty utility areas were kept free from clutter, which made them easier to keep clean.
- Cleaning audits took place to monitor the cleanliness of the environment. Patient-led assessments of the care environment (PLACE) is a national initiative where teams of local people go into hospitals to assess how the environment supports a patient's privacy and dignity, food, cleanliness and general building maintenance. The assessments apply to hospitals and other locations that provide NHS funded care. The Nuffield Health Haywards Heath's PLACE scores were the same as the England average for cleanliness (98%).
- We noted the Environment Agency conducted an audit in July 2016 to review compliance with environmental legislation. They found 'exemplary waste container placement, labelling and management, showing excellent appreciation of the benefits of good practice'.
- Patients were cared for in individual rooms which made it easier to isolate individuals if needed. Each room had hand wash basins and personal protective equipment readily available. However, there were no separate hand washing facilities for staff in the patients' rooms. This was not specifically noted on the infection control risk register, although two bedrooms with non-compliant sinks were recorded. The action was that this would be addressed in the refurbishment process. Health Building Note 00-09: Infection control in the built environment recommends that en-suite single-bed rooms should have a clinical wash hand basin for staff and separate general wash-hand basin for patients and visitors. Clinical wash hand basins should have lever or sensor operated taps so they can be operated without contaminating hands. They should not have a plug or overflow as these are difficult to clean and become contaminated. Clinical wash hand basins should only be used for staff hand washing as there is a risk of transferring infection.
- The bedrooms were cleaned and bed linen was changed daily. The fabric curtains in the bedrooms were

steam cleaned three times a year, while the visibly clean disposable shower curtains were changed annually unless soiled which was in line with the manufacturer's guidelines.

- The housekeepers carried out daily cleaning of the ward areas and emptying of the linen trolleys. Disposable mops and cloths were used for cleaning. We reviewed the cleaning records and noted all were complete, in date and signed appropriately.
- All equipment was stored neatly and as ready to use with 'I am clean' stickers attached. However, we noted that although clinical rooms had laminated flooring, the majority of individual patient rooms and ward corridors were carpeted. This was not so easy to clean if spillages should occur. The corridor flooring was not consistent with Health Building Note 00-09: Infection control in the built environment. However, relevant risk assessments together with mitigating actions such as regular deep cleaning were in place.
- We observed good hand hygiene practices throughout the hospital. Hand washing sinks, soap, and alcohol hand rubs were in good supply throughout the clinical areas and theatres. Staff were bare below the elbows and we saw they followed hospital procedures for hand washing between attending patients. In theatre we observed good hand hygiene practice. For example, we saw an anaesthetist change their gloves. They used alcohol gel after removing the old gloves and before putting on a new pair.
- Personal protective equipment was readily available, correctly stored, and worn by staff in accordance with the hospital's policy. All staff adhered to national dress requirements to minimise the risk of health care acquired infections. In theatre, scrubs and suitable footwear were worn by all staff to minimise the risk of cross contamination of healthcare practitioner's clothing.
- Feedback from patients during the inspection on the cleanliness of the hospital was consistently good. Comments included "it's very hygienic here"; "all areas are very clean"; "The standard of cleanliness was excellent"; "Although the environment is worn, it's kept spotless".

Environment and equipment

- The hospital was arranged over three floors. On the first floor was a 27 bedded ward with a two-bedded area used for patients who required closer post-operative observation.
- The hospital acknowledged that the patient environment was in need of refurbishment and there was a need for capital investment in equipment. Over the past year a new nurse call bell system had been installed, theatre air conditioning had been replaced and the lifts overhauled. The hospital also had approval for a number of equipment upgrades such as a diathermy machine and rigid endoscopy scopes.
- Environmental concerns were listed on the hospital's risk register. For example, the hospital had commissioned a fire safety survey which identified there was no compartmentalization in the roof space above the theatres. This meant in the event of a fire all theatres would need to be evacuated immediately rather than isolating the individual theatre. This was added to the risk register and theatre staff had undergone scenario fire training to ensure they were aware of the appropriate action to take.
- A major refurbishment programme started the week of the inspection. We noted that although the risks of the refurbishment were included on the hospital's risk register, patients were placed in rooms opposite the building works with no arrangements to mitigate noise and disruption. Patients would be moved if they complained and another room was available.
- Patients had individual rooms, each with its own dedicated piped oxygen and suction. Each room had a shower and en-suite toilet, television and Wi-Fi services. We noted the bedrooms were tired, many with damaged walls and worn furniture. The tiling in the en-suite bathrooms was lime encrusted with old grout, which made cleaning difficult. The bedrooms were in the ward refurbishment programme for the coming year. The patients we spoke with told us their rooms "really needed a lick of paint" and "It looks a little run down".
- Patient-led assessments of the care environment (PLACE) is a national initiative where teams of local people go into hospitals to assess how the environment supports a patient's privacy and dignity, food, cleanliness and general building maintenance. The 2016 PLACE scores for Nuffield Health Haywards Heath hospital were lower than the England average for condition, appearance and maintenance. The hospital scored 88% against an England average of 93%.

Good

Surgery

- There were two main theatres and a third theatre used for endoscopy and pain management. Both main theatres were suitable for emergency surgery. The theatre environment met national government standards.
- Theatre one had a specialised air filtration system called laminar flow, which reduced the risk of infection by circulating clean air. This theatre was open Monday to Friday 08:00 to 19:00 and on occasional Saturdays. It had a separate anaesthetic room. This theatre was used mainly for orthopaedic, neuro-spinal surgery that required the filtered air system, ear, nose and throat (ENT) and ophthalmic procedures.
- Theatre two was open Monday to Friday 08:00 to 19:00 and occasional Saturdays. It had a separate anaesthetic room, which it shared with theatre three. This theatre was used mainly for general surgery, gynaecology, urology, vascular, ENT, ophthalmic, dental and pain management procedures.
- Theatre two was also used for laser surgery as it was a designated laser protection area. This meant it had adaptations to make it safe for laser use. Laser procedures included laser prostate surgery and vascular laser treatment for varicose veins. The hospital used three class four lasers; however none of these were kept on site. There were suitable arrangements in place to ensure that the lasers were maintained and used appropriately by suitably trained personnel. This included having a nominated laser protection supervisor and a laser protection advisor who conducted annual reports on the safe use of the lasers. There was a list of authorised users and confirmation of their core of knowledge training. The most recent annual laser safety report and risk assessments confirmed that all environmental laser safety precautions were in place.
- Theatre three was used for endoscopy and minor operations. Endoscopy involves looking inside the body using an endoscope. An endoscope is an instrument used to examine the interior of a hollow organ or cavity of the body. From April 2015 to March 2016, the hospital performed 276 endoscopic procedures. Three percent of procedures were performed on NHS patients, 13% were self-funded and 84% were self-pay patients.
- This theatre was designed for ambulatory care and was open Mondays to Fridays from 08:00 - 19:00. The anaesthetic room was shared with theatre two. No procedures requiring general anaesthesia were performed in this theatre.
- The hospital was not Joint Advisory Group (JAG) accredited for its endoscopy services because the facilities were non-compliant with the standards. JAG accreditation demonstrates that the endoscopy service has met nationally recognised endoscopy standards. The hospital had plans to address this by moving decontamination off site, however at the time of the inspection this had not been actioned.
- Staff transported dirty scopes from the theatre into the cleaning area, which was within theatre three. We saw that there was a rinsing sink and a washer machine. There was equipment to carry out leak tests on the scopes. There was one drying cupboard, which was in the theatre. The endoscopy unit did not have separate clean and dirty utility areas, to facilitate flow from dirty to clean areas. At the time of inspection the hospital were considering moving their decontamination process to a facility off site, which met Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope Reprocessing Units, QPSD-D-005-2.2.
- The theatre manager told us the number and size of endoscopes met the needs of the service. We saw there were a variety of scopes available to perform different types of examinations.
- All equipment in the endoscopy washing room was regularly serviced. Information about when the next service was due was available.
- Staff kept full scope-tracking and traceability records. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014). An external company audited the traceability of records and in the last audit in January 2016, the department had achieved 100%. This indicated all stages of decontamination were occurring.
- Records were available to confirm that weekly water samples were taken from the final rinse cycle and tested for its microbiological quality. This was in line with Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. When the microbiological quality exceeded a certain number, all the filters on the machine were changed and the quality was retested to ensure the necessary levels were maintained.

- All patients who had a procedure under general anaesthetic or conscious sedation were cared for in a recovery area which was visible from a central communication station. Each recovery bed space had its own oxygen, suction and cardiac monitor.
- There were systems in place to monitor, check and maintain equipment. Outside contractors were responsible for ensuring the equipment was appropriately serviced, calibrated and functioning correctly. Management of the contracts was through service level agreements and regular contract monitoring meetings. Managers usually had access to the medical device service log however during the inspection the portal was off line due to maintenance issues. The theatre manager told us if he had concerns he could contact the engineer by phone.
- Over the past year there had been problems with the equipment and maintenance contract due to personnel issues. We found that when the air conditioning in theatres had been serviced in March 2016, a number of concerns and necessary actions were identified such as access holes were required to monitor the ventilation system and repair work to the doors and lights were required. Although some remedial action had taken place, there remained outstanding actions. The hospital provided assurance that these would be attended to during the November service and that the issues did not compromise the safety of patients.
- We reviewed the minutes of the contract monitoring meetings and identified that the contractor had not informed the hospital of all of the issues that required attention. The theatre manager was unaware of the concerns with the maintenance of the theatre air conditioning units. This issue was taken up by the hospital director with the contractor. There had been a change of contractor personnel and the hospital was assured that a more robust process to monitor the contract was now in place.
- The theatre manager told us they very rarely had to cancel an operation because of faulty or missing equipment. Any issue would be recorded on the hospital's incident recording system. The hospital had arrangements with the local NHS trust and other nearby hospitals within the Nuffield Health group which could supply equipment at short notice or in an emergency.
- We noted that each piece of medical equipment was labelled with an asset number and had stickers in place to identify when they had last been serviced, electrically tested and when the next service was due. All equipment we inspected within the electrical store had an inventory number and calibration dates attached. We examined 11 items of equipment and all were labelled appropriately.
- Staff told us that capital bids had been submitted for patient monitors which would make taking observations more efficient. Much of the existing equipment was old and near the end of its useful life. For example, the patient controlled analgesia pumps and syringe drivers, which although still functioning and safe to use, were at the limit of the manufacturer's recommended lifespan. In theatre some of the attachments used on older equipment were not compatible with newer models borrowed from other hospitals.
- The staff we spoke with confirmed they had access to the necessary equipment they needed to meet people's care needs. They told us the service provided by the contractors was "usually very good depending on the urgency of the situation". We observed staff reporting faults with the fire safety system and noted the system was easy to use and staff received a prompt response.
- Emergency resuscitation equipment, oxygen and suction equipment was available in the ward area and had been routinely checked to ensure it was ready for immediate use. Theatres had a difficult airway trolley shared between the theatres. This was checked daily by the operating department practitioners.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner. This made them easy to keep clean and locate in a hurry.
- We observed staff responding professionally and effectively to a routine fire test that did not go as planned. The issues were quickly identified and resolved. This demonstrated that there were systems and processes in place to address untoward and emergency situations. Staff were aware of what remedial action to take and took responsibility to address the situation.

Medicines

- The hospital had corporate medicines management policies that were readily available for staff to access. The hospital had antibiotic guidelines available (Standard Operating Procedure: MM46), which included

their use in surgical prophylaxis. The policy was due for corporate review in May 2015. Staff had access to relevant resources on medicines management such an electronic copy of the British National Formulary 71.

- We found that the ward and theatres handled medicines appropriately according to hospital policies and best practice guidance. This included patients' own drugs, medicines requiring refrigeration and controlled drugs.
- We spoke with the resident medical officer on duty, who was aware of the hospital's local antibiotic prescribing policy. They confirmed they would discuss any prescribing concerns with the pharmacist and consultant. For example concerns about the antibiotic chosen by the consultant. They were not involved in administering any chemotherapy medications as this was undertaken by the patient's consultant.
- We reviewed the untoward incidents recorded over the past year and noted that staff reported medicine related incidents. The staff we spoke with understood how to recognise and report medicines related incidents.
- The hospital had a pharmacy service with a pharmacist on site, supported by two part-time pharmacy assistants. There was no on site pharmacy; medicines were obtained through wholesalers or by prescription. The pharmacist told us that the local NHS hospital pharmacy department was very helpful if medicines were needed in an emergency or out of hours.
- The pharmacist's role included undertaking regular audits and checking drug charts. Results from the audits were fed into the medicine management forum and into the quality and safety committee. We saw there was a schedule of medicines audits undertaken on a regular basis. This included a controlled drugs audit, a medicines storage audit and a medical gas cylinder storage audit in theatres.
- There were procedures in place to implement any guidance and recommendations from the medicines and healthcare products regulatory agency (MHRA). Any action required was documented in the medicines forum minutes with all staff emailed with the new information. The pharmacist told us she conducted checks to make sure all staff had read the email and put the information on the staff communication board.
- We undertook random medicine checks on the ward and in theatre and found that medicine management met current best practice guidance. For example, both on the ward and in theatres, staff ensured medicine cupboards were kept locked when not in use and they regularly checked the controlled drugs. A medicine trolley was used on the ward to store and dispense medicines. We saw staff appropriately secured the trolley when it was not in use.
- The hospital had recently installed an electronic digital temperature monitoring system. The system continuously monitored fridge and room temperatures. Any anomaly was reported electronically to the hospital pharmacist who managed the system centrally. This meant temperature records were continuously accurately monitored and recorded. The hospital was assured that medicines and room temperatures were always safe.
- We found the controlled drug registers met the best practice guidance from the Royal Colleges, national agencies and Department of Health. Legislative requirements under the Medicines Act 1968 and associated regulations require that there is a contemporaneous record of controlled drug administration. We found that all records were traceable, which meant that practitioners were held accountable for their actions.
- The medical gas manifolds supplied the hospital pipeline system with sufficient quantity of gas by cylinders and/or tanks. Nuffield Health Haywards Heath had appropriate systems in place for the safe storage of medical gases. There were appropriate documents in place to confirm that medical gas regulators were serviced at regular intervals.
- The ward controlled drugs were stored in lockable cupboards and their use was recorded and monitored appropriately to ensure safe practice was maintained. Controlled drugs throughout the hospital were audited every three months. There were destruction kits available on the ward for the safe disposal of any unused drugs.
- Emergency drug packs for arrest, anaphylaxis and deteriorating patients were available and checked routinely.
- We noted that on the ward, medicines records were clear, well maintained and well documented. Allergies were recorded in the patient's care record and on patients' individual drug charts.
- In theatres, medicine was managed according to current best practice. Anaesthetic drugs were available during

the procedure but the cupboards were shut at the end of the operation. We observed that drugs were drawn up into syringes by the anaesthetist only when needed, and not drawn up in advance, which is good practice.

Records

- The hospital used a mainly paper based system of recording patient care and treatment although we were told the provider was working towards implementing digital health records. At inspection we found that complete sets of medical and nursing records were available for each patient having a surgical intervention.
- The hospital adhered to national Caldecott principles when protecting patient confidentiality. The Caldecott principles are seven recommendations for the safe management of data in order to manage information and ensure patient confidentiality. The matron was the hospital's Caldecott guardian.
- There was an information governance lead and information governance meetings were held on a quarterly basis. Administrative staff also sat on the committee and told us their voice and opinion was listened to. Records were held securely either in the office or with the patient. All staff undertook on-line training on protecting patient confidentiality. Any issues or concerns relating to data protection, information governance or patient confidentiality issues would be reported through the electronic incident reporting system.
- There were no concerns with obtaining patient records in a timely manner. Over the past three months no patients admitted to the inpatient ward were seen without all their relevant medical records being available. However, medical records were included on the hospital's risk register as consultants removed their medical notes once a patient left the hospital and there was no copy kept on site. This meant there was no record of the medical care patients received, which was a risk if a patient should contact the hospital with urgent concerns about their health related to the care they had received.
- We reviewed a sample of thirteen care records on the ward, in theatre and in endoscopy. We found that both nursing and medical records met Nursing and Midwifery Council and General Medical Council guidelines for good record keeping. The records were well completed and provided an accurate personalised record of each patient's care and treatment.
- We found that signatures were in place, complete with staff designation and date. The records were legible with up to date risk assessments and care bundles. The nursing instructions were appropriately recorded, carried out and then regularly reviewed. The medical and nursing records presented a clear picture of the patient's condition, care and treatment.
- Every month, 10 sets of patient notes were reviewed by the matron and two senior nurses in order to monitor the quality of documentation and compliance outcomes. The results were compared to previous audits and any action plans updated together with the learning which was shared with staff. For example, the most recent records audit undertaken in September 2016 identified that venous thromboembolism (VTE) assessments had not always been completed daily. In order to address this staff were reminded to complete the form and a new form was introduced in the pre-assessment clinic. A lead nurse had been appointed to oversee VTE compliance in September.
- We reviewed the three theatre surgical registers and the endoscopy scope log book. We noted all entries were complete, legible, signed and dated appropriately. A separate implant register was kept to provide the basic information needed to evaluate and compare the quality of implants, to enable early detection of serial defects, and to assess short- and long-term reactions and complications.
- We reviewed the audits of the endoscopy scope log book, which indicated all stages of the process were completed. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).
- The hospital kept all the required documentation relating to the safe use of lasers. This included local rules, authorisations, laser risk assessments, record of laser operatives and staff training. A loose leaf laser register was kept recording each time the laser was used. Loose leaf registers are not ideal as pages can be lost and easily damaged. However the register was separated into the individual lasers with appropriate records kept of each time the laser was used. Although the register was loose leaf, the records were tidy, easy to access and well maintained.

Safeguarding

Good

Surgery

- The hospital had a safeguarding vulnerable adults and children policy with guidelines readily available to staff on the hospital's intranet.
- The matron was the overall safeguarding lead for the hospital. Each of the clinical heads of department was responsible for their own department's safeguarding activities. The hospital also had rapid access to advice from a Nuffield Health children and young person lead nurse and a regional quality care partner. This is discussed in more detail in the children and young people section of the report.
- The hospital reported the hospital had made one safeguarding referral to the local authority in the past year. We reviewed the safeguarding referral and noted that concerns identified in theatre were appropriately escalated to the local authority safeguarding department and the patient's GP.
- CQC had not received any safeguarding concerns relating to the hospital during the reporting period from July 2015 to June 2016.
- All staff undertook basic safeguarding adults training at induction and then yearly as part of the mandatory training requirement. Although the hospital stated that children were not treated as inpatients in the hospital, 16 and 17 year old children were admitted to the ward and children visited the ward area on occasion. Both national guidelines and the corporate safeguarding children policy stated that all staff interacting with children should have level two safeguarding children training. Please see the children and young person's section of the report for more details.
- The hospital told us overall compliance for eligible staff completing safeguarding training was between 91% (Level one), 96% (level two) and 100% (Level three). On the ward the safeguarding training was at 88%. However the ward manager told us this was due to three members of staff who were either on long term sick or had not worked at the hospital for some time.
- The staff we spoke with told us they knew how to access the safeguarding policy. They said they would report their concerns to the nurse in charge or contact the matron as the safeguarding lead if needed.
- There were safeguarding flowcharts and posters available detailing what to do in the event of a safeguarding concern and who the named leads were.

Mandatory training

- The hospital had a corporate mandatory training policy which specified the type of training each staff group was expected to undertake on an annual basis. All staff were required to complete mandatory training on an annual basis and undertake specialised training for different clinical roles.
- All mandatory training modules could be accessed from Nuffield Health's learning management system known as Academy Online. This was updated daily and reflected any change in a staff member's job role including additional training requirements.
- The majority of mandatory training was electronically delivered.Staff were automatically informed of the training modules they were expected to undertake and completion was monitored by their line manager. Training levels were monitored and reviewed at ward and theatre meetings, the integrated governance committee and the senior leadership team (SLT) board meetings.
- Practical training such as intermediate life support training was run separately, six days each year. This was managed and overseen by the resuscitation committee which reported quarterly to the health and safety committee. We were told that the training included scenarios where staff would practice emergency first aid in different locations to develop their skills.
- Staff and managers told us the system worked well. One nurse confirmed there was good allocation of time to undertake training. In addition staff could do the training at home and were able to take the time back. Another staff member who had been employed by the hospital for over a year told us "I've never had so much mandatory training as I've had here – it's really good".
- Mandatory training for theatres was 89% to 90% completed for the year to date. The ward manager told us that the result was not as good as expected because of three staff members who were on long term sick leave or had not worked at the hospital for a while. All the staff we spoke with had completed all of their mandatory training.
- Non-clinical staff were given access to training. Although this was not verified at inspection, ancillary staff we spoke with told us about their training. They said they had completed a booklet with health and safety questions to answer, basic first aid training and infection control training.
- The resident medical officers (RMO) were supplied by an outside agency which was contracted to ensure each

RMO had completed all mandatory training before starting work at the hospital. Each RMO had a certificate of mandatory training available which included advanced life support training for children and adults.

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

- The hospital had a generic statement of purpose in place which did not specify whether the hospital could look after patients who required level two critical care. Level two critical care is required for patients who required immediate care following major elective surgery; emergency surgery in unstable or high risk patients or where there was a risk of postoperative complications or a need for enhanced interventions and monitoring.
- The hospital did not have the facilities to manage patients who required level two critical care support. We were told that should a patient's condition deteriorate, they were transferred as an emergency to the nearest NHS hospital. This meant that the hospital carefully screened patients during the pre-admission consultation to exclude operating on patients assessed as a surgical risk.
- There was a service level agreement, dated April 2016, with a local NHS hospital for the transfer of patients requiring critical care. The hospital matron told us she was engaging with the local critical care team to develop and improve staff competencies and the management of patients who needed to transfer.
- The hospital had a corporate policy for "The Management of the Risks of the Transfer of Patients". This had been due for review in October 2014 so was not current. We were told that all corporate policies were currently being revised at a national level. The matron told us that a local standard operating procedure had been developed for ensuring that all transfers out of the hospital were managed correctly. This had been recently introduced and included an analysis of the event in order to ensure that lessons were learnt.
- All patients were admitted under the care of a consultant and attended a pre assessment clinic to ensure the hospital could meet their needs. The patient's previous and current health conditions were evaluated, risk assessments were completed and the results documented in the patient's care record. Risk assessments included the risk of venous thromboembolism (VTE), falls, pressure ulcers, the patient's body mass index and malnutrition. Any concerns were documented and any discussions documented.
- On admission the results were reviewed and the patient was asked if any changes had occurred. Ward staff completed ongoing evaluations in the care records to help identify patients at risk from pressure damage and falls.The tools used included the measures needed to reduce the incidence of pressure ulcers or falls such as pressure relieving mattresses or bed rails.
- The hospital used an early warning system (NEWS) to alert staff should a patient's condition start to deteriorate. In the sample of records we reviewed the early warning tool had been completed appropriately. The quarterly audit of patients' notes included the completion of the early warning scores. The September 2016 quarterly audit of thirty sets of patients' notes documented 90% compliance, which indicated that NEWS scores were usually completed appropriately. One member of staff told us "There is no excuse not to do the observations properly – we have the time and the training".
- An escalation procedure was in place for nursing staff to escalate concerns to the RMO and for the RMO to contact the patient's consultant. If a patient's condition deteriorated and gave cause for concern, staff confirmed that both the RMO and consultant were informed. The patient would be taken by ambulance to the local NHS hospital's emergency department. There was no agreement for the patient to be admitted directly to a ward or intensive care.
- We spoke with the resident medical officer (RMO) on duty during our inspection and they told us that they carried a bleep and were always contactable. They did not have any problems with access to the consultants who were contactable by phone for advice.
- The theatre staff followed the five steps to safer surgery. This involved following the World Health Organisation (WHO) checklist before, during and after each surgical procedure. We observed staff in theatres following the WHO surgical safety checklist. For example before the theatre list started there was a team briefing and handover where members of the theatre team were introduced and their roles clarified. This reduced the risk of misunderstanding and errors during the operation.

- We observed staff undertaking the WHO checklist during our inspection. We noted this was not a 'tick box' exercise but staff were involved and committed to the process. The team brief was thorough and all staff contributed including the anaesthetist. Following the operation, a debrief was conducted by the surgeon, who was pleased that the team raised two minor issues that were easily resolved. We saw there were safe systems to protect patients and staff that were fully embedded in practice.
- The minutes from theatre meetings confirmed that auditing of the WHO checklist took place and that the results were monitored and acted upon.
- The hospital had a resuscitation committee that met quarterly. Practice resuscitation scenarios took place between each committee meeting to ensure staff maintained their skill level. Arrest, anaphylaxis and "deteriorating patient" medicine packs were available which were standardised across the service.

Nursing and support staffing

- The hospital did not use a recognised staffing tool to determine the number and skill mix of staff on duty. The hospital informed us that a national staffing tool had been piloted by the corporate group and found unsuitable for independent healthcare. The corporate body was investigating national alternative solutions to the staffing tool.
- The hospital told us that currently staff levels and skill mix were allocated according to patient ratios and acuity in line with expectations of an independent sector hospital. The level of staffing varied according to the predicted dependency and acuity of patients being admitted. In certain situations additional staff were allocated, for example, if a patient needed regular monitoring or help with personal care.
- The matron and ward manager assessed the staffing levels on a daily basis based on patient numbers, acuity, dependency, numbers of discharges, theatre cases and number of admissions. This was reviewed at regular intervals throughout the working day and week as required. The ward manager had authority to make the decision to increase the number or skill mix of the staff on duty if this was in the best interests of the patient. The hospital told us this was consistent with one of the Nuffield 'Beliefs' which was 'We believe commercial gain can never come before clinical need.' The matron and ward manager obtained regular feedback from staff and patients to monitor that the staffing levels were appropriate at any given time.
- We looked at samples of staffing duty rotas and noted the hospital was appropriately staffed for the acuity of the patients. The staff we spoke with confirmed that the ward manager did the weekly allocation of staff depending on the expected admissions. There were no concerns raised about the number of staff on duty although the hospital was now using more healthcare assistants (HCAs). The HCAs received competency based training according to their skills and interests. For example an HCA had undertaken additional training to undertake observations and collect patients from theatre.
- The ward maintained a nurse to HCA ratio of three to one. Theatres maintained a nurse to operating department practitioners (ODP)/HCA ratio of nurse of 2.3 to 1. This was similar to the other 12 independent acute hospitals that we hold data for.
- At the time of our inspection there were 11.6 full-time equivalent nursing staff employed on the inpatient unit with 11.3 full time equivalent nursing staff employed in theatres. There were 8.9 full time equivalent operating department practitioners (ODP) and healthcare assistants (HCA) employed on the ward and in theatres.
- When patients were admitted to the close observation unit, there was always a registered nurse allocated to care for them. Staff told us that this was usually on a one nurse to two patients ratio, but it could be increased to one to one care if the patients required a greater level of care.
- The theatre manager told us staff numbers were based on the theatre lists. For example the expected staff for an endoscopy list was an anaesthetist, operating department assistant, scrub nurse and a theatre assistant. We saw staff rotas which confirmed these members of staff were booked for an endoscopy list.
- The hospital told us there were no agency nurses, ODPs or health care assistants working in either the ward or theatres in the last three months of the reporting period (July 2015 to June 2016). The use of bank and agency staff for the ward and theatres was lower than the average of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 to June 2016).

- The theatre manager told us that agency staff had been used. There had been one long term agency member of staff used over the past year. They confirmed that the same agency staff were always used where possible and a checklist was completed to ensure they received an appropriate safety induction. We saw a completed induction checklist which demonstrated the checklists were used in practice.
- There had been no staff suspended from duty, subject to a fitness to practice or supervised practice review or with practising privileges removed within the reporting period (July 2015 to June 2016).
- The patients we spoke with told us there were plenty of staff on duty and they never had to wait for anything. They told us the staff were "Very attentive, all my needs responded to really quickly – very impressed". One patient said "Call bells were always answered in a timely manner – I never had to wait".

Medical staffing

- The provider had a practising privileges policy and revalidation and appraisal policy, which provided the framework for granting practising privileges at the hospital. The process for granting practising privileges included an online application, documentary evidence, occupational health and disclosure and barring checks. The medical practitioner then attended an interview with the hospital director and the matron where practising privileges were provisionally granted or denied. All the information was then submitted to the Medical Advisory Committee (MAC) for the practising privileges to be ratified. The medical practitioner was required to submit further information and updates on an annual basis.
- The hospital maintained a medical advisory committee (MAC) whose role included ensuring that any new consultant was only granted practising privileges if deemed competent and it was safe to do so. The role of the MAC included periodically reviewing existing practising privileges and advising the hospital on their continuation. They gave examples where practising privileges had been suspended or withdrawn as a result of concerns raised. For example, two consultants had been suspended for not meeting the CMA (Competition and Marketing Authority) remedy deadline and one consultant was suspended for contravention of the practising privileges policy as they had not informed the hospital about a suspension elsewhere. This demonstrated that the MAC was an effective body for monitoring the competence of the consultants working at the hospital.
- There were 147 consultants and dentists employed under practising privileges at the hospital. Eight (5%) consultants undertook over 100 episodes of care at the hospital. 26 (17%) consultants undertook 10 to 99 sessions. 13 (9%) of consultants undertook 0 – 10 sessions. 102 (68%) of consultants had not undertaken any sessions at the hospital. This included anaesthetists and radiologists who had participated in the care of patients.
- The hospital director was aware of the risks posed by consultants with practising privileges who rarely attended the hospital. When asked how the hospital could be assured of their familiarity with their systems and processes if consultants rarely attended, the hospital director told us he had recently challenged a consultant about this at their two yearly review and the consultant had chosen to resign following the discussion. The hospital director told us he was seeking to engage with the consultant body to ensure there was a robust process to manage this.
- There was a revalidation and appraisal policy in place to assist the corporate revalidation team in consultant revalidation. The majority of consultants practicing at the Nuffield Health Haywards Heath hospital also worked within the NHS and were part of the NHS revalidation process. However, not all the paper records we examined included verification of the consultant's NHS revalidation.
- The patient's consultant was the person in charge of their care and undertook any post treatment reviews. Out of hours the consultant was called if needed and staff gave examples of when this had taken place. When a consultant had inpatients at the hospital, in the event of an emergency, they were required to be able to attend the hospital within 30 minutes or else arrange suitable cover.
- The anaesthetists had an on call 24 hour rota and covered their own patients on the first day of surgery. A group of anaesthetists who were based at Nuffield Health Brighton Hospital also provided out of hours cover for the hospital.
- The hospital was staffed by resident medical officers (RMO) who were supplied under contract by a medical agency. The two RMOs worked a rotation of one week

on, one week off and were expected to cover two weeks on call availability during their six month contract. This allowed flexibility should a doctor become ill or need replacing at short notice. The hospital told us that it was unusual for the RMO to be called out at night due to the low acuity of most of the patients. There was a period of handover between any new RMOs, which consisted of a one week shadow period of the new RMO working alongside the established RMO.

- We spoke with the RMO who had worked at the hospital for over three years. They told us they undertook a last round at night at 22.30 to ensure that all patients were settled and that no additional medication such as analgesia needed to be prescribed. They confirmed they were rarely called at night but staff called when necessary. For example when nurses had concerns about variations in a patient's baseline observations or their early warning observation scores. They told us that although they worked at the hospital continuously for a week they always had enough breaks. They had a separate room away from the ward where they could relax and take a break when needed.

Emergency awareness and training

- The hospital had a disaster recovery and major incident handling policy which had recently been reviewed. The policy included a flowchart of the procedures and process to follow, scope and individual responsibilities. Also included were contact details of local health care providers, the emergency services, corporate contacts and details of the emergency gas shut off valves.
- The policy was individual to the Nuffield Health Haywards Heath hospital and detailed the responsibilities of each individual together with the actions they were expected to undertake. The disaster recovery plan was implemented shortly after our inspection in November 2016 when a burst hot water pipe caused flooding in the operating theatres. The hospital told us that immediate action was taken to stop further damage. The hospital liaised with partner hospitals to relocate and reschedule patients. Repair works were undertaken and all necessary cleaning and testing had been arranged.This demonstrated that the disaster recovery plan worked in practice.
- The staff we spoke with were aware of the policy and knew how to access it in an emergency. They told us that scenario training was undertaken where procedures for major incidents such as fire were tested.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- The hospital had a full range of policies and procedures available which were supplied by the Nuffield Health corporate provider. These policies ensured that care and treatment was provided in accordance with guidance from the National Institute for Health and Care Excellence (NICE) and other relevant bodies. For example in September 2015, Nuffield Health produced a report for Improving length of stay which referenced NICE guidance 50 'Acutely ill adults in hospital: recognising and responding to deterioration' and NICE guidance CG83 'Rehabilitation after critical illness in adults'. This report formed part of a larger national project aimed at finding ways to improve quality of care across the whole health system and reducing emergency admissions.
- The corporate Nuffield Health policy team undertook continuous review of new legislation, best practice guidance and advice from the Royal Colleges. For example the medicines management policies referenced NICE medicine management guidance, local medicines formularies and prescribing guidelines. We noted that any changes to policies were communicated through the Quality and Clinical Governance Committee. Policy items were a standing agenda item at this meeting.
- The hospital told us that monthly NICE guidance was disseminated to nursing and consultant staff as appropriate. All nursing staff had electronic access to a recognised NHS hospital nursing manual and a patient information service which gave procedure specific guidance to patients and nurses. There was online access to current medicines management guidance manuals through the Nuffield Health intranet site.
- The hospital also conducted local audits to provide assurance that staff and clinicians worked according to the evidence-based guidance. Local audit activity

included benchmarking their performance against national, local and group outcomes. The clinical audits fed into the monthly clinical dashboard, which was used to monitor performance.

- The ward staff had a programme of audits in place such as monthly infection control audits and quarterly medical records audits. We noted the records audits demonstrated an improvement in fully completed care records over the past year.
- The results from all audits were fed back into the quality and clinical governance committee where the results were recorded and actions put into place as needed. A quarterly governance report was presented to the MAC for information and discussion. The results were also fed back to staff at the ward and theatre meetings. The hospital gave examples of the outcome of various audits and the actions that were taken. For example the February 2016 theatre minutes details discussions about the outcomes of various recent audits and the actions required.
- The hospital used the data gathered and clinical indicators to review and identify any trends. The information included returns to theatre, readmissions, transfers, VTE, pulmonary embolism, unexpected deaths, infections and medication errors. For example it was identified that one consultant had a number of return to theatres for the same procedure. This was independently investigated and the numbers were within the expected parameters. Patient satisfaction surveys, PLACE audits and quality assurance reviews also provided feedback and information to enable the hospital to assess performance and improve patients' outcomes and general experience.

Pain relief

- There were systems to effectively manage patients' pain. The surgical care pathway contained prompts for staff to assess and record if the pain was being managed effectively. This included a pain score which was performed on every patient at every set of observations. Pain scoring was also part of the early warning system for alerting staff to a patient's condition deteriorating.
- A baseline pain score was recorded in the pre-assessment clinic and followed through surgery to post discharge when the patients were asked if they had good post discharge pain control. We were told that all patients seen at pre-assessment had the pain scoring system explained and were actively encouraged to discuss their pain or discomfort levels with the nurses.
- On admission, the nursing team discussed pain or discomfort levels with each patient using a pain score. Patients were asked to rate their pain level on a scale from 0 to 10. This gave a measured baseline for further treatment if required.
- Although the hospital did not have a dedicated pain team or pain link nurses, all staff we spoke with told us that a patient's perception of pain would be closely monitored by the ward staff and the RMO. If a patient experienced pain the RMO would contact their consultant or anaesthetist. One nurse we spoke with told us the anaesthetists were very good at responding out of hours. They gave an example where an anaesthetist had told staff not to hesitate to contact them. They had told the staff "Give me a ring – I want to know [if there are problems]".
- The hospital undertook quarterly pain audits where a sample of ten patients' records were reviewed to retrospectively assess the pain management of patients. The two audits we reviewed from June and August 2016 did not identify any action as the scores were all over 95%. The results from the audits were reported to the quality and safety committee.
- The patient satisfaction survey data included sections on pain relief. If responses fell below the required standard the hospital was notified and had 72 hours to respond directly to the patient to address their concerns. Any pain control issues were reviewed at clinical quality and strategy meetings where actions required were discussed.
- In the April 2016 patient satisfaction report 98% of patients agreed that staff did everything they could to control their pain. The patients we spoke with confirmed they were comfortable and their pain relief was well managed. We observed nurses caring for patients on return from theatre and we noted they always asked patients if they had any pain.
- The hospital also ran pain clinics with a dedicated consultant. We spoke with the nurse who assisted the consultant. She told us she had attended pain control study days and attended the local NHS hospital to ensure her practice in pain management was current.

Nutrition and hydration

- The hospital used a nutritional assessment tool to risk assess each patient's level of nutrition and hydration prior to surgery. The hospital told us that the majority of patients were fit and well on admission, however if risks were identified, management guidelines were provided for staff to follow. All discussions and outcomes were recorded to ensure the patient's nutrition and hydration needs were suitably met.
- On admission the RMO reviewed each inpatient again for their hydration and nutrition status.
- The hospital 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. Instructions about starve times were given during the patient's pre-admission visit. Staff checked as part of pre-procedure checks when the patient last ate or drank and this was recorded in the patient's care record.
- Following surgery, fluid input and output records were kept and the patient's condition monitored until normal urinary functions resumed. Patients were offered nutrition and fluid as soon as they returned from theatre, depending on their surgery and ability to consume. If concerns were identified through routine monitoring or observation, this would be escalated to the nursing team for investigation and action as appropriate.
- There was no access to a dietitian at the hospital. Should advice be needed then staff confirmed they would contact the local trust for advice.
- The hospital outsourced its catering service. They told us that the patient satisfaction survey data captured patient feedback around nutrition and the standard of food offered. Any issues with the catering service would be reviewed through clinical quality and strategy meetings and actions required discussed.
- We noted that there was a water dispenser and beverage machine in the ward reception area for visitors together with a selection of magazines.

Patient outcomes

- As a private hospital Nuffield Health Haywards Heath Hospital did not participate in the majority of national audits undertaken by the NHS. However the hospital did participate in national audit programmes when appropriate. This included quarterly audits as required by NHS England. For example patient reported outcome measures (PROMS), National Joint Registry (NJR) for hips and knees, patient assessment of the care environment (PLACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and Patient Related Outcome Measures (PROMS) for hips, knees, hernias and varicose veins.
- The hospital also engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- PROMS and NJR processes report patient outcomes in a format that allows hospitals to compare their results with other private providers and the NHS. The available data indicated that the hospital was either similar or better than expected when compared with other hospitals offering a similar service. This included readmission rates, returns to theatre and unplanned transfers to other hospitals.
- For some of the outcome measures such as primary knee replacements and primary hip replacements there were insufficient records for the England PROM adjusted average health gain to be calculated. However the data indicated the 61% of knee replacements reported improvement out of 18 records. The Oxford knee score reported 100% of 19 records reported improvement.Out of 24 hip replacement records, 83% reported improvement and 96% of 26 records reported improvement in the Oxford hip score. This indicated that patients were achieving positive outcomes for their conditions following intervention by the hospital.
- The data submitted confirmed in the reporting period (July 15 to June 16) there were four unplanned returns to theatre giving a rate of 0.14 per 100 visits to the theatre. This was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the reporting period (July 2015 to June 2016) there were six unplanned transfers of inpatients to other hospitals giving a rate of 0.76 per 100 patients. This was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- In the reporting period (July 2015 to June 2016) there were six readmissions to surgery within 28 days giving a rate of 0.14 per 100 patients. This is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.

- We noted the hospital undertook a separate investigation into a group of unplanned returns to theatre associated with a particular procedure undertaken by the same consultant. The review found no concerns as the return to theatre rate for the procedure was within national parameters. The results were shared with the MAC and Quality and Safety Committee. This demonstrated that the hospital routinely monitored untoward events and took action to reduce the risk of recurrence.
- Patients who were booked for joint replacement surgery were asked to consider giving consent for registration on the NJR which monitors infection and surgical revision rates. Patients were actively monitored following discharge for surgical site infections. There was no current information available on this audit. The hospital gave out PROMS questionnaires for those patients undergoing specific surgeries and then followed up the data by means of a monthly report. Details of healthcare associated infections were reported on a monthly basis.
- The hospital's adjusted average health gain for PROMS - primary hip replacement could not be calculated as there were less than 30 modelled records (April 2014 – March 2015).
- The PROMs data for NHS funded patients who had primary knee replacement could not be calculated as there were less than 30 modelled records. As part of PROMS the EQ-VAS asked patients to indicate their overall health on a vertical scale, ranging from “worst possible” to “best possible” health.Out of 18 records 66.7% were reported as improved and 22.2% as worsened. Using the Oxford Knee Score, which assesses the patients’ perspective of their outcome following surgery, 100% of 19 patients surveyed reported their condition had improved.

Competent staff

- The hospital provided opportunities for staff induction, learning development and appraisal. There was a formal induction process supplemented by mandatory training and other training and updates as required. Staff also completed competency based training relevant to their job role. The hospital director gave the example of staff at Nuffield Health Haywards Heath undertaking annual dementia training.
- We reviewed five sets of ward staff and two theatre staff records, which included their competency assessments. Competency assessments for registered nurses included scrub nurse, medical devices, and clinical competencies. We noted that the healthcare assistants undertook competencies on bringing patients back from theatre, airway management and observations. The theatre manager told us several staff were trained in the process of decontamination and this was a gradual induction until staff and trainer felt they were competent to undertake the process unsupervised. However, no training records were kept of this and we were unable to confirm this.
- Training needs were discussed during each staff member’s annual performance development review and an individual training needs analysis was developed taking into account staff requests and business needs.
- We spoke with staff both individually and in groups and they told us that Nuffield Health Haywards Heath hospital supported them with their learning needs. We heard individual stories of staff undertaking further development with the support of the hospital such as developmental and vocational courses. Staff told us that Nuffield Health was “generous with its courses and all information was cascaded back to all staff”. For example one nurse told us they had attended the King’s Fund Leadership course; another told us of the external study days and conferences they had attended.
- We saw that managers and heads of departments were responsible for ensuring all their staff had completed the required training. Training issues were picked up and chased where gaps were identified. Additional training was provided where there was an identified business need. For example leadership development and infection control.
- The RMO did not have access to the Nuffield Health learning academy. However, they maintained their competencies through independent continuous professional development activities. For example mental capacity and deprivation of liberty safeguarding training and advanced life support and paediatric advanced life support training. Much of this was arranged through their agency. The RMO confirmed they had been given training in fire evacuation at the hospital and fire practices had taken place.
- The staff we spoke with told us they received annual appraisals. This was confirmed by the records we saw for the previous year. This included the RMO who confirmed they had yearly appraisals since working at the hospital.

- There had not been any staff appraisals completed for the current year but we were told that appraisals were completed from January to March each year as the results fed into the annual pay review held in March.
- We noted that although there was little opportunity for formal clinical supervision all the staff we spoke with told us they felt well supported.
- We spoke with ancillary and administrative staff and they told us they received the training and supervision necessary for them to do their job in addition to the mandatory training for all staff.
- The role of the medical advisory committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. The hospital had processes in place to ensure consultants who worked under practising privileges had the necessary skills and competencies. For example senior managers ensured the relevant checks against professional registers and information from the Disclosure and Barring Service (DBS) were completed. We saw personnel records which indicated this occurred. The status of medical staff consultants' practising privileges was recorded in the minutes of the MAC notes.
- The MAC chair confirmed that any concerns or complaints about a consultant's practice were dealt with swiftly and could lead to suspension if necessary. We heard examples of clinicians practising privileges having been suspended and saw incidents where practising privileges were deferred pending further information.This demonstrated that clinicians' skills, competence and experience were monitored by the hospital.
- The provider's practising privileges policy required each consultant to provide details of the revalidation and evidence of annual whole practice appraisal including their appraisal and personal development portfolio. Those medical practitioners who were no longer employed by the NHS and undertook the majority of their private practice within Nuffield Health had a "Prescribed Connection" to Nuffield Health for the purpose of General Medical Council Revalidation.
- There were systems in place to share appraisal information with the local trusts where the individual consultants worked. This included sharing information on the consultant's practice such as surgical site infections, complaints and mortality/morbidity rates. However we reviewed five sets of consultant records and did not see evidence of current appraisals, either NHS or through the provider, for three of the five records reviewed.
- There were two surgical consultants and two anaesthetic consultants working at the hospital who did not also work in the NHS. These consultants used the Nuffield Health system for revalidation which the hospital's governance lead told us was challenging because of problems with the electronic data collection system.
- The hospital also collected data for national quality measurement initiatives such as the private healthcare information network (PHIN). Since January 2016 Nuffield Health Haywards Heath hospital had achieved 100% compliance in submitting data. The hospital submitted coding data to the Competition and Markets Authority (CMA) from January 2016. The data included the volumes of specific procedures each consultant performed and their outcomes including any variances. This information was made available to patients so they could make an informed choice about their surgery.
- Many consultants brought in their own first assistants to support them during surgery. A register of first assistants was kept which detailed their registration with their professional body and Disclosure and Barring Service (DBS) checks. The hospital required them to have their own indemnity insurance. These checks helped to ensure these staff had the skills and qualifications necessary and were of good character. However the training for this group of healthcare professionals could not be verified as they kept their own training records. The theatre manager told us the hospital realised the process was not robust and was in the process of ensuring all first assistants went through the practising privileges process. All paperwork had been reviewed such as professional registration and training certificates and no conflicts had been identified.

Multidisciplinary working

- We found throughout the hospital, staff worked collaboratively with other healthcare providers to promote the health and well-being of the patients.
- Nuffield Health Haywards Heath hospital was a small hospital and all staff groups knew each other and worked closely together to improve patients' health and recovery.

Good

Surgery

- During the inspection we observed positive interactions and collaborative working between the ward and theatre staff and in theatres between the surgeons and theatre staff. Each morning a multidisciplinary meeting was held which all clinical staff attended. The RMO confirmed they attended the daily ward meeting at the beginning of the day and told us there was a good handover with adequate time allowed for discussion of any potential issues. The RMO did not attend any of the hospital's management or safety meetings.
- Ward staff told us that although the hospital did not employ any specialist nurses, if they needed specialist advice, help and involvement would be sought from the NHS. Staff gave examples of the stoma therapy nurses who would attend the hospital to see patients on request and continued to care for patients following their discharge home.
- Ward staff told us that they liaised with the district nursing and General Practitioner (GP) services prior to patients returning home to make sure that support mechanisms were in place once the patient returned home. The integrated surgical care pathway included discharge planning and the support services to be arranged early on in the planning and assessment process.
- We noted that the treatment records we reviewed contained details of all the multi-disciplinary team involvement. This included the pre-assessment nurses, medical, nursing and anaesthetic teams, recovery input and physiotherapy when back on the ward.
- The physiotherapists and occupational therapists were based at the hospital. Other specialists such as dietitians and stoma nurses based at the local NHS hospital could be contacted if necessary. We spoke with the resident medical officer (RMO) who told us the hospital offered an excellent physiotherapy service. In particular he praised the care and treatment the physiotherapists offered to patients who had undergone a hip replacement.
- The hospital had service level agreements (SLA) with other service providers where needed. These included an SLA for transferring patients to a nearby NHS hospital in an emergency and another with a radiation service to provide radiation protection advice for the theatre lasers.

Seven-day services

- The hospital provided elective surgery Monday to Friday each week from 8am to 8pm. The theatres did not usually operate at weekends, although occasional weekend theatre lists took place if needed.
- The type of surgery was dependant on which consultant was booked in each day. Staff were aware of the patient lists in advance to enable appropriate staffing levels and room availability.
- Nursing staff were available to provide routine or urgent medical and nursing treatment 24 hours a day, seven days a week.
- An RMO was available on site 24 hours a day, seven days a week and was always available on a bleep system. The two RMOs worked a week on / week off rota. They were available throughout the 24 hour period seven days a week. The provider agency had a standby available should the RMO need to be absent for any reason.
- A senior nurse was on duty in the hospital at all times. There was a clinical on-call rota consisting of the clinical heads of department, deputies and a senior management team to support the ward team out of hours. The clinical and management on call person was available for telephone advice and, when required, would attend the hospital for more practical support, including direct nursing care if appropriate.
- The surgical team were able to access support from other health care professionals out of hours with an out of hours on call rota for theatre, pharmacy, pathology, radiology and physiotherapy. The pharmacist was available for telephone advice and there was a service level agreement in place for out of hour's provision of medicines. On call staff were required to remain within a thirty minute drive of the hospital and to be available at all times.
- All consultants were required to be available within a thirty minute radius of the hospital for the duration of their patient's stay or to ensure suitable cover was provided by a colleague within the same specialty. They had direct access to the ward through a landline and a back-up mobile telephone. Anaesthetists were also required to be available for the duration of their patient's stay.

Access to information

- There were systems to ensure that staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included 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. At inspection we found that complete sets of medical and nursing records were available for each patient having a surgical intervention.
- There were computers available on the ward and in theatre. These gave staff access to patient and hospital information for example policies and procedures. For endoscopy patients a report was produced electronically at the time of the procedure. We saw copies of the reports kept in patients' records which indicated this was completed on the day of the procedure with a copy sent to the patient's GP on the same day.
- When patients were transferred to other hospitals for further care, transfer letters were completed.
- Staff had access to GP referral letters when patients attended pre admissions clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The patient consent to examination or treatment policy (Version 5.0) was due for review September 2009 so was not current. We were told that all corporate policies were undergoing review at national level. However we noted that the corporate consent policy met current best practice guidelines issued by the Department of Health.
- The policy was readily available for staff to access and included guidelines for treating adults who were unable to consent to investigations or treatment. A separate consent form was used in these instances which included the involvement of the patient's family, a capacity assessment and a declaration of best interest.
- Staff we spoke with, both in theatres and on the wards, were aware of the policy and the correct procedures to ensure patients gave valid consent prior to any treatment or surgical intervention.
- All staff received training in the requirements of the Mental Capacity Act 2005 (MCA) as part of their mandatory training. One staff member told us that the dementia training had been very useful as, although they did not see many patients with dementia, the principles of obtaining consent from a vulnerable adult were useful when treating any patient with a learning difficulty. They gave the example of making sure they followed the correct process when caring for dental patients, many of whom had a degree of learning difficulty.
- We asked staff how they would manage a patient with limited capacity to make their own choices or decisions and although this rarely happened, they were clear on the process that would be applied if patients did not have capacity. However we noted that there were no formal capacity assessment tools available should a patient's capacity be questioned.
- We noted that training including MCA and Deprivation of Liberty Safeguards (DoLS) was a standing item for the quality and safety committee which met quarterly. The hospital's training matrix indicated that by November 2016, 97% of staff had completed DoLS training.
- We looked at the recording of consent for those patients undergoing surgery at the time of our inspection. We found that consultants recorded full details of the conversations they had with patients.
- Endoscopy patients received a variety of written and verbal information prior to their endoscopic procedure in order for them to consent to their procedure. We saw the information available was clear and comprehensive which was in line with the British Society of Gastroenterologist (BSG) guidelines.
- We saw signed consent forms in patients' records which had been signed by the patient and the endoscopist, in line with professional guidelines.
- Patients we spoke with confirmed the consultant had detailed the potential risks of their surgery and they were happy to sign the consent form with full knowledge of the surgical risks. One patient told us "My procedure was explained in great detail and all my questions were answered".
- The hospital had corporate policies available for the resuscitation of patients including 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions. The policy made clear that all patients who had a cardiac arrest would be resuscitated unless a current DNACPR order was in place. No surgical patients had a

DNACPR form in place at the time of our inspection. Staff explained it was unlikely that a patient who did not wish to be resuscitated would seek to have elective surgery at the hospital. However all staff were aware of how to access the policy.

Are surgery services caring?

Good

We rated caring as good.

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. The scores related only to those patients seen and treated on behalf of the NHS. In the reporting period (July 2015 to June 2016) the hospital had a response rate of 27% and the results indicated that 99% of NHS patients who responded would recommend the hospital. These scores were similar to the England average although there was a poor response rate noted for NHS patients. The response rates were worse than the England average of NHS patients apart from in February 2016 when the rate was higher.
- The Nuffield Health group used its own patient satisfaction survey where the results were compared monthly against other Nuffield Health hospitals. All patients were actively encouraged to complete a feedback questionnaire that reflected on all aspects of their patient journey through the hospital.
- The results were published on a monthly score report which could be broken down in to patient group, surgical speciality and department. The report was also sent electronically to every member of staff and consultants. This demonstrated the reported patient experience of care and performance was transparent and available to all. The report and its contents were discussed at the senior management team meetings and the clinical governance committee meetings. Patient comments were presented to staff again as part of the Hospital Director's regular 'Open Air' presentations.
- We noted that the majority of patients rated the overall quality of care as either excellent or very good. The April 2016 patient feedback report for Nuffield Health Haywards Heath hospital was consistently better than the majority of other Nuffield hospitals.The July 2016 patient satisfaction survey responses indicated that 83% of patients said they would be extremely likely to recommend the hospital to family or friends and 87% patients said that overall, they were satisfied with their experience. The Nuffield Health Haywards Heath hospital's 2016 patient led assessment of the care environment (PLACE) scores were the better than the England average for privacy, dignity and wellbeing (95%).
- The hospital was compliant with the Government's requirement to eliminate mixed-sex accommodation. Patients admitted to the hospital were only admitted to single rooms and only shared facilities when clinically necessary such as in the theatre recovery room. There were sufficient curtains and screening in these areas to maintain patient privacy and dignity.
- We spoke with twelve patients during our inspection and received completed comment cards from 26 surgical patients. Without exception, patients reported staff were polite, friendly and approachable, always caring and respectful. All the patients we spoke with were very happy with the care and treatment provided. We received comments such as "Very caring and professional – I always felt they had my best interest at heart"; "I'm always treated with the utmost dignity and respect"; "The staff are exemplary, I'm always recognised by name and warmly greeted – it's like meeting old friends"; "I've had several visits here, on one occasion I was extremely upset and the staff listened so well and were so sympathetic, I wasn't rushed at all"; "Staff excelled in every possible way- friendly, efficient, understanding, polite – I just felt safe and in good hands".
- We noted that patients receiving treatment and support were treated with dignity and respect, particularly on the wards, where staff always knocked before entering and addressed patients in a professional manner. We observed the reception staff greeting patients and staff in a friendly manner with a smile. Patients and visitors were put at ease and staff dealt with all enquiries promptly and efficiently. One member of staff told us "The best thing about working here is having time to care; having time to listen to their stories, their concerns and worries".

Good

Surgery

- In theatres we saw staff reassuring patients with friendly, light hearted banter when collecting them from the ward and talking gently with them, holding their hands to reassure them in the anaesthetic room. We observed staff being mindful of patients' privacy and dignity, taking care to ensure they were always covered appropriately when they were vulnerable and unable to look after themselves.
- Staff brought endoscopy patients into the theatre three endoscopy unit by a separate entrance. The anaesthetist did the final patient identification checks and questions in this area, away from other staff and patients in order to maintain privacy, dignity and respect.

Understanding and involvement of patients and those close to them

- Prior to admission for surgery every patient had their individual needs assessed and a plan of care was put in place to address those needs. This included social and psychological wellbeing. Patients were given time to assimilate any information and ask questions. We spoke with patients who confirmed the procedures were fully explained at the pre-operative assessment and they had the opportunity to ask questions. One patient told us "I knew what to expect from arrival right the way through, they [the nurses] explain everything every time they do anything".
- The patient satisfaction feedback was analysed monthly and included questions related to how engaged the patient felt with their treatment regime and pain management.
- Patients told us that the doctors took time to discuss what was happening and their treatment plans were discussed at the ward rounds. One patient told us "They just have the time to listen to my worries, they answer all of my questions and I'm not hurried at all".
- The staff supported family and friends to visit with open visiting until after 10pm when visiting was by arrangement with the ward staff. Visitors were able to have meals at the hospital which were charged to the patient's account. Patients told us their visitors were always made to feel welcome with a cup of tea. The hospital told us that beds could also be provided for family members who wished to stay overnight if needed.

Emotional support

- During the pre-assessment consultation staff took time to allay patients' fears. We saw that the assessment tool included assessing the patient's psychological well-being, maintaining interpersonal relationships and recording any significant life events which may have impacted on their health.
- There was not a separate assessment for anxiety and depression, however the documentation included discussing any anxieties about the surgery and confirming that the patient had realistic expectations.
- The hospital told us the Nuffield beliefs directly related to their responsibilities, they told us about the beliefs which included "We believe in taking care of the small stuff and we believe caring starts with listening".
- During our inspection we noted the emotional support available for patients recovering from surgery. For example where a patient was identified at pre-assessment as requiring extra support, transport was arranged and they were admitted early to allow the time to settle and adjust to the ward environment.
- The hospital also arranged support for patients from members of staff who had had the same surgery. They gave examples of a member of staff who had had surgery who visited the hospital in order to support an anxious patient.
- Staff had contact details for religious and cultural leaders if needed for cultural or spiritual support. Staff told us that this service was very rarely needed or asked for, as a patient's own minister tended to visit them. The list was checked every two years and the religious leaders contacted to make sure they remained happy to attend the hospital.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- As an independent hospital treating mainly elective patients, the hospital was constantly looking at the services it offered in order to meet the needs of the local population. The hospital told us they communicated with the local NHS trust, clinical commissioning groups, GPs and practice managers in order to identify gaps in

the local healthcare economy, and the services needed to support the local strategic plan. The hospital used this to explore new services or expand current procedures to help support local patient need.

- The hospital told us they worked in partnership with the NHS and other organisations to respond to the pressures within the local healthcare community. They gave the example of working with the local NHS Trust to relieve some of the waiting list issues.
- From the minutes of the senior leadership team meetings we saw that the hospital was working closely with NHS commissioning groups regarding providing surgical services for NHS patients.
- There were 4,233 inpatient and day case episodes of care recorded at the hospital in the reporting period (July 2015 to June 2016). This related to 785 inpatients and 3,448 day case patients. Of these patients 17% were NHS funded and 83% had other means of funding treatment. During the same reporting period, 20% of all NHS funded patients and 18% of all other funded patients stayed overnight at the hospital.
- The majority of patient treatment episodes occurred in the outpatient department. Inpatients made up 7% of all patients seen and treated in the hospital with 31% seen as day cases. Patients aged between 18 and 74 years of age made up the majority of patients admitted for surgery. Of these 644 were inpatients and 2,866 day cases. There were 141 inpatients admitted over the age of 75 and 568 older patients seen as day cases.
- We saw through minutes of the MAC that practising privileges were kept under review by the MAC and executive director to ensure that they were only offered practising privileges at the hospital if there was an identified need. The chair of the MAC told us that Nuffield Health Haywards Heath hospital was "very much a community hospital". It had built its reputation and was very comfortable and popular with patients who often returned for care and treatment.
- The ward and theatre staff told us that they had good teams in place who could work flexibly if circumstances needed. Extra staff could be brought in if the workload was extra busy although this rarely happened as most eventualities were planned for.
- We saw that booking staff gave consultants the endoscopy list to see what days and times were available for patients. Consultants were then able to discuss with patients the most suitable or convenient time for them to attend.

Access and flow

- The hospital offered a patient centred, flexible service, which included variable appointment times and choices regarding when patients would like their surgery, subject to consultant availability. Most specialisms had more than one consultant which meant patients had more choice about when they could be admitted.
- We found that patients had timely access to assessment, diagnosis and urgent treatment. Staff told us that there were no delays in accessing surgical intervention once the patient was identified and had accessed the hospital's booking systems. The hospital offered rapid access to diagnostic imaging and physiotherapy services, usually within a week. The hospital told us they were proud of their staff who understood the importance of responding to patients' needs and worked flexibly to help patients access the right treatment in a timely way.
- The patients we spoke with told us the service was very quick to respond. One patient told us they had been given a date for their operation as soon as the GP referral was received. They were seen on time and the operation took place as scheduled. They were very pleased with the service.
- Following an initial appointment or referral all patients were reviewed in outpatients at a pre-assessment clinic and then normally booked in for surgery. This allowed the hospital time to carry out a thorough pre-assessment. Assessments were made for mental capacity, falls risk, body mass index and manual handling so that any necessary actions started before the patient was admitted. For example ensuring the right equipment was available prior to admission and referring bariatric patients elsewhere if the hospital was unable to meet their needs.
- Patients all told us they had been able to arrange their surgery at a convenient time for them. One patient told us how pleased they were that the hospital had rearranged their appointment at short notice as they couldn't attend the booked date due to unforeseen family commitments.
- Consultants with scheduled theatre lists were able to add private patients to their list after seeing them in clinic. Urgent cases for lists were only added after consultation with the theatre department to make sure there were adequate staff available. The hospital had few capacity issues, waiting times were minimal and

often reflected patient preference rather than hospital capacity. The majority of private patients had their surgery within four weeks of the decision to operate, which allowed for an appropriate cooling off period and the pre-operative assessments.

- The NHS patient theatre bookings were managed between the bookings department, the consultant and theatre. The NHS contract reflected the national waiting list expectations of 18 weeks and the hospital was measured against this target. The bookings staff monitored the NHS waiting list times and advised the senior management team if a breach was likely. Breaches were reported to the clinical commission group. The hospital had not been penalised for any breaches to date.
- The wait times for the e-referral NHS patients were tightly controlled by the NHS referral to treatment time management system. This was reported on a monthly and quarterly basis. Over 90% of patients were admitted for treatment within 18 weeks of referral in the reporting period (July 2015 to June 2016).The percentage of patients admitted for treatment within 18 weeks of referral was below 90% for July, September 2015 and January 2016 .
- The muscular-skeletal (MSK) NHS contract lead was kept informed of waiting times. The MSK service was operated under a separate contract organised by the local clinical commissioning groups.
- Due to the elective nature of the admissions, a planned duration of stay was between one and four days dependant on the type of surgery. Each type of surgery had an expected care pathway and any variances to this were monitored and investigated.
- In the reporting period (July 2015 to June 2016) the provider cancelled seven procedures for a non-clinical reason. The hospital offered each of the seven patients another appointment within 28 days in line with government guidance. Any cancellation was usually due to patient choice, adverse test results or decisions at pre-assessment; for example, the need for high dependency care following surgery.
- Any re-admissions were recorded as incidents and the patients were followed up by their consultant in the outpatient department. Most patients who had joint replacement surgery were reviewed in the outpatients' clinics for up to a year following surgery. The hospital had a local protocol to conduct post-operative follow up courtesy calls in relation to all joint replacement patients 30 days after surgery, to ensure their recovery was on track and as expected.
- We spoke with staff who told us that they liaised with social services and the patient's GP to ensure there was a safe discharge plan in place. This was then documented in the integrated surgical care pathway.
- Staff explained the discharge procedure where an electronic discharge letter was sent to the patients' GP on the day of discharge. We saw copies of the discharge letters kept in patient's notes. Staff told us that delays in discharge did not happen often and there were very few cancellations.
- On discharge patients were given contact details for clinical telephone support which was provided by the ward and available 24 hours a day, seven days a week. A member of staff also contacted patients by phone once they had returned home, to ask if there were any problems and if they had any questions. Patients were also given a written report which gave recovery advice including eating and drinking, mobility, driving and returning to work. Individual information was given on physiotherapy, wound care, healing, pain relief and medication.
- The provider had also introduced 'The Promise' for self-pay patients in 2013 which enabled the patient to have further care and follow up appointments at no extra cost should they have clinical complications as a consequence of their procedure.

Meeting people's individual needs

- Nuffield Health Haywards Heath hospital was built in 1993 as a purpose built hospital. There was reasonably good access throughout. For example there was level flooring and disabled toilet facilities. However the entrance to the bedrooms could not accommodate bariatric equipment, which meant the hospital could not admit patients with a high body mass index. Any patient that was assessed as needing specialist bariatric care would be referred elsewhere.
- The hospital had an equality, diversity and inclusion policy which aimed to create an environment where all individuals were valued.
- The hospital's February 2016 to June 2016 PLACE scores were the same or better than the England average for disability (85%), food (97%), organisational food (95%),

ward food (98%) and privacy, dignity and wellbeing (87%).However the PLACE scores for dementia were lower than the England average. The hospital scored 75% against an England average of 80%.

- The action plan developed following the PLACE report included basic dementia training which had been given to all staff. The training described what the condition was and raised awareness amongst staff. However, senior staff acknowledged that it was a first step and further training was needed on how to care for this group of patients.
- The hospital had also refurbished a bedroom to be a dementia friendly environment. There were plans for two additional dementia friendly rooms. The room had basic adjustments, which included a large face digital clock, brightly painted bathroom door and bathroom fittings in a contrasting colour. There was also laminate flooring in place. Staff told us that signs could be placed on the bathroom door to aid identification. They would also ensure that patients living with dementia would have a blue pillow case which was a discrete method for staff to identify those patients living with dementia who may need extra support.However staff informed us that there had not been any patients living with dementia admitted for surgery in the past year.
- Staff told us there was no discrimination between NHS and private patients, all were treated the same and were admitted to a private room with en suite bathroom facilities, TV and Wi-Fi which promoted dignity and comfort.
- We were told that patients' individual needs and requirements were assessed and documented during the pre-assessment clinic appointment. If specialist requirements were identified these would be put in place before admission. Specialist aids included specialist moving and handling devices or dietary requirements.
- The hospital provided three meals a day for inpatients with snacks available if required. Copies of the food menus were available in each room and included dietary options such as vegetarian, gluten free and vegan. The hospital's 2016 PLACE assessment scores for food ranged between 95% for organisation-wide food to 98% for ward food. This was the same as or better than the England average for the same period. The patients we spoke with spoke positively about the quality and quantity of food provided.
- Staff told us that visitors were always offered drinks. They could order food from the menu at an added cost. This meant a patient could eat with their relatives if they wished. Patients could request additional beverages any time day or night.
- Information was sent to patients prior to them being admitted for their procedure. This included information about meal choices, which gave the patient the opportunity to inform the hospital of any food allergies or special dietary requirements.
- We noted in the July 2016 patient satisfaction survey, 83% patients rated the overall quality of the catering services as excellent. This was discussed at the August quality and safety meeting and agreed that the menus would be discussed with the head chef and regional manager of the catering supplier.
- Useful and appropriate information for patients was available in folders in the rooms. This included an introduction to the healthcare team, room information (television, telephone, nurse call system etc.) and menus. There were also information leaflets available on various conditions, physiotherapy, health and wellbeing in the reception areas.
- A translation service was available for patients. We saw a list of contact numbers for an interpretation and translation service available in the ward sister's office. This included sign language, deaf/blind interpreters and braille translators. Audio and large print documents were available on request. However on speaking with staff they told us although they knew it was available if needed, it was rarely used, as the majority of patients who attended the hospital spoke English as their first language.
- The Nuffield Health website also included information for patients on the services available at the hospital and detailed information about the individual operations, their risks and their benefits.
- The surgical care pathway included documenting that suitable arrangements were in place for a safe discharge. This included ensuring that family and carers' needs and responsibilities were taken into consideration. For example community services were considered and discussions documented if the person's carer would not be able to meet the patient's discharge needs.
- We observed patients being cared for in recovery. They appeared comfortable, relaxed and pain free. The recovery nurse was engaged with the patient at all times

and gave a verbal handover to the ward nurse who came to transfer the patient back to the ward. The handover included details about the patient's clinical condition, instructions from the surgeon and a safety checklist and was documented in the patient's notes. The comprehensive handovers helped to ensure that patients' individual needs were met and that their surgical care was continuous between theatre and the ward.

Learning from complaints and concerns

- There were systems in place to listen to patients' concerns and take appropriate action if required. This included the patient satisfaction survey, the hospital website enquiry form, written complaints and verbal complaints (which were then recorded and actioned by staff), the NHS choices website and social media. There were complaints leaflets available in the main reception areas. All complaints were uploaded onto the incident reporting system which enabled the hospital to generate reports and identify trends.
- Nuffield Health had a three stage process for dealing with complaints: local resolution; divisional organisational review; and an independent review by the Independent Sector Complaints Adjudication Service (ISCAS). Staff confirmed they encouraged patients to raise their concerns with them or their managers in the first instance, where the issue would be addressed without accessing the formal three staged formal complaints process. The hospital matron told us that conflict resolution training was not a standard training module for staff, however she was investigating potential training to help staff in managing complaints.
- We noted that the hospital director took overall responsibility for the management of complaints. The matron would lead and investigate any clinical complaints involving the relevant head of department where necessary. The matron and hospital director met weekly with the complaints co-ordinator and tried to meet or speak with as many patients as possible in respect of complaints.
- If a complaint involved a consultant with practising privileges the hospital director and the matron met with the individual to discuss the issues raised and notify the MAC if required. The matron gave an example where a complaint about a consultant's practice was discussed with the MAC and additional support had been put in place which resolved the issue.
- In the reporting period (July 2015 to June 2016) the provider received 29 complaints. The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the rate of other independent acute hospitals we hold this type of data for. No complaints had been referred to the Ombudsman or ISCAS in the same reporting period.
- CQC had received no complaints regarding this hospital in the reporting period (July 2015 to June 2016).
- We reviewed four complaints files in detail. Each complaint pre-dated the new management team. We noted that overall, staff demonstrated poor understanding of how to write a statement and respond to specific instance. With the most serious complaint, the Hospital Director responded promptly and effectively.The time frames for completing the complaints process were followed in two of the four complaints. Not all complaints files identified any lessons to be learnt. Two of the four documented 'no lessons to be learnt' when there were learning points that had been missed.
- Complaints were reviewed formally at the monthly board meetings, head of department meetings, the quarterly MAC and clinical governance meetings. We saw minutes from these meetings and noted that complaints were reviewed for themes, patterns and lessons learnt.
- Learning from complaints was then fed through team meetings. We saw evidence of discussions and information sharing regarding incidents, complaints and concerns seen in various ward and theatre meeting minutes provided. The matron told us she would monitor this to see where improvements had been made or look at areas that had not improved.
- The matron told us that each Monday the heads of department had a meeting where complaints and areas of concern were discussed. This meeting was not minuted. We saw that complaints were also discussed at the hospital director's quarterly open air presentation and learning from complaints was shared nationally through regional quality and safety meetings.
- We saw the hospital had listened to patients' concerns and made changes where indicated. We were given examples where complaints had led to a change in practice. For example a complaint from a visually impaired patient led to the catering manager putting on additional training for all of his team to develop their skills in caring for patients with visual and cognitive

impairments. Another complaint related to a patient who came in for surgery with a pre-existing complaint which led to a change in practice whereby all patients were measured for thrombo- elastic VTE stockings during their pre- assessment appointment.

Are surgery services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- As part of a large independent healthcare provider the Nuffield Health Haywards Heath hospital had the corporate vision and values of Nuffield Health. The corporate values were displayed throughout the hospital in staff and public areas and staff were aware of them.
- The hospital's own vision was to become the independent private hospital of choice for people living in and about the mid Sussex area. The hospital director told us he had developed the vision for the hospital based on his last post. There had not been staff involvement in developing the vision although the hospital director told us that the heads of departments and senior leadership team had "buy in" for the vision. The vision and strategy of the hospital formed part of the annual business plan set by the senior leadership team.
- This hospital's vision was delivered through the local hospital goals and objectives which aligned to the agreed hospital business plan and the Nuffield Health corporate strategy. The hospital board reviewed the strategic objectives monthly. The hospital produced an annual business plan and budget which was presented to the corporate provider's operating board to ensure the hospital plans were aligned to the overall corporate strategy.
- The hospital had a statement of values. We saw that the six Nuffield Health beliefs and values were embedded into the staff culture. All the staff we spoke with were aware of these values and applied them during their work at the hospital.
- The values were:
  - we believe that commercial gain can never come before clinical need.
  - we believe in no nonsense.
  - we believe in being straight with people.
  - we believe in taking care of the small stuff.
  - we believe that caring starts with listening.
  - we believe in you.
- Staff in theatres and on the wards told us that the hospital was committed to delivering safe and effective clinical care and could tell us about the corporate values.
- We saw that the hospital had a strategy in place for delivering safe care. At ward level and in theatres senior managers were aware of the business objectives for core surgical services, however they did not feel they were involved at a senior management level in developing the objectives for the service. Minutes from senior leadership meetings and the medical advisory committee (MAC) confirmed that the senior management teams and consultants practicing at the hospital were aware of current issues and the hospital's plans to address them.
- For 2016 the hospital had developed five goals linked to CQC's five key lines of enquiry. Each goal had specific objectives and actions in place. For example to achieve the well led goal the specific objectives were to: assure the delivery of high quality person-centred care; support learning and innovation; and promote a fair culture.To meet these objectives the hospital put in place training for heads of departments, wellbeing initiatives and had encouraged feedback from staff.

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

- The Nuffield Health group had a governance structure in place. Financial and operational performance was reviewed monthly by the hospital board and the hospital director submitted a monthly performance report to the south regional director. Quality and safety was monitored monthly with information from local hospital performance received at regional level. The regional team were able to offer support when needed to the local hospital team. For example over the past three months while the hospital was waiting for the new matron to be appointed the regional team supported the hospital director with clinical aspects of hospital management.
- The hospital had local quality and safety governance frameworks in place to identify and manage risks.

Departmental risk registers fed in to into the hospital's main risk register. The risk register was discussed regularly at quality and safety meetings. We reviewed copies of minutes which confirmed this. The risk register was reviewed monthly by the hospital board and the health and safety committee. Where appropriate, risks were escalated to the Nuffield Health group health and safety officer, the regional director, chief nurse and medical director. We reviewed copies of minutes which clearly demonstrated the local governance systems linking into the regional team.

- Actions arising from the hospital's audit programme were agreed and cascaded through various forums including infection prevention and the quality and safety committee. The hospital used monitoring tools such as the monthly quality and safety governance report, the clinical dashboard, the patient satisfaction report, complaints and incident reports to continuously monitor safety.
- There were systems to monitor the environment such as in house environmental audits, patient lead assessments of the care environment (PLACE) and environmental agency waste audits. We noted that sometimes the corporate response was slow and the hospital then took mitigating actions. For example independent reports were commissioned such as the recent fire safety audit where concerns were identified. We saw that results from audits fed into the hospital's risk register and were escalated for corporate action where needed.
- Consultants were required to comply with the requirements of the group's practising privileges policy. This was monitored by the MAC and hospital director with support from the regional and central HR, central clinical and medical teams.
- The hospital's policies stated that practising privileges should be reviewed bi-annually or if concerns were raised about a consultant's practice.
- There were 147 doctors and dentists employed under practising privileges. We noted that 100% of the doctors, dentists and inpatient nurses had their professional registration validated within the reporting period (July 2015 to June 2016). This meant they were legally registered to practice in the UK.

Leadership / culture of service related to this core service

- In January 2016 Nuffield Health appointed a new Chief Executive Officer, Executive Board and Operating Board to redefine the strategic direction of the Nuffield business. In April 2016 Nuffield Health held a conference for senior leaders to communicate the new strategic direction and five staff from the hospital attended. Staff were kept informed of the organisational change resulting from the change in the provider management structure through regular on-line updates, monthly newsletters and weekly bulletins.
- The hospital director (Registered Manager) had the overall responsibility for the hospital's activities, supported by the senior management team who had clear lines of responsibility and accountability for the delivery of the hospital's business plan and operational performance. The senior management team consisted of the hospital director, matron, finance manager and head of sales and services manager.
- We spoke with the hospital director who stated he was most proud of the commitment and care given by the staff. He told us they "went the extra mile" and the feedback from patients confirmed this.
- Over the past year the hospital had had a new senior management team. The hospital director had been in post 18 months, and the matron had started seven weeks before the inspection. The staff spoke positively about the changes telling us that a "fresh pair of eyes was welcome". They told us the new matron had made them think about their practice and where they could make improvements.
- Staff gave the example of improvements in confidentiality where the new matron had made them aware that practice could be improved. They now made sure notes were not left unattended and filing cabinets were kept locked at all times.
- The hospital told us of the Nuffield beliefs of 'We believe commercial gain can never come before clinical need'. These beliefs were delivered in staff workshops to ensure there was a consistent message across all employee groups as to what the Nuffield Health message should be.
- The hospital director gave 'Open Air' presentations to all staff where the results of the patient satisfaction survey were disseminated and staff received recognition for the work they had done. The hospital stressed that it was not only the front line staff but those in the support services that contributed to the whole team effort that made the difference.

Good

Surgery

- We saw good local leadership from the theatre and ward manager. All staff we spoke to were very positive about their leadership and told us they received support and encouragement to "go the extra mile" for patients. They told us the new matron was always "visible" and their managers had an "open door" policy where they always made themselves available if staff needed to discuss an issue. One new member of staff told us they were impressed that the new matron knew her name and was interested in what was happening on the "shop floor". They said "managers are all very approachable".
- The theatre manager told us that Nuffield Health was very good at providing management courses. However it was acknowledged by all the managers that they now had additional responsibilities under the new matron and it was a challenge to ensure they remained on top of everything. Having dedicated management time helped them to complete their new management duties.
- We found staff were proud to work for Nuffield Health and the majority had worked for the individual hospital for many years. They told us they felt that the care they provided was excellent and it was a very supportive environment to work in. One staff member told us "It doesn't feel like coming to work I enjoy it so much". Other staff told how they cared for each other and supported each other through personal issues.
- Sickness rates for theatre staff were low when compared to other independent acute hospitals. The sickness rates in the reporting period (July 2015 to June 2016) for nurses working in theatre departments were lower than the average of other independent acute hospitals we hold this type of data for, except for in January 2016 to April 2016 when the rates were higher than the average.
- The sickness rates in the reporting period (July 2015 to June 2016) for operating department practitioners and health care assistants working in theatre departments were lower than the average of other independent acute hospitals we hold this type of data for in the same period, except for in October 2015 and April 2016 when the rates were higher than the average. The hospital told us there were no vacancies in theatre departments as of 1 July 2016.
- Sickness rates were variable on the inpatient ward. The sickness rates for nurses working in inpatient departments were higher than the average of other independent acute hospitals in the reporting period (July 2015 to June 2016), except from January 2016 to March 2016 and May 2016 when the rate was lower than the average.
- There were variable sickness rates for health care assistants working on the ward in the same reporting period. There were no reported vacancies for inpatient staff as of 1 July 2016.
- We were told of one full-time vacancy for other staff which gave a vacancy rate of 3%. This was lower than the vacancy rate for this staff group in other independent acute hospitals we hold this type of data for.
- Staff turnover on the inpatient ward and in theatres was low when compared to other independent acute hospitals.
- None of the staff we spoke with said they had experienced bullying from their colleagues or managers. There were no whistleblowing concerns identified.
- The hospital completed the Workforce Race Equality Standard for the first time in February 2016. The reporting form identified there were gaps in data with low numbers of staff (12.4%) reporting their ethnicity.

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

- The hospital had a patient feedback system that operated across the Nuffield Health group. The hospital also operated the NHS family and friends test which was a short survey where patients were asked four questions relating to the quality of care and if they would recommend the hospital to family and friends.
- There were no items of rated feedback on the NHS Choices website for Nuffield Health Haywards Heath Hospital in the reporting period (July 2015 to June 2016).
- There were no other forums identified where the hospital engaged with the general public.However, the hospital did undertake health promotion events and support patients' groups following discharge. The hospital described good working relationships with local and national NHS bodies together with developing links with local GP practices.
- The hospital told us that the Nuffield Health beliefs were delivered in staff workshops to ensure that there was a consistent message across all staff groups about their expectations in how to behave towards patients and each other.

- The hospital told us that staff welfare was also included in the Nuffield Health's caring ethos. They gave examples of the employee assistance programme that offered confidential counselling support, access to occupational health, phased return to work programmes for those returning from long term-sick leave, flexible working and a supportive and caring attitude according to individual needs.
- Equality responsibilities were taken seriously and where staff had an illness that incapacitated them the hospital prioritised their wellbeing over business need. The hospital told us that their charitable status allowed them to focus on the needs of the patient and staff rather than financial constraints.
- The hospital arranged social events at key times of the year. For example at Christmas all staff received a Christmas Lunch, and a separate external party was held in the summer to mark the retirement of the out-going matron and as a 'Thank You' to staff. When monthly financial targets were met staff were offered lunch at hospital expense.
- Throughout the year the hospital rewarded staff who went 'above and beyond'. They also recognised when staff had personal issues or family celebrations and sent flowers from the hospital. We saw the 'Nuffield news' bulletin included 'Hospital Stars' where positive patient feedback on named members of staff members was shared.
- The staff we spoke with told us "It was the little things" that made all the difference within the team. They gave examples of receiving a card and chocolates on their birthday, organising social events and supporting each other through problems at home. One member of staff told us "They are all lovely here – they are not work colleagues they are family". Another told us "We look after each other, we genuinely care about each other and can talk about anything that we are worried about".
- The hospital had an established system of departmental meetings where staff felt able to contribute and raise issues and concerns. Team meetings were held on a regular basis and staff told us they felt able to contribute where necessary. We saw minutes from team meetings from both the ward and theatres which included team member discussions about relevant issues such as team behaviour and concerns.
- In theatre staff told us that pizzas were ordered for staff meetings which helped to encourage staff to attend. We reviewed the theatre team meeting minutes and noted the risk register was discussed in detail together with proposed solutions, time scales for completion and escalation to the quality and safety committee. Items were colour coded for prompt identification. Staff discussed the outcomes from recent audits and provided feedback from incident investigation which demonstrated clear learning and a change in practice.
- Staff told us that patients fed back to them how pleased they were with the care they received. They told us it made staff feel good knowing they had done a good job and that patients went home happy. They told us it made them proud knowing that patients' expectations had been fulfilled and they had done a worthwhile job".
- Many staff had worked for many years at the hospital and told us how proud they were to work at the hospital. All the staff we spoke with were proud to work for the hospital and felt fully engaged with the success of the hospital and their role in making it happen.
- The hospital gathered feedback from consultants in a twice yearly survey.

Innovation, improvement and sustainability

- Staff felt that there was little scope for innovative practice because the hospital was small and tended to "follow [new procedures] at a safe distance" rather than be at the forefront of innovation. However staff told us the managers were always asking for ideas or areas for improvement.
- One new staff member told us of a small change that had been put in place following raising the issue with the ward manager. They told us "We are always listened to and good ideas are taken on board". For example one member of staff told us it was not always easy for staff to take their breaks due to patients arriving and leaving for theatre. This was raised at a ward meeting and the staff were asked for their ideas on how to manage the issue.
- The hospital had recently installed an electronic digital temperature monitoring system. The system continuously monitored fridge, and room temperatures. Any anomaly was reported electronically to the hospital pharmacist who managed the system centrally. The pharmacist demonstrated the system and we saw that the hospital was no longer relying on staff to record temperatures on a daily basis. This meant staff were now free to undertake other duties and temperature records were traceable, always recorded and accurate. The hospital was assured that medicines and room temperatures were always safe.

Good

Surgery

- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- We spoke with the pre-assessment staff who told us that two clinics were run each day. However the objective was to operate evening clinics so that patients did not need to take time off work for their pre-assessment appointment. Staff told us “We recognise that taking time off work is difficult when jobs may be at risk”.

Requires improvement

Services for children and young people

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

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement. Although there were many good things about the service, it breached a regulation relating to the maintenance of patient records and we had concerns regarding the qualifications and safeguarding training of all staff, which means we cannot give a rating higher than requires improvement.

Incidents

- There were no reported incidents relating to the services provided for children and young people aged between three and 15 years. Any incidents relating to 16 and 17 year olds attending for a surgical procedure or an outpatient consultation under the adult pathway have been reported in the surgery and outpatients sections of this report, although incidents relating to 16 and 17 year old patients have not been differentiated in the report as the hospital did not report them separately.

Cleanliness, infection control and hygiene

- There were no reported incidents of meticillin resistant Staphylococcus Aureus (MRSA) in the period July 2015 to July 2016.
- There were no reported incidents of e-coli in the period July 2015 to June 2016.
- There were no reported incidents of Clostridium Difficile (C.diff) in the period July 2015 to June 2016.
- Hand sanitising gels were available across the hospital and were seen to be used by staff. We also observed that all staff were bare below the elbow in clinical areas.
- Patients aged 16 and 17 attending the hospital for surgical procedures were cared for under the adult pathway. Details about cleanliness, infection control and hygiene can be found in the surgery section of this report.

Environment and equipment

- The hospital had resuscitation equipment available across the hospital. This was checked daily and was recorded as such. However, there was no paediatric blood pressure cuff on the resuscitation trolleys. There were separate bags hung on the resuscitation trolley that contained different sized paediatric equipment. These bags were unsecured, plastic rucksacks.
- The theatre recovery area did not have any specific area for patients aged 16 or 17 years old. We were told by nursing staff that although the number of patients seen was low, a number of the patients who had attended for dental surgery had complex needs and challenging behaviour. Staff told us that challenging behaviour was reported to be disconcerting for other patients recovering from their surgical procedure.

Medicines

- There were no separate areas specifically provided for children's medication. Patients aged between three and 15 only attended for outpatient consultations. The management and storage of medicines for this group of patients is reported in the outpatients section of this report.
- Patients aged 16 or 17 attending the hospital for surgical procedures or outpatient consultations were cared for on the adult pathway. The management and storage of medicines is reported in the surgery and outpatients parts of this report.

Requires improvement

Services for children and young people

Records

- We reviewed 10 sets of patient notes. Three sets of notes were for 16 and 17 year old patients who were seen under the adult care pathway and the other seven were for patients aged between three and 15 years who were seen as outpatients.
- The three sets of notes for 16 and 17 year old patients related to patients who had attended for surgery. The notes were thorough and the level of detail was tailored to the complexity of the procedure that was undertaken. There was a paper file with the information filed in the correct order and held in place securely. There was also a sticker placed on the front of the file with the patient's personal details such as name and date of birth. The treating consultant's names were also on these labels. These records were easily obtained from a storage room on site.
- The records we reviewed that were held for children between the ages of three and 15 attending for outpatient appointments were considered not to be fit for purpose. We were told that the files were colour coded blue or pink, blue for boys and pink for girls. Although this was the case in the majority of records, we saw there were some records stored in a buff coloured folder which could cause staff confusion. The files themselves had a handwritten name and date of birth on the front but did not have any details of the treating consultant. The information contained within the files was not bound in any way and the contents were therefore loose. This meant that papers in patients' files could come out and be misfiled in another patient's notes. During the inspection, we found a note regarding an adult patient in a child's file.
- The information contained in the files was very limited and in the main consisted of a GP referral letter and a care record completed by a Healthcare Assistant (HCA) or nurse at the time of the consultation. There was no record kept of the actual consultation in these files. This was because the consultants kept them in their own records. This issue was on the hospital risk register. The effect of this lack of information could be that the patient, or in all likelihood the parent, could call the hospital for some information or assistance and the staff that handled the call would have had nothing more than very basic information to refer to.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 201417 (2) (c) states the provider must "maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided."
- Keeping separate file notes in this manner did not meet the requirement of the regulation and because of this, our rating lowers to 'requires improvement' for safety.
- These records were stored in the bottom drawer of a filing cabinet in a locked room but were accessible when required.
- Records for patients attending physiotherapy were kept electronically and no paper based records were kept at all. This meant that the physiotherapists had instant access to any records they required.

Safeguarding

- The hospital had three staff who had been trained to level three in children's safeguarding. They were the Hospital Director, the matron and the outpatients' manager. All nursing staff had been trained to level two. Some HCAs had been trained to level two but most HCAs and other hospital staff were only mandated to train to level one. Level one training was provided to all staff annually. Intercollegiate guidance for safeguarding children and young people indicates that level two is the minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers.
- All consultants with practising privileges had to demonstrate that they had been trained to level three child safeguarding to gain or retain those privileges. We saw evidence in the consultants' files that demonstrated compliance with this requirement.
- The matron, who at the time of the inspection had been in post seven weeks, told us that one of their first tasks when starting at the hospital was to ensure that all of the safeguarding processes and protocols were in place. This included checking that all of the flow charts placed around the hospital displayed correct information such as who to contact and the phone numbers to use. The matron also made sure all staff would know what to do and how to escalate safeguarding concerns. Discussions with a range of staff across the hospital confirmed this.
- The hospital staff also had access to a Nuffield Group national safeguarding lead and their deputy who could be contacted for advice 24 hours a day. The national safeguarding lead also delivered the level three

safeguarding training on a face to face basis to the matron, hospital director and lead nurse for outpatients every three years in compliance with the Nuffield safeguarding policy.

- The matron was aware of who the Local Authority Designated Officer (LADO) was. We were told there was already a relationship between the LADO and the hospital and that they were looking to further develop this relationship in the future.
- We saw evidence that the safeguarding flow chart was available for staff in clinical areas. This gave all staff a clear direction as to how to escalate safeguarding concerns. Staff we spoke with had been unanimously clear in how they would report child safeguarding concerns.
- Chaperones were provided for all patients at their first consultation and when requested thereafter. HCAs or nurses would provide this if necessary and all HCAs and nursing staff had been given chaperone training.
- We were shown that the hospital had a clear protocol on how to deal with cases of female genital mutilation (FGM). The process for reporting and escalating FGM issues was kept in the form of a flow chart which was available across the hospital, and online. This was kept alongside the safeguarding flowchart. FGM was also covered in the safeguarding training provided to clinical staff.
- The physiotherapy department told us that if a patient did not attend an appointment they would initially follow it up with the family. If however they failed to attend for a second time, they would then refer the non-attendance to the GP to look at whether there were any safeguarding concerns.
- The hospital completed an annual safeguarding report that detailed any safeguarding referrals made, and details of relevant policies as well as training compliance.

Mandatory training

- Data provided regarding mandatory training did not contain core service specific information for children and young people. However, all staff completed corporate mandatory training and certain staff or 'target groups' completed paediatric specific training.
- Corporate mandatory training included Datix: Level 1: Incident reporting, fire safety, health safety and welfare, managing stress and whistleblowing. The compliance rates for this training, as at 15 November 2016, was 91% for incident reporting, fire safety was 95%, health safety and welfare was 94%, managing stress was 93% and whistleblowing was 98%.
- Compliance rates for level one safeguarding children was 94%. The compliance rate for paediatric basic life support was 76%. Paediatric physiotherapy training compliance was 100%. Safeguarding children level two was 100% and safeguarding children level three was also 100%.
- The hospital target for mandatory training was 90%.

Nursing staffing

- There was no dedicated paediatric nurse employed at the hospital to provide care for children and young people. The hospital had decided in February 2016 to cease doing any surgical procedures on children aged three to 15 years and to only provide outpatient appointments. However, young people aged 16 and 17 were still seen under the adult surgical pathway. All nurses involved in the care of children were general outpatient nurses without specific paediatric nursing qualifications. Nursing staffing for outpatients appointments can be found in the outpatients section of this report. Nursing staffing for the young people accessing surgical services on the adult pathway can be found in the surgery section of this report.
- Although there was no children's nurse employed at the hospital, staff did have access to lead nurses at other Nuffield Health Hospitals and the Nuffield Health children's and young person's (CYP) lead nurse should queries arise. Adult nurses employed at the hospital did have experience of caring for young people and were aware of their particular needs.

Medical staffing

- The resident medical officers (RMO) working at Nuffield Haywards Heath were provided by an agency and worked a rota of one week on and one week off. The RMO was available 24 hours a day if required.
- All other medical practitioners working at the hospital worked under practising privileges. There were no medical practitioners directly employed by the hospital.

Emergency awareness and training

Requires improvement

Services for children and young people

- There were in total seven staff that had received either basic paediatric life support or immediate paediatric life support. All physiotherapy staff had received basic paediatric life support training. The RMOs were trained in advanced paediatric life support.

Are services for children and young people effective?

Not sufficient evidence to rate

There was insufficient information to rate the effective domain.

Evidence-based care and treatment

- Patients referred for consultations at the hospital were referred by their General Practitioner (GP).
- The physiotherapist service saw patients between the ages of three and 15. However, the patients were not seen for developmental physiotherapy. The patients they saw at the time of the inspection were overwhelmingly older children who had received sporting injuries.
- Patients accessed the physiotherapy service predominantly through referrals from their GP or directly from consultants. The service did accept adult self-pay patients through their website although there were safeguards in place to prevent those under 18 accessing the service in this way.

Pain relief

- Children and young people between the ages of three and 15 years only attended the hospital for outpatients and physiotherapy appointments. Therefore the need for pain relief was minimal during any consultations. Advice would be given to patients and / or their parents on how to manage any pain arising from their condition.
- Any 16 or 17 year olds undergoing surgery on the adult pathway would have their pain managed by the surgical team and therefore pain management for this patient group is reported in the surgery part of this report.

Nutrition and hydration

- Outpatient appointments for children aged between three and 15 were, in the main short and did not require any arrangements for food or drinks to be provided. However, there were adequate facilities for them to get a drink in the reception area if needed.
- Any 16 or 17 year olds undergoing surgery on the adult pathway would have their food and drink requirements managed by the surgical team and is reported in the surgery section of the report.

Patient outcomes

- Due to the fact that the patients aged between three and 15 were only seen for outpatient consultations, the hospital did not contribute to any national reporting for this specific age group.
- The outcomes for patients cared for aged 16 or 17 on the adult care pathway are reported in the surgery section of this report although this patient group is not differentiated in the report.

Competent staff

- The hospital achieved a 100% completion rate for staff receiving their appraisals in the reporting period April 2015 to March 2016.
- Although the hospital saw special needs patients aged 16 and 17, at the rate of two every two weeks, the only training staff had to deal with this patient group was online. This training did have a pass / fail outcome with a minimum pass rate of 80%.
- Senior staff we spoke to told us that recognising domestic violence was part of the level three safeguarding training but was not part of level one or two. There was limited assurance among senior staff that other members of staff had been sufficiently trained, or were sufficiently equipped to recognise and deal with suspected domestic violence. Senior staff had been looking at ways that they could enhance and promote the awareness and reporting of domestic violence.

Multidisciplinary working

- We were told how nursing staff worked closely with carers when patients with special needs aged 16 and 17 attended for dental surgery. If there was a difficulty with communication with the patient, they would use the experience of the carer to understand if they were in pain and how much pain. Once that had been decided, pain relief would be provided accordingly.

Requires improvement

Services for children and young people

- The hospital had set up a children and young people's committee in August 2016. The committee had a representative from all areas of the hospital including reception staff. The group was scheduled to meet quarterly but at the time of the inspection they had met in both August and October and it was anticipated that they would meet bi-monthly in the future. The structure of the meeting used the CQC domains of safe, effective, caring, responsive and well led. Comments from all areas of the hospital were recorded under these domains and captured in the minutes.

Access to information

- Information about the services provided for children and young people was not easily found on the Nuffield Haywards Heath website and it did not have a specific section for members of the public to access.
- Parents of patients aged three to 15 years attending for consultations were sent details about the consultation they would be having including details of how to get to the hospital.
- Surgical patients and outpatients aged 16 and 17 were treated under the adult pathway. As such access to information is reported in the respective sections of this report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients attending for physiotherapy between the ages of three and 15 had to attend with parents or a responsible adult and the adult had to sign consent. Patients aged 16 or 17 were treated on an adult pathway and could sign their own consent. Patients aged 16 or 17 had their wishes respected if they wanted to be treated without their parents or carers in the room.
- The consent form for patients aged 16 and 17 undergoing surgery was comprehensive with clear guidance on how it should be completed for both the patient and medical professional.
- The hospital followed the Nuffield Health Consent Policy and specifically, Consent to treat children and young people. Consideration would be given to Gillick Competency. Young people (aged 16-18 yrs) were deemed to have capacity to consent for treatment and were encouraged to include those with 'parental responsibility' for them in this discussion. If they were unable to consent to treatment due to a lack of capacity, a 'best interest' meeting would be held which would include the young adult, the person with 'parental responsibility', the clinician, and a carer from the residential home, if the young person was living in a residential home. The outcome of this was clearly documented in the medical record. The policy stated that a learning difficulty may not necessarily mean that there was a lack of capacity and as such, each case would need to be carefully reviewed, and then the person with 'parental responsibility' may give consent.

Are services for children and young people caring?

Not sufficient evidence to rate

There was insufficient information to rate the caring domain.

Compassionate care

- All the patients and parents we spoke with were happy with the care they and their children had received from the staff treating them or their child. All the children and parents we met were attending their first consultation on the day of our inspection. We were therefore unable to judge the level of compassion shown as the interactions had until that point been limited.

Understanding and involvement of patients and those close to them

- We spoke with three sets of parents who were attending appointments with their children. All were positive about the care they had received and the involvement they had in the care of their children. They told us information that had been provided was useful and commented on the ease of arranging an appointment.

Emotional support

- Due to the fact that the hospital only saw patients aged between three and 15 for consultations, most of the emotional support was provided by the parents that attended with the child. There were no specific services offered by the hospital in this regard.
- When reviewing the records of one patient in the 16 to 17 age group, we saw strong evidence in the records that demonstrated the consultant had been honest with a patient during their consultation about the likely long

Requires improvement

Services for children and young people

term effects of a sports injury. This demonstrated that they had appropriately managed expectations and were aware of the emotional impact the surgery could have had on the patient.

Are services for children and young people responsive?

Not sufficient evidence to rate

There was insufficient information to rate the responsive domain.

Service planning and delivery to meet the needs of local people

- Children and young people attended the hospital for consultations with specialist consultants. The majority of patients saw consultants in ear, nose and throat, dermatology and orthopaedics. The number of attendances was relatively low and lists were not set up specifically for children and young people. As a consequence of this, there was no separate area for children to wait.
- Given the ages of the patient group, the majority of the consultations took place within school hours although the time spent in the appointments was kept to a minimum. Of the three sets of parents we spoke with, this was not reported as a problem.

Access and flow

- Children and young people attending the hospital were predominantly those who had been referred to a consultant by their GP and were being funded through insurance policies held by their parents. However, some 16 and 17 year old patients attending for dental surgery were NHS patients and, at the conclusion of their treatment were referred back to community dentists.

Meeting people's individual needs

- Although there were only low numbers of children between the ages of three and 15 attending the hospital, there was very little for younger children to do while waiting for their consultation. Reception staff did have some colouring pencils and paper available on request although there was nothing to indicate that these were available.
- The hospital did see patients with special needs. Most of these patients were aged 16 or 17, had come from a residential care environment and were attending the hospital for dental surgery. These patients would attend with a carer and staff at the hospital would try to orientate the patient to the hospital environment prior to their appointment. Staff reported how there could be communication and cooperation difficulties with these patients. They explained how they would have to take observations by sight. If this were the case, they would then arrange for the patient to be closely monitored with a minimum of one nurse to two patients.
- Prior to surgery the patients would stay outside the theatre environment until they were asleep. Following surgery patients would be recovered in the company of their carer and would normally stay for four hours. However, patients who were agitated by the hospital environment could be discharged early if they were deemed well enough to leave.
- This clinic would operate twice a month with a maximum of two patients on the list.
- The hospital had access to telephone interpreters in the event that they were treating a patient or needed to speak to a family member whose first language was not English.

Learning from complaints and concerns

- There had been no complaints regarding the services provided to children and young people aged three to 15 between July 2015 and June 2016. There had been no complaints about, or from, any 16 and 17 year olds in the period between July 2015 and June 2016.

Are services for children and young people well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this this core service

- The hospital made the decision in February 2016 to stop carrying out surgery on any patients aged between 3 and 15 but to continue seeing these patients for outpatient consultations. They continued to undertake surgery on 16 and 17 year olds on the adult pathway.

Requires improvement

Services for children and young people

- We spoke with senior staff who explained that there were no plans to reverse this decision, predominantly because of the difficulty in getting paediatric nursing staff.
- The hospital was looking to develop its physiotherapy service for children and to increase the number of younger patients they could care for in physiotherapy.

Governance, risk management and quality measurement

- There was a Nuffield Health Group governance structure to support local governance processes: this included Quality Care Partners (QCP) for each hospital and the leadership provided by the group lead Children's and Young Persons' Nurse. A consultant paediatrician was part of the Medical Advisory Committee and the local CYP committee. The purpose of this committee was to review best practice, national guidance, patient feedback, complaints, incidents and lessons learned. Given that no incidents had been reported, no complaints had been made and the relatively low number of patients seen within the reporting period, it was difficult to understand how sufficient information could be gathered to make the meetings of the CYP committee effective.
- At the time of the inspection the CYP committee had met twice, once in August and once in late October. The agenda for October 2017 showed that the committee was still to finalise its terms of reference. We were not provided with the minutes of this meeting.

Leadership and culture of service

- All staff we spoke with told us how there had been a change in the culture since the appointment of the new matron. In addition to this, the matron told us how they had made it a priority to understand the culture, then look to further develop the staff.
- We were told how staff had been given more autonomy to resolve any issues themselves rather than reporting everything to the matron and relying on the matron to resolve it.
- Since the appointment of the new matron, the hospital had given the role of lead nurse for children and young people to the outpatient's manager. This recognised the importance of having a lead nurse and had given added responsibility to an experienced member of staff. However, we did not have assurance that incorporating the children's service within the general outpatients' department enabled the department to effectively meet the specific needs of children attending the service.
- The culture was open, with staff telling us that they felt comfortable reporting anything that concerned them to their manager, or if necessary, to the matron. This was true across all areas where children were present in the hospital.

Public and staff engagement

- At the time of the inspection there was little public engagement specifically aimed at services for children and young people as the patients they dealt with were generally referred to see a specific consultant with practising privileges at the hospital.
- The creation of the Children's and Young People's Committee had brought staff from across many disciplines and all areas of the hospital together to discuss any matters relating to the care provided to children and young people.

Innovation, improvement and sustainability

- In August 2016 a review of the service was carried out, led by the Nuffield Health's lead Children's nurse, and an action plan was generated from that review. A local children's and young people's (CYP) committee had been set up as a result of this.
- The CYP committee included theatre representation as well as representation from physiotherapy and reception staff. This committee reported into the Quality and Safety Committee and via the matron, to the Medical Advisory Committee (MAC).
- At the time of the inspection the physiotherapy department had recently appointed a paediatric physiotherapist. This was to enable the hospital to expand its physiotherapy service to younger children with musculoskeletal needs. The enhanced service had not yet been advertised or promoted but plans were in place to do this in the early part of 2017. We were also told by staff that the Nuffield Group were planning to appoint a national paediatric lead in physiotherapy.
- We were told by senior staff in the physiotherapy department that they were looking to mirror other services in the group that were offering physiotherapy for posture problems that had developed as a result of children spending long periods of time on games consoles and laptops.

Requires improvement

Services for children and young people

- We were told about a proposal to introduce happiness emojis for children attending consultations at the hospital. This was a sheet of paper with a number of emojis on that showed faces with different expressions that described their feelings. The plan was to ask patients before and after their consultations to identify the emoji that suited their level of happiness. At the time of the inspection this idea was yet to be ratified and was to be taken to the next children's and young people's committee meeting.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement. Although there were many good things about the service, it breached a regulation relating to the maintenance of patient records, which means we cannot give a rating higher than requires improvement.

Incidents

- We found evidence that indicated the hospital had a good safety culture. All staff we spoke with knew how to report incidents through the hospital's electronic incident reporting system and felt confident in doing so. The topic was included in the annual mandatory training programme and records showed 91% staff compliance, which was better than the corporate target of 85%.
- The hospital had a comprehensive process of reviewing incidents and sharing the lessons learned from these, as well as sharing incidents from other Nuffield hospitals. We saw the minutes of monthly heads of department (HoD) and hospital board (HB) meetings, which showed this was occurring and we noted that the minutes had been structured to match the assessment criteria used by CQC. The hospital director explained this was a deliberate strategy to enhance the clarity and focus of the meetings. The director had also shifted the emphasis on incident investigation to the level of the HoDs, who had all received training in root cause analysis (RCA) techniques and reporting skills.
- We saw two sets of quarterly medical advisory committee (MAC) minutes that contained incident summaries and action plan updates, which demonstrated that senior medical staff maintained clinical oversight of incident reporting and management. Managers circulated the minutes of these meetings to their staff by email and during weekly team briefings.
- Outpatient and diagnostic imaging services reported 41 clinical incidents last year. The overall rate of clinical incidents per 100 outpatient attendances was worse than other independent hospitals. However, the percentages of clinical incidents that caused moderate harm (7%), low harm (21%) and no harm (72%) were all better than other independent hospitals we hold data for.
- The hospital reported no serious incidents or never events in the last year. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Providers are obliged to report never events for any patient receiving NHS funded care and the occurrence of never events may highlight potential weaknesses in how an organisation manages fundamental safety processes.
- Under the law, hospitals must report to CQC any radiology incidents that result in exposures "much greater than intended". None had occurred last year.
- The radiology manager stated that there had been no serious incidents in the department for "five years" and

the manager of the physiotherapy department, which provided services to both inpatients and outpatients, stated that there had been no clinical incidents in her department "for years".
- Three non-clinical incidents were reported last year, which is about the same as the rates seen in other independent hospitals.

Cleanliness, infection control and hygiene

- All staff were 'bare below the elbow' apart from two consultants. When we asked about this, managers explained that doctors could wear jackets when the consultation was a discussion only and did not involve direct patient contact. We checked the Nuffield policy (IP 02), which states: "Staff working in clinical areas will be "bare below the elbows" – this includes no wrist watches, stoned rings, long sleeved clothing, and specifically, for direct patient contact, ties tucked under apron/shirt, jackets removed and a single use disposable apron worn and where shirts have long sleeves, these must be rolled up". In this instance, staff were not following or did not understand their own policy.
- We inspected the outpatients department, which included consulting rooms and waiting areas on the ground floor and second floor, the radiology suite on the ground floor and physiotherapy suite on the second floor. We also visited the pathology "hub" and clinical storage rooms.
- All of the areas we inspected were visibly clean, tidy and free from clutter. This included higher-level dust traps such as door surrounds, window frames and curtain rails.
- Throughout all departments, we saw that trolleys, couches and medical equipment, including specialist items in radiology such as patient movement slides, imaging cassettes, lead aprons and thyroid collars, were visibly clean and stored correctly.
- Carpeting covered the floors in waiting rooms and corridors, with the exception of the waiting area leading to the new MRI suite. The hospital acknowledged the increased hygiene risk from carpets and had taken action to minimise this by a programme of specialist cleaning. As part of the cleaning schedule, carpets were vacuumed daily, shampooed and deep cleaned if spills occurred. They were routinely deep cleaned at least once a year, during periods when the hospital was less busy. We saw checklists which indicated this was occurring. The carpets were due for removal as part of the refurbishment programme.
- The flooring of the consulting and treatment rooms in the rest of the outpatient department, diagnostic imaging and physiotherapy treatment areas, was made from seamless, smooth, slip-resistant material that complied with Health Building Note (HBN) 00-09: Infection control in the built environment (Department of Health, March 2013).
- Housekeeping staff were directly employed by the hospital and responsible for cleaning rooms up to a height reached without the use of stepladders. Housekeepers carried daily cleaning schedules on their trolleys that they signed as they progressed to show the work was completed and recording any problems encountered. They handed these to the housekeeping supervisor at the end of their shift for checking. If a consulting room was still in use by the end of their day, it was reported to the supervisor who allocated an evening cleaner to attend. In the radiology and physiotherapy suites, we saw cleaning logs displayed on doors.
- Specialist cleaners had been contracted to provide high level cleaning, which included ventilation grills, radiators and windows.
- Over the last 12 months, there had been no reported cases of healthcare-associated infections such as meticillin resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or, meticillin sensitive Staphylococcus Aureus (MSSA) for the outpatients and diagnostic imaging department. These are all infections that could cause harm to patients.
- The hospital's patient led assessment of the care environment (PLACE) audit for 2016 showed the hospital scored the same as the England average (98%) for cleanliness.
- Staff participated in infection control training as part of their annual mandatory training programme. Ninety per cent of staff had attended training in the last year, which was better than the Nuffield group target of 85%.
- We saw antimicrobial hand-rub dispensers mounted on the walls between consulting rooms and readily available in all other areas including the main reception desk where patients booked in for their appointment. These contained gel and we observed staff using the product as they moved around the department.

Good

Outpatients and diagnostic imaging

- There was information displayed near handwashing sinks in treatment rooms demonstrating the 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in health care. Lever operated taps were in place, with liquid soap dispensers and paper hand-towel dispensers nearby. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment.
- We saw the last hand hygiene audit for outpatients (May 2016) showed 100% compliance. In line with Nuffield group policy (IP 05), and managers assessed staff using the WHO observation tool. This helped to check that staff followed the principles of "My Five Moments for Hand Hygiene" and other recommendations, such as not wearing jewellery, all of which were designed to reduce the risk of passing germs to other people.
- We checked patient and staff toilets in each area, which were visibly clean. Outpatient consulting rooms on the second floor had en-suite toilets, which were also clean. We saw a cracked sink tile in consulting room 202 and reported it to the senior sister, who explained it had already been identified and escalated to the maintenance contractor.
- We observed good use of safe sharps and self-sheathing needles in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, which is intended to reduce injuries caused by needles and other sharp objects in the healthcare environment.
- We saw sharps bins available in treatment areas and correctly used in accordance with the regulations. The bins were secure containers, clearly marked and placed close to work areas. The bin labels included instructions for staff on safe disposal.
- All single-use items we saw were in date, such as syringes and wound dressings. Correct storage and stock rotation ensured the sterility of items was maintained and thus the risk of bacterial contamination reduced. We saw these items being used once and disposed of afterwards.
- Personal Protective Equipment (PPE) such as gloves in all sizes and aprons were available in each of the treatment rooms we inspected. We saw staff using the items correctly and we observed that specialist PPE was provided for hospital staff handling medical gas cylinders and cryogenic containers.
- We saw disposable curtains used in the treatment rooms and each had a label showing the date changed. All had been changed within six months. This complied with HBN 00-09. Frequently changed curtains helped to reduce the chances of germs passing from one person or object to another.
- All rooms had colour-coded waste bins to separate clinical and general waste. This allowed the hospital to handle hazardous waste safely and was in accordance with Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and the Hazardous Waste Regulations (2005). Clinical waste was kept in lockable 'wheelie bins' and stored in a secure compound ready for collection by the waste disposal contractor. Hospital staff used traceable (numbered) cable ties to seal bags and we saw examples of correctly completed consignment notes.
- A recent Environmental Agency clinical waste audit (July 2016) concluded the offensive waste stream was managed correctly and waste container placement, labelling and management was "exemplary", showing "excellent appreciation" of good practice.
- Some areas of the outpatient department used endoscopes (an instrument used to examine the interior of a hollow organ or cavity of the body); Staff transported dirty endoscopes from outpatient treatment areas to the endoscopy unit for cleaning in a covered, solid walled, leak proof container. A red cover indicated it was dirty. This was in line with the Health and Safety Executive (HSE) Standards and Recommended Practices for Endoscope reprocessing Units, QPSD-D-005-2.2.
- Staff kept full scope-tracking and traceability records, which showed each stage of the decontamination process was occurring. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014). An external company audited the traceability records and in the last audit in January 2016, the department had achieved 100%. This indicated all stages of decontamination were occurring.

Environment and equipment

- The outpatient department, located on two floors of the hospital, comprised five general consulting rooms, two ophthalmic (eye) rooms and two minor operation or treatment rooms, plus office and storage areas. The diagnostic imaging department, on the ground floor,

included two x-ray rooms, an image viewing room, offices and stores. The physiotherapy department was located on the second floor and had three treatment rooms, an office, equipment store and exercise area.

- Some of the rooms on the ground floor had been refurbished during the construction of a new magnetic resonance imaging (MRI) facility, which was operated by another registered provider contracted to the hospital.
- We saw that wheelchair users visiting the hospital could reach the main entrance by a ramp that led from a lay by fitted with dropped kerbs. Inside the hospital, automated entrance doors led to the waiting area and lifts to the upper floors. Corridors and consulting, imaging or treatment rooms were spacious with doors wide enough to fit trolleys or wheelchairs.
- The Patient Led Assessments of the Care Environment (PLACE) for 2016 showed the centre scored 88% for the condition, appearance and maintenance, which was worse than the England average of 93%. The senior management team (SMT) acknowledged the décor was "tired" and explained that renovation and redecoration had been approved. We saw that preparatory work outside the hospital building had commenced.
- The areas we observed supported the safe delivery of diagnosis, treatment and care. The hospital controlled access to imaging and consulting or treatment rooms, stores and staff areas by the use of electronic interlocks or keyless door locks.
- Rooms were well lit, air-conditioned and equipped with sufficient equipment and consumable items for their intended purpose. The main waiting area was spacious and appeared well-appointed with amenities for refreshments and comfortable seating. We noted that some of the chairs had leg extensions fitted to raise them to a height suitable for patients recovering from hip surgery.
- All rooms including patient toilets had call buzzers fitted to summon assistance in an emergency. The call bell system linked to visual displays sited at strategic points, which enabled staff to monitor the status of calls made from anywhere in the hospital. This included a lone-working feature used in the physiotherapy department, where therapists carried a remote call bell when they helped patients to mobilise and practice skills such as stair climbing.
- There was access to emergency equipment, including portable oxygen, suction and resuscitation items. We saw two resuscitation trolleys based in outpatients. One was located on the ground floor and the second on the second floor. Trolley features included brackets and space for resuscitation items, drugs and consumables. Tamper-proof security tags controlled access to the shelves. Records showed the trolleys were checked daily and contained consumables and medicines in accordance with the provided checklist. When we checked, all of the emergency equipment was in order and items in date. This meant all items were ready for immediate use should an emergency occur.
- We saw patient examination couches, furniture and equipment labelled with asset numbers and service or calibration dates. These helped hospital managers identify, control and maintain equipment in accordance with manufacturer recommendations and corporate policy.
- Staff showed us the defect labels and decontamination forms used to identify faulty equipment and prepare it for return to the contractor. Outpatient staff kept a diary of equipment returned to maintenance. None of the staff we spoke with had concerns about equipment availability and if anything needed repair, it was fixed quickly. Maintenance contracts with external providers had been arranged for larger items of technical equipment, such as ophthalmic examination tables. We saw examples of equipment files and computer records containing these details.
- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests. We checked a sample of devices in each of the rooms we visited. These had been labelled with the dates of the most recent electrical testing, which provided staff with a visual check that the items had been examined to ensure they were safe to use. This complied with Nuffield group Health & Safety policy (HS01)
- We saw lead gowns in radiology designed to protect staff members from radiation exposure and we saw these used during our inspection.
- The Radiation Protection Advisor performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks as part of a quality assurance programme. This helped to assure the hospital that

equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IRMER 2000. We saw records of these checks during our visit.

Medicines

- We saw Nuffield group private prescription pads signed out by the registered nurse on duty and placed in each consulting room as part of the routine clinic preparation. Pages were numbered and staff counted these on issue and return. Consulting rooms were kept locked until the clinic started and prescription pads stayed under the control of the consultant until they were collected back and stored in the locked office at the end of the day. This ensured prescription pads were kept securely which was in line with NHS Protect, Security of prescription forms guidance, 2013.
- We saw medicines kept in outpatients were stored in a locked cupboard and a registered health professional held the keys. This was in line with the Nuffield policy (Medicines Management Policy V2.0 April 2016) and prevented unauthorised access to medicines.
- A consultant in the department used a cytotoxic medicine and we saw the drug secured on a separate shelf of the medicine cabinet. A purpose-made spill kit was observed next to the cupboard. It was provided and maintained by a contractor and included clear user instructions.
- Medicines that required refrigeration in outpatients were stored in a locked fridge, keys were held by the registered nurse on duty and temperatures were checked and recorded daily. In addition, the hospital used an electronic monitoring system fitted to drug and blood fridges that automatically reported any changes to the pathology collection room and after hours, the main nurses' station on the first floor. This provided additional assurance that pharmaceutical items were safely stored in accordance with manufacturer specifications.
- Contrast medium (used for radiological procedures) was stored in a locked cupboard in the diagnostic imaging department and the keys for this cupboard were kept in the main office. The medium was made available to the radiologists on request.
- Each consulting room contained a copy of the British National Formulary (BNF) Issue 71, which was the latest edition in print. The BNF is updated in book form twice a year and details all medicines that are generally prescribed in the UK, with information about indications and dosages, contraindications, cautions and side effects. It is considered an essential adjunct to safe prescribing and the availability of the latest copy indicated that an appropriate level of support was provided to the consultant in clinic.
- Staff told us that consultants and radiologists administered any medications required. This included items such as eye drops and contrast media. This was supported by a patient specific direction (PSD), which was a written instruction from the consultant for the medicine to be supplied to a named patient. We saw examples of a form used as a record of administration and for billing purposes.

Records

- During our inspection, we observed a number of outpatient records kept in a lockable filing cabinet in a utility room. We saw the folders contained care notes for patients attending the clinic for dressings or other interventions. These records were stored separately from the medical files we had previously viewed and were papers held loosely in clear plastic wallets. The wallets were labelled with patient's names and all were stored in an alphabetic filing system.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 201417 (2) (c) states the provider must "maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided."
- Keeping separate file notes in this manner did not meet the requirement of the regulation and because of this, our rating lowers to 'requires improvement' for safety. The way the records were kept added to the risk that papers could be separated or misfiled, which was an unsafe practice. We noted this had occurred in a file viewed by inspection colleagues who had looked at another part of the service. In addition, separating the medical records in this way made it harder for the consultant to monitor the results of treatments and the patient's progress. We were not assured that the notes we saw had been consistently added to the files the consultant viewed. We raised our concern with the head of the department at the time, who explained that electronic record keeping was an objective for that department.

Good

Outpatients and diagnostic imaging

- We saw that diagnostic imaging and physiotherapy outpatient files and treatment notes were electronic records that included scanned papers or images as required. These could be accessed immediately by any manager or clinician with the appropriate security access. Administrative and clinical staff we spoke to were clear about the need to 'lock' computer screens when unattended and we saw privacy filters used on visual display units.
- The main outpatient notes we reviewed comprised paper records held in colour-coded folders that signified the source of the initial referral. We looked at 19 paper or electronic files during our inspection. The paper files were neatly presented and legible and the electronic files we saw in radiology and physiotherapy were clear and easy to follow.
- The hospital employed booking administrators who prepared the appointment grids for each planned clinic. Referrals arrived from a variety of sources, including the NHS, insurance companies, local GPs and consultants. The format of the patient record differed slightly depending on the source of the referral. For example, NHS referrals varied according to the contract and a copy of the referral form was printed and inserted into the file. Papers from the consultant were submitted by their medical secretary.
- Once prepared, the files for each outpatient clinic were kept in a locked cabinet in the booking office until the afternoon prior to the clinic. At that stage, administrators took the files to the outpatient office for review by the nurse, who then locked the notes in the office until the consulting room was prepared.
- While the clinic was operating, we saw appointment grids placed on a purpose-built shelf outside the outpatient office. Each was covered in a folder to prevent casual observation and help preserve patient confidentiality. We noted that the appointment grids contained patient names and times but no other relevant details.
- According to data supplied, five per cent of patients were seen in outpatients without all relevant medical records being available, which is worse than other hospitals we hold data for. Staff we spoke to felt this figure was incorrect and were confident that notes were usually available when needed. For example, the radiology department scanned referral forms into an electronic records system as soon as they arrived. This prevented loss of any records.
- Correct completion of accurate and contemporaneous medical records formed part of the practising privileges agreement for all consultants. Consultants were registered as data controllers and any breaches in information security were reported through the incident risk management system. We were informed that the Nuffield Group Information Risk Manager was automatically notified in this event and a formal investigation followed.
- We were told that all Nuffield files relating to an admission in the last six months remained in the hospital's medical record facility. For patients last seen prior to this, their medical records were stored off site by a third party contractor and in urgent cases, the records could be retrieved within three hours.

Safeguarding

- There had been no safeguarding concerns raised from the hospital. Safeguarding adult policies were in date and procedures were accessible to staff in both outpatients and radiology.
- Staff could explain the process if a concern was identified. There were named safeguarding leads and these were displayed at various points around the hospital and staff were able to point these out to us in both outpatients and diagnostic imaging.
- Staff completed on-line learning modules as part of the annual mandatory training programme. Training records showed 94% of staff had received Level 1 Safeguarding training for Children and Young Adults and 96% had completed Level 1 Safeguarding Vulnerable Adults. These figures were better than the corporate target of 85%.
- We saw that all staff in the target groups for Level 2 and Level 3 Safeguarding Children and Young Adults training were in date.
- This was an appropriate level of training and in line with Nuffield policy.

Mandatory training

- All staff completed mandatory training using online learning and assessment programs. Compliance rates were monitored and staff were advised when necessary by their line managers.

Good

Outpatients and diagnostic imaging

- Training data showed that outpatient and diagnostic imaging department staff achieved 94% compliance in ten core subjects such as manual handling and fire safety, all of which exceeded the corporate target of 85%.
- We saw copies of a mandatory training tracker spreadsheet that heads of departments could filter and view the status of their staff. Managers explained that the Nuffield "academy online" had required reconfiguration and maintenance because of problems reported with access to modules. We saw a circular dated 7 November explaining the issue. Compliance reporting was unaffected.
- The data we viewed showed all outpatient and diagnostic imaging staff had completed Basic Life Support (BLS) and Intermediate Life Support (ILS).
- The duty of candour (DoC) and Mental Capacity Act 2005 were integral parts of the mandatory training programme. DoC training was included in the business ethics modules (96% compliance) and MCA training compliance was 98%.
- We saw records showing that staff who handled medical gas and cryogenic equipment had received formal training conducted by the supplier.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.

Assessing and responding to patient risk

- The hospital had an appointed radiation protection supervisor (RPS) and a radiation protection adviser (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This meant that the hospital had an independent annual audit of the imaging services.
- We saw copies of the independent annual RPA audit of the imaging service. We found that all files and documents supporting IRMER compliance had been completed to a high standard.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in all areas we visited and signed by all members of staff, which indicated they had read the rules. Diagnostic imaging staff had a clear understanding of protocols and policies. We saw protocols and policies stored in folders in each room.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the diagnostic imaging suite, in line with best practice. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.
- We saw patient information sheets used in radiology that gave appropriate and relevant information for the examination undertaken. These included clear 'before and after' instructions that were sent to patients as part of the appointment confirmation.
- We assessed 14 sets of records in the diagnostic imaging department and saw examples which contained a signed form to confirm female patients had been asked about their pregnancy status and confirmed that they were not pregnant prior to radiological exposure.
- The radiology suite had illuminated signs outside imaging rooms to warn staff and patients not to enter while the machines were operating. We saw lead aprons available in all imaging areas of the department, which were stored correctly and used by staff or patients as directed. Lead aprons limit exposure to radiation to keep patients and staff safe.
- In imaging, we saw six-point identification checks for patients taking place. This helped ensure that patients received the test ordered by the doctor and prevented excessive exposure to ionising radiation. In addition to this, additional checks were undertaken to ensure patients did not receive more than one screening scan in a 12-month period.
- Immediate or emergency assistance could be summoned by the use of the hospital 'crash call' or resuscitation team. Medical assistance was provided by the RMO and the patient's consultant.
- Staff explained that the resuscitation trolley was not suitable for use in the MRI suite, as its metal construction made it incompatible with the strong magnets used in the device. The MRI provider maintained their own resuscitation equipment inside the suite and both departments had practised emergency scenarios based on the protocol that a patient who had collapsed was wheeled out of the suite on the MRI trolley for ongoing resuscitation.
- There were clear and known protocols in place for the transfer of patients to the local NHS accident and emergency facility by ambulance.

Nursing, radiology and physiotherapy staffing

Good

Outpatients and diagnostic imaging

- Managers confirmed there was sufficient staff to deliver care safely within outpatients and diagnostic imaging, which we observed.
- The hospital did not use a patient acuity tool to assess staffing needs in this service. The clinic schedule was used to determine staffing levels in advance to ensure patient needs were met. The hospital told us that no shifts had gone below agreed staffing numbers.
- The use of bank or agency nurses in outpatients was lower than the average of other independent hospitals and no agency nurses or health care assistants had been used in the last three months.
- There were no nursing vacancies in outpatients and the sickness rate for the outpatients department was better (lower) than the average for independent hospitals. Managers explained that any nursing sickness was normally covered by ward nurses. The same applied for annual leave.
- In radiology and physiotherapy, we saw evidence of minimal sickness rates and managers stated that staff turnover was "very low". This was attributed to a number of factors such as a pleasant working environment, the availability of training and continuous professional development plus a range of other employee benefits.

Medical staffing

- There were 147 consultants who had been granted practising privileges at the hospital, all of whom had been undertaking work at the hospital for over 12 months. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital.
- The hospital had a resident medical officer (RMO) on site 24 hours a day, seven days a week to support the clinical team in the event of emergencies or with patients requiring additional medical support. The diagnostic imaging department had three radiologists with practising privileges.
- Consultants provided details of suitable cover arrangements as part of obtaining privileges and informed the hospital management of annual leave arrangements. We saw details of planned consultant absences and cover arrangements displayed for staff to reference.

Emergency awareness and training

- We observed a fire alarm test where one of the alarms did not sound correctly. We observed the matron and estates management dealing with this and we were informed later that morning the fault had been rectified.
- We saw that the stand-by generator, designed to ensure a constant supply of electrical power to key parts of the hospital (such as the imaging suite and MRI) had been tested. This indicated the hospital was ready for any unexpected power outages in the locality.
- Registered healthcare professionals in each area of the department were qualified in basic and intermediate life support. This meant that these members of staff could be called upon in the event of a patient collapse or emergency with a patient, relative or member of staff. There were emergency call buttons or cords in all of the consulting and treatment rooms as well as the reception desk in outpatients and diagnostic imaging.
- A receptionist gave a positive example of the rapid response from the clinical staff when a patient fainted in the waiting area and staff activated the emergency call system.
- We saw a range of fire extinguishers suitable for extinguishing electrical and liquid fires mounted at strategic points. These were tagged and in date. We also saw an evacuation chair mounted on the stairwell wall. Staff confirmed that fire evacuation drills had taken place, which included using the device.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the effective domain.

Evidence-based care and treatment

- Staff told us they were able to access national and local guidelines through information folders held in the main outpatient's office and through the hospital intranet.
- We viewed policy documents that had been written and updated regularly by Nuffield Health and cascaded to the hospital for implementation. These were available on the hospital intranet as well as in files located in the outpatient staff office.
- We saw how policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. New National

Institute for Health and Care Excellence (NICE) guidelines were sent to the hospital monthly by the quality care team. These were assessed within the hospital for their relevance by the Medical Advisory Committee (MAC) and cascaded to all staff, including to Consultants.

- The hospital MAC met quarterly to review clinical performance, incidents or complaints and obtain feedback from the consultant body on new developments and initiatives from within the various specialities.
- Staff followed the NICE and Royal College of Radiologists (RCR) Standards and guidelines in the speciality areas we visited. We saw evidence of checks and audits, which demonstrated the department monitored compliance with these guidelines.
- Audits included environmental, handwashing and infection control checks and the results of these were shared among staff. We observed examples shared in monthly team meeting notes and on staff notice boards.

Pain relief

- None of the patients we spoke with required pain relief at the time of our inspection.
- Staff told us that they would escalate any concerns around pain relief to the resident medical officer (RMO) or would use the emergency bells.
- The physiotherapy department provided acupuncture for pain relief, which they offered to appropriate patients.

Patient outcomes

- We saw examples of physiotherapy and radiology outcomes listed in electronic records. There were a variety of processes described to measure and audit patient outcomes, including a quarterly internal audit programme and National Joint Register. For physiotherapy, these included the use of patient-reported outcome measures (PROMs), a method of capturing the patient's opinion on the impact of their disease or disorder and the effect of the treatment. We saw PROMs results for patients rehabilitating after groin hernia, hip replacement and knee replacements, where up to 93% had reported an improvement.

Competent staff

- We spoke with the human resources (HR) lead for the hospital, who was able to show us that the provider had systems to ensure that staff were appropriately recruited.
- All employees had the necessary pre-employment checks completed prior to commencing work. This included Disclosure and Barring Service (DBS) checks, references, qualification verification and an interview.
- All new staff had an induction package, which included core competencies and knowledge that was signed off by their line manager. We saw examples of this in the staff files we reviewed.
- We checked local staff files and found all appraisals had been completed. Regular appraisal allowed the hospital to identify and monitor staff performance and personal development.
- Nursing staff told us they had access to local training and other continuous professional development activities offered at the Nuffield academy based in Epsom. This contributed to maintaining their registration with the nursing and midwifery council (NMC).
- There was a robust performance management system in place. Concerns about staff performance were initially dealt with through informal discussions that were documented in the staff file. If concerns continued, the formal process was triggered in consultation with the HR lead supported by a third party HR support partnership. We were told this had never been necessary.
- In the radiology and physiotherapy departments, we saw evidence of competency check matrixes and monthly peer reviews of imaging and treatment records.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) approach across all of the areas we visited. For example, clinical leaders and managers formed the heads of department group, which met monthly with the senior management team.
- We observed good collaborative working and communication amongst all staff in and outside the department. Staff reported they worked well as a team. For example, the visiting pathology manager spoke highly of the outpatient department staff and said that the rate of sample errors from this hospital was “a fraction” in comparison with others in his area of responsibility.

Good

Outpatients and diagnostic imaging

- In addition to reporting to the hospital management, the radiology and physiotherapy managers had access to regionally based professional leads and national leads in specialist topics. We were shown posters and emails advertising continuous development study days for staff as well as development activities offered to local GPs and other healthcare practitioners in the wider community.

Seven-day services

- Due to the nature of the work undertaken by the hospital, some activities in outpatients were not required seven days a week. Outpatient clinics operated between 8.00 am and 8.00 pm Monday to Friday with some clinics scheduled on Saturdays if needed.
- Radiology services were available from 8.00 am to 6.00 pm Monday to Friday, with evening clinics during the week when required.
- The physiotherapy outpatient department provided services five days a week but offered evening appointments on request and also ran exercise classes on evenings and Saturdays. The physiotherapy department provided weekend cover for inpatients requiring mobilisation post operatively and an on call service to the wards.
- Radiology consultants worked seven days a week, on a rota basis, to provide consultant-directed diagnostic tests and completed reports. In addition, the diagnostic imaging department provided a full seven day on call service. This complied with NHS priority clinical standard 5 (2016), which requires hospitals with NHS inpatients to have seven-day access to diagnostic services such as x-ray and ultrasound with radiology consultants available.

Access to information

- Hospital staff received medical information regarding NHS patients from their GP as part of their referral process via the NHS e-referral system (choose and book). This is a national electronic referral service, which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- Imaging and physiotherapy departments used electronic systems to book appointments and maintain patient records. The computerised radiology information system stored patient data and was used for booking appointments either in the main x-ray department or with the MRI provider.
- The imaging department used a specialist technology called picture archiving and communication system (PACS). This enabled the hospital to quickly store, retrieve, distribute and view high-quality medical images. In addition, staff and radiologists could share images with the local NHS hospital or other healthcare providers that had access to an image exchange portal (IEP). Likewise, staff could request scans from NHS hospitals if needed.
- Overall, staff were positive about the information and features published on the corporate webpages. Staff said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet. Moreover, this could be easily accessed from home or any location with broadband internet facilities using a secure log in. This feature was viewed positively by staff who worked shifts or part time hours.
- In addition to meetings and briefings, staff and managers reported effective communication achieved by via secure e-mail.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 16 patient records during our inspection. These showed that consent was signed prior to any procedure and on the day of the procedure in line with the hospital's consent policy, which had been recently reviewed. The provider had a policy to guide staff in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA). We did not observe any situations where this policy needed to be applied during the inspection.
- Nursing staff we spoke to demonstrated awareness of how the Mental Capacity Act 2005 related to their practise and were aware of whom to contact if they required guidance. Consultants told us that they rarely came in to contact with patients who lacked capacity due to the nature of their respective specialities but were aware of their responsibilities and the hospital processes for this.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Good

Outpatients and diagnostic imaging

Compassionate care

- The hospital took part in the friends and family test (FFT), a survey that asks NHS patients whether they would recommend the service they have received to friends and family who needed similar treatment or care. Of the patients who responded, between 98 – 100% said that they would be extremely likely to recommend the service. The hospital's FFT scores were similar to the England average of NHS patients across the reporting period.
- As part of our inspection process, we provided the hospital with CQC comment cards and sealed ballot boxes in the week prior to our visit. This gave patients an opportunity to leave anonymous feedback about their experience at the hospital. We received 22 comment cards from people visiting outpatients, radiology and physiotherapy. The comments were all positive and praised the hospital staff and environment. For instance, one patient said "I have used the hospital in the past which is why I came back this time. Excellent place – good staff who treated me with respect" Four respondents commented specifically and favourably on the consultant, while others commented on physiotherapy, radiology and reception, again all in positive terms. In addition to praise, two respondents commented on the time taken for staff to return a call.
- Patents we spoke to commented on the 'family feel' at the hospital and felt the staff "had the time" to provide good care. This was supported by the arrangement of appointment slots we saw. For example, ophthalmology appointments were scheduled for an hour and staff told us that psychiatric appointment slots could be three hours in duration.
- We saw good examples of compassionate care during our visit. In addition to interactions observed between clinical staff and patients, we heard bookings and reception staff on telephone calls being polite and reassuring.
- Consulting and treatment room doors were kept closed in all areas including physiotherapy and imaging and we saw that staff knocked before entering rooms to help maintain patients' privacy. In addition, rooms had 'free/ busy' signs on entrance doors and we observed staff using these.
- We saw an up-to-date privacy and dignity policy which staff were aware of and in the radiology department, there were curtained sections to promote dignity when patients changed into hospital gowns.
- We observed chaperone posters in visible areas around the outpatient department and inside the consultation rooms, for example, there were posters above the examination couches. We also saw posters in the radiology department and staff showed us the hospital chaperone policy on their local intranet. Consultation rooms were private and could be used to speak with patients away from the waiting area if required.

Understanding and involvement of patients and those close to them

- Patients liked the fact that their consultant had the time to explain things in detail and allowed time for any questions. We saw a comment card from a family member stating that the consultant had included them in the decision-making, along with their relative, which was appreciated.
- Staff introduced themselves with 'my name is' and we observed consultants introduce themselves and shake a patient's hand when they were called in for their appointment slot. We also saw instances when patients were invited to bring family members into the consultation.
- Staff photographs and names were clearly and legibly displayed on the waiting room wall and we saw patient satisfaction scores displayed along with a range of literature and health education leaflets in the waiting area.

Emotional support

- Throughout our visit, we observed staff giving reassurance to patients both over the telephone and in person.
- Patients told us that staff and consultants working in the outpatient clinics were approachable and "had the time to explain everything". Information such as side effects of medicine were also made clear.
- We saw relatives being invited to accompany patients into consultation rooms, which indicated that the hospital encouraged a friend or partner to attend the appointment in order to provide emotional support.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The environment provided was appropriate and patient centred, with comfortable and sufficient seating, toilet and refreshment facilities.
- Outpatient and physiotherapy offered extended hours during the week and outpatients also ran clinics on Saturdays if needed. Evening and weekend appointments allowed patients who worked to access healthcare that suited their circumstances.
- The radiology department worked similar hours during the week and staff gave examples of being flexible to provide extra clinics or appointments to meet the consultant's requests or patient needs.
- Clinical decision-making in outpatients was supported by diagnostic services including MRI, x-rays and ultrasound scans. Patients who required MRI were seen by the contracted provider on site.
- Physiotherapy services were available seven days a week and the outpatient physiotherapy service was available five days a week. This meant that patients could access physiotherapy following their surgery, where appropriate, in a timely manner to aid recovery. NHS patients were referred promptly to help ensure a smooth transition between their physiotherapy treatment commenced in the hospital and their ongoing rehabilitation. We saw examples of advice and exercise sheets that supported the patient during this transition.
- Physiotherapists also provided a variety of exercise and conditioning classes for the local population. They had targeted specific groups in the local community and as part of their outreach efforts had visited the local railway station to offer courses designed to suit commuters returning from work.

Access and flow

- Consultant-led referral to treatment (RTT) waiting times is a measure used to monitor the length of time from referral through to elective treatment for NHS patients in England. Monthly RTT waiting times data has been published since March 2007. Initially data was only published for patients whose RTT pathways ended in admission for treatment (admitted pathways). Non-admitted and Incomplete RTT pathway data has been published since August 2007. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. Outpatients and diagnostic imaging met the target of 92% of patients on incomplete pathways waiting 18 weeks or less from the time of referral in the reporting period (July 2015 to June 2016), except for two occasions in summer 2015.
- Booking and nursing staff confirmed that clinic wait times rarely exceeded "two weeks" for many specialities and if a clinic list built up, the consultant would agree an extra clinic on a Saturday. Physiotherapy wait times rarely exceeded one week for both initial appointments and follow-up treatments. Radiology appointments were usually available within three days and there were no patients waiting six weeks or longer from referral for non-obstetric ultrasound or diagnostic sleep studies.
- Wait list performance was audited monthly along with room utilization and submitted to the SMT as part of the monthly business report. This meant the hospital was able to identify and implement a response to undue delays.
- Patients accessed NHS services via a GP referral through the e-referral system, or via direct referral for private patients or through their health care insurer. We spoke to a patient who regularly visited the hospital for appointments. They told us the longest they ever had to wait for an appointment was two weeks, but generally the wait was much shorter.
- On arrival, patients reported to the main reception where they would then be directed to the outpatients, physiotherapy or diagnostic imaging departments. The relevant receptionist at the front of the department would then book them in via an online system and direct them to the waiting area or clinic room. We observed patients easily finding their way to their destination. There was sufficient space and flexibility for the number of patients being treated at the time of inspection.
- We observed reception staff advising patients if there was a delay to their clinics and staff confirmed they would always tell patients verbally as soon as they were aware of a clinic overrunning.

Good

Outpatients and diagnostic imaging

- According to booking staff, clinic cancellations were "rare" and examples were given of "one or two a month". In all cases, patients were contacted and full explanations and apologies given. Staff gave a good account of the rebooking process that had clear clinical oversight from the consultant involved. For instance, if the referral was marked urgent, the case would be transferred to another consultant or possibly referred to the NHS. Staff explained that in every case they could recall, the consultant arranged extra sessions or extended clinic times in consultation with the SMT and Head of Department.
- There were no available figures for outpatient and diagnostic imaging did not attend (DNA) rates, but staff said they always contacted the GP when a patient failed to attend an appointment. Consultants reviewed failed appointments or lists from any cancelled clinics and had clinical oversight of any urgent appointments required.

Meeting people's individual needs

- Free car parking was provided on-site for the convenience of visitors.
- Hearing loops were available in the waiting area, which helped those who used hearing aids to access services.
- We saw a number of chairs in the waiting area of differing heights and we noted that free Wi-Fi was available, which enabled patients and relative to access the internet via their smartphones whilst in the waiting room.
- There was a water dispenser and hot drinks machine in the outpatients waiting room. We observed patients using these and staff offering to make drinks for patients and family members whilst in the waiting area. Managers explained that the department had a budget to provide refreshments and light meals from the kitchen should a clinic overrun through a mealtime.
- 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 and we saw staff including these leaflets in the letter envelopes to be sent out.
- Staff told us that they used a telephone translation service if they had patients who did not speak English as a first language. Staff told us that the need for translation services was flagged at the time of booking appointments.
- The hospital could be accessed by those who had a physical disability, as there was a lift available to all floors, and a ramp at the front entrance of the hospital. Staff could arrange porter assistance for patients travelling alone or who may need more help.
- There were arrangements to ensure self-funding patients were aware of fees payable. A member of the booking staff spoke to us about providing quotes. We saw information leaflets which gave an explanation to the pricing structure for self-funding patients and gave advice on whom to contact if patients had any queries.
- The group website also detailed different payment options for self-funding patients such as finance and pay as you go options and both were described clearly.
- There was reading material such as recent magazines and current newspapers for patients and their family to read whilst waiting for their appointment and we observed them doing so. There was also a TV on low volume in the background which promoted a relaxed environment for patients and relatives to wait.

Learning from complaints and concerns

- We spoke with the complaint lead and hospital director, who both described an open and honest culture and a willingness to accept responsibility for any shortcomings.
- There was an effective system in place for capturing learning from complaints and incidents. The senior management team were well informed about any complaints or incidents and changes were fed back through the heads of departments to frontline staff.
- Consultants with practising privileges were informed of all complaints made to the hospital via the Medical Advisory Committee.
- There was good local ownership of complaints and incidents with teams working together to resolve issues that arose. Complaints and concerns were responded to effectively, support was offered and a full investigation completed. Face-to-face resolution was offered to all people raising complaints.
- A health care assistant explained that sometimes clinics fell behind, which was annoying for patients. Staff supported the consultant as best they could by tactfully prompting and at the same time by ensuring the patients were kept informed.

Good

Outpatients and diagnostic imaging

- Concerns picked up through the survey and comment cards were acted upon and the matron discussed any concerns or complaints received with the head of department as soon as possible.
- All written complaints were acknowledged within two days of receipt. The timescale for a response was 20 days or, where it was a complex situation requiring a longer time to investigate, a holding letter was sent. There were 20 complaints and one written letter of appreciation logged under outpatients for the last year. Topics ranged from the hospital environment to clinical care without any obvious pattern. The largest group of complaints (seven) related to billing concerns. Where complaints involved clinical care, the consultant responsible for the patients' care was contacted and involved in the investigation. We saw four complaints and one written compliment under this category.
- All complaints were reported to the provider via the regional reporting structure. This enabled Nuffield Healthcare hospitals to learn from complaints within the group.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- There was no specific strategy for the outpatient and diagnostic imaging department, however there was a corporate level statement of purpose, which listed effective organisation, conducting business with integrity and providing the highest quality of care as some of their strategic priorities.
- Staff showed a good understanding of the Nuffield values programme called "EPIC" (Enterprising, Passionate, Independent & Caring) and told us they felt engaged and committed.
- Some staff could describe the recent change of directors at corporate level, although this appeared less well known. All staff were confident that they could find further information about the Nuffield group on using the corporate intranet.

Governance, risk management and quality measurement

- There were good structures for reporting against the governance framework in place for all Nuffield Healthcare hospitals with regional and national benchmarking against other hospitals.
- The provider had an electronic incident reporting system that fully linked complaints, incidents and risk reporting.
- The risk register was reviewed monthly by the hospital board and Health & Safety Committee. Where appropriate, risks were escalated to the Group Health & Safety Officer, Regional Director, Chief Nurse and Medical Director.
- The Quality & Safety committee and Health & Safety committee routinely reviewed risks and performance using the clinical dashboard, various KPI reports and the monthly Quality & Safety Governance report.
- Effective HR processes were in place to ensure employment checks were completed and there was regular performance review of staff. Consultants were required to fulfil their obligations under the Practising Privileges Policy and compliance was monitored.
- We noted the hospital had specifically contracted the MRI service to a company accredited by the Imaging Services Accreditation Scheme, which is a quality assurance system developed by the Royal College of Radiologists and College of Radiographers. The scheme is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services delivered by competent staff working in safe environments. By insisting on ISAS accreditation the provider had achieved additional assurance about the quality of the contracted service.

Leadership and culture of service

- Nursing, radiology and physiotherapy heads of department all reported to the Head of Clinical Services (Matron) who, as part of the hospital senior management team, was accountable to the Hospital Director. The heads of department met monthly and discussed items including action plans, hospital activity, risk registers and business plans. We saw evidence of these meeting minutes.

Good

Outpatients and diagnostic imaging

- We saw strong leadership at the location with an open and transparent culture. The hospital director utilised the head of department (HoD) forum as a governance and performance management tool to maintain and improve the quality of the service.
- Staff were overwhelmingly positive about their experience of working at the hospital and showed commitment to achieving the provider's strategic aims and demonstrating their stated values. Staff told us they were supported by the hospital director and the new matron, both of whom were visible and approachable. They described an open culture with an emphasis on delivering the best care possible.
- The low staff turnover reflected the positive regard in which staff held the service and their colleagues. There were high levels of staff stability and many commented in positive terms about the "advantages of a small hospital" where "everyone knows each other".
- We saw examples of Nuffield group news on staff noticeboards, including "Hospital Stars" where positive patient feedback about named staff members was shared. This indicated the management team had made efforts to recognise positive staff contribution and celebrate high performance.
- Staff told us that they would feel happy speaking to senior management or the corporate human resources (HR) department if they were unable to speak to their direct line manager.

Public and staff engagement

- Staff told us about being involved in a public information and marketing evening for the hospital and really enjoyed the chance to be involved in this and to help publicise a hospital that they were proud to work in.
- Physiotherapists ran a variety of exercise courses for the local population, charging a nominal fee. We saw course leaflets advertising core muscle strengthening classes, antenatal recovery and pre-ski conditioning. Core muscle strengthening classes had proved popular and five sessions a week were conducted with more planned. Leaflets had been distributed at the local railway station and response had been encouraging.
- Staff spoke highly of the flexibility offered by the hospital to its employees. Examples given included the support given to staff when returning to work after injury or maternity leave.
- There was a Nuffield Group Wellbeing scheme which staff told us about. The scheme offered assistance and support in areas such as physiotherapy or counselling which some members of staff had utilised and benefited from.
- Staff told us that there was a list of Friends and Family test (FFT) results in the staff canteen which was useful for them to see.
- The hospital was selected by the waste contractor to be part of a rubbish recycling trial. Staff expressed pride in being part of the project and the environmental benefits of the scheme.

Innovation, improvement and sustainability

- We were told that vision and values events were regularly held in order to celebrate staff achievements and enhance communications. We saw evidence of formal and informal social events that supported the positive comments about the work culture we observed.
- There was a proactive approach to career progression, which included a change of role for some staff. Staff told us there was good internal promotion and opportunities to undertake further training and education. We saw a good example of this in the pathology department.

Outstanding practice and areas for improvement

Outstanding practice

- The service had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The hospital had recently installed an electronic digital temperature monitoring system. The system continuously monitored fridge and room temperatures. Any anomaly was reported electronically to the hospital pharmacist who managed the system centrally. The pharmacist demonstrated the system and we saw that the hospital was no longer relying on staff to record temperatures on a daily basis. This meant staff were now free to undertake other duties and temperature records were traceable, always recorded and accurate. The hospital was assured that medicines and room temperatures were always safe.

Areas for improvement

Action the provider MUST take to improve

- Regulation Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17 (2) (c)

The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Action the provider SHOULD take to improve

- There was no compartmentalization in the roof space above the theatres. This meant in the event of a fire all theatres would need to be evacuated immediately rather than isolating the individual theatre.

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