

# Nuffield Health Hereford 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?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Nuffield Health Hereford Hospital is operated by Nuffield Health. The hospital has 23 beds including a three bedded day care unit and a ward for 20 inpatients. Facilities include two operating theatres and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery and outpatients and diagnostic imaging. We inspected surgery and outpatients and diagnostic imaging services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 7 to 8 November 2016, along with an unannounced visit to the hospital on 21 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.

### Services we rate

We rated this hospital as good overall.

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff had awareness of the importance of the duty of candour regulation.
- Patients' with complex needs, such as a learning disability or mental health condition, were identified at pre-assessment. Appropriate arrangements were made to meet individual patient needs, such as increased staff levels, or the use of a dedicated room for patients living with dementia to use. The hospital also had a dedicated room for patients living with dementia to use.
- Operation cancellation rates were low and patients had been offered another appointment within 28 days of their original appointment date.
- Patients had their needs assessed, and care was planned and delivered in line with evidence-based guidance, standards and best practice.
- Staff complied with use of personal protection equipment and handwashing to prevent cross infection.
- There were systems in place to ensure that staff were competent to provide effective care, including 100% staff annual appraisal rate.
- Hospital staff had completed their mandatory training (94%, which exceeded the target of 90%).
- Medical staff working with practising privileges at the hospital had their agreements reviewed every two years.
- There were effective arrangements for the discharge of patients. Discharge planning began during the pre-operative assessment process.

We found the following areas of good practice in surgery:

- Staff complied with use of personal protection equipment, handwashing and the rate of surgical site infections were low.

# Summary of findings

- Patient's records included risk assessments and were completed appropriately and stored securely.
- Early warning scoring was used and a checklist to ensure that patients were well enough to return to the ward from recovery following surgery.
- Processes and service level agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated. This included critical care if required.
- Patients felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patients with respect.
- Patients whose operations were cancelled were offered another appointment within 28 days of the cancelled procedure.
- There were processes and procedures in place for staff to manage patients' pain and ensure that patients' nutrition and hydration needs were met.
- The hospital performed better than the national standard of patients being treated within 18 weeks from referral for nine months out of 12 (July 2015 to June 2016).
- Appropriate arrangements were made to meet individual patient needs, such as increased staff levels, or the use of a dedicated room for patients living with dementia to use.

We found the following areas of good practice in outpatients and diagnostic imaging services:

- Patient safety was monitored and incidents were investigated to assist learning and improve care.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005.
- Patients had short waiting times in departments prior to consultations or appointments.
- Patients' with complex needs, such as a learning disability or mental health condition, were identified at pre-assessment.
- Patients had their needs assessed, care planned and delivered in line with evidence-based guidance, standards and best practice.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits.

We found areas of outstanding practice in surgery and outpatients and diagnostic imaging services:

- Patients told us how staff treated them with kindness and dignity and consistently went the extra mile to meet their needs. Patients were truly respected and valued as individuals and were empowered as partners in their care.
- Staff worked in partnership with patients and showed determination and creativity to overcome obstacles to delivering care. For example, the matron and the team worked closely with a patient with anxiety issues to empower them to attend and undergo surgery.
- The imaging department worked closely with patients and their families. An example of this had enabled a patient to undergo treatment in their local area, instead of travelling to another provider, 150 miles away.

We found areas of practice that required improvement in surgery:

- While we found there were arrangements in place to safeguard people from abuse that reflected relevant legislation and local requirements, we were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for, from abuse.

# Summary of findings

- Not all required staff (68%) had completed immediate life support training. However, they were compliant with Nuffield Health group cardiopulmonary resuscitation policy regarding provision of advanced life support trained staff at the hospital and all trained inpatient nurses had completed the immediate life support course.
- There were issues regarding medicine management including preparation in advance of cases and documenting stock checks. Actions were taken by the provider and this practice was not seen during our unannounced inspection.
- The use and documentation of the World Health Organisation safer surgery checklist was inconsistent. However, during our unannounced inspection, this had been addressed and an action plan was in progress.
- The flooring and clinical hand wash sink provision on the ward was not in line with health building guidance.
- We found areas of practice that required improvement in outpatients and diagnostic imaging:
- There was not a lead anaesthetist identified for the pre-assessment service.
- The recommended thresholds (relative to the reference levels) at which excessive radiation doses should be reported were not clearly displayed in the diagnostic imaging department. This was addressed during our inspection.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve.

**Ted Baker**

**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

### Surgery

### Rating Summary of each main service

We rated this service as good for being, safe, effective, responsive to people's needs and well-led. We rated this service for being outstanding for caring.

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff had awareness of the importance of the duty of candour regulation.
- Staff complied with use of personal protection equipment; handwashing and the rate of surgical site infections were low.
- There were arrangements in place to safeguard people from abuse that reflected relevant legislation and local requirements. Staff knew how to recognise and report a safeguarding incident.
- Patients received care according to national guidelines such as National Institute for Health and Care Excellence and Royal College of Surgeons.
- Patients had their needs assessed, care planned and delivered in line with evidence-based guidance, standards and best practice.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits.
- There were processes and procedures in place for staff to manage patients' pain and ensure that patients' nutrition and hydration needs were met.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005.
- There were effective arrangements for the admission and discharge of patients. Discharge planning began during the pre-operative assessment process.
- There were systems in place to ensure that staff were competent to provide effective care. Annual appraisals and registration checks were carried

Good



# Summary of findings

out. Medical staff working with practising privileges at the hospital had their agreements reviewed every two years. However, clinical supervision was not always formalised.

- Patients were unanimously complimentary about the care they had received. This was also reflected in the positive feedback in patient satisfaction surveys.
- Staff took time to understand the patient as an individual and would provide care to help patients feel comfortable. These relationships were highly valued by staff and promoted by leaders.
- Patients felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patients with respect.
- Patient's privacy and dignity was maintained at all times during our inspection.
- Patients' with complex needs, such as a learning disability or mental health condition, were identified at pre-assessment. Appropriate arrangements were made to meet individual patient needs, such as increased staff levels, or the use of a dedicated room for patients living with dementia to use. The hospital also had a dedicated room for patients living with dementia to use.
- Operation cancellation rates were low and patients had been offered another appointment within 28 days of their original appointment date.
- Patients had short waiting times in departments prior to consultations or appointments.
- The hospital performed better than the national standard of patients being treated within 18 weeks from referral for nine months out of 12 (July 2015 to June 2016).
- Complaints were handled effectively and confidentially. We saw these were discussed at department meetings and actions taken to address issues.
- We were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for, from abuse.

# Summary of findings

## Outpatients and diagnostic imaging

Good 

- Flooring and hand wash sink provision on the ward and in patients rooms, did not meet infection control and prevention guidelines, such as in inpatient areas and Department of Health, Health Building Notes.
- There were inconsistencies with the use and documentation of the World Health Organisation safer surgery checklist. However, during our unannounced inspection, this had been addressed and an action plan was in progress.
- There were medicine management issues including medicine drawn up in advance of theatre cases and stock checks not always carried out. Actions were taken by the provider and this practice was not seen during our unannounced inspection.

We rated this service as good for being safe, effective, caring, responsive to people's needs and well-led. 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.

- Patient safety was monitored and incidents were investigated to assist learning and improve care.
- Staff complied with use of personal protection equipment and handwashing.
- There were arrangements in place to safeguard people from abuse that reflected relevant legislation and local requirements.
- Patients had their needs assessed, care planned and delivered in line with evidence-based guidance, standards and best practice.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005.
- There were systems in place to ensure that staff were competent to provide effective care. Annual appraisals and registration checks were carried out.

# Summary of findings

- Patients told us how staff treated them with kindness and dignity and consistently went the extra mile to meet their needs. Patients were truly respected and valued as individuals and were empowered as partners in their care.
- Staff worked in partnership with patients and showed determination and creativity to overcome obstacles to delivering care. For example, the matron and the team worked closely with a patient with anxiety issues to empower them to attend and undergo surgery.
- Patients were unanimously complimentary about the care they had received. This was also reflected in the positive feedback in patient satisfaction surveys.
- There were areas that did not meet infection prevention and control guidance. Flooring in five of the consulting rooms in the outpatient department was non-compliant with Health Building Note (HBN) 00/10 Part A Flooring (Department of Health 2013) 2.9.
- Re-sheathable needles were not available to reduce the risk of sharps injuries and the sharps bin on the resuscitation trolley was not labelled to allow traceability when disposing of sharps. These issues were addressed during the inspection.
- There were no indications for staff in the diagnostic imaging department as to the recommended thresholds (relative to the reference levels) at which excessive radiation doses should be reported, which is recommended to assist and remind radiographers. This was addressed during our inspection.
- There was no anaesthetic consultant lead for the pre-assessment service.
- The reception waiting area, backed onto two patient changing cubicles. These were not sound proofed, which could compromise patient dignity and confidentiality.



# Summary of findings

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Good 

# Nuffield Health Hereford Hospital

## Services we looked at

Surgery; and Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to Nuffield Health Hereford Hospital

Nuffield Health Hereford Hospital is operated by Nuffield Health. The hospital opened in 1974. It is a private hospital in Hereford City, Herefordshire. The hospital primarily serves the communities of Herefordshire. It also accepts patient referrals from outside this area.

The hospital had a registered manager who had been in post since September 2015.

The hospital also offers cosmetic procedures, such as dermal fillers. We did not inspect these services.

## Our inspection team

The team that inspected the service comprised of a CQC lead inspector, a CQC inspection manager, two other CQC

inspectors, and five specialist advisors with expertise in surgery, governance and outpatients and diagnostic imaging. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

## Information about Nuffield Health Hereford 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 the ward, theatres and outpatients departments, x-ray and diagnostic imaging. We spoke with 27 staff including; registered nurses, health care assistants, reception staff, medical staff, radiographers, operating department practitioners, and senior managers. We spoke with 20 patients and their relatives. We also received 62 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 18 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected twice and the most recent inspection took place in January 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

In the reporting period July 2015 to June 2016, there were 2,012 inpatient and day case episodes of care recorded at the hospital; of these 49% were NHS-funded and 51% other funded.

42% of all NHS-funded patients and 44% of all other funded patients stayed overnight at the hospital during the same reporting period.

There were 16,666 outpatient total attendances in the reporting period; 71% of these were other funded and 29% were NHS-funded.

84 medical staff including surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Resident medical officers supplied through an agency, worked on a week on, week off rota. The hospital employed 25 full time equivalent (FTE) registered nurses, 20 FTE operating department practitioners and care assistants and 34 FTE other hospital staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There were no never events reported from July 2015 to June 2016.

# Summary of this inspection

- Clinical incidents in the reporting period included 46 no harm, 28 low harm, 12 moderate harm and none resulting in severe harm or death.
- There were no serious injuries reported from July 2015 to June 2016.
- There were no incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin -sensitive staphylococcus aureus (MSSA) or Clostridium difficile (C. difficile) reported from July 2015 to June 2016.
- There had been one incidence of hospital acquired E-Coli from July 2015 to June 2016.
- There were 16 formal complaints received by the hospital from July 2015 to June 2016.

## **Services accredited by a national body:**

None

## **Services provided at the hospital under service level agreement:**

Archiving of medical records

Catering

Facility management

Laundry services

Maintenance of medical equipment

Pathology and histology

Resident medical officer

Security

Mobile MRI and mobile CT

# 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?

We rated safe as good because:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff had awareness of the importance of the duty of candour regulation.
- Staff complied with use of personal protection equipment; handwashing and the rate of surgical site infections were low.
- Patient's records included risk assessments and were completed appropriately and stored securely.
- Early warning scoring was used and a checklist to ensure that patients were well enough to return to the ward from recovery following surgery.
- Processes and service level agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated. This included critical care if required.
- There were processes and arrangements in place to safeguard people from abuse that reflected relevant legislation and local requirements. Staff knew how to recognise and report a safeguarding incident. However, we were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for, from abuse.
- We observed clinical areas to be clean and tidy. However, there were multiple areas that did not comply with Health Building Note (HBN) standards and infection control and prevention policies. This included type of flooring on the ward and consulting rooms in the outpatient department. There were not separate sinks for clinical handwashing for staff in patient's rooms.
- There were inconsistencies with the use and documentation of the World Health Organisation safer surgery checklist in theatre. However, during our unannounced inspection, this had been addressed and an action plan was in progress.
- There were medicine management issues, including medicine drawn up in advance of theatre cases and stock checks not always carried out. Action was taken by the provider and this practice was not seen during our unannounced inspection.
- There were no indications for staff in the diagnostic imaging department as to the recommended thresholds (relative to the reference levels) at which excessive radiation doses should be reported, which is recommended to assist and remind radiographers. This was addressed during our inspection.

Good



# Summary of this inspection

## Are services effective?

We rated effective as good because:

- Patients had their needs assessed, care planned and delivered in line with evidence-based guidance, standards and best practice.
- Policies and procedures reflected current guidelines and adherence was monitored with a schedule of local audits.
- There were processes and procedures in place for staff to manage patients' pain and ensure that patients' nutrition and hydration needs were met.
- Staff were aware of their responsibilities surrounding consent and staff understood their responsibilities under the Mental Capacity Act 2005.
- There were effective arrangements for the admission and discharge of patients. Discharge planning began during the pre-operative assessment process.
- There were systems in place to ensure that staff were competent to provide effective care. Annual appraisals and registration checks were carried out. Medical staff working with practising privileges at the hospital had their agreements reviewed every two years. However, clinical supervision was not always formalised.

Good



## Are services caring?

We rated caring as outstanding because:

- Staff worked in partnership with patients and showed determination and creativity to overcome obstacles to delivering care. For example, the matron and the team worked closely with a patient with anxiety issues to empower them to attend and undergo surgery.
- Patients were unanimously complimentary about the care they had received. This was also reflected in the positive feedback in patient satisfaction surveys.
- Patients told us staff had gone the extra mile to make them feel at ease and had felt comfortable and relaxed prior to having surgery.
- Staff took time to understand the patient as an individual and would provide care to help patients feel comfortable. These relationships were highly valued by staff and promoted by leaders.
- Patients felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patients with respect.
- Patient's privacy and dignity was maintained at all times during our inspection.

Outstanding



# Summary of this inspection

## Are services responsive?

We rated responsive as good because:

- Patients' with complex needs, such as a learning disability or mental health condition, were identified at pre-assessment. Staff made appropriate arrangements to meet individual patient needs, such as increased staff levels, simplified patient information, staff collaboration or the use of a dedicated room for patients living with dementia to use.
- Operation cancellation rates were low and patients had been offered another appointment within 28 days of their original appointment date.
- Patients had short waiting times in departments prior to consultations or appointments.
- The hospital performed better than the national standard of patients being treated within 18 weeks from referral for nine months out of 12 (July 2015 to June 2016).
- Complaints were handled effectively and confidentially. We saw these were discussed at department meetings and actions taken to address issues.
- There was no anaesthetic consultant lead for the pre assessment service.
- The reception waiting area in the outpatient department, backed onto two patient changing cubicles. These were not sound proofed, which could compromise patient dignity and confidentiality.

Good



## Are services well-led?

We rated well-led as good because:

- Leaders were visible, supportive and approachable. Staff were complimentary about their leaders. The hospital had clear roles and accountabilities and managers we spoke with knew what their responsibilities were.
- There was a positive patient centred culture and staff worked well together. Staff contributions were valued and examples of when leaders had listened and made changes were given.
- Not all staff were able to define the values and strategy of the hospital.
- There were clear governance structures in place and incidents, risk registers and performance were discussed regularly. However, there were areas such as immediate life support training and medicines management that were not in line with hospital policy.

Good



# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:






	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	 Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	 Outstanding	Good	Good	Good

### Notes

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both outpatients and diagnostic imaging.



# Surgery

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

## Are surgery services safe?

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 of this report.

We rated safe as good.

### Incidents

- Data provided by the hospital showed that 112 incidents were reported from July 2015 to June 2016. These consisted of 86 clinical incidents (affecting patients) and 26 non-clinical incidents (affecting staff and public). Of these, 74 were reported as no or low harm with 12 reported as moderate. The number of incidents reported from July 2015 to June 2016, relating specifically to surgical services was 58. The rate of clinical incidents was lower than the rate of other independent acute hospitals we hold this type of data for.
- We reviewed the details of the 12 reported incidents that were classed as moderate harm. Most of the incidents were when patients were transferred out of the hospital. We reviewed the reasons for the unplanned transfers and found no specific trends. Staff completed full root cause analysis (RCA) investigations of the moderate incidents and we saw the hospital had identified lessons learned and actions to be completed. Senior nurses were often involved in investigating incidents. We saw and staff told us, that findings from the reports were shared with during staff meetings.
- There were no serious incidents or never events reported 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.
- Staff had access to an incident reporting policy, which included the incident grading system and reporting requirements. Incidents were reported through the hospital's electronic reporting system. Staff we spoke with knew how to report incidents and were confident to do so.
- Staff said managers encouraged them to report incidents. They gave examples of when they would do this, such as following falls medicine errors, surgical site infections and unplanned patient transfers out of the hospital.
- Staff told us about changes in practice following an incident they had raised. For example, if a patient was identified as having poorly controlled diabetes, consultants would postpone surgery until it was well managed. This reduced the risk of a patient's condition deteriorating after surgery. Another example was the introduction of a lockable safe in patient rooms to keep patient medicines secure.
- Staff said managers shared information and learning about incidents which occurred at other hospitals and NHS trusts with them. We saw evidence of this in theatre quality and safety meeting minutes. Staff we spoke with could describe learning from recent incidents within the

# Surgery

hospital and from other Nuffield Health hospitals. We saw printouts of feedback from incidents for staff in each department to read and sign once they had done so.

- A surgical site infection occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues. The number of surgical site infections reported by the hospital was four (in the period from July 2015 to June 2016). This was not high when compared with other independent acute hospitals that we hold this type of data for. The infections occurred in urology, vascular, cranial, and gynaecology surgery.
- There had been no reported inpatient deaths for surgical services in the reporting period July 2015 to June 2016. At the time of our inspection, consultants did not attend mortality and morbidity meetings. However, they were due to begin attending them at a local trust.
- 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 majority of staff we spoke with, including the resident medical officer (RMO), were familiar with the term 'duty of candour' and knew their responsibilities to be open and honest with patients when things did go wrong and offered an apology. A senior nurse gave examples of involving patients in incident investigations. They said they kept patients involved and informed at various stages of incident investigation and documented this in patient records. We reviewed three RCA incident investigations and saw there was information about patient involvement.

## Clinical Quality Dashboard

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms, pressure ulcers, falls, urinary tract infections in patients with a catheter and blood clots or venous thromboembolism (VTE).
- Safety thermometer information was not displayed in the clinical areas at the hospital. This meant patients and the public could not see how the ward was performing in relation to patient safety.

- Safety thermometer results for the period July 2015 to June 2016, showed one incident of VTE and no incidents of pressure ulcers. We reviewed the VTE incident investigation and saw staff had identified learning. This included, staff at pre-assessment establishing any predisposing factors relating to previous deep vein thrombosis (DVT) or pulmonary embolism. Staff also reviewed National Institute for Health and Care Excellence (NICE) guidance regarding the management of a patient with a suspected DVT to ensure an ultra-sound scan was performed within four hours of staff identifying symptoms.
- The VTE screening target of 95% for all patients was consistently achieved in the reporting period July 2015 to June 2016. The hospital consistently scored 100% of patients screened for VTE. Local audits showed compliance with reassessment of VTE risk 24 hours after a patient's admission.

## Cleanliness, infection control and hygiene

- The patient-led assessment of the care environment (PLACE) in 2016 scored 100% for cleanliness at the hospital. This was better than the national average of 98%. PLACE is a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers.
- The ward, theatres, endoscopy and recovery areas were visibly clean and tidy. This included clinical areas, corridors, bathrooms, offices and storage rooms. We saw the hospital had a cleaning schedule for rooms and equipment. We saw staff signed and monitored the completion of cleaning schedules. A member of staff was allocated daily to undertake cleaning throughout the day.
- The patient bedrooms and ward corridors were fitted with short pile carpet. Health Building Notes (HBN) 00-09 Infection control in the built environment, states in clinical areas where spillages are anticipated (including patient rooms, corridors and entrances) carpets should not be used. This was not documented on the risk register. No invasive procedures were carried out in these areas, which reduced the risk of any

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spillage. A standard procedure for cleaning if spillages occurred was in place and staff knew how to access this. There was also cleaning equipment used to clean the area with anti-microbial cleaning agents.

- We observed a lack of clinical hand washing facilities in the patient rooms. Clinical hand basins were provided in utility areas but not in patient rooms. Department of Health Guidelines 2013 HBN00-09 stated that ‘en-suite single bed rooms should have a general wash-hand basin for personal hygiene in the en-suite facility in addition to the clinical wash-basin in the patient’s room’. Therefore, the hospital was not compliant with infection control guidelines in all rooms. This was not documented on the risk register. The hospital was aware of this and stated that cleansing gels were also in place for every room.
- The hospital had reported no incidence of MRSA, Clostridium difficile (C. difficile) or Meticillin-sensitive Staphylococcus Aureus (MSSA) from March to May 2016. MRSA, MSSA and C. difficile are types of infections that have the capability of causing harm to patients.
- From July 2015 to June 2016, the hospital had one incident of hospital acquired Escherichia coli (E.coli). E.coli is a bacterium that can cause infections in the body. We reviewed the root cause analysis carried out following the incident and saw the hospital had taken appropriate action.
- Cleansing hand gel was available at the entrances to each area, on reception desks and in each room. Patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively. We observed the majority of staff and patients using the cleansing gel in line with the information provided.
- Staff had ‘arms bare below the elbow’ to allow effective hand washing. The ‘arms bare below the elbow’ dress code requires staff to wear short sleeves or ensure that long sleeves are securely rolled up and any wrist watches and jewellery (other than a plain metal wedding band) must be removed.
- Protective equipment, such as gloves and aprons were available and we observed staff using these appropriately and washing their hands between patients and tasks.

- Changing into surgical scrubs and theatre caps was a requirement of all staff and visitors to theatre. Staff did not wear for example theatre shoes outside of the theatre department. Our observations during inspection confirmed that this was adhered to.
- We saw staff adhering to procedures in line with national guidance to minimise the risk of infection to patients undergoing surgical procedures. For example, skin preparation and the use of sterile drapes.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. This minimised the infection risk.
- There was a system for ensuring equipment and rooms were clean. For example, ‘I am clean’ stickers. These were clearly visible, dated and signed to indicate cleaning had taken place on equipment and on room doors. We observed equipment for patient-care to be visibly clean and ready for use.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps such as needles and environmental cleanliness.
- Weekly water testing was carried out, such as testing and controlling the risk of exposure to legionella bacteria. Staff discussed these during infection control meetings and no issues had been raised.

## Environment and equipment

- All areas we visited appeared clean and free of clutter, ensuring unobstructed access.
- Access to the theatre department was through a keypad system. This meant the area was secure and minimised the risk of unauthorised access.
- The hospital had two operating theatres, one of which was used for surgical procedures and one for endoscopy procedures. One theatre had laminar flow. This theatre was used for surgical procedures. Laminar flow provides incoming air blown straight down through micro filters above the operating table. The downward airflow prevents air masses from mixing in the work area and increases the cleanliness of the air.
- The layout of the theatre department presented some infection control risks. The theatre and endoscopy room

# Surgery

were situated along the same corridor. Therefore, there was no separate flow for clean and dirty instruments. The instruments had to pass along the same corridor along with staff and patients. This was not best practice. Staff were restricted by the environment in which they worked. However, they were aware and were vigilant to prevent cross infection. There was a risk entered on the hospital's risk register that related to the lack of space in theatre and alternative storage mechanisms were being researched.

- There was a separate clean and dirty room for washing endoscopes after use and the hospital had specialist equipment for cleaning the endoscopes. We saw records showing that 23 members of theatre staff had completed operator training for the washer and drying cabinet. The washer had a traceability system to log details of the sterilised equipment.
- Staff had access to resuscitation trolleys in theatre and the surgical ward area. Both trolleys were visible and easy to access and had tamper event systems in place. We saw documentation from October to November 2016 that showed daily checks of the accessible equipment and disposable items, and weekly detailed checks of expiry dates. Following the weekly detailed check, a security tag was reattached and its number recorded. In addition, the theatre department had a major haemorrhage box located with the resuscitation trolley. The box had accompanying information including protocols and instructions. Staff we spoke with knew how to use the box. We saw that staff checked the box regularly in line with the resuscitation trolley checks.
- The theatre department had a difficult airway trolley available. Staff knew how to use the trolley and we saw staff checked it regularly.
- An offsite department provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if necessary.
- Registers of implants, for example hips and knees, were kept by theatres. This ensured that details could be quickly provided to the healthcare product regulator if required.

- There were piped medical gases on the ward and in the theatre suite. Portable oxygen cylinders were available for the transfer of patients from the theatre suite to the ward and were stored securely.
- Theatre staff conducted swab and instrument checks prior to procedures. We saw staff completed and recorded the checks.
- We saw storage space was limited but staff organised storerooms well to maximise space. Therefore, items of equipment were organised and easily accessible. Storerooms had enough plug sockets so equipment requiring to be fully charged before use could remain on charge.
- Each patient room on the ward had an emergency buzzer in the bedroom and en-suite bathroom. Patients and staff used the buzzer to alert other members of staff there was an emergency. During our inspection, we saw the buzzer used on two occasions and saw staff were quick to respond. Staff checked that buzzers were working correctly daily using a rota system. This meant all buzzers were checked during a single month.

## Medicines

- We saw injectable medicines drawn up in the anaesthetic room in advance for multiple operations. The medicines were placed in bowls waiting for future patients arriving in the anaesthetic room prior to surgery. This presented a risk to patients because there was a possibility of mixing up medicines. We escalated this to the hospital management team who established a series of actions to ensure this did not happen again. Actions included introducing a new standard operating procedure and further conversations with anaesthetists. We checked during the unannounced inspection and found that medicines were not drawn up in advance.
- Pharmacy services were available within the hospital Monday to Friday. There was also on-call support available Saturday and Sunday. Access to the pharmacy department out of hours was only permissible to the RMO and senior nurse on duty, who both held keys and would attend together for security reasons.

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- The stock medicines were ordered from and delivered to a room on the hospital's first floor. The majority of stock was analgesia (pain relief), with a small stock of other medicines commonly used by the services within the hospital.
- Medicines were safely stored in line with legal requirements, including controlled drugs (CDs) in a designated double locked cabinet.
- Staff checked medicine stocks daily and recorded the results of their checks. In the anaesthetic room we saw staff had not checked stock on four occasions from September to November 2016. Staff said this was because they could not check stock when the room was in use or closed. However, we found that a reason for the missed check had not been documented on the sheet.
- We looked at prescription and medicine administration records for 10 patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.
- CDs used for patients receiving post-surgical care on the wards and use in theatres were kept in secure cupboards within locked rooms. CDs are prescription medicines that are subject to stricter legal controls under The Misuse of Drugs Act, 2001. We saw accurate records, which showed that CDs were routinely counted, checked and administered by two nurses.
- We reviewed CD medicine administration records in theatres. These were mostly found to be well maintained. However, we saw three examples of anaesthetists not completing documentation in line with hospital policy. Anaesthetists should sign when a particular medicine had been supplied, administered and destroyed, therefore needing three separate signatures. We saw anaesthetists sign once across all three lines.
- Medicines that required storage at low temperatures were kept in dedicated fridges. Of the three fridges checked, all had the required temperature monitoring sheets completed correctly. The minimum, current and

maximum room temperatures were monitored and recorded. We saw temperatures had been consistently and appropriately recorded on the wards and in theatres.

- The hospital had specific staff injectable and medicine administration competencies. We saw an example of a signed competency sheet for a member of staff. Senior nurses signed off competences after observing practice to ensure staff administered and injected medicines safely.
- We saw intravenous fluids (IV) stored in an unlocked cupboard in the theatre corridor. IV fluids should be stored in locked cupboards. However, we noted the theatre department was locked and had controlled access. Therefore, there was a low risk of unauthorised persons gaining access to these cupboards.

## Records

- Records were paper-based. Nursing records were stored in the patient's room and medical records stored in the nurse's office behind the reception desk. Patient records arrived the day before patient's admission and were prepared by administrative staff.
- Patient records were multidisciplinary and we saw where nurses, doctors and allied health professionals including physiotherapists had made entries. Records were legible, accurately completed signed by clinicians and up-to-date.
- Integrated care records for day case surgery and long stay surgery were in use. These covered the entire patient pathway from pre-operative assessment to discharge. They also included comprehensive care plans for identified care needs.
- Risk assessments were completed in each healthcare record. These included assessment of a patient's risk of pressure ulcers, malnutrition and a home environment assessment. This was particularly important for patients undergoing joint replacement surgery. The clinical risk assessments followed national guidance, for example, included the use of a recognised score for the prevention of pressure ulcers.

## Safeguarding

- Staff we spoke with had a good understanding of how to protect people from harm and abuse. They understood



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the process and who to refer concerns to. The matron was the overall hospital lead for safeguarding. The majority of staff knew who the safeguarding lead was and told us they would approach them for guidance.

- Staff had access to the provider's adult safeguarding policies and procedures via their intranet. Safeguarding resource folders were also available on the ward. These included flow diagrams to assist staff in following the safeguarding process and helpline numbers.
- Not all staff had experience making safeguarding referrals. However, some staff could give examples of when they had raised concerns with the hospital safeguarding lead. One example given was concerns regarding the condition of a patient's home environment.
- A member of the safeguarding committee attended a bi-monthly meeting with local safeguarding board. This enabled the hospital to establish relationship with the local board, improving communication and risk.
- Staff undertook an on-line electronic safeguarding adult training module as part of their mandatory training programme. Safeguarding training was undertaken every two years. At the time of our inspection, 93% of staff had completed adults safeguarding training level one. This was better than the hospital's target of 90%.
- Nuffield Health Hereford Hospital did not provide services for children. National guidelines state that all staff potentially interacting with children should have level two safeguarding children training. However, the Nuffield Health policy stated that staff should be trained to level one. In October 2016, 96% of staff had completed safeguarding children level one training, which was above the 95% target. The records indicated that none of the staff had completed level two safeguarding children training.
- The Nuffield Health policy required the safeguarding lead for the hospital to have completed safeguarding children level three training. The hospital director was trained to level three for safeguarding children. However, the matron who was the safeguarding lead for the hospital, had completed level one safeguarding children training. This meant that we were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for, from abuse. We discussed

this with the provider, who explained that they had misinterpreted the Nuffield Health policy. The hospital director would therefore take on the role of safeguarding lead, until the matron had completed the required level of training.

## Mandatory training

- Mandatory training was mostly completed using an on-line electronic system. Although practical sessions, such as infection prevention, manual handling and basic life support, was a face-to-face module taught by a trainer.
- Mandatory training topics included information governance, infection prevention and control, safeguarding adults, fire training, basic life support, consent to examination or treatment, incident reporting, Mental Capacity Act (2005) and whistleblowing (raising concerns).
- There was an expectation that all staff completed their annual mandatory training. Information provided by the hospital showed that 94% of hospital staff had completed their mandatory training. This was better than the hospital's target of 90%.
- Managers monitored and tracked staff compliance with mandatory training. We saw an electronic spreadsheet managers used to see whether staff had completed, were due or overdue their mandatory training.

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

- A RMO was on duty 24 hours a day, seven days a week at the hospital in order to respond to any concerns staff may have about a patient's medical condition. Patients also saw their named consultant at each stage of their journey. Patients' needs were assessed throughout their stay and in line with their care pathway. An anaesthetist remained on site when patients were in the recovery room post operatively.
- Anaesthetists and pre-assessment nurses calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of their assessment prior to surgery. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels with level one being the lowest risk. Surgical procedures were only performed on patients who had been assessed as low risk at the hospital. The

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pre-operative assessment nurse had direct access to contact details for the consultants and the anaesthetist, so any issues in relation to a patient's condition could be escalated at the pre-operative stage.

- Staff completed several safety checks before, during and after surgery to avoid errors. These were based on guidance, such as the World Health Organisation (WHO) five steps to safer surgery safety checklist and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). We observed that there was inconsistency completing the checklist regarding when the 'time out' took place and one occasion when it seemed that not all the team were fully engaged. We raised our concerns with the senior management team during the inspection. At the unannounced inspection, we observed a pre-list briefing meeting and the WHO safer surgery safety checklist was completed in line with guidelines. We also found that there was an action plan in place to address this issue.
- The hospital used a system to record routine physiological observations, such as respiratory (breathing) rate, blood pressure, temperature and pulse in order to monitor patient's physical condition. This was used as part of the modified early warning scores (MEWS) throughout the ward and in theatre recovery to monitor patients and identify early signs that their condition may be deteriorating.
- The hospital audited the staff use of MEWS. Data from the hospital showed from January to November 2016 varied performance against evidence in the patient's clinical record that MEWS was completed each time staff recorded the patient's observations. Performance varied from 70% to 90% during this period. Managers identified actions including further reminders and training for staff where poor performance was identified.
- Within recovery, MEWS was recorded as the patient woke from their anaesthetic and observations were undertaken before the patient returned to the ward. Patient records we reviewed showed all of the MEWS charts were completed. MEWS audits showed there was evidence in the patient's clinical record staff completed MEWS at least twice while surgical patients were in recovery and before transfer to a ward. The audit also showed that when required, staff had escalated concerns to consultants in line with hospital policy.
- We saw in the recovery room that equipment was available for measuring capnography. Capnography is the monitoring of the concentration or partial pressure of carbon dioxide in the respiratory gases. Its main development has been as a monitoring tool for use during anaesthesia and intensive care. The AAGBI standards of monitoring recommend the use of capnography in recovery when patients have airway adjuncts in place. There was a local policy to guide staff in the use of capnography based on the AAGBI standards. However, the provider did not audit compliance with the policy and therefore we could not be assured that it was used appropriately.
- We saw theatre staff complete patient observations against a criteria checklist before discharging them back to the ward.
- Staff used risk assessments to assess and monitor specific risks. For example, staff used a national pressure ulcer screening tool. Staff also assessed the patient on admission for risk of falls. We saw staff completed and documented risk assessments in patient records. However, we saw one example when a patient's pressure ulcer had been identified in recovery and an appropriate risk assessment completed. However, it was unclear whether the pressure ulcer had been subsequently assessed and treated on the ward due to no further documentation about this.
- Staff used green wristbands to identify patients at risk of falling. We also saw in patient records the staff involved physiotherapists to support the rehabilitation of patients who were at risk of falling.
- There was an adult sepsis screening tool displayed in the ward area. Sepsis is a severe infection that spreads in the bloodstream. Staff told us they would alert the RMO if there was any deterioration in a patient's condition and administer treatment as required.
- Processes and service level agreements were in place to transfer patients to an alternative acute hospital if their condition deteriorated. This included critical care if required. There were 11 unplanned transfers to other hospitals from July 2015 to June 2016. We reviewed the reasons for the unplanned transfers and found no specific trends.
- On discharge, patients were given a comprehensive discharge booklet, which was specific to the surgery

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they had undergone. This contained the contact details for the hospital so they could call if they experienced any problems. Staff told us if patients did contact the ward following discharge with problems or for advice, they would inform the RMO. Advice and conversations were recorded in a book and documented in the patients' notes. During our inspection, we observed this process in its entirety.

- Any patients who had received a general anaesthetic were to have a responsible adult identified for the first 24 hours following discharge. We saw this documented in patient care records.
- Theatre staff had processes and procedures to reduce the risk of patient harm, for example to prevent using the incorrect sized prosthesis (joint or implant). Surgeons led daily team briefs to review the day's theatre lists. We observed the whole theatre team attended. The brief discussed any risks to patients including allergies and expected prosthesis to be used. The anaesthetist also added their review of patients. A scrub practitioner recorded the brief and displayed the notes in theatre for staff to review. We observed staff checking and clarifying with each other before using a prosthesis. We observed the surgeon pausing the procedure to ensure they had the correct sized prosthesis to insert. This meant that procedures were being followed to prevent patient harm in theatres. However, in two out of 10 records we saw staff had not fully documented each safety check in accordance with the WHO safer surgery checklist. For example, in one record we saw the sign out check completed after surgery, had not been documented. However, during our unannounced inspection this had been addressed and an action plan was in progress.
- Managers allocated staff daily to respond to emergencies in the hospital. This was in line with Resuscitation Council guidelines. Staff rotated in these roles, which were identifiable by a red sticker on the staff duty rota. Should a member of staff call for help or in the event of a patient pressing their emergency buzzer, the allocated members of staff would immediately attend the scene. During our inspection, we saw a member of staff used an emergency buzzer after a patient fainted and staff responded quickly.
- Staff took part in emergency scenarios training, for example resuscitation, major haemorrhage and heart

attacks. The scenarios took place on a quarterly basis. However, records showed that not all required staff at the hospital had completed the immediate life support training (ILS). The compliance rate was 68%, with 10 out of 31 staff to complete the training. The provider clarified that 100% of the nursing staff who worked on the ward caring for inpatients had completed the ILS and that there was a member of staff on duty each day in the theatre department that had completed ILS training. There were also members of the team available who had completed the advanced life support course at the hospital, including the RMO, which did meet best practice and corporate policy. This meant that although not all staff had completed the ILS training, there were arrangements in place to respond appropriately in the event of a clinical emergency such as requiring cardio-pulmonary resuscitation.

## Nursing and support staffing

- The hospital used NICE guidelines (2014) safe staffing for nursing in adult patient wards in acute hospitals. Senior nurses calculated staffing levels on a weekly basis and checked and adjusted daily as required according to patient requirements. Staffing levels were calculated on a ratio of five or six patients per registered nurse in the daytime and maximum of eight patients per registered nurse at night. Health care assistant (HCA) staffing levels were calculated depending on patient needs.
- Sickness rates fluctuated across theatre and inpatient areas for nursing, HCA, and operating department practitioners (ODP) staffing. For inpatient nursing staff sickness rose from 1% in July 2015 to 16% in November 2015 before reducing to 2% in June 2016. HCAs had higher rates of sickness, averaging 16% from July 2015 to June 2016. This peaked in May 2016 when the sickness rate for ward HCAs was 44%. Sickness rates for theatre nursing staff remained low throughout the same period with most months showing less than 1% staff sickness. For HCA and registered ODPs sickness rates rose from 3% in July 2015 to 19% in May 2016. This reduced to 11% in June 2016.
- There was evidence of the hospital following the Nuffield Health sickness policy in five personnel files we checked during the inspection. For example, documentation of return to work interviews conducted for staff members who had been off sick.



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- Data from the hospital showed as of July 2016, there were no staff vacancies and the number of full time equivalents (FTE) for nursing, HCA and ODPs met the hospital's establishment levels.
- Data from the hospital showed turnover rates for nursing staff in theatre and inpatient areas had increased from previous years. From July 2014 to June 2015, turnover rates for inpatient and theatre nursing staff was 18% and 14% respectively. For the period July 2015 to June 2016, this had increased to 24% for inpatient staff and 34% for theatre staff. We discussed this with the theatre manager who explained there had been three staff who had left during this time, all for different reasons including promotion.
- The hospital used agency and bank staff to cover staff absences. From July 2015 to June 2016, bank and agency usage for inpatient nursing was consistent ranging from 8% to 14%. Bank and agency usage was higher for health care assistants with an average of 22% for the same period. In four months of this period, bank and agency usage was over 30%.
- Bank and agency usage for theatre nursing staff averaged 8% for the period July 2015 to June 2016. There were no bank and agency staff used for the first five months of this period. For theatre HCA and registered ODPs bank and agency usage was 8%.
- The use of bank and agency nurses for the ward was lower than the average of other independent acute hospitals we hold this type of data for. However, the use of bank and agency HCAs for the ward was higher than the average of other independent acute hospitals we hold this type of data for, in the same reporting period.
- We reviewed staffing rotas and saw the ward had a minimum of two registered nurses always on shift as a minimum. The ward had a higher nurse to patient ratio when they had patients requiring a higher level of care. Nursing numbers and one-to-one care was used to meet patient needs. The registered nurse in charge was responsible for reviewing predicted ward activity for the coming days.
- The theatre manager planned theatre staffing on a weekly basis and adjusted where necessary according

to speciality and case mix. The theatre manager used The Association for Perioperative Practice (AfPP) 2014, for general guidance. We saw staffing levels were in line with this guidance.

- New staff to the hospital underwent a comprehensive induction process, which included for nursing staff, completing competency assessments. Induction was tailored to the role and the needs of individual members of staff.
- Nursing staff held three comprehensive daily handovers at 7am, 2pm and 9pm. Staff discussed each patient in turn including personal preferences, medicines, early warning scores and discharge arrangements. Staff used handover sheets to discuss any patients due for admission.
- Three members of theatre told us they were unhappy when lists sometimes overran. This meant that they could not be off duty on time. During our inspection, one surgical list had overrun by at least one hour.

## Medical staffing

- The hospital had 84 doctors employed or working under practising privileges with more than six months service. All 84 had received validation of their registration within the last 12 months. Practising privileges are the authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital. Practising privileges are limited by the individual's professional license, experience, and competence. The hospital's medical advisory committee (MAC) had the authority to advise the hospital director regarding eligibility for PPs and for their continuation, suspension or restriction (or the issue of any warnings connected with them) in the interests of patient safety. All seven practising privileges folders that we looked at had been reviewed within two years.
- Consultants visited inpatients at least once every 24 hours and were available via telephone 24 hours a day, seven days a week whilst they had patients in the hospital. If they planned a period of absence, a fellow consultant would be identified to cover and the hospital informed at least six weeks in advance.
- A RMO provided 24-hour medical and surgical cover for patients. The hospital had processes to ensure the RMO

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received adequate rest. The RMO we spoke with estimated they were called for assistance two of the seven nights on duty and generally they got enough sleep to be fit for work each day.

- Resident doctors worked one week on and one week off and were supplied by an agency. The RMO stayed on site during their week of work. The RMO we spoke with explained the handover to the next RMO, took place on a Monday. There was a reduction in patients over the weekend; so there were usually around three or four patients to handover.
- The RMO joined the clinical team at the commencement of the early shift to receive a handover from night duty staff. They undertook a ward round and checked in with the pharmacist. The RMO room was located at the end of the ward corridor and the RMO was contactable by telephone. A senior nurse assessed and discussed the work allocation for the coming day with the RMO. In the event of the RMO being called out during the night, the early morning handover was delayed.
- The hospital used an out of hours on-call rota and provided clinical cover for weekends and out of hours. If a patient was required to return to theatre out of hours because of complications, consultants could be notified quickly.
- The RMO reported that if a patient deteriorated they would call a consultant. They felt consultants were supportive and they had experienced no incidents of not being able to access a consultant when required since they had started in September 2016.
- Surgeons and anaesthetists had the responsibility in line with their practising privileges to ensure the hospital had clinical cover for their cases and for any patient advice required following discharge. The hospital had a designated consultant with practising privileges to cover when another consultant was away. All consultants were within a 30 minute journey time from the hospital.

## Emergency awareness and training

- The hospital had a major incident policy to guide staff in the event of an emergency and we saw this had been reviewed and was in date (June 2016).
- There were no practice scenarios for a major incident. However, there were emergency scenarios practiced by

staff, including resuscitation and haemorrhage. The RMO reported they had taken part in two scenarios since starting September 2016. For example, there was a patient major haemorrhage drill in October 2016, with areas of good practice and areas for improvement identified.

- The hospital had a weekly major incident schedule, which outlined the member of the senior management team who was responsible for major incident roles, such as fire officer and assembly point coordinator.
- The hospital had fire evacuation procedures. Staff we spoke with knew about the policy and what to do in the event of an emergency. The hospital had protocols to transfer any patients with major injuries to the nearby NHS trust. We saw the hospital displayed fire safety procedures on the walls of the ward area.
- The hospital had a service level agreement with another provider in the event of an emergency or the hospital being unable to take patients. This meant patients could still receive care and treatment in the event of a service stopping event at the hospital.

## Are surgery services effective?

Good 

We rated effective as good.

## Evidence-based care and treatment

- Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines, for example the Royal College of Surgeons. Staff kept a folder with all relevant NICE guidelines on the ward. Staff said they referred to it for guidance and information.
- We saw the hospital's clinical governance quarterly report (for June to September 2016), contained details of policies that were new or had been updated. For example, there was a new managing medical devices policy. This described the process for management of medical devices and best practice, based on the principles outlined in Medicines and Healthcare

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products Regulatory Agency (MHRA) managing medical devices (2015). The clinical governance quarterly report also contained detail of what the key updates to the policies were included.

- The clinical governance quarterly report (for June to September 2016) benchmarked how the hospital was meeting national guidance. For example, the hospital reported that they were compliant with guidance from the patient safety alert (NHS/PSA/RE/2016/006) regarding naso-gastric tube misplacements. They commented that the alert had been disseminated to all clinical staff and that pH strips, to test gastric juice, had been sourced for staff to check the position of the naso-gastric tube. The report did not necessarily provide assurance that they were compliant with the entire guidance. However, where the hospital benchmarked themselves as non-compliant with guidance, there were actions in place to improve compliance.
- Staff said they measured clinical performance by searching literature, responding to guidance (NICE), taking action at patient safety alerts, seeking patient feedback and collecting data on clinical variances. Staff said they reflected on their own practice through risk assessment, gap analysis and audits. This enabled the hospital to identify how and where to act to improve.
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines [CG74].
- Staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: reducing the risk for patients in hospital NICE guidelines [CG92].
- Reducing the risk of VTE was part of the care pathway for major operations. This included the use of anti-embolism stockings and medicine prophylaxis. Prophylaxis is a treatment or medicine designed and used to help prevent a disease from occurring. For example, patients who had received a planned hip or knee operation had this in place.

## Patient outcomes

- We saw the hospital participated in a number of national audits, for example Patient Recorded Outcome

Measures (PROMS), the National Joint Registry, Public Health England and safety thermometer data. We saw hospital staff identified and implemented actions based on evidence from audits. We saw changes to pre-assessment procedures because of audit findings.

- The hospital undertook endoscopy. Although not Joint Advisory Group (JAG) accredited for the endoscopy procedures, the hospital had advice from other Nuffield Health hospitals. Managers said they had started the process to apply for accreditation. The JAG accreditation scheme is based on the principle of independent assessment against recognised standards. It was developed for all endoscopy services and providers across the UK in the NHS and independent sector.
- The hospital had a standard operating procedure (SOP) for day surgery based on The Association of Anaesthetists of Great Britain and Ireland and The British Association of Day Surgery guidelines. We saw staff worked in line with the hospital standard operating procedure.
- The hospital sepsis screening tool available was adapted from the UK Sepsis Trust tool and was evidence based.
- Staff had access to evidence based patient pathways. For example, the hospital acute kidney injury pathway was in line with a patient safety alert (released August 2016) on acute kidney injury.
- The provider was engaged with the Private Healthcare Information Network (PHIN) so that data can be submitted in accordance with legal requirements regulated by the Competition Markets Authority.

## Pain relief

- Staff discussed pain management with patients as part of the pre-assessment process and staff implemented any actions following this. Staff also discussed patient's pain requirements during morning and evening handovers. Staff discussed what pain relief patients had previously received. There was a dedicated pre-operative assessment and post-operative monitoring for this in the care record.
- We observed staff regularly reviewing patients' experience of pain in the recovery area post-surgery.

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Staff administered pain relief as prescribed. We also saw an anaesthetist ensuring a patient's pain was adequately controlled in theatre recovery before the patient returned to the ward.

- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery. Information about the medicine prescribed, including how to use it and any side effects was given to patients.
- A patient controlled analgesia (PCA) was available as an option of pain relief. PCA is a method by which the patient controls the amount of pain medicine (analgesia) they receive
- Senior nurses and matron visited patients during their stay and issues regarding pain could be identified. The hospital performed pain audits and through documentation audits could identify whether staff had acted upon the patient's perceived pain score the effectiveness of the pain management plan. Daily RMO ward rounds and regular pharmacist visits to patients enabled staff to discuss pain relief with the patient and its effectiveness.
- Nursing staff completed pain assessments as part of the modified early warning scores and documented these in the patients care record post operatively. Pain assessment scores used on the ward assessed the comfort of patients both as part of their routine observations and at a suitable interval of time after giving pain relief. Nursing records we checked demonstrated staff were identifying the patient's level of pain and evaluating the effects of pain relief on a consistent basis.
- The hospital had a clinical working party looking at best practice and evidence based pain management. A consultant anaesthetist supported the group. The group was set up to assess the quality of practice after an incident of a challenging event in managing a patient's pain level.
- The hospital conducted pain audits to monitor staff practice in assessing and administering pain. For example, an audit for June 2016 showed that patients received a regular pain assessment using a pain

assessment tool. An area that was highlighted on an action plan following this audit included development of patient information leaflets regarding pain management.

- Patients we spoke with said staff managed their pain and responded in a timely manner when patients experienced pain. One patient said staff ensured they had enough of the correct type of pain medicine to help them manage it. Patients said staff discussed ongoing pain management before they were discharged home. Staff also provided patients with information to take home about pain management.
- We observed staff responding quickly and compassionately to patients in pain. Staff provided pain relief promptly and in one case re-admitted the patient attending another department quickly back on to the ward.

## Nutrition and hydration

- Staff informed patients to follow guidance on fasting prior to surgery, which was based on best practice, aligned to the recommendations of the Royal College of Anaesthetists. This permitted healthy patients requiring a general anaesthetic to eat up to six hours prior to their surgery and to drink water up to two hours pre-procedure.
- We saw anaesthetic staff prescribing medicines to ensure effective management of nausea and vomiting should this occur.
- The hospital was in the process of establishing a clinical working group to re-assess compliance with the national fasting guidelines. The aim was to provide assurance staff were maintaining patient's hydration levels appropriately prior to surgery.
- The hospital had access to dietitian support and where able to make referrals for advice as required.
- Staff discussed patients' nutrition and hydration requirements at morning and evening handovers. We observed staff discussing making sure food was available at night for patients, especially those who missed their afternoon meal due to being in surgery.

## Patient outcomes

- The hospital submitted data to the National Joint Registry including data on patient consent, at

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pre-assessment and following the surgical procedure. This provided information on the outcome of surgery and provided a comparison on revision and infection rates for each consultant.

- The hospital took part in several national audits. They monitored infections and submitted data submitted monthly to the clinical safety thermometer audit. In addition, the hospital collected data on 30 day surveillance of infections following joint replacement surgery, trans-rectal ultrasound (TRUS) biopsies, breast augmentations and spinal surgery. Staff entered any adverse outcomes onto the electronic incident reporting system so that managers could identify trends. These were investigated and discussed at quality meetings and at the medical advisory committee (MAC).
- The hospital participated in providing PROMs data for primary knee and hip replacements. Data from the hospital showed the hospital had PROMS adjusted Oxford Knee and Hip scores were better than the England average.
- For cosmetic surgery procedures the hospital recorded all implant information for patients who underwent breast implant surgery to ensure the traceability of all implants. At the time of the inspection, the hospital was in the process of registering with the National Breast Implant Registry. However, there was a delay following a pilot of a new registry by the Health and Social Care Information Centre. The medical device lead for Nuffield Health was awaiting a further update and the hospital said they would comply with the findings from the pilot.
- In the reporting period July 2015 to June 2016, there were 11 unplanned transfers of care from the hospital to a nearby NHS trust. This was not high when compared with other independent acute hospitals and consistently a low rate per 100 inpatient and day case attendances in this reporting period. We reviewed the reasons for the unplanned transfers and found no specific trends.
- For the reporting period July 2015 to June 2016, there were five emergency readmissions within 28 days of discharge. This was not high when compared with other independent acute hospitals that we hold this type of data for. There were three cases of unplanned returns to

the operating theatre for the same period. We reviewed the details of the unplanned transfers and saw hospital staff acted in a timely manner and in accordance with hospital policy.

- The hospital audited its endoscopy service against national standards in preparation for applying for Joint Advisory Group (JAG) accreditation. The JAG accreditation scheme is based on the principle of independent assessment against recognised standards. It was developed for all endoscopy services and providers across the UK in the NHS and independent sector. The results for October 2016 saw the service score 69% against these standards. We saw managers identified learning and actions. At the time of our inspection, managers were implementing them. Examples of learning included ensuring patient information was clearly available, increased staff training, and an updated software module.

## Competent staff

- Surgeons operated under practising privileges. The hospital followed robust procedures to ensure that surgeons who worked under practising privileges had the necessary skills and competencies. Checks undertaken ensured that surgeons performed only the procedures they carried out in their substantive NHS role. The MAC conducted the formal ratification of practising privileges and the hospital had procedures to review them regularly.
- An agency provided the RMOs who worked in the hospital 24 hours a day. The RMOs were required to undertake mandatory training with the agency that supplied them as part of their contract. Each resident doctor had a personal file held within the human resources (HR) department, which contained the mandatory training certificates. The HR officer and matron reviewed these to ensure training was up-to-date. This included health and safety, fire training and equality and diversity. The RMO we spoke with reported that when they started working at the hospital they received a week shadowing before working as the sole RMO. During induction, they received training in basic life support, safeguarding, do not attempt pulmonary resuscitation policy and procedures.
- There was evidence of a robust recruitment processes in the five personnel files we reviewed. Each contained a



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- We spoke with seven health care assistants (HCAs) from across the hospital who spoke positively about the training and development opportunities they had been given. They described being offered additional training in skills, such as taking patient observations and removing catheters and cannulas. Senior nurses assessed their competencies and the HCAs we spoke with felt encouraged and empowered as a result. Theatre support workers were also completing their Care Certificates, which were qualifications in standards of care.
- Clinical supervision was provided at the hospital. However, it was not always formalised meaning there was a lack of evidence to confirm the depth or frequency of supervision sessions. Nursing staff we spoke with told us that they received between 30 to 60 minutes per month. The clinical training lead advised us that they were looking at formalising this process with documentation to evidence participation.
- Some nurses had undertaken further training as 'link' nurses, for example in safeguarding, infection control and dementia care. The nurses attended regular meetings and updated ward and theatre staff about any changes or up-dates to practice that were required. Staff provided an example related to the benefits of pre-operative showering. We saw that this was discussed in the infection control link nurse meeting minutes (June 2016).
- Data from the hospital showed all registered nursing and operating department practitioners (ODP) requiring revalidation, had undertaken this (July 2015 to June 2016). We spoke with two members of staff who were undertaking revalidation at the time of our inspection. They said colleagues and senior nurses supported them with their revalidation and they were given time to complete any required work. ODPs are required to register with the Health and Care Professions Council every two years.
- Data from the hospital showed that all hospital staff had received an appraisal for the period July 2015 to June 2016. Staff we spoke with on inspection confirmed they had received an appraisal. The majority of staff said appraisals were meaningful.
- Staff were positive about access to further training and development courses. Courses were available externally or online via the Nuffield Health Academy.
- Nursing staff new to the hospital were supernumerary (treated as additional staff) for two weeks, and went through a probationary period and six week induction process. New staff induction included orientation to the environment, policies and guidance, administering medicines and equipment competencies and mandatory training completion.
- New theatre staff were supernumerary for three months or until the member of staff and their managers judged they were ready to be part of the established staffing levels. New members of staff we spoke with said colleagues and senior staff supported them and felt their induction was robust.
- The hospital had three medical staff that held practising privileges for cosmetic surgery. These practitioners were on the specialist General Medical Council (GMC) specialist register. This meant they specialised in cosmetic surgery.
- Two members of staff had completed specific endoscopy competencies. The lead member of staff for endoscopy had been assessed by a consultant to ensure they could practice effectively.
- We spoke with a HCA who had undertaken a corporate foundation quality care programme. Staff across the Nuffield Health group could access this course. We reviewed the HCAs course folder and saw they had completed 10 competency units including duty of care, information governance and person centred care. We saw competencies had been signed off by senior nurses and the HCA had completed written work in relation to the competencies.

## Multidisciplinary working

- A multidisciplinary team (MDT) approach was evident throughout the service. There was effective daily communication between MDTs within the ward and theatres. Staff told us they had a good relationship with consultants and the RMO.
- Patient records showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.

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Physiotherapists offered treatment to patients both before and after joint surgery. We observed positive interactions and communication between nursing, medical, and therapy staff. Staff worked well as a team.

- When patients were discharged, the hospital worked with external services. A letter was sent to the patient's GP to inform them of the treatment and care they had provided.
- The hospital ensured the objectives of 'The Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients' were implemented. The objectives included patients having a responsible clinician coordinating their care and patients knowing who the clinician was. We saw patients had a named clinician and patients we spoke with knew who their named clinician was. The hospital monitored performance against these objectives through review of consultant practising privileges and the MAC.

## Seven-day services

- Theatre one was available for two to three sessions per day Monday to Friday from 8am to 7pm, and one Saturday per month from 8am to 5pm.
- Theatre two, used for endoscopy procedures, was available Monday to Friday from 8am to 7pm, and every Saturday from 8am to 5pm.
- Physiotherapy services were provided by Nuffield Health and were available from 8am to 5:30pm, Monday to Friday. Evening appointments were available until 8pm on Wednesdays and Thursdays, with on call services available during normal working hours at the weekend.

## Access to information

- There were comprehensive, paper based, integrated care records for each patient. These included evidence based risk assessment tools, multidisciplinary evaluation notes, observation charts, anaesthetic and theatre records. This enabled consistency and continuity of record keeping throughout the patients stay, supporting all staff to deliver effective care.
- Staff had access to information they needed from electronic and paper based sources, such as policies, incident reporting forms, test results and medical records.

- There were computers available on the ward and the theatre areas, which gave staff access to patient and hospital information, for example SOPs.
- Staff used a 'transfer out pack' when patients transferred between care settings. We saw staff had a checklist of what information was required when patients left the hospital to go to another provider. This meant staff had systems to enable them to send the correct information to providers, to ensure appropriate ongoing treatment and care for patients.
- Staff used theatre list collection slips when collecting patients from wards. The slips included patient details to help staff identify they were transporting the correct patient to surgery.
- The hospital sent letters to district nurses and GPs regarding ongoing patient care. We saw examples of letters sent to other healthcare providers regarding post-operative wound care instructions.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had received training about consent and the Mental Capacity Act 2005 (MCA). Staff stated if they had concerns about a patient's mental capacity they would refer them to a senior member of staff. Senior members of staff were aware of their responsibilities under the MCA. Data from the hospital showed 100% of staff had received MCA training.
- Patients were consented for surgical procedures on the day of surgery by the consultant. Patients we spoke with confirmed they discussed the procedures with their consultant during outpatients appointments and with a nurse during pre-operative assessment, this allowed time to consider the procedure planned before consenting to treatment on the day of surgery.
- We reviewed 10 consent forms, which had been completed and signed appropriately. We observed theatre staff checking that consent forms were signed before the patient underwent surgery. This included anaesthetic consent gained by the anaesthetist prior to surgery.

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- Staff told us patients who may lack capacity to make an informed decision about surgery at the hospital were extremely rare. Any difficulties would be identified at the pre-admission assessment and if any consideration was needed, this would be undertaken at this stage.
- During our inspection, there were no patients requiring Deprivation of Liberty Safeguards (DoLS), mental capacity assessments or do not attempt cardio pulmonary resuscitation orders. Patients' resuscitation status was assessed and documented both before and during their admission.
- All staff we spoke with knew about (DoLS) and the use of mental capacity assessments. Data from the hospital showed 91% of staff had completed DoLS training.

## Are surgery services caring?

Outstanding



We rated caring as outstanding.

### Compassionate care

- Patients were unanimously complimentary about the care they had received. Feedback from patients and those who are close to them was continually positive about the way staff treated people. All the patients we spoke with were very pleased with the quality of care they had received. A patient told us that the service was "excellent, (they had) been here six times and would choose to come here every time." Patients said staff spent time making sure they were comfortable, at ease and patients did not feel rushed in anyway. A patient told us that 'staff brought me refreshments, sat and chatted with me. I expected to get my own refreshments and sit in a waiting room". Another patient said their partner was allowed to stay with them until they went into the operating theatre because they were distressed.
- Patients told us that staff had gone the extra mile to make them feel at ease and as a result had felt comfortable and relaxed prior to having surgery. Staff had spoken to them in a kind manner and treated them with dignity and respect. One patient said they arrived at the hospital feeling anxious and staff helped reassure them. The funding of patients care did not influence the care that was provided by staff. For example, staff did not differentiate patients whose care was NHS funded.
- We observed numerous consistently positive interactions between staff and patients throughout our inspection. We saw staff offering patients assistance at every opportunity. For example, following surgery, staff ensured patients were comfortable by elevating arms or legs as required. Staff supported patients with mobility issues without compromising their dignity. Staff helped patients to choose clothes and attend to basic needs such as brushing their hair.
- Patients gave us examples of staff going over and above their expectations. For example, a patient said a member of staff gave them a shoulder rub to help relieve pain and anxiety. Another member of staff moisturised a patient's feet because they could not have a shower. The member of staff explained, "I just wanted to make them feel good".
- There was a strong, visible person-centred culture throughout the hospital. This began with the staff at reception and throughout the patient's journey. This culture was promoted by hospital leaders. We observed a senior nurse making and providing patients with refreshments including biscuits after returning from surgery. The senior nurse talked with patients ensured they were comfortable, and laughed and joked with them when appropriate. During this task, the senior nurse was visible and accessible to patients. The senior nurse said it was important patients felt relaxed and comfortable.
- Staff were highly motivated to offer care that promoted patient's dignity. Staff ensured confidentiality and privacy by knocking before entering a patient's room and kept the door closed while providing care. We observed staff closing and using privacy curtains. We noted that staff introduced themselves when they met a patient for the first time.
- Staff offered dignity underwear for patients to use who were going to theatre. Dignity pants and bras are single use items of clothing used to wear underneath a theatre gown.
- After surgery, staff kept patients covered to maintain their dignity at all times. A patient told us they had a



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headache after surgery and staff dimmed the lights to make them feel more comfortable. Patients who remained awake for their surgery, including minor procedures, said staff talked to them during the procedure.

- The hospital's patient-led assessment of the care environment (PLACE) score for privacy, dignity and wellbeing was 78%. The England average was 83%. We discussed this result with the senior managers during the inspection. An area that had affected the score was related to the lack of hearing loop at the hospital. Assessors felt that this was a dignity issue for people with a hearing impairment. We saw that in response to this, the hospital had installed hearing loops for patients using hearing aids. Senior managers had also fitted privacy curtains to the entrance to patients' rooms. This meant that when the door to the room was opened, the curtain could be used to further protect patient's dignity. Patients were positive about the privacy curtains. Senior managers monitored local patient satisfaction surveys for any issues related to privacy and dignity.
- The hospital collected Friends and Family Test (FFT) data from patients. The FFT is a survey that asks patients whether they would recommend the NHS service they have received to friends and family who may need similar treatment or care. Data from NHS England showed an average of 98% of NHS funded patients would recommend the hospital in the period January 2016 to June 2016. This was better than the England average for this period, which was 96%.
- The hospital also sought feedback from patients about their services. For example, patients using the pre-assessment service scored from 92% to 97% for patient satisfaction (May to July 2016).

## Understanding and involvement of patients and those close to them

- Staff worked in partnership with patients and showed determination and creativity to overcome obstacles to delivering care. Patients felt that they were part of the decision making process regarding their treatment plan. We saw that staff provided an unhurried approach and treated patients with respect.
- Relationships between patients and staff were caring and supportive. We saw staff built strong appropriate relationships with patients and got to know them as

individuals. Patient's individual preferences and needs were reflected in how care was delivered. Staff spent time to understand a patient's background and home life and we observed conversations about patient's family and interests. For example, a patient told us that staff at the hospital "treat the person, not the condition". They took patient's personal, cultural, social and religious needs into account. Staff told us about how they had ensured that a patient's religious needs were met by helping them to face Mecca for prayer during their stay. Patients we spoke with agreed that staff were friendly and got to know them as individuals. We saw an appropriate familiarity between staff and patients, and saw that these relationships were highly valued by staff and promoted by leaders of the service.

- We observed staff discussing patient's personal preferences during handover between shifts. For example, staff discussed by what name patients liked to be called to make them feel more at ease.
- Patients told us staff had given clear explanations, in sufficient detail for each stage of their care and treatment, from the initial consultation through to discharge. They had been given written information to support the discussions that had taken place.
- Staff were clear about the risks and benefits of the planned treatment and patients understood how their recovery would progress. Patients told us staff had made them aware of any costs they may incur.
- Staff used different techniques for ensuring they could communicate with patients and making sure they were involved in their own care and treatment. For example, staff asked patients questions to clarify they had understood what they had been told. They gave patients time for queries and used pictures or writing pads for patients who were hard of hearing.
- Patients said staff kept them informed and involved them in their care and treatment during their stay in hospital, at each stage of their pathway. We observed staff in theatre and on the ward explaining to patients what was going to happen regarding their treatment. Staff spent time with patients ensuring they understood what they were being told. They did not rush or leave the patient; until it was clear they understood.
- Staff worked in partnership with patients and showed determination and creativity to overcome obstacles to

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delivering care. For example, a patient with anxiety issues had raised a complaint about their consultation with a consultant at the hospital. The complaint was investigated and responded to as per policy. However, despite the patient's anxiety and initial concerns, the matron and the team worked closely with the patient to empower them to attend the hospital again and undergo the surgery. This included the matron attending the pre-assessment appointment and involving the patient in developing a plan for their admission. We could see from the healthcare record that the patient successfully attended for the procedure and had an uneventful stay.

## Emotional support

- Patient's emotional needs were highly valued by staff and were embedded in their care and treatment. Staff understood the impact of patient's care and treatment varied. Staff assessed the emotional needs of patients on an individual basis. If a patient experienced distress, staff changed their language and tone to suit the situation. Staff gave patients time and said they would not do anything until the patient was ready.
- We observed that staff spent time reassuring anxious patients about to undergo surgery. Staff said some patients needed more reassurance than others and would spend time with those who needed it. Staff also reassured anxious relatives and carers about procedures too.
- Staff empowered patients to manage their own health and wellbeing to maximise their independence. Staff provided patients with information on support groups, exercises and information to manage their own medicines. Patients we spoke with confirmed that staff gave them the information they needed to manage their condition at home.

## Are surgery services responsive?

Good 

We rated responsive as good.

## Service planning and delivery to meet the needs of local people

- The hospital worked with the local clinical commissioning groups (CCG) to plan services for NHS patients and participated in the NHS e-Referral Service. This service allows NHS patients requiring an outpatient appointment or surgical procedure to choose both the hospital they attend and the time and date of their treatment. Through this initiative, the hospital was able to provide a selection of NHS services including, hip and knee surgery.
- The inpatient ward had 20 beds used by both NHS and self-paying patients. All patients were cared for in individual rooms with private en-suite facilities, which helped maintain their privacy and dignity.
- In addition, the inpatient ward had a day case and ambulatory care units. The day case unit consisted of three beds and bathroom and toilet facilities. This was provided through a contract with the local CCG. The unit was used as a single-sex facility. The ambulatory care unit consisted of a number of chairs for patients receiving day surgery or minor procedures. Patients could sit in the unit and recover after their surgery without having to lie in a bed.
- The day case and ambulatory care units were clean, bright and well decorated. They had been purpose built to provide patients with additional facilities to meet their individual requirements post-surgery. At the time of our inspection, the day case unit was not in use.
- Some parts of the hospital environment were dated and presented challenges to staff. For example, the floor in the theatre department was uneven. The floor was not unsafe and the issue was documented on the hospital risk register. There also was no staff room available on the ward.

## Access and flow

- Patients accessed hospital services in a number of ways. Patients could be referred by their GPs, consultants at the local NHS trust, or self-refer. The hospital treated both NHS and self-funded (private) patients.
- Both private and NHS patients were admitted on a planned basis for elective surgery and staff provided care in a timely manner. The admission process and care provided was the same for self-funded patients and NHS patients. There were 2,012 inpatient and day case episodes of care recorded at the hospital in the

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reporting period July 2015 to June 2016. The split between self-funded patients and NHS patients was 51% and 49% respectively for inpatients activity. The hospital did not have a waiting list for private patients requiring surgery. Patients were offered treatment according to their availability, taking into consideration the clinical urgency for the surgery and the need for a 'cooling off' period following consultation. A 'cooling period' is an agreed length of time in which someone can decide on whether to proceed with surgery or not.

- Patients should start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral. The national standard is 92%. For the period July 2015 to June 2016, data showed the hospital performed better than the national standard nine months out of 12 and consistently met the target from November 2015.
- There were staggered admission times for patients to attend for surgery. This meant that any unnecessary waiting for procedures was avoided.
- Admission, transfer and discharge of patients from the ward and theatres were managed appropriately. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements. Dates for surgery were discussed with patients at their initial outpatient appointment. Patients were able to choose to have their operations at times suitable for them.
- From July 2015 to June 2016, three patients had unplanned returns to theatre. We reviewed the incidents of patients returning to theatre and saw the hospital had processes in place to manage these appropriately and in a timely way.
- We observed staff quickly readmit a patient who was in pain following a procedure. Staff provided pain relief and a scan before returning the patient to theatre the same day. The patient told us they were very happy with the response of staff at the hospital.
- Data showed the hospital had cancelled 14 patient procedures from July 2015 to June 2016. However, all 14 patients had been offered another appointment within 28 days of their original appointment date, as per NHS England standard.
- Nursing staff recorded information on patients' additional needs during the pre-assessment visit. They gave patients information leaflets about their planned procedure or treatment during their appointment or the hospital sent the leaflets with their outpatient appointment letter. The information leaflets were written in English only.
- Patient requirements were identified during the pre-assessment appointment and services were planned to meet their individual needs. Staff told us they did not often admit patients living with dementia or patients with a learning disability. However, they were able to describe adjustments they would make for specific individual needs if required, such as additional staffing, simplified written documents and greater collaboration with carers.
- The hospital had a dedicated room for patients living with dementia to use. The room had pictures and signs in large print to help patients find facilities including the toilet. The room had a clock with large numbers so patients could see the time. The toilet had a red toilet seat in-line with best practice guidelines. Staff used red crockery so patients could see their plate. This was also in-line with best practice guidelines.
- The hospital had no materials translated into different languages. For patients whose first language was not English, telephone interpreting facilities were available. There was no information on general display related to the availability of interpreting services. However, when we asked staff how to access this, they could provide the information.
- The hospital ward had a hearing loop installed for patients with hearing impairments using hearing aids.
- The hospital had admission criteria, meaning patients with complex conditions, alcohol dependency, or complex mental health conditions would not be treated at the hospital. Patients with more complex needs would be treated at the local NHS trust. However, staff provided one-to-one support for those patients who required it.
- Each room and ambulatory care unit had radios and televisions to entertain patients before and after their surgery. The ambulatory care unit had a range of

## Meeting people's individual needs

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magazines for patients and their relatives to read. Patient's relatives or friends could sit in the ambulatory care unit while waiting for the patient to return from surgery.

- Staff discussed patients' individual needs and care plan requirements at handovers. For example, staff discussed whether a patient with mobility issues required any extra support prior to discharge. Another example was staff discussing the needs of a patient with diabetes and referral to a dietitian.
- Water jugs were available to all patients in their rooms. We saw and patients told us staff changed these regularly.
- The patients were seen on admission by the ward hostess to take an order for a post-operative meal. These meals were made available in the kitchen ready for the patient on their return. In addition, soup, cheese, biscuits and bread was available in the ward kitchen area for patients. If a patient had a reduced appetite, staff told us the chef would visit the patient and offer alternative food choices as requested.
- The hospital's patient-led assessment of the care environment (PLACE) score for food was 89%. The England average was 91%. Patients we spoke with were positive about the hospital food.
- Pre-assessment consultations included questions about patients' dietary requirements and allergies. Staff gave this information to the external catering company every day to ensure nutritional needs were met.
- We observed staff providing patients information tailored to their needs upon discharge. For example, physiotherapists provided advice on when to drive or what exercises to do at home to help their recovery. Patients requiring any particular help were referred to specialists.
- The hospital had a stair-lift in addition to a lift, so patients with mobility difficulties could access the theatre, which was on the second floor of the hospital.

## Learning from complaints and concerns

- From July 2015 to June 2015, the hospital received 16 complaints. This was lower than the previous year (July 2014 to June 2015) when the hospital received 24. We reviewed the 16 complaints and there were no obvious

trends or themes. For each complaint we saw managers investigated and where appropriate identified learning and actions to change practice. For example, the hospital reviewed patient admission times and discussed procedures with anaesthetist after a complaint about lack of information.

- Patients knew how to raise concerns or complaints. Patients we spoke with said they felt comfortable raising issues with staff. There were a number of methods in which patients could raise concerns or make formal complaints. Patients could raise concerns through the patient satisfaction survey, by telephone, in person, through their consultant or using the Nuffield Health website. We saw complaint information leaflets in each patient bedroom on how to make a complaint.
- If a patient raised a concern, staff said managers empowered them to try to resolve the complaint the moment it was raised. Staff said if they could not resolve it, they would speak to a more senior member of staff to assist. The hospital provided patients with the opportunity to attend a face- to-face meeting if they wished.
- The Hospital Director (HD) had overall responsibility for managing complaints. If the complaint was of a clinical nature, the HD delegated responsibility of investigating the complaint to the matron. Staff logged complaints onto the electronic incident reporting system. We saw the hospital had processes to involve staff in complaint investigations and receive their comments. Once all of the information was gathered, the hospital provided the patient with a written response.
- The hospital's quality and safety meetings, discussed complaints and complaint summaries were distributed to staff via the quality and safety report. The MAC also reviewed complaints and any lessons learned were discussed with heads of departments at quality meetings.

## Are surgery services well-led?

Good 

We rated well-led as good.

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## Leadership/culture of service related to this core service

- The hospital was led by the senior management team (SMT), which consisted of the hospital director, matron, sales and service manager and the finance manager. Each department such as the ward, had a head of department. All staff members we spoke with said that the hospital director and matron were visible and approachable. Staff from all departments including nursing, admin and housekeeping, reported that they felt valued, included and respected by leaders at the hospital. Staff felt that their wellbeing was cared for and described examples of the senior management team supporting them and allowing flexibility to cope with personal problems. Leaders spoke about how proud they were of staff and how well they worked as a team.
- Staff told us during our inspection, they felt supported by the managers and leaders at the hospital. Staff had no concerns approaching their line managers or members of the senior management team if they wanted to raise issues.
- Consultant staff we spoke with said they felt there was sufficient clinical leadership especially through the medical advisory committee (MAC). Consultants we spoke with said they felt they were a part of the hospital and had a good relationship with staff.
- There was a positive culture amongst ward and theatre staff. We observed staff using first names and staff had an appropriate familiarity with each other. Staff laughed and joked with each other and staff demonstrated knowledge of how other staff and teams worked. Staff felt well supported by their colleagues.
- We observed a patients centre culture across all departments we inspected. Most of the staff we spoke with had been at the hospital over two years and were happy working there. Morale was positive and staff said one of the best things about the job was having the time to get to know patients and care for them. One member of staff gave an example of ringing a family member to offer their condolences regarding the passing of a patient known to the service.
- There were examples of senior managers listening to staff suggestions and improvements being made as a result. For example, reception staff had raised concerns that patient confidential information was left unlocked

and unsupervised when reception staff had gone home. The reception staff raised this issue to senior managers and suggested installing a lockable shutter. This was approved and installed within one week.

- Some members of staff said there was a culture of staff feeling unable to challenge consultants in theatres on some issues. However, we did not see evidence of this during our inspection.

## Vision and strategy for this this core service

- The hospital's strategy included playing a vital role in the Herefordshire health community and its surrounding areas. The management team looked to expand the reach of the hospital and deliver services to a wider catchment area. Senior managers we spoke with had a clear vision of how to achieve this, including offering extended support along the patient pathway to include educational events and enhanced recovery. The hospital had an investment case to improve the capacity of diagnostic services. The MAC chair reported that one of the biggest risks to the hospital was lack of capacity. They reported that this was discussed during MAC meeting and it decisions were to be made regarding where to invest in the future.
- The key strategic initiatives were discussed at heads of department meetings, and fed back to operational teams. Senior managers told us the strategy was discussed at SMT meetings and the local board meeting. The board meetings discussed strategic matters and progress towards objectives. Senior managers communicated the strategy and its progress at staff briefings and through team meetings. Most of the staff we spoke with knew about the strategic aim to expand across Herefordshire.
- Underpinning the vision and strategy, were the core values of Nuffield Health corporate group. These were the 'EPIC' values: Enterprising, Passionate, Independent, and Caring. Staff we spoke with knew about the core values and could explain how they related to their role.
- In addition, the hospital had adopted six beliefs they expected staff to demonstrate through their behaviour. These were: 'we believe 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 caring starts



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with listening and we believe in you'. Staff we spoke with could not describe the beliefs. However, from our observations we observed staff behaving in a way that reflected them.

- As part of the health care assistant (HCA) foundation quality care programme, staff wrote about the values and beliefs of the organisation. This meant staff could reflect on what the values and beliefs meant to them.
- The hospital had recently established a quality, safety and clinical strategy and this had been agreed at the MAC. The strategy outlined the framework of the clinical governance agenda and how they met CQC regulatory requirements.
- Staff said the not for profit values of the provider was a key reason as to why they worked at the hospital.

## Governance, risk management and quality measurement

- There was a clear governance structure in place, with committees such as clinical governance, senior management and heads of department feeding into the MAC and SMT. Consultant surgeons were represented at the MAC. The hospital had clear roles and accountabilities and managers we spoke with knew what their responsibilities were. However, the matron who was the safeguarding lead for the hospital, had not completed level three safeguarding children training. This meant that although processes and arrangements were in place we were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for, from abuse. We discussed this with the provider, who explained that they had misinterpreted the Nuffield Health policy. The hospital director, whose role included overall responsibility for the governance of the hospital, would therefore take on the role of safeguarding lead, until the matron had completed the required level of training.
- There was an established governance and risk management strategy with clearly defined roles to support the delivery of good quality care. For example, learning from complaints and incidents was discussed at monthly senior management, MAC and clinical governance meetings. A clinical governance report was compiled each quarter. This was presented and discussed at the MAC meetings. Information was then disseminated at departmental staff meetings.
- The MAC met quarterly and provided clinical advice and guidance. Topics discussed included incidents, complaints and reviews of surgical procedures. Evidence from the meeting minutes showed actions were made and reviewed.
- The hospital monitored its performance through a timetable of audits, incident reporting, patient feedback, risk assessments and gap analysis. Performance indicators were benchmarked against other Nuffield Health hospitals. The hospital monitored trends through the governance framework and reports submitted to the MAC. Senior managers said that through the process of monitoring performance, they could identify the areas where improvement was required. However, we found areas that were not compliant with policy, including that not all required staff at the hospital had completed the immediate life support training. The compliance rate was 68%. However, the provider had arrangements in place to respond appropriately in the event of a clinical emergency and was compliant with requirements in the Nuffield Health group cardiopulmonary resuscitation policy regarding provision of advanced life support trained staff at the hospital and all trained inpatient nurses had completed the immediate life support course.
- There was a focus on clinical governance and senior managers used the wider organisation for support. Quality care partners (individuals from other Nuffield Health hospitals who provided specific expertise and guidance) offered clinical support to the matron and managers and could access organisational leads for specific guidance in key service and risk areas including; medicines management, medical devices, infection prevention, health and safety, theatre and pre-assessment. However, we found areas of poor practice related to medicines management during our inspection, such as medicines drawn up in advance of theatre cases. The provider took actions and this practice was not seen during our unannounced inspection.

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- Processes were in place to ensure clinicians working at the hospital with practising privileges undertook their mandatory training with their primary employer as part of their appraisal system. The MAC chair reported that there was an agreement in place for consultants employed by a nearby NHS trust, to have their appraisals sent electronically to the hospital. Consultants, who did not work at the local NHS trust, were responsible for bringing in their own appraisal documentation.
- All applications for practising privileges were discussed at MAC meetings, which took place quarterly. Practising privileges are the authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital. Practising privileges are limited by the individual's professional license, experience, and competence. The MAC has the authority to advise the hospital director regarding eligibility for practising privileges and for their continuation, suspension, restriction or the issue of any warnings connected with them, in the interests of patient safety. If concerns were raised a wide consultation took place involving management, medical and nursing staff.
- The matron and heads of department reviewed consultant activity every week to ensure the consultants were working within their scope of practice. If any planned activity was identified that was outside of the consultant's usual scope of practice, they would ask for them to provide evidence of competence and experience before carrying out the procedure. We saw evidence of these discussions in practising privileges personnel files.
- Consultants were required to provide evidence of indemnity insurance annually. We saw evidence in MAC meeting minutes and personnel files of practising privileges being suspended until certificates of indemnity had been received.
- The heads of each department were responsible for managing their own departmental risk register. High and moderate risks were escalated to the SMT to be considered if they needed to be incorporated on the hospital risk register.
- Senior nursing and theatre staff could mostly identify the key risks to their service. Many of the risks involved staffing or environmental risks. These risks were on the hospital risk register. Staff had processes to escalate local risks onto the hospital risk register via the matron.
- The provider was engaged with the Private Healthcare Information Network (PHIN) so that data can be submitted in accordance with legal requirements regulated by the Competition Markets Authority.
- Emergency scenario drills took place regularly. We saw that records of the drills outlined the timing of events and the commentary alongside the process taken. However, where learning points and actions were identified to improve, we saw no individual allocated to take responsibility for these or an action log to denote when had been completed. The blood transfusion committee did have a rolling action log, which included learning from other scenarios.

## Public and staff engagement

- The hospital used patient feedback as a source of performance information. This was collected through using patient satisfaction surveys, Friends and Family Test data collection and matron's daily visits to the patients. Patients could easily access information on how to provide feedback. In addition, a patient focus group had been set up in February 2016. Minutes of the meetings (February and July 2016), showed that the patient representatives were involved in assessing patient satisfaction responses and invited to take part in the hospital's patient-led assessment of the care environment.
- Patient compliments were captured by the hospital director's personal assistant and distributed to the heads of departments. If any particular members of staff are mentioned the comments are forwarded to that individual. Any complaint that was made was seen as an opportunity to learn and to ultimately make improvements. Complaints were reviewed to identify any common themes or trends and if so measures were put into place to mitigate them.
- The inpatient ward had a 'you said, we did' information board. The board displayed what hospital staff had done in response to patient feedback. For example, in

# Surgery

response to a patient comment regarding the need for a raised toilet seat after a total knee replacement, staff ensured any patient undergoing this procedure was provided with this.

- Consultant surgeons led daily team brief meetings for surgical teams to discuss the day's theatre list. A scrub practitioner recorded the brief and displayed it in theatre for staff to view.
- Staff felt they were communicated with and said they received regular updates, newsletters and minutes of governance meetings. In addition, departments held regular team meetings and daily handovers. There was a positive culture of staff engagement at the hospital.
- One of the ways in which managers communicated with staff was by using noticeboards. We saw staff noticeboards had key hospital and provider information for staff, including results of patient feedback. Staff said they could find key information on noticeboards.
- The hospital had a six-weekly staff forum where they could discuss and raise issues. Staff representatives attended on behalf of the hospital or department.





- Staff at all levels, were involved in making decisions or influencing service delivery. Consultants we spoke with said the hospital involved them in choosing new anaesthetic machines.
- Staff said they were listened to by the SMT. Staff provided an example of when the hospital director purchased air coolers for the hospital corridors in the summer when they requested them.

## **Innovation, improvement and sustainability**

- Staff were continuously looking for ways to improve patient care. For example, the development of a 'dementia friendly' room on the ward, which had been implemented. Overall, leaders encouraged staff to think of ideas and ways to improve their service.
- The hospital had a capital investment programme, which senior theatre and nursing staff used to improve services for patients. For example, the theatre manager told us about large investments in endoscopy, eye instrumentation and orthopaedic surgical equipment.



# Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are outpatients and diagnostic imaging 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 but cross-refer to the surgery section.

We rated safe as good.

### Incidents

- There were 14 clinical incidents reported within the outpatient and diagnostic imaging services in the period from July 2015 to June 2016. This rate of clinical incidents was lower than the rate of other independent acute hospitals in the same reporting period.
- A never event is a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined. There were no never events or serious incidents reported by the outpatient and diagnostic imaging services from July 2015 to June 2016.
- Staff understood their responsibilities to raise and record safety incidents, concerns and near misses using the hospital electronic reporting system (the system to collect and report incidents). Investigations into incidents took place and lessons learnt were shared with staff at team and governance meetings.

- The hospital had a process in place to ensure radiation incidents were reported as required under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). One incident of unnecessary radiation exposure had been reported by staff and the radiology manager had investigated the incident thoroughly. Additionally, we saw the patient had been informed in line with duty of candour regulations.
- Staff were able to tell us about the duty of candour regulations, which state that as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

### Cleanliness, infection control and hygiene

- The outpatient and diagnostic imaging department's main reception areas, clinic rooms and waiting areas were visibly clean, tidy and free from clutter.
- There was hand sanitiser gel available at the main reception of the hospital and throughout the outpatient and diagnostic imaging departments for staff and patient use. We observed both patients and staff using these on entry to the hospital and the outpatient and diagnostic imaging departments.
- In the reporting period July 2015 to June 2016, there had been no reported cases of healthcare-associated infections, such as MRSA, Clostridium difficile (C. difficile) or, Meticillin Sensitive Staphylococcus Aureus (MSSA) for the outpatient and diagnostic imaging departments.

# Outpatients and diagnostic imaging

- Staff complied with hospital policies regarding infection prevention and control. This included 'arms bare below the elbow' and hand washing policies.
  - Hand hygiene audits were carried out each month in outpatients and diagnostic imaging departments. Compliance for the period from May to July 2016 was 95% to 100%.
  - The outpatient department achieved around 95% for their monthly cleaning audits. However, a departmental audit score of 90% was recorded for July 2016. Two consulting rooms were rated as being below the cleaning standard of 100%. We saw that actions had been taken to address the shortfall in high dusting and cleaning of door furniture in the two consulting rooms.
  - The cleaning and decontamination of naso-endoscopes (an instrument used to view the larynx) was undertaken in theatre. This process was compliant with the Health Technical Memorandum HTM 01/06 management and decontamination of flexible endoscopes (Department of Health March 2013). Therefore, the hospital had ensured reliable systems were in place to prevent and protect people from healthcare-associated infection.
  - Armchairs in the two outpatient waiting areas could be wiped clean, but not in the diagnostic imaging waiting area. Non-wipe chairs were in place in the majority of consulting rooms in the outpatient and diagnostic imaging departments. The outpatient lead said there was a replacement programme in place and we saw evidence of this. Steam cleaning was also in place for equipment that was difficult to clean (including non-wipe chairs). We saw evidence that steam cleaning was undertaken six monthly. During our inspection, the provider moved wipe-able chairs into the consultation rooms to reduce infection control risks.
- made reasonable adjustments. For example, closing the reception office door whenever possible to improve privacy. Plans were in place to redevelop the radiology service in 2017.
- There were suitable safety arrangements in place in the diagnostics area to restrict access where x-ray and imaging equipment was in use. This included warning signs for patients and staff. There was specialist personal protective equipment (PPE) available for staff in all rooms.
  - Computerised tomography (CT) and magnetic resonance imaging (MRI), were provided by a third party provider through a service level agreement (SLA).
  - An external provider performed servicing and maintenance of diagnostic and screening equipment. The radiology department maintained an inventory of equipment, including replacement dates as required by IR(ME)R.
  - Radiology staff all wore individual dosimetry badges that monitored cumulative radiation. The individual dosimeters were read by an external company every month to ensure levels were not harmful to staff.
  - Fluoroscopy equipment was 17 years old and was rarely used due to changes in radiology practice. The equipment was well maintained and deemed fit for purpose and recorded on the hospital risk register. Replacement equipment in line with the redevelopment of the radiology service was planned for 2017.
  - Resuscitation equipment was available in the outpatient department. Risk assessments had been undertaken to enable staff to support patients requiring emergency treatment in diagnostic imaging (CT). Scenario based training sessions enabled staff to use resuscitation equipment appropriately in an emergency. The resuscitation trolley was tamper evident and emergency equipment and medicine boxes were locked in line with hospital policy. Staff clearly documented daily equipment checks.
  - Flooring in five of the consulting rooms in the outpatient department was non-compliant with Health Building Note (HBN) 00/10 Part A Flooring (Department of Health 2013) 2.9. This stated that there should be a continuous return between the floor and the wall, for example covered skirting with a minimum height of 100mm for

## Environment and equipment

- The radiology department was small and in need of reconfiguration and modernisation. The reception waiting area, backed onto two patient changing cubicles. These were not sound proofed, which could compromise patient dignity and confidentiality. Staff were aware of the limitations of the department and

# Outpatients and diagnostic imaging

easy cleaning. In the non-compliant areas, there were gaps in skirting boards and no covered edges and therefore may make cleaning less effective and could be a collecting point for bacteria. We spoke with the outpatient lead at the time of the inspection and were advised they would enter this issue onto the risk register and inform the operational manager.

- There were tears on the covers of two examination couches in consulting rooms in the outpatient department. We spoke with the outpatient lead that removed the couches from the clinical areas and replaced them with couches that were intact. This ensured the risk to patients was mitigated, as tears could allow a collecting point for bacteria.
- Staff were not always complying with the Safer Sharps EU Council Directive 2013, which is a directive implemented to prevent sharps injuries in the healthcare environment. Staff were unable to re-sheath needles used for some clinical procedures in the outpatient department, as re-sheathable needles were not in stock. The sharps bin on the resuscitation trolley was not labelled to allow traceability when disposing of sharps. This was raised with the outpatient lead who immediately ordered re-sheathable needles and labelled the sharps bin.
- PPE, including gloves and aprons were available in all of the outpatient consulting areas and were stored in a way that enabled staff to access them easily.

## Medicines

- There were effective arrangements in place in the outpatient department and diagnostic imaging department for managing medicines, including recording, handling, storage and safe administration.
- Medicines that required refrigeration in the outpatient department were stored in a locked refrigerator and keys were held by the nurse in charge. Temperatures were checked and recorded daily.
- Medicines were stored in a locked cupboard in the treatment room in the outpatient department. However, a patient had complained that staff needing access to the medicines had interrupted their treatment. The outpatient manager had responded to the complaint by storing additional medicines in a second locked

cupboard in another area of the department. This demonstrated the hospital responded to the needs of patients and learned from complaints and made changes to systems when required.

- Prescription pads used by consultants were stored in a locked cupboard and allocated to consultants on request. When there were no more prescriptions required, the pads were returned to the hospital pharmacist for storage.
- Radiologists prescribed all contrast media used for scanning procedures and this was stored in a locked cupboard, in the diagnostic imaging department.

## Records

- Health care records were paper based. We reviewed eight sets of health care records and found they were accurate, complete legible and up to date.
- Medical records were stored securely in office areas with keypad entry during clinic times and locked away overnight.
- Private patient referrals were sent directly to the consultant. Consultants treating privately funded patients at the hospital maintained their own notes. This was in line with the hospital's health information risk framework. We were told if the referral letter for a private patient was not available for the outpatient clinic a copy would be obtained from the patients GP.
- NHS healthcare records were sent to the hospital from the local NHS trust and were retained until discharge. All NHS health care records were already integrated to ensure all aspects of patient's care was documented.
- Health care records (Nuffield Health Hereford) were compiled and included a referral letter available for their attendance at the outpatient clinic. If the patient was previously an inpatient at the hospital (Nuffield Health Hereford) or had undergone an outpatient procedure, their Nuffield Health healthcare record would be available from medical records.
- All Nuffield Health healthcare records were retained at the hospital in the medical records department, or at a secure facility managed by a third party provider. When health care records were removed from medical records, a tracer card system was in place detailing who had accessed them.

# Outpatients and diagnostic imaging

- Radiology records and reports were accessed via the electronic radiology reporting system.
- The hospital was working towards fully integrated patient records in outpatients. The hospital had a plan in place to move all consultants to hospital integrated notes and 20% of the patients seen in outpatients (Nuffield Health) had integrated notes.
- The outpatient lead told us that patients were seen in the outpatient department with the relevant medical records. Patient's notes were audited and there were no incidents of missing notes reported.
- Nuffield Health medical records covering 18 months of the patients care episode remained on site. Records past 18 months, were transferred to a secure storage facility off site.
- Any breaches in information security were reported using the electronic incident reporting system. Information governance was a rolling agenda item at the hospital's information governance committee.

## Safeguarding

See information under this sub-heading in the surgery section.

- There had been no safeguarding concerns reported to the Care Quality Commission from July 2015 to June 2016.
- An electronic learning management system enabled staff to complete training at level one for safeguarding children and young people and adults. The radiology manager and the outpatient lead informed us that they were trained to level two safeguarding for adults and children. However, evidence of this was requested but not provided.
- Staff in outpatients and diagnostic imaging were up-to-date with level one adult and children safeguarding training. Attendance rates were 100% in October 2016.
- The hospital lead for safeguarding was the matron. The Nuffield Health policy required the safeguarding lead for the hospital to have completed safeguarding children level three training. However, the matron had completed level one safeguarding children training. This meant that while there were processes and arrangements in place to safeguard people from abuse

that reflected relevant legislation and local requirements and staff knew how to recognise and report a safeguarding incident. We were not assured that staff were trained to the appropriate level for their role in order to protect children associated with the adults they were caring for, from abuse. We discussed this with the provider, who explained that they had misinterpreted the Nuffield Health policy. The hospital director was trained to level three for safeguarding children. The hospital director would therefore take on the role of safeguarding lead, until the matron had completed the required level of training.

## Mandatory training

- The hospital delivered mandatory training using a combination of on-line electronic learning packages and face-to-face learning. The training included basic life support, infection prevention and control, manual handling, fire safety and information governance.
- Staff compliance with mandatory training required for their role in outpatients and diagnostic imaging was 100% in October 2016. Staff in radiology and imaging undertook role specific training, such as competencies on radiation protection, which was a mandatory requirement for the service.

## Nursing and radiology staffing

- All staff we spoke with and the rotas we checked confirmed there were sufficient nursing and radiology staff to deliver care safely and we observed this to be the case throughout the inspection.
- The use of bank and agency nurses in the outpatient department was lower than the national average of other independent acute hospitals from July 2015 to June 2016. There was no use of bank and agency health care assistants in the outpatient department in the same reporting period. Records showed no agency nurses were used in the outpatient department in the last three months of the reporting period July 2015 to June 2016.
- There were no nursing vacancies in the outpatient department. Two part time nurse posts had recently been recruited to provide additional support to the pre-assessment service for patients undergoing elective procedures to assess their fitness for treatment.

# Outpatients and diagnostic imaging

- The outpatient department did not use a patient acuity tool to assess the staffing needs in this service. The outpatient department lead told us they reviewed patient' dependency and staffing levels in advance and throughout the day to ensure patient's needs were met.
- In the outpatient department, there were 7.2 full time equivalent staff including a lead nurse, registered nurses and health care assistants. The ratio of registered nurse to health care assistant was two to one.
- Sickness rates for outpatient nurses were similar to the average of other independent acute hospitals for the reporting period July 2015 to June 2016.
- Sickness rates for outpatient health care assistants were varied when compared to the average for other independent acute hospitals in the same reporting period. Sickness rates were from 10% to 25% and were notably higher than the average in September 2015, January 2016 and March 2016. There were no staff vacancies for outpatients as at 1 July 2016 and no staff turnover for outpatient nurses and health care assistants in the reporting period June 2015 to July 2016. The outpatient lead had addressed the sickness issues within the small team of health care assistants and there had been no recurring issues.

## Medical staffing

See information under this sub-heading in the surgery section.

- Consultants arranged their clinics and planned appointments with the administrative staff.
- If required consultants in outpatients or the resident medical officer would be available in emergencies.
- Nursing staff reported a good working arrangement with the medical staff and staff worked as a team to provide care and treatment.

## Emergency awareness and training

See information under this sub-heading in the surgery section.

- There were emergency procedures in place in the outpatient and diagnostic imaging departments

including call buzzers to alert other staff in the case of an emergency. Resuscitation equipment was available and nursing and radiology staff had undertaken immediate life support training.

- Effective arrangements were in place in case of a radiation or radioactive incident occurring.
- Nurses and radiographers in the outpatient and diagnostic imaging team were part of a hospital wide response in the event of a patient collapse or emergency of a patient, relative or member of staff.
- Staff were allocated emergency responsibilities from the duty rotas by the outpatient and radiography leads. This was indicated using a red dot against staff names and recorded on a white board that was clearly displayed in the outpatient and diagnostic imaging departments. Staff attended scenario-based training on the management of emergency procedures. For example, performing cardiac pulmonary resuscitation. Staff received feedback on their performance, which enabled them to improve their practice in an emergency.
- Staff monitored patients following their outpatient treatments, providing one to one care when required.

## Are outpatients and diagnostic imaging services effective?

We inspected but did not rate effectiveness for this service.

## Evidence-based care and treatment

- Care delivered by the departments was in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. Staff told us they were able to access national and local guidelines through information held in the outpatient and diagnostic imaging departments and via the hospital intranet.
- NICE guidance was routinely discussed and reviewed at hospital quarterly clinical governance meetings. For example, in the minutes of the meeting in June 2016, NICE NG45 routine preoperative tests for elective surgery were identified as a best practice recommendation for the preoperative assessment of patients undergoing elective surgery. The actions required to implement NICE NG45 into the pre assessment clinics in outpatients, were recorded in the minutes.



# Outpatients and diagnostic imaging

- Staff involved in diagnostic imaging, demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) to protect patients from the risks of unnecessary exposure to radiation. The radiographers were involved in monthly clinical audits, including patient identification, consent and records of previous imaging and compliance with IR(ME)R.
- Standard radiological protocols were in place to ensure patients underwent the same (optimised) procedure. Protocols were maintained in the department through a combination of written protocols, exposure charts and the use of equipment programmes.
- Patient radiography dose reference level (DRL) audit software was in use and local DRLs had been established and were within national DRLs. The annual rejection rate was 2%, which was within acceptable limits (less than 3%). The Radiation Protection Supervisor (RPS) audited these levels.
- Local diagnostic reference levels were available (normal expectations for dose levels) in the diagnostic imaging department. However, there were no indications for staff as to the recommended thresholds (relative to the reference levels) at which excessive doses should be reported. This was raised with the radiology manager at the time of the inspection, as it is recommended that displaying the thresholds would assist and remind radiographers. This was addressed during our inspection.

## Pain relief

- Patients who attended clinic for pre-operative assessment, were given pre-operative information, including information about pain relief and managing their pain.
- None of the patients we spoke with required pain relief during our inspection. Staff told us that they would escalate any concerns around pain relief to the resident medical officer (RMO).

## Nutrition and hydration

- Generally, patients were not in the department for long periods so food was not provided. Patients who attended clinic or diagnostic appointments were able to

access hot and cold drinks in the reception area of the hospital. Patients and visitors were able to access the dining room at the hospital, which served hot and cold meals, snacks and beverages.

- Patient's nutrition and hydration needs were assessed as part of the pre-assessment process for patients undergoing elective surgical procedures and outpatient clinic treatments.

## Patient outcomes

- Information about the outcomes of people's care and treatment were routinely collected and monitored in outpatients and diagnostic imaging services. For example, audit, internal and external assessments, patient reported outcomes and feedback from patients and service users.
- The hospital submitted data to the National Joint Registry and patients were asked to consent to being included at pre-assessment clinics in the outpatient department. Data was then submitted following surgery.
- The outpatient department supported the hospital in providing patient reported outcome measures (PROMs) through the surveillance of infections following joint replacement surgery. We saw evidence of telephone contact made with patients 30 days after they had undergone joint replacement surgery at the hospital. Adverse outcomes were reported using the electronic incident reporting system, so that any trends could be identified.
- Audits undertaken in diagnostic imaging demonstrated good outcomes for patients in the reporting period April to June 2016. For example, 100% of patients had been consented for treatment, all eight points of the IRMER checks were completed for radiological examinations and radiographers had completed 100% of justifications for patients to undergoing x-rays.
- The diagnostic imaging department did not participate in the Imaging Services Accreditation Scheme or Improving Quality in Physiological Services.

## Competent staff

# Outpatients and diagnostic imaging

- Competency assessments were completed by staff and available in the outpatient and imaging departments. For example, competency documents were completed for pre-assessment clinics, outpatients and for radiology procedures in the imaging department.
- We saw evidence that staff had received an annual appraisal in outpatient and imaging departments to support their clinical development.
- Data provided by the hospital showed that from April 2015 to June 2016, 100% of nursing and medical staff were appropriately registered with their professional body. This meant the hospital conducted checks to make sure the nurses and doctors were registered with the Nursing and Midwifery Council or the General Medical Council.
- Consultants were required to provide evidence of appraisals and revalidation as part of their practising privileges (PPs). A database was maintained and was reviewed by the medical advisory committee and the clinical governance committee. The outpatient department lead and radiology manager were aware of PPs arrangements in place for their service, and where necessary would raise concerns with the hospital director.
- In diagnostic imaging, the radiography manager was trained as the Radiation Protection Supervisor (RPS). The role monitored and secured compliance with legislation set out under IR(ME)R. A second radiographer deputised for the manager and was undertaking training in the RPS role.
- The diagnostic imaging service worked closely with GPs to ensure compliance of requests for radiological examinations set out by the Royal College of Radiologists. The need for appropriate referral was promoted through GP meetings, attended by a radiographer from the diagnostic imaging department.

## Seven-day services

- The outpatient department was open from 8am to 8pm, Monday to Friday. Outpatient services were not usually provided at weekends. However, consultants would provide a consultation only service on Saturdays, if patients needed this. If for example, a patient could not drive in the evenings or attend on weekdays.
- X-ray and diagnostic imaging services were available from 8am to 5pm, Monday to Friday, with on call services outside of these hours.
- Physiotherapy services were provided by Nuffield Health and were available from 8am to 5pm, Monday to Friday. Evening appointments were available until 8pm on Mondays and Wednesdays, with on call services outside of these hours.

## Access to information

- Hospital staff received medical information from GPs for NHS funded patients as part of the referral process via the NHS e-Referral Service. 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.
- The outpatient lead reported there were no incidents of patients seen in outpatients without relevant medical records being available.
- X-ray and diagnostic imaging results were available electronically, which made them readily available to staff in the outpatient clinics.
- Results for routine x-rays and magnetic resonance imaging (MRI) were available within two working days.
- Information was exchanged via letters between GPs and hospital staff. An incident was reported concerning a discharge letter, which had been sent to the incorrect GP practice in the reporting period April to June 2016.

## Multidisciplinary working

- Outpatient and diagnostic imaging department's staff worked with speciality teams across the hospital and local NHS providers to plan and deliver patients' care and treatment. Staff reported good multidisciplinary working with access to medical and physiotherapy staff as required.
- Examples of multidisciplinary working in the department were given. For example, physiotherapists were asked to see a patient in outpatients with mobility issues, which was not the reason for their clinic attendance. This was accommodated and the physiotherapist assessed the patients' needs and put an appropriate treatment plan in place.



# Outpatients and diagnostic imaging

Following this incident, the hospital reviewed the patient information arrangements to ensure the correct GP surgery was recorded on the hospital's electronic patient information system.

- Previous images of patients were always accessed prior to new exposures being undertaken and 95% of patients previous images were held by the local NHS provider meaning the arrangement worked well. However, facilities for image exchange with another NHS provider (close to the geographical border) were not available. Issues were being addressed with the hospital director and the NHS provider. Arrangements were in place to forward patient information in line with information governance arrangements to enable patient's radiology status to be assessed prior to committing to new exposures.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatient and diagnostic imaging services were able to describe the relevant consent and decision making arrangements relating to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards and understood their responsibilities to ensure patients were protected.
- We saw evidence that staff had received training about the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and dementia awareness.
- Nursing, diagnostic imaging and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients. We observed radiographers, nurses and health care assistants following the hospital policy regarding consent. Patients consent was obtained before procedures were undertaken for example, scans and clinical procedures in outpatients.
- We reviewed eight patients' records during our inspection. All records showed consent was signed prior to procedure in line with the hospital's consent policy.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as good.

### Compassionate care

- Patients were extremely positive about the care and treatment they received in the outpatient and diagnostic imaging departments.
- The outpatient department received feedback via patient satisfaction surveys, verbally during outpatient clinics and diagnostic imaging procedures and through the complaints process. Outpatients participated in the NHS Friends and Family Test (FFT) and collected monthly patient feedback and comments using a local patient satisfaction survey.
- Feedback from patients from comment cards, monthly outpatient and diagnostic imaging surveys and the Friends and Family Test, identified that 92 to 100% of respondents would recommend the service to friends and family.
- Overall, patient satisfaction scores for the local outpatient survey were rated from 92% to 94% in the reporting period from May to July 2016. Pre-assessment, physiotherapy and radiology services were rated from 92% to 100% for the same reporting period.
- We saw and were told by patients, all staff working in outpatient and diagnostic imaging services, were kind, caring and compassionate at every stage of their treatment. We observed reception staff greet patients in a courteous and friendly manner and directed them to the appropriate waiting area.
- Patients who arrived at reception stood in a queue before they were called forward to the reception desk. This reduced the risk of confidential information being overheard when patients were asked to confirm their personal details.
- Reception staff described that in situations where there was a need for privacy or if a patient appeared distressed, there were areas they could use for greater privacy.

# Outpatients and diagnostic imaging

- Patients were provided with the option of being accompanied by a friend or relative during consultations. Clinics that involved examinations that were more intimate had a nurse assigned to support the patient throughout the procedure. This was recorded on a chaperoning label signed by the consultant, and placed in the patient's records. These ensured chaperoning arrangements were in line with patient choice and were clearly documented. A patient, chaperoned by a nurse said, "the nurse was totally professional, ensured my dignity was maintained whilst still being reassuring and kind".
- Without exception, patients reported that; they found staff to be polite, friendly and approachable.
- Patients told us "everybody is so friendly, that's what makes the difference, it's the attitude" and "staff are very, very good, very helpful, they're lovely, they do everything they possibly can".
- We observed that radiology staff introduced themselves to patients when they arrived in the department. A patient said, "Everyone put me at my ease and I was seen promptly. The consultant explained everything to me clearly. The radiographer was very attentive and put me at ease".
- Patients' comments included "friendly caring nurses and an excellent surgeon" and "fantastic, kind, considerate and respectful appointment" and "wonderful treatment from all nursing staff". The survey demonstrated that patients in receipt of outpatient services rated the care they received as being good or very good.

## Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment. One patient told us they "could not fault their treatment, I've always felt they answered all our questions and I was able to make an informed decision".
- Patients understood when they would need to attend the hospital for repeat investigations or when to expect a follow up outpatient appointment. One patient told us that the hospital had been "really good at rearranging appointments around my holiday and changed appointments had been confirmed in writing".

- We observed that reception staff checked that patients knew which clinic they were attending and the consultant they were going to see.
- We observed many examples of compassionate care during the inspection, including a nurse on the telephone being very patient, empathetic and reassuring. Patients told us that staff were good at explaining procedures or examinations before they were asked to consent to them being carried out.

## Emotional support

- A patient described being given emotional support during a clinical procedure in outpatients. The patient said, "I was given lots of reassurance and support by the nurse who explained the procedure in detail and answered any questions and concerns I had. The consultant was very kind and the nurse held my hand throughout the procedure. I can never thank the hospital enough for staff who were so kind and supportive to my needs".
- Patients told us they were supported by the nurses and consultants if they were worried about their test results and were given the necessary time and support they required.

## 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 outpatients department covered a wide range of specialities including, orthopaedics, general surgery and ophthalmology. Consultants would provide a consultation only service outside of normal operating hours, on Saturdays, if patients needed this. If for example, a patient could not drive in the evenings or attend on weekdays.
- The outpatient department had five consulting rooms, a small treatment room for minor procedures, an eye suite and two pre-assessment rooms.

# Outpatients and diagnostic imaging

- The diagnostic imaging department had ultrasound, x-ray, digital mammography and a visiting magnetic resonance imaging (MRI) and clinical tomography (CT) service provided by a third party health care provider.
- The environment in the hospital was comfortable for patients and visitors. There was sufficient seating in the two waiting areas and drinks and snacks were available.
- Car parking on site was free. Signage throughout the hospital was clear and easy to follow.
- Figures for outpatient and diagnostic imaging 'did not attend' (DNA) rates were routinely collected by the hospital. From May to October 2016, there were 257 patients (approximately 3%) that DNA for outpatient appointments. Of the patients who DNA, 209 (2.5%) were for NHS and non-privately funded clinics, and 43 (0.5%) were privately funded patients.
- The hospital kept a log of cancelled clinics and appointments. This meant the hospital were able to monitor the reasons why patients DNA, or why clinics were cancelled and were able to make any necessary changes if they were required. We were told that there were low numbers of cancelled clinics.
- Patients who DNA, were contacted following the booked appointment and another appointment was arranged with them.

## Access and flow

- There were 16,666 outpatient attendances from July 2015 to June 2016; of these 29% were NHS funded and 71% were other funded.
- Patients accessed NHS services via a GP referral through the NHS e-Referral Service, or via direct referral for private or/self-funding patients or via their healthcare insurer.
- The national standard for referral to treatment time (RTT) for NHS patients states, 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. Data from the hospital, showed from July 2015 to June 2016, the hospital were performing above the 95% standard for RTT and therefore meeting the national standard.
- The hospital was meeting the target of 92% of patients on incomplete treatment pathways waiting 18 weeks or less from time of referral to being seen from July 2015 to June 2016.
- The hospital had no patients waiting six weeks or longer from referral for MRI, CT or non-obstetric scans in the period from July 2015 to June 2016.
- Patients told us throughout the inspection, that there were minimal waits for outpatient clinics. A patient said, "I didn't have time to drink my coffee I was called so quickly" and another said "my appointment was very quick today and I have never had to wait more than 10 minutes for previous outpatient appointments".
- The hospital audited patient waiting times after arrival. They found no patients waited more than 30 minutes. If clinics were delayed, patients were informed and offered the opportunity to wait or to reschedule the appointment.

## Meeting people's individual needs

- Information leaflets were available to patients regarding their treatment. Staff either sent leaflets in appointment letters or gave them to patients to take away. Leaflets were printed in English. These were not available in other languages but could be accessed if required
- There was a chair available in one of the two outpatient waiting areas for patients who were obese. We were told if patients required specialist equipment, the hospital would arrange for the equipment to accompany the patient whenever possible. However, we noted the internal doorway to the eye suite could only just accommodate a wheelchair.
- The radiology manager told us that a patient with a long term clinical condition had required a radiological procedure at the hospital. The imaging department worked closely with the patient, their family and the clinical nurse specialist who supporting their care at home. The patient's own equipment was utilised and the procedure was carried out successfully. This had enabled the patient to undergo treatment in their local area instead of travelling to another NHS provider 150 miles away.
- Staff told us a service level agreement with a third party provider was in place for the provision of translation services and staff knew how to access the service.
- Staff in outpatients and diagnostic imaging departments, had received training to support patients

# Outpatients and diagnostic imaging

with a diagnosis of dementia, memory problems and a learning disability. Staff provided additional support to patients. Staff would contact the patient, their family or carers in advance of the appointment, to arrange a suitable time for the patient to visit and to identify any complex needs they may have. This also helped to minimise any unnecessary stress or anxiety to patients when attending the services.

- Staff described how they referred patients to colleagues during appointments if an additional opinion was required. For example, to the physiotherapist. This reduced the need for patients to return for other appointments.
- The diagnostic imaging service provided rapid access to breast screening services in the radiology department. This enabled women over 40 years of age, with no breast symptoms and who had not undergone a mammogram within the last 12 months, to have a breast scan. Women were able to book a mammogram within seven days and results were reported directly to them within two working days.
- Women with concerns about possible breast cancer symptoms were advised by the service to book an appointment with their GP or a consultant.
- A chaperoning policy was in place in the outpatient department. This person acted as a safeguard and witness for patients or healthcare professionals during medical examinations or procedures.
- Patients' needs were assessed prior to planned surgery and invasive clinical procedures at pre-assessment clinics in the outpatient department. Patients were assessed by a nurse or health care assistant trained in pre-assessment standards, in line with national guidance (National Institute for Health and Care Excellence). The hospital did not routinely collect pre-assessment data. However, approximately 10 to 12 patients attended pre-assessment clinics each day. Staff had raised concerns around the growth of the service and we noted additional staff had recently been recruited to the outpatient team.
- There was no anaesthetic consultant lead for the pre-assessment service. This had resulted in a lack of clarity around anaesthetic support to patients undergoing surgical procedures, which could incur delays to patients. For example, where an anaesthetist

had not been identified at pre-assessment, a date for the proposed surgery could not be agreed with the patient. An action plan was in place, monitored by the outpatient lead and Nuffield Health pre-assessment lead.

## Learning from complaints and concerns

See information under this sub-heading in the surgery section.

- Notices in the outpatient and diagnostic imaging departments informed patients of how to raise an issue or make a complaint. The patients we spoke with said they would discuss a complaint with the consultant or nurse in charge if they needed to.
- Staff were aware of the hospital's complaints policy and were able to advise patients on how to complain. They would however, try to resolve the complaint at the time if appropriate.
- We saw evidence in minutes of clinical governance meetings of investigations and changes in practice that had taken place following complaints. For example, the provision of an additional medicine cupboard in outpatients ensured that staff, no longer interrupted patients undergoing procedures in the treatment room. This demonstrated that suitable governance arrangements were in place to facilitate learning from complaints.

## Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as good.

## Leadership and culture of service

See information under this sub-heading in the surgery section.

- Outpatient and diagnostic imaging services were led by the outpatient lead and the radiology manager.
- We found the leadership of outpatients and diagnostic imaging services were good overall. Although there were some issues in the departments. For example, non-compliant flooring in outpatient consulting rooms

# Outpatients and diagnostic imaging

and inconsistencies around the Safer Sharps EU Council Directive 2013. We raised these concerns during the inspection and found that leaders were responsive. During our announced inspection, where it was possible to do so, issues had been addressed by the outpatient lead and outstanding actions were clearly documented on an action plan.

- Staff told us and we saw that outpatient and diagnostic imaging departments were well-led. Staff said senior managers were approachable and supportive and the matron and lead director visited the departments daily. Senior managers worked closely with staff to address issues or concerns. For example, involving the radiology manager in developing plans for the reconfiguration and modernisation of the radiology department in 2017.
- Staff spoke positively about working in the hospital and described an open culture with an emphasis on delivering the best possible care to patients.

## Vision and strategy for this service

- We found there was no specific strategy for the outpatient and diagnostic imaging departments. However, the corporate group Nuffield Health had a vision and strategy they referred to as 'EPIC' values. These involved staff being enterprising, passionate, independent and caring. The outpatient lead and radiology manager spoke of a culture of quality and continuous improvement for services provided to patients and staff.
- Staff expressed an ethos of working together for a quality service for patients. However, not all staff quoted the EPIC values.

## Governance, risk management and quality measurement

See information under this sub-heading in the surgery section.

- The outpatient lead and radiology manager participated in monthly clinical governance meetings, which gave each department an opportunity to discuss relevant governance issues. For example, incidents, complaints, infection control issues and hospital risks.

- Outpatient and diagnostic imaging departments carried out a series of audits. For example, medical records, hand hygiene, cleaning audits the pre assessment tool and waiting times audit. Results of audits and action plans were reviewed at the relevant meetings and staff changed processes to address issues that had been highlighted. For example, cleaning audits in outpatients did not meet the hospital standard of 90% and were categorised as being a medium risk. Issues were immediately addressed and were re-audited within a month. We saw evidence of improvement in the outpatient departmental action log.

## Public and staff engagement

- Staff spoke highly of the flexibility offered by the hospital. Examples given included the support given to staff when returning to work from a period of sickness and being supported when coming back to work from having a child.
- Sickness rates for outpatient nurses were similar to the average of other independent acute hospitals (IAH) for the reporting period July 2015 to June 2016.
- Feedback from patients comment cards, monthly outpatient and diagnostic imaging surveys and the Friends and Family Test, identified that 92% to 100% of respondents would recommend the service to friends and family.

## Innovation, improvement and sustainability

- The radiology department was very small and was in need of reconfiguration. The service was only able to provide magnetic resonance imaging (MRI) services two days a week and clinical tomography (CT) services one day a week. The radiology manager told us they were involved in developing the business plan to develop diagnostic imaging facilities and building work was planned for 2017.



# Outstanding practice and areas for improvement

## Outstanding practice

- Patients told us how staff treated them with kindness and dignity and consistently went the extra mile to meet their needs. Patients were truly respected and valued as individuals and were empowered as partners in their care. A patient told us that the service was “excellent, (they had) been here six times and would choose to come here every time.”
- Staff worked in partnership with patients and showed determination and creativity to overcome obstacles to delivering care. For example, the matron and the team worked closely with a patient with anxiety issues to empower them to attend and undergo surgery. This included the matron attending the pre-assessment appointment and involving the patient in developing a plan for their admission. We could see from the healthcare record that the patient successfully attended for the procedure and had an uneventful stay.
- The radiology manager told us that a patient with a long-term clinical condition had required a radiological procedure at the hospital. The imaging department worked closely with the patient, their family and the clinical nurse specialist who supporting their care at home. The patient’s own equipment was utilised and the procedure was carried out successfully. This had enabled the patient to undergo treatment in their local area, instead of travelling to another provider, 150 miles away.

## Areas for improvement

### Action the provider SHOULD take to improve

- The hospital should ensure that staff complete the appropriate level of safeguarding children training in order to protect children associated with the adults they were caring for, from abuse.
- The hospital should ensure that all required staff complete the appropriate training in immediate life support, to ensure they could respond appropriately in the event of a clinical emergency.
- The hospital should ensure flooring in all clinical areas is in line with health building regulations.
- The hospital should ensure clinical hand wash sink provision on the ward, is in line with health building regulations.
- The hospital should ensure the replacement programme for non-wipe chairs is completed in outpatients and diagnostic imaging.
- The hospital should ensure recommended thresholds (relative to the reference levels) at which excessive radiation doses should be reported are clearly displayed in the diagnostic imaging department.
- The hospital should ensure that there are safe and effective systems in place for medicine management including preparation, stock checks and intravenous fluids stored securely.
- The hospital should ensure a lead anaesthetist is identified for the pre-assessment service.
- The hospital should ensure consistent use and documentation of the World Health Organisation’s safer surgery checklist.