Nuffield Health Cheltenham 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?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection as part of our programme of independent healthcare inspections under our new methodology. The comprehensive inspection was carried out through an announced visit on 15 and 16 March 2016. We did not carry out an unannounced inspection.

Our key findings were as follows:

We rated the hospital as good overall, with surgery, rated as good in all domains, children and young people's services and outpatients and diagnostic imaging services were also rated good in all domains except for effective which we did not rate due to insufficient evidence being available.

Are services safe at this hospital/service

- Most staff spoke confidently about the duty of candour and training had been provided in some cases. However some staff were not familiar with the term duty of candour. Staff we spoke with confirmed they informed and apologised to patients when care was not as it should have been.
- Safeguarding practices were clear and staff were aware of the actions needed if they had concerns. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures. There had been no safeguarding concerns relating to adults or children reported to CQC between October 2014 to September 2015.
- The systems in place to monitor patient safety including the World health Organisation (WHO) checklist were mostly in place and well managed.
- The service had a good reporting culture for incidents and took learning from those and incidents which were reported at other Nuffield hospitals. Quarterly governance meetings were held which were attended by representatives of each department and reported incidents were discussed.
- Each patient's consultant was the overall person in charge of their care and undertook any post treatment reviews. Out of hours the consultant was called if needed and we saw when this had taken place. In the interim the Registered Medical Officer (RMO) was available to provide medical support should the consultant not be available. An escalation procedure was in place for nursing staff to escalate to the RMO and for the RMO to escalate to the consultant for the patient.

Are services effective at this hospital/service:

- Treatment was provided in line with national guidance and staff were aware of the relevant National Institute for Health and Care Excellence (NICE) guidance. Policies and procedures were in place to support staff and were monitored to ensure a consistency of practice.
- Reviews took place of the effectiveness of surgical procedures. The reviews took place through the Medical Advisory Committee meetings which took place quarterly where issues, incidents and clinical outcomes were reviewed to ensure good practice.
- The Hospital participated in the Patient Led Assessment of the Care Environment (PLACE) audit annually which was undertaken by 'expert' patients provided by the Health and Social Care Information Centre together with the Hospital's Infection Prevention Coordinator.'

  The hospital's PLACE scores were the same or higher than the England average for cleanliness, dementia, food, privacy, dignity and wellbeing.

Summary of findings

- Some information about patients care and treatment and their outcomes was collected and monitored. There was not always sufficient data to submit to national audits. Local audits were undertaken using a system called GOV14 to review 20 patient records per quarter for venous thrombo embolism (VTE), falls, catheter care and monitoring of the WHO checklist. Local audits were carried out in diagnostic imaging for example monitoring the quality of plain film x-ray results and levels of radiation that staff experienced while carrying out their duties. Cleaning audits were in place to ensure monitoring of the environment.
- Systems were in place to ensure staff were competent to care for children and young people of the age range that visited the hospital as outpatients. Guidance was available and easily accessible for staff to follow if they were unsure of procedures.
- Most of the consultants worked in the NHS and so received their appraisal and revalidation there and the information was forwarded on request to Nuffield Cheltenham. The hospital had a responsible officer in post to ensure those consultants not employed elsewhere for validation purposes were suitably appraised and revalidated.
- Staff were aware of their duties in law when obtaining consent and ensured explanations were given to patients in a way they could understand.
- Nuffield staff told us that the Nuffield Cheltenham does not accept referrals for patients who lack the capacity to consent, however the provider told us they did.

Are services caring at this hospital/service

- Patient feedback about the care provided was positive. Staff were seen to be kind and caring and their focus was on individualised patient care. Patients were kept informed at all times about their plan of care and their relatives and carers were encouraged and supported to be involved in the patients care. This included both the admission and discharge process. Patient's privacy and confidentiality was respected at all times.
- We saw staff working with patients and those who attended outpatient appointments with them in a respectful and considerate manner. Some patients had mobility issues and staff ensured that patients and those with them were not rushed when they called patients and showed them where they were to go.
- We chose a random selection of ten patient satisfaction survey forms from approximately 100 available in the breast care service in outpatients. All ten were positive comments.
- The Friends and Family Test scoring system was in place for NHS surgical patients. For patients funded by any other method an alternative scoring system was in place to gather patient's views.
- For NHS patients the sample size was small due to the low numbers of NHS patients but the scores were high which indicated satisfaction with the service.

Are services responsive at this hospital/service

- Services were planned to meet patients' needs. The flow of admissions and discharges through the hospital was well organised. The needs of different patients were considered in the planning and delivering of the service. The provider was aware of further work needed to develop dementia care as part of the service and was taking action to address this shortfall.
- Complaints were responded to in a timely manner and learning taken to develop future practice. CQC did not directly receive any complaints about the hospital between October 2014 and September 2015. All complaints, investigation findings and lessons learnt were captured centrally with review at quality and safety committee

Summary of findings

- Care and treatment was only cancelled or delayed when absolutely necessary. We saw evidence of reasons for when patients had appointments cancelled which were shared with patients for example delays in consultants attending the hospital. The cancellations were explained to people honestly and patients were supported to access care and treatment again as soon as possible.

Are services well led at this hospital/service

- The vision and objectives for the service were evident and understood by staff.
- There were clear governance processes in place to monitor the service provided. However, some areas including the management of Venous Thrombo Embolism needed further development to ensure they were safe.
- Leadership at each level was seen to be visible and responsive. Staff had confidence in leadership at each level.
- The senior management team were aware of the risks in the hospital and there was an effective governance framework to support the delivery of good quality care through actions from meetings.
- Staff we spoke with described feeling part of a team and that they were respected and valued.

Our key findings were as follows:

- Overall the service leadership was good because leaders engaged with staff and people working at the hospital and acted on suggestions and outcomes of learning from incidents and complaints.
- Cleanliness was good in all departments and, infection prevention and control was managed well.
- The systems in place to monitor patient safety including the World health Organisation (WHO) checklist were mostly in place and well managed.
- Full records for children being seen in outpatients were not available to hospital staff.
- Staffing levels in all departments were safe.
- The hospital did not hold morbidity and mortality meetings. There were no unexpected deaths and no cases of mortality between October 2014 and September 2015.
- All patient complications were reviewed by the Medical Advisory Committee (MAC).Patients received treatment which considered their levels of pain and their nutritional and hydration needs.
- The Hospital had established two new services in the previous 12 – 18 months. A private breast care service which included a clinical nurse specialist in breast care, a certified complementary therapist and a private multidisciplinary team to support the four breast surgeons.
- Complaints were managed and investigated with learning being shared within teams.

There were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider MUST take action to:

- Ensure that all records are stored securely and there are no risks of patient confidentiality.
- Ensure that the management and recording of venous thromboembolism prophylaxis is clarified. That risks are appropriately recorded and managed and policies ensure patient safety.
- Maintain secure, accurate and contemporaneous patient records at the hospital, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided
- Ensure that World health organisation checklists are signed correctly by all staff including consultant staff working in imaging.

Summary of findings

The hospital SHOULD take action to:

- Ensure sufficient World Health Organisation audit records are in place to provide reassurance that sufficient have been completed to provide an accurate measure.
- Ensure that safety audits for non NHS patients are undertaken to ensure safety of all patients.
- Improve the labelling and security of medicines prepared for operating theatres, ensuring they are disposed of within appropriate and safe timeframes.
- Ensure leadership arrangements for services for children and young people's services are defined.
- Ensure all staff having contact with children and young people are trained as outlined in national guidance - Safeguarding children and young people: roles and competences for health care staff, March 2014.
- Consider improving links with local safeguarding children boards.
- Consider providing information suitable for young people attending as patients.
- Consider how to gather feedback from children and young people.
- Ensure that regular feedback on voluntary monitoring of radiation exposure levels to staff is obtained within recommended time frame.
- Ensure that required mandatory training is completed for outpatients and diagnostic imaging staff.
- Ensure that major incident scenarios and practice include outpatient department and imaging staff and are held to supplement the business continuity plans.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated surgery as good overall because: • The service for surgery was well run with safe practices, had a good reporting culture for incidents and took learning from those and incidents which were reported at other Nuffield hospitals. • The systems in place to monitor patient safety including the World health Organisation (WHO) checklist were for the majority of cases in place and well managed. • Treatment was provided in line with national guidance and staff were aware of the NICE guidance related to their practice. • Patients received treatment which considered their levels of pain and their nutritional and hydration needs. • Staff were trained to enable them to be competent to provide the care needed. • Patient feedback about the care provided was positive. Staff were seen to be kind and caring and their focus was on individualised patient care. • Services were planned to meet patient's needs. The flow of admissions and discharges through the hospital was well organised. • The provider was aware of further work needed to develop dementia care as part of the service and was taking action to address this shortfall. • Complaints were responded to in a timely manner and learning taken to develop future practice. • There were clear governance processes in place to monitor the service provided. Leadership at each level was seen to be visible and responsive. Staff had confidence in leadership at each level. However: • Some areas including the management of venous thromboembolism (VTE) needed further development to ensure they were safe. • The security of patient's records was not consistent to protect patient confidentiality.

- There was not always sufficient data to submit to national audits.

Services for children and young people

Good

We rated the services for children and young people as good overall because:

- Patient safety was important to the leadership team of the hospital. Children and young people's services had been reviewed and actions taken to reduce risk.
- The hospital now offered an outpatient only service for young people aged between12 and 18 years of age.
- Managers ensured staff were competent to care for young people within the age group in the outpatient setting.
- Safeguarding children training had been attended by staff and plans were in place to offer further training at level two in line with guidance.
- Incident reporting, infection prevention and control and safety of equipment procedures were followed for all patients attending the hospital which included children and young people.
- Interactions we saw with young people and their parents were caring and appropriate for their age and understanding.
- Young people were assessed for their suitability to attend this hospital before an appointment was offered.
- Privacy and dignity of young people was respected and there were flexible waiting areas.
- Steps had been taken to provide leadership of the service but senior managers misunderstood Nuffield Group Policy about leadership of children's services.
- Consultants managed their own patient record systems and we were told GPs received information in a timely way.

However:

- Consultants arranged for records to be available for patients who were attending their clinics. The patient notes were retained by the consultant and not usually available for outpatient nursing staff to view. This meant that records of consultations were not available for staff to reference if a patient should call the hospital outside of the consultation.

Summary of findings

Outpatients and diagnostic imaging

Good

We rated the outpatients and diagnostic imaging service as good overall because:

- The service had processes which staff followed to report serious and other incidents and concerns. The service demonstrated that staff learned lessons and then changed practice when required.
- The outpatient and diagnostic imaging department was clean and tidy and there were systems in place to protect patients from acquiring infection.
- Equipment was maintained and patient records were stored safely.
- Nurses, radiographers, physiotherapists and others had appropriate qualifications, skills, knowledge and experience to carry out the role in outpatients and diagnostic imaging.
- Staff spoke with patients and those who attended outpatient appointments with them in a respectful and considerate manner.
- Reasonable adjustments were made so that disabled patients could access and use the outpatient and diagnostic services.
- Complaints were handled effectively and confidentially. Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care.
- There was an effective governance and management framework to support the delivery of good quality care through learning from complaints or incidents.
- Staff we spoke with described feeling part of a team and that they were respected and valued.

However:

- We saw some evidence that World Health Organisation checklist were not completed correctly in radiology.
- Some staff said they would rely on family members for translation. This could lead to situations where patients needs and wishes were not properly known.
- The strategy for developing the outpatient and diagnostic imaging department and means to deliver the vision had not yet been fully developed. The strategy was not yet embedded beyond the

Summary of findings

leadership team of the outpatients department. Although there was evidence of action plans and proposed audits to monitor and improve the service and inform strategy in the department.

Summary of findings

Contents

Good

Nuffield Health Cheltenham Hospital

Services we looked at

Surgery; Services for children and young people; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Nuffield Health Cheltenham Hospital

Nuffield Health Cheltenham Hospital is an independent hospital, which is part of the Nuffield Health corporate group. It provides inpatient and outpatient services to adults and outpatient services to children and young people.

Nuffield Cheltenham provides routine, non-urgent elective surgery for adults. Surgery was not provided for patients below the age of 18 years.

There are 34 inpatient beds which comprise of 32 beds, all single ensuite rooms, which can be used for either inpatients or day cases. The remaining two Close Observation beds (COU) were used to monitor occasional surgical patients post-operatively who have undergone a more major procedure and have associated co-morbidities that may make them more at risk from a serious post-operative complication.

The service comprised of three operating theatres. There was a six bedded recovery area for initial care after theatre. Theatres two and three had a laminar flow; this is a specialised air filtration system. Endoscopy was also undertaken in theatre one. Surgery provided included orthopaedic surgery, cosmetic and reconstructive surgery, dermatology, ear, nose and throat surgery, gynaecology and ophthalmology. The theatres were open for sessions Monday to Friday between 08.00 and 8.30pm and Saturdays on an ad hoc basis at the request of the surgeons. There were 3,782 visits to the theatre between Oct 2014 and Sep 2015.

Prior to September 2015 Nuffield Health Cheltenham Hospital offered both outpatient and inpatient services for children and young people. All children and young people above the age of three years could receive care as outpatients and those aged 16 and 17 years could receive further care as inpatients.

The outpatient and diagnostic imaging services at Nuffield Hospital Cheltenham consisted of equipment and rooms for consultation, treatment and pre admission clinics. There were 11 general consulting rooms, an ear, nose and throat suite (for consultation and treatment), ophthalmology room, phlebotomy room, three further treatment rooms, and two pre assessment rooms. Minor operations for procedures requiring local anaesthetics only, were undertaken in the outpatients department.

The outpatients department was usually open 08.30-19.30 Monday to Friday however the department did open 08.00 -21.00 if patients had appointments that required it.

The radiology department performed scans and x-rays using a variety of equipment which included a magnetic resonance imaging (MRI) and computer tomography (CT) scanner, ultrasound equipment, x-ray, bone densitometry and mammography. An alternative provider to Nuffield Health operated the MRI scanning service at the hospital four days a week and the CT scan service one day a week. The imaging services were overseen by the Nuffield Health Cheltenham diagnostic and imaging department staff and operated according to Nuffield health policies. Nuffield Health Cheltenham operated a radiology department which provided services for plain x ray, fluoroscopy, ultrasound and mammography. Laser procedures were managed under the outpatient department management but were out of the scope of the CQC registration requirements so were not part of this inspection.

There were physiotherapy treatment rooms with space and equipment for sports rehabilitation in a gymnasium including an exercise studio.

Our inspection team

Our inspection team was led by:

Inspection Lead: Tracey Halladay Inspection manager Care Quality Commission.

The team included four CQC inspectors and a variety of specialists: a consultant surgeon, a theatre nurse, a pharmacist, a paediatric nurse and an outpatient nurse.

Summary of this inspection

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider :

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

The inspection team inspected the following three core services at the Nuffield Heath Cheltenham Hospital

- Surgery
- Services for children and young peoples
- Outpatient and diagnostic imaging services.

Prior to the announced inspection, we reviewed a range of information we held about the service.

We carried out this comprehensive inspection as part of our in depth inspections of independent hospitals. Our inspection was carried out through an announced visit which took place on 15 and 16 March 2016. During our visit we spent time on the ward and in the outpatient department observing the treatment and care provided. We also spent time in the operating theatres, recovery, and endoscopy area of the hospital. We spoke with the management team of the hospital and the chair of the medical advisory committee, a variety of staff, including nurses, healthcare assistants, doctors, therapists, radiographers, department managers and support staff. We also spoke with patients and relatives.

Information about Nuffield Health Cheltenham Hospital

The Nuffield Cheltenham Hospital is run by Nuffield Health Group. It is situated on the outskirts of Cheltenham and offers services to patients from the NHS and those using other methods of funding. Nuffield Health has had a presence in Cheltenham since 1973 when its first hospital opened in the town. The hospital has 34 overnight beds, three operating theatres and an outpatient and diagnostic imaging department. There are also gym and rehabilitation facilities on site.

The Nuffield Cheltenham Hospital was previously inspected by CQC 14 November 2013 prior to the change to the new fundamental standards. At that inspection all the areas inspected were found to be compliant.

The majority of patients were treated as in patient day cases (2509) and (1273) as inpatients between October 2014 September 2015.There were 3,782 visits to the theatre between October 2014 and September 2015. The majority of inpatient activity was for non NHS patients with NHS 3%, 23% self-pay, 74% insurance pay. The theatres were open for sessions Monday to Friday between 08.00 and 8.30pm. and Saturdays on an ad hoc basis at the request of the surgeons.

Between October 2014 and September 2015 the five most common procedures performed were:

• Injection into joint(s) without x-ray control (390)

• Phacoemulsification of lens with implant-unilateral (243)

• Facet joint injection (under x-ray control with sedation/ general anaesthetic) (216)

• Injection into subcutaneous tissue/painful trigger point (141)

• Therapeutic endoscopic operations on cavity of knee (140).

Prior to September 2015 Nuffield Health Cheltenham Hospital offered both outpatient and inpatient services for children and young people. All children and young people above the age of three years could receive care as outpatients and those aged 16 and 17 years could receive further care as inpatients.

Between October 2014 – September 2015 endoscopy, surgery, medical care and diagnostic imaging were offered to children. Eight 16 and 17 year olds stayed overnight and 16 returned home on the same day as admission, 107 were seen for an initial consultation in OPD and 69 attended OPD for follow up consultation.

Summary of this inspection

During the same period 231 children between three and 15 years of age were seen in OPD for an initial consultation and 145 were seen for a follow up consultation.

There were 87 NHS funded patients who attended the outpatient and diagnostic imaging department for their first appointment from October 2014 to September 2015. There were 102 NHS funded patients who attended the outpatient and diagnostic imaging department for follow up in the same period.

There were 8036 patients who were funded from insurance or self-pay schemes who attended the outpatient and diagnostic imaging department for their first appointment from October 2014 to September 2015 There were 7336 who attended the outpatient and diagnostic imaging department for follow up in the same period.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Surgery

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

Information about the service

Nuffield Cheltenham provides routine, non-urgent elective surgery for adults. The patients have to meet eligibility criteria to ensure their safety. Surgery was not considered appropriate for patients who were assessed as potentially needing a higher dependency of care post-surgery. Surgery was not provided for patients below the age of 18 years. Patients between 16 and 18 years were seen as outpatients.

The majority of patients were treated as in patient day cases (2509) and (1273) as inpatients October 2014 September 2015.

The service comprised of three operating theatres. There was a six bedded recovery area for initial care after theatre. There are 34 inpatient beds which comprise of 32 beds, all single ensuite rooms, which can be used for either inpatients or day cases. The remaining two Close Observation beds (COU) were used to monitor occasional surgical patients post-operatively who have undergone a more major procedure and have associated co-morbidities that may make them more at risk from a serious post-operative complication, this area was next to the nurse's station and allowed more space to care for the patient.

Theatres two and three had a laminar flow; this is a specialised air filtration system. Endoscopy was also undertaken in theatre one. Surgery provided included orthopaedic surgery, cosmetic and reconstructive surgery, dermatology, ear, nose and throat surgery, gynaecology and ophthalmology.

Between Oct 2014 and Sep 2015 the five most common procedures performed were:

- Injection into joint(s) without x-ray control (390)
- Phacoemulsification of lens with implant-unilateral (243)
- Facet joint injection (under x-ray control with sedation/ general anaesthetic) (216)
- Injection into subcutaneous tissue/painful trigger point (141)
- Therapeutic endoscopic operations on cavity of knee (140).

The theatres were open for sessions Monday to Friday between 08.00 and 8.30pm and Saturdays on an ad hoc basis at the request of the surgeons

During our inspection we visited all surgical areas, including theatres, recovery areas and the surgical ward. We spoke with six patients, two relatives of patients and approximately 20 staff. These staff included consultant surgeons, consultant anaesthetists, nurse managers and nurses in a variety of roles. We also spoke with allied health professionals including physiotherapists. We spent time talking with administrative staff, housekeeping staff and catering staff.

We observed care being provided to patients and reviewed 11 sets of patient's records.

Before and after our inspection we looked at information about the service and data provided.

Good

Surgery

Summary of findings

We rated surgical services to be good overall because:

- The service had a good reporting culture for incidents and took learning from those and incidents which were reported at other Nuffield hospitals.
- The systems in place to monitor patient safety including the World health Organisation (WHO) checklist were for the majority of cases in place and well managed.
- Treatment was provided in line with national guidance and staff were aware of the NICE guidance related to their practice.
- Policies and procedures were in place to support staff.
- Patients received treatment which considered their levels of pain and their nutritional and hydration needs.
- Staff were trained to enable them to be competent to provide the care needed.
- Patient feedback about the care provided was positive. Staff were seen to be kind and caring and their focus was on individualised patient care.
- Services were planned to meet patient's needs. The flow of admissions and discharges through the hospital was well organised.
- The provider was aware of further work needed to develop dementia care as part of the service and was taking action to address this shortfall.
- Complaints were responded to in a timely manner and learning taken to develop future practice.
- There were clear governance processes in place to monitor the service provided.
- Leadership at each level was seen to be visible and responsive. Staff had confidence in leadership at each level.

However:

- Some areas including the management of venous thromboembolism (VTE) needed further development to ensure they were safe.
- The security of patient's records was not consistent to protect patient confidentiality.
- There was not always sufficient data to submit to national audits.

Are surgery services safe?

Requires improvement

We rated surgical services as requires improvement for safety because:

- The management of the safety thermometer to provide an overview of safety management for non NHS patients was not in place. A similar system of monitoring was in place for non NHS patients.
- The Venous Thrombo Embolism (VTE) policy in place was not specific and did not give a definitive way Nuffield wanted VTE managed for maximum patient safety. The pre-operative assessment completed by nursing staff contained definitions of VTE risks which were not clearly categorised and did not reflect prophylaxis management. There was no evident way to categorise and communicate risks and this did not promote patient safety.
- Carpeted areas of the ward were less easily cleaned than vinyl areas and so posed a risk of cross infection.
- The security of patient's records was not safe and did not ensure the security and confidentiality of all patient records.

However:

- ▪ The hospital promoted a culture of reporting and learning from incidents.
  ▪ The management of infection control was ongoing with audit tools and observation used to monitor the infection prevention practice.
  ▪ Safeguarding practices were clear and staff were aware of the actions needed if they had concerns.
  ▪ The provider had a compliance level of mandatory training achievement level of 85%. Most mandatory training achieved 100%.
- **Incidents**
- The provider had in place a Standard Operating Procedure for the reporting and managing of adverse events (2015). A Nuffield Health Adverse Event was defined as 'any unintended or unexpected incident which could have, or did lead to harm for one or more

individuals, or an incident on/to Nuffield Health property'. Learning from a Never Event at another hospital had been taken and practice amended at the Cheltenham Nuffield as a result.

- In February 2015 all staff underwent training on how to report an incident which had then resulted in a higher number of incidents being reported.330 clinical incidents were reported between October 2014 and September 2015.The rate of clinical incidents (per 100 inpatient discharges) had increased over the reporting period apart from in April to June 2015 where there was a slight decrease before another increase in July to September 2015. There were no serious injuries or serious incidents. Senior management told us that the high level of reporting was because staff were encouraged to report all incidents. Staff told us they received feedback from incidents and that learning was cascaded through handovers and the team brief.
- Matron confirmed learning and feedback from incidents would be from matron to the heads of departments for onward communication and cascade to ensure learning was implemented.
- All adverse events and variances (e.g. transfers out, returns to theatre, re-admissions etc.) were recorded onto an electronic reporting system and investigated accordingly. The electronic report and investigation results were discussed at the monthly Hospital Board and Heads of Departments meetings and the quarterly Quality and Safety, Clinical Governance and Medical Advisory Committee meetings.
- We reviewed two incidents classified as serious; one was a near miss where a piece of equipment malfunctioned. A full investigation was completed which included sending an alert to the medicine healthcare regulatory authority and the manufacturer. Additional staff training was put in place to ensure all were familiar with the equipment and its correct assembly.
- The hospital did not hold morbidity and mortality meetings. There were no unexpected deaths and no cases of mortality between October 2014 and September 2015. All patient complications were reviewed by the Medical Advisory Committee (MAC).

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a new regulation which was introduced in November 2014. This Regulation requires the trust to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- The Nuffield Standard Operating Procedure (SOP) on the Process for Reporting and Managing Adverse Events made reference to duty of candour but did not provide staff with guidance as to which incidents this applied or how staff should approach or record that the duty had been used.
- Staff spoke confidently about the duty of candour. Training had been provided in some cases.

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

- As the majority of patients at the Nuffield Cheltenham were not NHS the safety thermometer was not used to look at safety issues related to pressure ulcers, falls, catheters and urinary tract infections. However the safety thermometer was completed for all NHS patients one day each month with data being submitted to the NHS.
- The Cheltenham Nuffield used a system called GOV14 to review 20 patient records per quarter for venous thromboembolism (VTE), falls, catheter care and monitoring of the WHO checklist. This system applied to both NHS and private patients.
- We saw that scores for completion within GOV 14 were generally high. However, some scores were identified as red rated which was a higher level of risk. These included risk assessment for falls (60%), escalation of the patients deteriorating condition (50%), measurement of patients temperature every 30 minutes intraoperatively, (35%) and handover of information between departments (30%).
- Senior management staff monitored GOV 14 with the results being discussed at the quality and safety Clinical Governance and Medical advisory Committees.
- The provider reported 100% compliance with VTE screening rates in each quarter of the reporting period (Oct 2014 to Sep 2015). This was for the screening process only. There were no incidents of hospital acquired VTE or pulmonary embolism in the reporting period above.
- Within the pre-operative assessment document, completed by nursing staff before admission, the definitions of VTE risks were not clearly categorised. There were three definitions of risk

- -No risks identified
- -Risk factors identified
- -Bleeding risk identified

A further list was provided at the rear of the care record but was not referenced as part of the risk assessment. When risk factors were identified by staff, the care record did not have space to record what these risks were and what information had been communicated to medical staff. We saw two sets of records when the 'risks factors identified' box had been ticked but no other information recorded and no record of what action was taken to manage the risk safely. This level of risk management did not protect the patients.

- The VTE policy in place was not specific and did not give a definitive protocol for management of VTE for maximum patient safety. As a result there was potential for consultants to treat deep venous thrombosis prophylaxis in different ways. The policy was open to interpretation. Admitting Consultants were responsible for ensuring that appropriate prophylaxis was provided. The only record of the choice of VTE prophylaxis would be on the patients medicine record.
- We reviewed the GOV 14 document for VTE and saw that regular monitoring took place. 20 records were reviewed every three months. This showed that for quarter three (October to December 2015) two patients did not have an assessment of VTE. The following quarter (January to March 2016), the audit of VTE showed that assessment had taken place in 95% of the records reviewed. However, 100% of prophylaxis for VTE had been given when indicated. The audit showed that only 17% of records recorded that when prophylaxis was indicated that patients were offered written information about side effects. This meant that not all patients would be informed about any side effects they may experience.
- We spoke with consultants and nurses who gave different schedules for the prophylaxis to be given. Ward staff said it was given prior to theatre; one consultant gave two hours after surgery. We spoke with the MAC chairman who could not confirm an absolute Nuffield policy for consultants to follow.

Cleanliness, infection control and hygiene

- All areas of the hospital we visited appeared visibly clean. Some areas of the ward had carpet which was not as easily cleaned as the laminated flooring when spills occurred. We saw staff followed hospital procedures for infection prevention and control and were bare below the elbow and used personal protective equipment and hand gel. Staff were monitored by the infection control lead coordinator and should poor hand hygiene be noted a 'yellow card' is served. This was a reminder that practice needed to be improved. All infection control policies were corporate for Nuffield and were accessible on line.
- Patients were risk assessed in outpatients as part of the key health questionnaire prior to their surgery. There was no incidence of Clostridium difficile or Methicillin resistant Staphylococcus Aureus (MRSA), between October 2014 and September 2015.
- Matron was the director of infection prevention and control for the hospital with a staff nurse supporting as lead for infection control on the ward and infection control between each area of the hospital. The lead provided face to face training sessions for all hospital staff which was additional to an on line learning session. Each area had a designated link co-ordinator. Links had been made with the local trust to discuss any issues of concern. Matron and two other staff had attended an accredited infection prevention control course. Further support and guidance was available from the Nuffield Health corporate infection prevention and control lead. Who was felt to be accessible and helpful and would visit the hospital if required and had carried out an audit. Microbiology advice was obtained from the local NHS trust with a microbiologist attending the hospital infection control committee. The committee met every quarter and included the matron, infection control lead, microbiologist and link staff.
- Monthly infection prevention meetings were held to review and update the Hospital's infection prevention action plan and agree, sign off and upload the Health care Associated Infection HCAI data. All identified infections had an investigation performed and all infection prevention audits were up to date and cascaded to the teams.
- Surgical site infections were monitored and recorded. Between October 2014 and September 2015 there were seven recorded in abdominal surgery, four in thoracic surgery, and three in lower limb surgery. There were two each in knee. hip and pelvic surgery. There did not appear to be a link between the infections other than a possible risk caused by the patients low body temperature in theatre. Matron confirmed patients were being monitored for hypothermia during surgery and

the plan was to consider implementing pre warming of patients prior to their surgery. A summary of all infections was submitted to the MAC meeting and emailed to all consultants.

- The patient's admission document included a section completed by staff which confirmed that the patient had showered and pre procedure care checklist identified if make-up and nail varnish had been removed. Should an indwelling catheter be inserted during theatre procedure this was recorded in the care record, together with any rationale and details of equipment used. Patients daily records included a prompt about urinary catheters to ensure appropriate care of these was not missed.
- Cleaning audits were in place to ensure monitoring of the environment. We observed the daily records were completed to identify when staff had completed the cleaning. Cleaning staff undertook daily cleaning of the ward and nursing staff cleaned areas they used in both the ward and theatres. 'I am clean' stickers were seen to be in use on equipment which was ready for use such as commodes. Theatres were cleaned overnight by cleaning staff. There was a monthly walk about with heads of each department and the head of housekeeping to monitor the standard of hygiene.

Environment and equipment

- We saw resuscitation equipment available in each area of the hospital, ward, theatre, recovery etc. The trolleys were checked daily and all portable equipment had been serviced within the last year.
- Hoists were available on the ward for patients who required assistance to transfer. Bariatric care was not provided and so specialist equipment was not needed.
- Equipment safety checks were undertaken daily in theatres by the Operating Department Practitioner (ODP's). This included checks of oxygen cylinders. The anaesthetic machines had a secondary check from the anaesthetist prior to use.
- Staff confirmed that equipment and implants used were in line with the Medicines and Healthcare products Regulatory Authority (MHRA) requirements and should faults or problems be identified feedback was provided to both the equipment provider and the health care products regulator. When lenses were used as part of ophthalmic surgery, extra lenses were available and were included as part of the WHO checklist. This was in case there was any problems identified with the lenses and so enabled surgery to continue.
- The sterile equipment for theatre was provided by the Nuffield Health sterile services unit off site. The lists for surgery were prepared up to two weeks in advance which enabled staff to plan for and order equipment. We saw staff complete the equipment checklist when the surgical trays were opened and again checked post-surgery. We saw that some equipment was not available on the tray. This had been identified by staff as an ongoing problem and the system in place did not always work correctly. This meant staff had to check and access equipment that was missing. Staff told us they had good relationships with the local trust to enable them to get the equipment and so be able to continue the surgery. The hospital management had included these issues on their risk register as a moderate risk. There had been feedback to the supplier of the surgical sets and matron reported that things had improved but this was an area they continued to monitor closely
- The hospital management had included as a moderate risk on the risk register the inadequate fire compartmentation within theatres. They assured us that action was being taken to address this risk and the appropriate specialists were involved to ensure theatre safety.
- The hospital blood dispensing system had been identified on the providers risk register as causing delays. This was because of obsolete parts for repair. We were assured this system was being replaced.
- There were Inconsistencies in the standards of décor between newly refurbished departments and the rest of the hospital. The 2016 budget included plans for upgrading the hospital as a whole to ensure décor was uniform.

Medicines

- Medicines practices observed were considered overall to be good. Medicines were supplied from an onsite pharmacy and were available Monday to Saturday 9am to 5pm. There was an on-call pharmacy service on a Saturday. Advice and support was available out of hours by telephone. Medicine trolleys were used on the wards to store and dispense medicines. We saw they were appropriately secured. Medicines which required cool storage were appropriately stored in medicines fridges

and the temperature monitored daily. We observed staff administering medication safely. Controlled medicines were appropriately stored and monitored to ensure safe practice was maintained.

- Allergies were recorded in the patients care record and on patients individual drug charts. The GOV 14 audit showed that the recording of known allergies on the prescription chart was 63% and red rated.
- On discharge patients were given a leaflet about the medications they would be taking home. This leaflet was developed as a result of patients ringing the hospital when they got home to ask more questions about their medication. The leaflet provides a greater understanding of the discharge medications. If the patient left hospital on anticoagulant medication a letter would be sent to the patients GP to inform them of this.
- Anaesthetic medicines were drawn up and checked in the anaesthetic room by the anaesthetist and the ODP. The anaesthetist described the disposal process for controlled drugs which were only part used. This process ensured safe practice.

Records

- Each patient had a care record. This was a booklet for either day and overnight surgery or long stay surgery. The records included all preadmission health checks, investigations and results, risk assessments and reviews. This document was used to ensure that patients met the safe criteria to have treatment at the hospital. Once admitted, the records included pre procedure care, anaesthetic room care, and care during the procedure, all theatre care and checks and recovery care. Post procedure each day had risk assessments, interventions and outcomes recorded. All entries were signed and dated by staff. Patient's length of staff was in the majority of cases, no longer than four days.
- We reviewed 11 sets of records and found them to be completed and readable. The records maintained of the patient's time in theatre were fully completed and included the WHO checklist.
- Each anaesthetist and surgeon maintained a clinical record and these were stored in the patients medical records held on site during any procedure and stored securely on site after treatment was completed.
- We saw that the security of records was not always safe. Records were left unattended at both nurses stations. The main reception was staffed by a receptionist. However, when new patients arrived, the receptionist would show them to their room. This left a time when the records were not supervised. The nurse's station at the far end of the ward for patients having endoscopy was seen to not be manned and records accessible.
- Records audits took place as part of GOV 14. For example this audit included VTE, WHO checklist, handover of information, catheter management and discharge. The audit was 20 sets of records every three months. An overall percentage score was given for each outcome and a red, amber, green rating provided. The level of achievement varied depending on the area of review.

Safeguarding

- A safeguarding policy was in place and accessible to all staff. There were flow charts within each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures.
- There had been no safeguarding concerns reported to CQC between October 2014 to September 2015.The Hospital Director and the Matron were jointly responsible for leading on all safeguarding within the hospital. Both have completed their level three Safeguarding training. All members of staff complete level 1 safeguarding training as part of their mandatory training and this included information on prevention.
- There was a policy in place for staff to follow regarding Female Genital Mutilation (FGM). Staff confirmed they knew about the policy and would follow this if needed.

Mandatory training

- Mandatory training included basic and intermediate life support, fire safety, moving and handling, infection prevention and safeguarding vulnerable adults and children. Staff training levels were monitored on an early warning system and training days were provided. Ward staff had completed intermediate Life Support Training and the RMO had completed Advanced Life Support training
- The provider had a compliance level of training achievement level of 85%. Most mandatory training achieved 100%. Theatre staff did not achieve full compliance for the practical part of infection prevention,

moving and handling and safer blood transfusions. The ward staff achieved 100% in most areas except aseptic technique, which is the procedure used to avoid the introduction of organisms into a body, infection prevention and practical moving and handling. Even though provider level of compliance had not been achieved the scores remained high.

- The risk register documented some training and recording of staff competency for using individual pieces of equipment is not robust. This is classed by the provider as low risk. The provider has said this is a recording and not a training issue.

Assessing and responding to patient risk

- The service for each patient was consultant led for both day surgery and inpatient admission. This meant that each patient's consultant was the overall person in charge of their care and undertook any post treatment reviews. Post-surgery the consultant saw the patient, however GOV 14 recorded that only 56% of patients had a record by the consultant written daily. Out of hours the consultant was called if needed and we saw when this had taken place. In the interim the Registered Medical Officer (RMO) was available to provide medical support. Should the consultant not be available, it was their responsibility to provide suitable cover for their patients. An escalation procedure was in place for nursing staff to escalate to the RMO and for the RMO to escalate to the consultant for the patient. We noted the actions taken when a patient deteriorated and the plan in place was followed, the systems were seen to work.
- Prior to admission all patients were seen in the outpatients department. A pre assessment key health questionnaire was completed which included questions about previous and current health conditions. A pre-assessment was then completed which reviewed all the patients' health information. A series of risk assessments were then completed including VTE, nutrition and discharge planning. There was then a multi-disciplinary evaluation and variance record. Any issues which the pre-admission staff felt did not ensure the safety of a patient to be admitted were recorded and a record of any subsequent discussion was made. The hospital did not provide care and treatment for patients who had complex needs or needed care the hospitals staff could not safely provide.
- The MAC confirmed that only the physical status classification system for rating patients going under anaesthesia ASA grade 1-3 patients were accepted for admission. This meant that only low risk patients would be considered for treatment. Any grade 3 patients were discussed with the anaesthetist to ensure the admission would be safe.
- Day case patients underwent the same pre-assessment key health questionnaire and risk assessments during the initial outpatients visit to ensure they were suitable for day surgery. On admission the risk assessments were reviewed / repeated and the patient was asked if any changes had occurred since the key health questionnaire had been completed. Any results of pre-operative investigations were reviewed to indicate suitability for surgery.
- Post-surgery the provider does not have facilities or staff with suitable training to care for patients classed as level 2 where patients have a higher dependency needs. A close observation unit was available but this was not a high dependency unit which would require specific staffing to meet higher patient need. Staff were clear that they area was used post-surgery when a need was identified and was booked and staff planned to meet the close supervision required. Should an increased level of dependency occur which staff could not safely meet; the patient was transferred to the local acute trust. Escalation protocols were in place for those transfers and staff and the RMO were clear of their roles and responsibilities in those transfers.
- The theatre staff followed the five steps to safer surgery. This involved following the World health Organisation (WHO) checklist before during and after each surgical procedure. We visited anaesthetic rooms and theatres and saw the WHO checklist completed on each occasion with only one exception. There were no radiological interventions undertaken which required the checklist and we saw that for cataract surgery the list was modified to enable it to be suitable for purpose.
- We observed that in most cases all staff participated in the WHO checklist. We advised the provider when full cooperation with the list was not evident and the provider took immediate steps to review this.
- The theatre manager undertook an audit of the WHO checklists completed. Ten sets of records were reviewed every three months. The MAC minutes for October 2015 noted WHO checklist and documentation audit – scored 95% but hospital scored low on patients being signed in and out.

- The GOV 14 document for quarter four January to March 2016 showed that 75% of records showed the inclusion of anaesthetic staff. Only 85% of records were completed for the sign out process.
- In between this audit the theatre manager told us they visited theatres each day at different points of the WHO checklist to ensure compliance. They told us that when any deviation was seen the theatre staff were challenged. These checks were not recorded.
- There had been an issue identified that the telephone switchboard did not always ensure calls got through out of hours. As a result the provider had put a mobile phone system in place to ensure that all calls out of hours were received by the nurse in charge of the ward. The nurses confirmed the mobile phone system had been successful.
- There was no access to interventional radiology out of the nine to five hours they worked.
- Cosmetic services were provided. We saw from two cosmetic surgery records that psychiatric and psychological reviews had not been undertaken to ensure that appropriate consideration had been given around body image and patient expectations. Psychological support services were available for the breast service but this did not include cosmetic surgery.
- Staff used the Modified Early Warning System (MEWS) to monitor patients to identify deterioration in health. This is a series of physiological observations which produce an overall score. The increase in score would note deterioration in patient's condition. A plan was available in each patient's records for staff to follow if the scores were to increase. We did not see any records which showed an elevated MEWS score. The hospital management were planning to change the MEWS to the National Early Warning Score. We looked at the GOV 14 audit and saw improvements in completed MEWS scores between October 2015 to March 2016.
- Resuscitation scenarios took place each month to enable staff to be well prepared should a cardiac arrest take place. A report was produced after the exercise to ensure appropriate staff training took place.

Nursing staffing

- Ward staffing levels were calculated using a Daily Staffing workload Tool. The tool considered the minimum/maximum number of patients at specific points during the day, predicted dependency of those patients (based on experience and any pre- identified co-morbidities, type of surgery planned and the timing of that the surgery). The tool considered any additional care that the patient may require following surgery. Staff told us they felt sufficient staffing levels were met. Handovers took place at the start of each shift and time was built into the shift to enable sufficient time for information to be transferred.
- On each day of our inspection there were five or six trained nurses and two health care assistants each morning, and five trained nurses and two health care assistants in the afternoon. Overnight there were two trained nurses and one health care assistant. One 'twilight' nurse was also on duty over the early evening. Agency and bank staff were included in that number. All bank and agency staff completed on line training and induction to ensure all competencies had been met.
- We spoke with senior staff who confirmed the staffing level varied dependant on the planned daily activity. At the time of inspection the staffing levels had been achieved for the identified level of activity.
- In theatres the Association for Perioperative Practice Staffing Standards (2011) were followed with each theatre having an operating department practitioner, a health care assistant and two scrub practitioners per list as a minimum, with the addition of a first assistant if required. Recovery was staffed with a 1:1 ratio for patients requiring airway support decreasing to 2:1 once the airway was secured.
- At the time of our inspection there were sufficient recovery staff to meet the planned theatre activity. Two trained nurses were seen in recovery. We observed recovery and saw that no more than two patients were in recovery at any time.
- Each day of inspection a senior nurse was on duty at all times on the ward. There was a clinical on-call rota out of hours consisting of the nursing Heads of Department and Matron. The clinical on call person provided telephone advice and, where required, would attend the hospital. When on call, this individual was required to remain within a thirty minute journey of the hospital
- Should a patient need to return to theatre out of hours, there was an on call theatre team, which included Radiography and Pathology staff. The Pharmacist was available for telephone advice and there was a service level agreement in place for out of hour's provision of medicines.
- We saw agency and bank staff being used on both days of the inspection when permanent staff were not

available. Data received showed occasional use of agency staff (less than 20%) between October 2014 and September 2015 for nurses working in theatre. Some moderate (between 20% and 39%) and some occasional (less than 20%) use of agency operating department practitioners for the same timescale after Feb 2015. There was no use of agency staff in the reporting period for health care assistants working in theatre departments.

- There were moderate rates of sickness (between 10% and 19%) for nurses working in inpatient departments in Jan 2015 and low (less than 10%) sickness rates for all staff groups working in theatre. This is with the exception of operating department practitioners (ODPs) August to September 2015 who had high sickness levels (greater than or equal to 20%)

Surgical staffing

- There were adequate consultants in post to meet the surgical needs of patients. There were 206 Consultant surgeon and anaesthetists employed at Nuffield Cheltenham with practising and privilege rights. Practising privileges were granted to consultants who agreed to practice following the hospitals policies and provided evidence of appropriate skills and registration. Most of the consultants worked in the NHS and so received their appraisal and revalidation there and the information was forwarded on request to Nuffield Cheltenham. The hospital had a responsible officer in post to ensure those consultants not employed elsewhere for validation purposes were suitably appraised and revalidated.100% validation of professional registration was completed in theatre. As part of extended communication the provider told us that the local trust requests surgical data relating to consultants practice for their records.
- All surgery at Nuffield Cheltenham was consultant delivered. This means that consultants were responsible for their own patients 24 hours a day. It was the responsibility of each consultant to cover their absences and ensure that the person appointed to cover for them had the appropriate skills and practice and privilege agreement in place.
- Each consultant and anaesthetist saw their own patients pre and post operatively and were available on call until the patient left the hospital.
- There was no hospital organised on call anaesthetist rota to ensure that in an emergency and anaesthetist could be contacted. The anaesthetist for each patient was on call for the duration of that patient's admission. Should the anaesthetist not be available, it was up to the surgeon to ring around for a consultant anaesthetist, but failing this the provider had in place an agreement with the Gloucestershire Anaesthetic Service (GAS) rota. This meant that the provider would ring the GAS contact who would try and organise an anaesthetist to attend. Should this system not be effective this would not satisfactory from a patient safety aspect.
- The Registered Medical Officers role was to support all staff but this did not include working in conjunction with surgical staff in theatre. The RMO provided ward support and was the first line of contact for ward staff should they need immediate medical advice in the absence of the consultant.
- There were two Resident Medical Officers (RMO) who alternated a week on/week off 24/7, rota. Should the RMO need to be absent for any reason, the provider agency had a standby available. We saw this take place and a replacement by RMO provided.
- The Healthcare Professionals Council (HPC) registrations were renewed every 2 years. All staff had current and in date HPC registration.

Major incident awareness and training

- We saw fire alarms were tested weekly. Staff confirmed the emergency generator for theatre was also tested weekly.
- A major incident policy and plan were in place. There was a senior manager on call rota every day for any such event.
- CCTV was at the nurse's station and night security attended the building at night. A panic button was available for nursing staff but alerted the hospital only and was not linked to any external services. The hospital doors were secured after 9:30pm. Access to the building was by intercom and supervised by staff.
- Theatres were all locked at night with keys stored securely on the ward. A secondary set of leys were also secured. Should theatre open at night the keys were signed in and out for audit purposes.

Good

Surgery

Are surgery services effective?

Good

We rated that surgical services were effective because.

- Treatment was provided in line with national guidance and staff were aware of the relevant National Institute for Health and Care Excellence NICE guidance. Policies and procedures were in place to support staff and were monitored to ensure a consistency of practice. Patients had comprehensive assessments of their needs. This did not include psychological reviews for patients undergoing cosmetic surgery.
- Some information about patients care and treatment and their outcomes was collected and monitored. There was not always sufficient data to submit to national audits. Local audits were undertaken.
- Patients received treatment which considered their levels of pain and their nutritional and hydration needs.
- Staff were trained to enable them to be competent to provide the care needed. Staff training and appraisal was ongoing. There was coordinated care provided by the range of teams and services.
- Consent to care and treatment was obtained in line with legislation and guidance. Cooling off periods were not recorded for cosmetic surgery.

Evidence-based care and treatment

- Care and treatment was provided with guidance from the National Institute for Health and Care Excellence (NICE). A central Nuffield team supported all Nuffield hospitals to remain updated and informed the hospital of changes to the NICE guidance. We saw NICE guidance accessible to staff on the ward for QS90 for urinary tract infections, CQ65 for hypothermia and CG49 for surgical site infections. The guidance was being followed.
- The hospitals governance document 2015 for continuous improvement stated that robust systems for cascading NICE Guidance had been developed to ensure all clinicians had seen and commented on the Guidance in the context of their own practice.
- Patients undergoing hip and knee surgery consented to their data being submitted to the National Joint Registry. Data was submitted to enable monitoring by the NHS of the performance of joint replacements. Insufficient numbers were undertaken for knees so only hip data was being used. The provider told us that whilst the hospital participates in some major national audit programmes (National Joint Registry (NJR), National Ligament Registry (NLR), Patient Reported Outcome Measures (PROMS)), analysis of the resulting data was not currently being reviewed or utilised to effect any changes to the service. PROMS and NJR data was very limited to single digit numbers, which the provider told us did not generate significant, meaningful results on which to base decisions to change practice.
- The Nuffield Cheltenham is liaising with the Corporate Clinical Team to establish how best to obtain, disseminate and utilise more meaningful outcome data from the National Registries. A quarterly audit meeting had just commenced with one of the Orthopaedic surgeons, which would be used to review data and disseminate to staff. A similar approach could be taken with the surgeons in other specialties to ensure outcome monitoring is more relevant to the locality.
- Cosmetic surgery practice was monitored to ensure that practice was in line with the Professional Standards for Cosmetic Practice-Cosmetics Surgical Practice Working Party, Royal College of Surgeons (RCS Professional Standards). The audit was to monitor compliance to the RCS Professional Standards to provide assurance regarding compliance & to identify any areas for improvement. Some areas for improvement were identified. These included an identified need for improved documentation relevant to Then cosmetic practice, and including basic understanding of psychological processes specifically referencing body image disturbance
- Psychological evaluation and support was not provided as part of the cosmetic surgery service at this hospital. However, it was available for the breast service. The cosmetic surgery audit identified that the referral pathway for psychological review need to be evidenced with the records.
- NICE guidance guidelines for referral are followed in particular for Obsessive Compulsive disorder were also not evidenced and were being sought by the provider.
- Reviews took place of the effectiveness of surgical procedures. MAC meetings took place quarterly where issues, incidents and clinical outcomes were reviewed to ensure good practice.

- The Hospital participated in the Patient Led Assessment of the Care Environment (PLACE) audit annually which was undertaken by 'expert' patients provided by the Health and Social Care Information Centre together with the Hospital's Infection Prevention Coordinator.'
- The hospital's PLACE scores were the same or higher than the England average for cleanliness, dementia, food, privacy, dignity and wellbeing. However the hospital PLACE scores were lower than the England Average for condition, appearance and maintenance.

Pain relief

- We saw pain relief was discussed pre-operatively, in theatre and on the ward. As part of the WHO checklist it was clarified that pain relief was planned. Post-operatively the level of the patient's pain was monitored and recorded on the MEWS chart and action taken as needed. Whilst in recovery pain levels were constantly monitored and the patient was only moved back to the ward when pain was under control. Recovery staff gave intravenous opiates titrated according to the patients pain score.
- Patients we spoke with confirmed they were comfortable and pain relief was managed.
- For patients on the enhanced recovery programme for hip and knee surgery, spinal analgesia was provided and a specific pain protocol was in place for regular pain relief.
- There was a link pain nurse to provide advice and support if needed. Pain relief was prescribed for patients being discharged home.
- We saw patients mobilising post-surgery. Pain relief was managed to prevent pain impacting on recovery and so when required extra pain relief was prescribed before physiotherapy and mobilisation. We saw that as required medicines were prescribed appropriately and recorded when given.

Nutrition and hydration

- The provider used a nutritional assessment tool to risk assess each patients level of nutrition and hydration. A nutrition score was also used for parental and enteral feeding regimes. If risks were identified management guidelines were provided for staff to follow. All discussions and outcomes were recorded to ensure the patients nutrition and hydration needs were suitably met.
- Instructions about starve times was given during the patients pre-admission visit. Staff checked as part of pre procedure checks when the patient last ate or drank and this was recorded in the patients care record.
- We saw for some patients at pre-assessment, a recorded discussion about their level of nausea was in place which included any previous experience of post-surgery nausea. This would enable medical staff to review how this would be managed. Any symptoms of nausea and vomiting were reviewed and treated whilst the patient was in recovery. All patients had nausea and vomiting recorded and the actions taken with an outcome.
- There was no access to a dietician at the hospital. Should advice be needed then staff confirmed they would contact the local trust for advice.

Patient outcomes

- The Hospital uploaded data to the National Joint and Ligament Registries, Patient Related Outcome Measures. Public Health England (PHE) Surveillance for Breast, Hip and Knee patients (commenced Jan 2016).
- For Patient Reported Outcome Measures (PROMS), the total figure for Nuffield Health Cheltenham Hospital for April 2014 to March 2015 for groin hernias showed, 108 patients were eligible, of which two reported an improvement in health and one reported no change in health.
- For hip procedures, 103 patients were eligible, of which two reported an improvement in health and one reported worsening health.
- For knee procedures, 98 patients were eligible, of which two reported an improvement in health and one reported no change in health. It was noted that for health improvement, no change in health and worsening health data was not available for groin hernia surgery from Jul to Sep 2015 and was not available for hip and knee procedures from Apr to Sep 2015.
- Breast surgery outcomes were reported locally within Nuffield but also externally to Public Health England (PHE) No data results were yet available.
- The provider met the target of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral in the reporting period (October 2014 to September 2015) except in Nov/ Dec 2014 and May 2015.
- There was a Hospital audit of cosmetic surgery undertaken at Nuffield Cheltenham. The provider recognised within the cosmetic surgery audit

that records available of discussion of outcomes from National and regional audits at hospital IGC/MAC meetings was missing and data was to be sought and included in the future.

- There was an increase in the rate of unplanned returns to theatre. There were 12 cases of unplanned returns to theatre between October 2014 and September 2015. There was a constant rate of unplanned returns to theatre until an increase from July to September 2015. This area was reviewed at the December 2015 board meeting and no trends were identified. We looked at records provided and saw that the majority were related to blood clots (haematomas) requiring draining and seven of the 12 were breast surgery.
- There were eight cases of unplanned transfer of an inpatient to another hospital between October 2014 and September 2015. An increasing rate of unplanned transfers (per 100 inpatient discharges) over the same period. The hospital transferred a small number of patients to Gloucestershire Hospitals NHS Trust (nine in 2015). Minutes for the Integrated Governance Report August 2015 noted no transfers that quarter. The rate of unplanned readmission events for Cheltenham in the year to date was within the expected range, based on the performance of all hospitals in the group.
- There were eight cases of unplanned readmission within 29 days of discharge in the reporting period between October 2014 and September 2015. This area was reviewed at the December 2015 board meeting and no trends were identified.
- Senior management explained that those patients who have unplanned return to theatre and those that are readmitted are tracked. While it can be difficult to track a patient who is readmitted to another hospitals all efforts are made to ensure this information is captured as there may be learning for the Nuffield.
- The hospital management told us they were working towards accreditation with Joint Advisory Group for endoscopy units and complete Global Ratings Scale census. The hospital does not currently have Joint Advisory Group (JAG) accreditation for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its competence to deliver against the measures in the endoscopy standards.
- Healthcare Associated Infections surveillance took place – a monthly submission to the Nuffield Health Corporate Infection Prevention Nurse was undertaken. They collated the same data from all Hospitals and uploaded it for Public Health England reports (includes MRSA and E-Coli blood stream infections, and C Difficile toxin, surgical site infections for all hip/knee patients, catheter-related urinary tract infections and any other infections);
- Competition and Markets Authority (CMA) coding data was commenced in January 2016 which will be uploaded to private healthcare information network from Sept 2016. This included the volumes of specific procedures each consultant performs plus their outcomes (including variances) to enable patients to make an informed choice about their surgery.
- Local audits included hand hygiene audits, surgical site infection, surgical care bundle, asepsis. The results of these audits were reviewed at the infection control committee and the HCAI team meeting.

Competent staff

- The management team were clear that all consultants for both surgery and anaesthesia registrations were in date and that they were only performing surgery they were able to evidence they were sufficiently skilled to do. Systems were in place to alert the administrative team when registrations were due and consultant's appraisals were received and recorded. Management staff confirmed that should there be any delay in receiving proof of registration the consultant would be suspended from practice and privilege rights until such time as proof was received.
- Review of requirements for practising privileges was monitored by the hospitals director and human resources manager. When a consultant was due their appraisal they would receive written advice asking them to provide the required detail. A period of four weeks after the due date would be allowed but if the appraisal documentation was not received then the consultant would be suspended.
- The hospital's responsible officer maintained a good relationship with the medical director of the NHS organisations where the majority of consultants worked. They ensured oversight of appraisals being provided and we saw an example where the trust had been written to in regard to appraisals which were due to be completed but had not yet been provided. The responsible officer role was also to ensure receipt of two professional references for consultant staff in line with the policy.

- Expiry dates for indemnity were also tracked with letters being sent to remind consultants to submit the documents. Oversight of both these aspects was robust and we were shown a letter to a consultant advising of the suspension of their practising privileges until indemnity cover was produced. This was subsequently provided and they were reinstated.
- We reviewed five sets of medical staff records all of which contained two professional references, proof of professional registration, GMC registration, indemnity cover, appraisal documentation and DBS checks.
- The medical advisory committee played a key part in the approval of practising privileges with all new applications being discussed. We saw evidence of this in minutes of the meetings along with examples where consultants wanted to undertake new procedures and these were discussed and agreed by the medical advisory committee. Once approved by the medical advisory committee consultants were sent a formal agreement to sign to agree to work within the practising privilege policy and within the scope of practice agreed.
- At the review of their practising privileges each surgeon would be asked to review the procedures they had carried out in the last year and confirm these were still in their scope of practice. Where the number was low for any procedure a discussion was held to confirm whether or not they would be able to continue to carry out any of these at the Nuffield Cheltenham hospital. Again we saw evidence of this where the consultant was written to agree not to undertake one type of procedure. Any complaints or incidents relating to the consultant would also be reviewed as part of the process.
- Where a consultant wants to add a procedure to their practising privileges they were required to evidence they were undertaking the procedure in another hospital then meet with matron prior to submitting to the medical advisory committee for approval.
- There was no formal revalidation for physiotherapists. All physiotherapists at the hospital renew their registration with the HPC annually. This is in May this year for all inpatient physiotherapists.
- Staff training records for theatres showed that additional training had been provided to ensure the competency of staff. Training included human factors, blood transfusion, intravenous administration, specific equipment including scopes and the spinal table. Staff told us that induction training was comprehensive to ensure they were suitably competent.
- Ward staff told us and records confirmed ongoing training was provided. Staff were supported to attend training and should they request anything specific related to their practice they felt this would be considered.
- Student nurses were at the hospital as part of their training. Following a period of time when student nurses were not working in theatre nurses were now being scheduled to spend time in theatre.
- Agency and bank staff confirmed they undertook an induction and training to ensure they were competent to undertake Nuffield practices.
- For non-medical staff appraisals were completed at the beginning of the year to set objectives and staff met with their managers mid-year to see how progress was being made. Staff told us 100% of staff had appraisals and all had personal development plans. There were moderate levels of staff appraisal (between 50% and 74%) in 2014 for all staff working in theatre departments. Appraisals in theatre were being undertaken and the theatre manager confirmed they were all planned or undertaken.

Multidisciplinary working (in relation to this core service only)

- Staff told us they felt the hospital worked as a group and not as individual departments. There was good communication between departments with good handovers of patient information. There was communication between nursing and allied health professionals to support patients with pain relief, appropriate moving and handling and arrangements for discharge.
- Multidisciplinary working between medical staff and allied health professionals was undertaken electronically with patient's reviews taking place. We saw the governance records and heads of department minutes which demonstrated the presence of allied health professions at all meetings.
- The consultant handed over any information they felt relevant to the RMO before leaving the hospital. We saw that when needed the RMO contacted the consultants at home.
- Should a transfer need to take place between hospitals, a Nuffield policy was in place. This informed staff that the consultant in charge of the patient must contact the local trust to arrange the transfer. A checklist was completed to transfer with the patient to provide current treatment.

- Physiotherapists were working on the ward from 8.30 am until whenever they were needed in the afternoon. At a minimum this would be until 5pm but if there were late theatre lists where patients may have a procedure that requires them to be discharged with crutches, the physiotherapist will stay until the patient was ready for discharged.
- There were five physiotherapists working on the ward on a rota basis. They attend the ward every day from Monday to Friday and at weekends if they are required. Most of the physiotherapy delivered was purely for mobilisation, so if there are no patients in at a weekend requiring help, then no-one would attend but could be called in if needed. If there was a patient with a chest problem, there was a respiratory physio on call and available.
- Out of hours physiotherapy could be called for advice by the ward staff. There was on call physiotherapist available to be contacted every evening from 5pm until 7am.
- Discharge planning was considered at pre admission and at each stage along the patient's pathway. Nursing staff liaised with families and carers on admission to check there will be suitable care provision available before treatment started. The patients GP and the consultant were able to speak by telephone to ensure a continuity and accuracy of information provided. Any follow up appointments would be arranged for the out patients department and the patient's notes would be sent there.
- On discharge each patient's GP received a letter including the treatment provided and details of any implants used. This letter was either transported by the patient or sent through the mail. We viewed the template used and it included any planned follow up arrangements.
- Should the patient already have community support at home, nursing staff contacted the community teams to update and ensure services recommence.
- Should the community district nurse services be needed the ward staff would contact them via the patient's GP, prior to the patient being discharged. Any support needed would be discussed and arranged.

Seven-day services

- The hospital provided elective surgery Monday to Friday between 08.00 and 8.30pm and Saturdays on an ad hoc basis at the request of the surgeons. The type of surgery was dependant on which consultant was booked in for which day. Staff were aware of the patient lists in advance to enable staffing levels and rooms to be available.
- Nursing staff and the RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of senior management was available to support staff as part of an on call rota.
- The surgical services were able to access support from other health care professionals out of hours. A radiographer was available and was contactable out of hours. There was access to a physiotherapist and the pharmacy service was available Monday to Saturday out of hours by telephone. Should urgent diagnostic tests be needed, there was an on call member of the pathology team. We were also aware that the RMO had been able to undertake some diagnostic tests overnight by access to the lab.
- There was an out of hours on call theatre rota available including the consultant and anaesthetist for that patient should a patient need to return to theatre. This team were available within a 30 minute timescale to enable urgent return to theatre.

Access to information

- Patients had two sets of records whilst in hospital. One set of records remained at the nurse's station and travelled to and from theatre with them. A further file was left in the patient's room and contained observations and letters relating to the patient.
- All the Hospital's own records were kept on site, or recalled from a medical records store in time for their outpatient appointment.
- For those consultants whose secretaries were off site, it was a requirement of their practising privileges that they registered as a Data Controller with the Information Commissioner's Office. This information was held on their personnel file. All Nuffield Health files remained in the hospital's Medical Record facility, or at the local file store.
- We observed files being received ready for planned procedures and being returned to the store. They were secured in a key pad locked cupboard.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nuffield staff told us that the Nuffield Cheltenham does not accept referrals for patients who lack the capacity to

consent, however the provider told us they did. We saw 11 sets of records and all showed that the patients had capacity to consent. We saw consent records were fully completed and signed by the consultant and the patient. Records also indicated when a patient gave consent for their health conditions to be discussed with their next of kin. The consent form also included a facility for a translator to sign to say what input they had provided and an area for signature of a witness should the patient not be able to sign but had indicated his or her consent.

- Consent was completed by the consultant at the pre-admission visit and again during the procedure preparation. There was also a section in the patient's record to check the patient could demonstrate a clear understanding of the proposed procedure. We observed in theatre as part of the WHO checklist consent was confirmed. Further consent was seen for patients' data to be included in the National Joint Registry.
- The key health questionnaire also included questions for patients over the age of 65 about forgetfulness and dementia. Staff told us that they rarely had any patients with any level of dementia as the hospital was not a suitable environment to provide that level of care. There were no patients who lacked capacity to make their own decisions admitted at the time of inspection.
- We looked at records for two patients having undergone cosmetic surgery. The records did not state the cooling off period indicated to enable the patient to think about the procedure. Staff explained that often the period between pre assessment and admission was considered to be the cooling off period and that should the patient not wish to continue they would not attend for admission.
- The records also did not include in both cases a record of discussion about the patient's expectations and any risks to the surgery.
- Mandatory training was provided for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and theatres and the ward had achieved in excess of the providers level of compliance. A flow chart was available on the ward for staff to follow should escalation be needed.
- Staff told us a patient's choices for resuscitation were rarely requested to be noted. This was because the hospitals pre- assessment process for non-urgent elective surgery, considered all patients to be for resuscitation. The patient's consent record included any patient advanced directives/living will and the patients care record included a consideration of the patient's mental state. We did not see any choices for resuscitation in the records we saw. When a choice for resuscitation was requested the decision would be recorded on the appropriate form from the Reus Council and filed in the patient's care record.

Are surgery services caring?

Good

We rated surgical services as good for caring because:

- Patient feedback about the care provided was positive. Staff were seen to be kind and caring and their focus was on individualised patient care. Patients confirmed staff were professional, kind and attentive.
- Patients were kept informed at all times about their plan of care and their relatives and carers were encouraged and supported to be involved in the patients care. This included both the admission and discharge process. Patient's privacy and confidentiality was respected at all times.

Compassionate care

- We spoke with five patients who were complimentary about staff and the care they had received. They told us staff had been kind and caring and had treated them with dignity and respect.
- We observed staff knocked on doors before entering and addressed patients respectfully by the name they had requested. We also observed that staff asked patients for consent before any activity. We observed staff answering questions fully and checking that their answers had been fully understood.
- We saw cleaning staff interacting with patients and ensuring all conversations were courteous and pleasant.
- The hospital board meeting minutes noted for December 2015 patient satisfaction 93%; overall experience 96% - NHS patient satisfaction 100%
- The provider had a Privacy and Dignity Policy in place, this was accessible to staff and they were aware of its

content. All clinical staff, including therapy and medical staff, were responsible for ensuring the privacy and dignity of individual patients and clients is maintained in line with the policy.
- The Friends and Family Test scoring system was in place for NHS patients. For patients funded by any other method an alternative scoring system was in place to gather patient's views.
- For NHS the sample size was small due to the low numbers of NHS patients but the scores were high which indicated satisfaction with the service.

Understanding and involvement of patients and those close to them

- Each patient had a named nurse who they knew was caring for them. This ensured a continuity of care and enabled staff to hand over to the next person taking care of the patient. We saw that visiting was available for most of the day with a protected period after lunch for patients to rest. If a carer or patient's relative who provided a support role wanted to stay at the hospital, that was enabled to ensure the patient was as comfortable and settled as possible.
- All patients were involved in the pre-operative assessment and health questionnaire and some patient's records recorded discussions about treatment options. Patients told us they felt updated and included in their plan of care.
- If the patient was not an NHS patient costs and fees were discussed at the pre admission visit to enable the patient to make an informed decision about continuing with treatment

Emotional support

- With the patients consent we observed some procedures being provided. We saw staff were supportive and tried hard to ensure the patients physical and emotional wellbeing. We saw staff make patients comfortable, answer questions and ensure the patient was caused as little distress as possible.
- The patients anxiety was regularly assessed to ensure the patient was as comfortable as possible. This was monitored an included in the patient care record.
- Staff told us that should a patient with learning disability or any level of care support at home, the carer would be enabled to stay and support the patient. This would be assessed at pre-assessment to ensure the admission was safe and suitable for the patient.

Are surgery services responsive?

Good

We rated surgical services good for responsive because:

- Services were planned to meet patients' needs. The flow of admissions and discharges through the hospital was well organised.
- The needs of different patients were considered in the planning and delivering of the service. The provider was aware of further work needed to develop dementia care as part of the service and was taking action to address this shortfall.
- Complaints were responded to in a timely manner and learning taken to develop future practice.

Service planning and delivery to meet the needs of local people

- Patients were seen to arrive at different times to enable staff to manage admissions and to reduce the patients waiting times for patients.
- Staff in theatre and recovery told us that they were flexible to stay late if needed. Ward staff told us that should the workload be anticipated as busy, extra staff would be requested
- Patient satisfaction surveys were undertaken and the results collated and actions taken. Comments were seen to be positive. Feedback was provided to departments from the surveys.
- The hospital supported patients to be as fit as possible by providing access to health information in the outpatients department. Leaflets relating to giving up smoking and weight loss advice were available.
- We looked at the patient satisfaction surveys and saw that all written comments were positive but some of the most recent scores were low. These scores were about information and detail provided.

Access and flow

- Systems were in place to manage flow through the hospital. Following the pre-operative consultation in the out patients department, a planned date for admission was confirmed by letter. The length of waiting time varied dependant on the consultant and the procedure. We observed the flow of patients to be well managed without delays. When patients had to be cancelled, they

were immediately rebooked and a suitable time agreed. We observed when this took place and discussions with the cancelled patient took place. There had been 13 cancellations in the previous quarter, no trends were noted.
- Admission times varied and we saw that reception staff greeted patients and showed them to their rooms. Staff were responsive and attended the patient shortly thereafter.
- Due to the elective nature of the admissions a planned duration of stay was between one and four days dependant on the type of surgery. Staff told us that patients very rarely stayed over four days.

Meeting people's individual needs

- Patients told us they were well informed about their treatment prior to admission and that staff had provided any further information they needed. On discharge further information in a 'Going Home' pack which including contact details for the ward should they have any concerns. This pack also included advice about eating and drinking and any complications they may encounter.
- Each patients care record included if the patient suffered from delirium, which is a state of confusion, during their treatment. This was monitored and all care and treatment recorded.
- The hospital had lift access to each floor and wide access for patients using a wheelchair or walking aids. For patients with visual or hearing loss signage was available but no hearing loop was available.
- The provider told us "Managing the small numbers of patients with dementia is a work in progress. The few that are referred currently for surgery will either be accompanied by a relative or carer to maintain their safety, or an individual nurse provided for them, however, further education for staff is required and an environmental assessment needs to be undertaken to cover all areas to ensure the hospital can provide high quality services for this vulnerable group of patients". The provider recognised more work was needed to support patients with dementia and a new member of staff with dementia understanding was leading the work needed. Dementia training was planned for all staff.
- Specialist diets could be catered for and we saw hot drinks were provided on request and that relatives could also eat with the patients. There was a wide menu available and some flexibility in the serving times of meals.
- Patients were supported to be mobile post operatively by the physiotherapy staff and nursing staff. Advice and care plans were provided by the physiotherapy staff to ensure safe mobilisation post-surgery.
- Staff told us that should language be a barrier to ensuring consent they would access language services through the local trust.
- Visiting times were flexible during the day but the last visitors were required to leave by 9:30pm.
- All discharges were followed up, but more complex discharges were planned with the patients' GP and community services.

Learning from complaints and concerns

- CQC did not directly receive any complaints about the hospital between October 2014 and September 2015.
- Information on how to make a complaint was available within a leaflet which set out the process and what people should expect.
- There had been 35 complaints in 2015/16 of which we reviewed five. The Hospital Director was responsible for ensuring that all complaints were acknowledged in writing within two working days of the day on which the complaint was received. All those reviewed included an acknowledgement letter and response within the timescales set out in the policy. Responses were clear and set out the findings along with actions and any learning to be implemented as a result of the complaint. In some cases a wider investigation was undertaken, again with explanation of the findings and any actions.
- All complaints, investigation findings and lessons learnt were captured centrally with review at quality and safety committee. In one case staff had not followed the process for checking results which led to a review of process and staff awareness.
- A complaints policy was in place and accessible to staff. The hospital director took overall responsibility for the management of complaints. However, if the complaint involved any aspect of the clinical care of the patient, Matron, would lead on the investigation but would ensure the relevant Head of Department (HOD) was fully involved so that the investigation became a 'lessons learnt' experience for everyone involved.

- If the complaint involved a consultant with practising privileges then either the Hospital Director (HD) alone or Matron and the HD would meet with that individual to discuss the complaint, involving the Medical Advisory Committee Chairman as necessary.
- Of the complaints we reviewed we saw issues identified included areas of communication, attitude and some issues related to catering.
- We noted an outcome for each issue and when appropriate a letter of apology had been sent. A timescale was recorded for each response and all were within acceptable time limits. There was a process for complaints to be resolved independently if the complainant felt it had not been addressed by the hospital.

Are surgery services well-led?

Good

We rated surgical services as good for well led because:

- The vision and objectives for the service were evident and understood by staff.
- There were clear governance processes in place to monitor the service provided. However, some areas including the management of VTE needed further development to ensure they were safe.
- The current workforce was being stabilised and ongoing development was taking place to ensure strong and cohesive teams on the ward and in theatres.
- Leadership at each level was seen to be visible and responsive. Staff had confidence in leadership at each level.

Vision and strategy for this this core service

- There was a corporate vision for the hospital which included whole health and well-being. Matron and the governance lead tailored the corporate goals to the Cheltenham Nuffield Hospital. These goals were then cascaded to heads of department and to staff.
- Ward and theatre staff were not included in the choices of the goals or the development of the vision but were aware of their content. The organisations vision and objectives were seen to be on the ward wall for staff and patients to read.

Governance, risk management and quality measurement for this core service

- The governance structure for the hospital was the hospital board with the MAC and the Quality and safety committee providing information to the board. Information travelled from ward to board and vice versa.
- The hospital board consisted of three members, the hospital director, the matron and the finance manager. Matron was the only clinical representative on the board. The MAC reported to the board. The board met formally monthly and discussed a set agenda. They met informally each week to discuss the week. This meeting was not formalised or minuted to enable an audit trail of discussion.
- We reviewed board minutes and saw the agenda included infection control, incidents and review of the risk register.
- The Medical Advisory Committee had a representative from each surgical speciality and was an integral part of the governance structure. The Medical Advisory Committee (MAC) was led by a chairman and deputy Chairman. Surgery was monitored and reviewed by the MAC
- There were eight areas who reported to the Medical Advisory Committee (MAC) and Quality and Safety Committee, which in turn reported to the board. The eight groups included clinical heads of department, the resuscitation forum, the information governance forum (including medical records) and infection prevention committee. This enabled the flow of information from the hospital, through a divisional level to the board.
- Regular staff meetings took place every three months, the last nurses staff meeting was December 2015. We saw minutes for theatre and ward staff and these included discussions about areas of risk and development of the service.
- There was a ward bulletin produced weekly and this disseminated learning for staff. It was seen in the staff room and was emailed to staff and they signed to say they had read it.
- Matron had responsibility for maintaining the clinical risk register which covered all clinical services at the hospital. The highest clinical risk was associated with supply of instruments for theatres where ongoing issues with ripped packs and missing instruments had been a

cause for concern. Matron had raised the issues with the provider and while things were improving there was some more progress required for the hospital to be confident in the service.

- The Medical Advisory Committee (MAC) met quarterly throughout 2014 and at each meeting was provided with a short Infection prevention summary. Following the DIPCs attendance at the NMAH 3384 course, this report had been strengthened to include more detail to explain the development in infection prevention.
- On a monthly basis complaints were discussed at the Hospital Board Meeting and Head of Departments meetings and on a quarterly basis at the Medical Advisory Committee (MAC), Quality and Safety (Q&S) and Clinical Governance Meetings. At this time themes and trends are considered.
- We noted that the policy for VTE and how this was monitored lacked oversight. The policy was not specific did not give a definitive way Nuffield wanted VTE managed for maximum patient safety and as such different practices were taking place. We discussed this with the MAC chairperson. This had not been noted by hospital management and addressed.

Leadership / culture of service

- There was a recent increase in staff stability and a more defined leadership. Staff spoke positively about these changes and how this stability had improved the working environment. Leadership at local level for surgery was the MAC chairman, the lead for nursing theatre, recovery and ward was Matron. The RMO was responsible to Matron.
- At a divisional level each department had a head of department who reported to Matron. Either Matron or the Theatre Manager had a deputy and should they be unavailable long term, arrangements were not robust to support staff.
- Staff told us they felt the divisional and board level leads were visible and approachable. Matron was proud of the staff teams and reflected that they often went the extra mile for patients. There was a positive approach to 'thinking outside of the box' with staff willing to have a go at new ideas.
- Should staff require a level of performance management, this was undertaken by the head of department with the support of Matron. We spoke to some heads of department who confirmed that this support had been available.
- Following difficulties with CSSD, theatre staff now had a nurse lead for coordinating this aspect of service to address any issues.

Public and staff engagement

- The Patient Satisfaction Group had not been as pro-active recently as it had been in the past, due to changes in personnel. A new team had been put in place and they had held their first meeting but no actions as yet had been completed. The plan was for the team to encompass discussions about lessons learned from complaints going forward and patient satisfaction surveys.
- The 'You said, we did' personal feedback was being used and in some instances changed practice. For example, the provider had started to look at the where the patient lived to adjust admission times to enable a more convenient admission.
- We looked at the patient satisfaction monitoring results and there were 68 responses for the latest survey February 2016. There were lower scores for pre-operative assessment for the question 'where you told who to contact after you left hospital'. Of the 96 comments written, 93 were positive and patients spoke highly of the staff and service provided.

Innovation, improvement and sustainability

- The Hospital had established two new services in the last 12 – 18 months. Firstly, a Private Breast Care Service which included a Clinical Nurse Specialist in Breast Care, a certified complementary therapist and a private multidisciplinary team to support the four breast surgeons.
- The provider had also implemented a Musculo-skeletal (MSK) service which was led by a Consultant in Sports and Exercise Medicine.

Good

Services for children and young people

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

Information about the service

The Nuffield Cheltenham Hospital is run by Nuffield Health Group. It is situated on the outskirts of Cheltenham and offers services to patients from the NHS and those using other methods of funding.

The hospital does not offer an inpatient service for children and young people. It offers an outpatient service for young people between the ages of 12 and 18 years. This is for consultation and non-invasive procedures only and includes radiography and physiotherapy.

A review of children and young people's services was carried out in September 2015 resulting in some changes to services offered:

- Children under the age of 12 years are no longer seen at this hospital
- Children and young people of 12 years and above are seen for non-invasive and diagnostic procedures on an outpatient basis. For example, ENT, ophthalmology and orthopaedic specialties.
- 16 and 17 year olds are no longer offered inpatient services

Prior to September 2015 Nuffield Health Cheltenham Hospital offered both outpatient and inpatient services for children and young people. All children and young people above the age of three years could receive care as outpatients and those aged 16 and 17 years could be cared for as inpatients.

Between October 2014 – September 2015 endoscopy, surgery, medical care and diagnostic imaging were offered to children. Eight 16 and 17 year olds stayed overnight and 16 returned home on the same day as admission, 107 were seen for an initial consultation in OPD and 69 attended OPD for follow up consultation.

During the same period 231 children between three and 15 years of age were seen in OPD for an initial consultation and 145 were seen for a follow up consultation. All children and young people seen were non-NHS funded patients.

The outpatient department has:

- 11 consulting rooms
- an ear, nose and throat suite used for consultation and treatment
- ophthalmology room
- phlebotomy room, three treatment rooms
- two rooms used for pre-assessment

Radiology has rooms for general x-rays, and other for more specialist investigations such as magnetic resonance imaging, CT, Ultrasound, bone densitometry and mammography.

Physiotherapy services are part of the Wellbeing section of the service and is being integrated into One Nuffield. Services offered are treatment, rehabilitation gym services and an exercise studio.

An agency supplies trained medical staff who act as resident medical officers in the hospital.

During the time of our inspection we spoke with16 staff which included senior managers, directors, nurses, consultants, allied health professionals and administration. We also spoke with two parents and two young people at the hospital. We viewed information about the service and its performance but were unable to view any patient records at the time of our visit.

Good

Services for children and young people

Summary of findings

We rated children and young people's services as good overall because:

- Services for children and young people were offered in a safe way and changes had been made within the previous five months to ensure this was the case. The hospital now offered an outpatient only service for young people aged between 12 and 18 years of age.
- Managers ensured staff were competent to care for young people within the age group in the outpatient setting.
- Safeguarding children training had been attended by staff and plans were in place to offer further training at level two in line with guidance.
- Incident reporting, infection prevention and control and safety of equipment procedures were followed for all patients attending the hospital which included children and young people.
- Consultants managed their own patient record systems and we were told GPs received information in a timely way.
- Interactions we saw with young people and their parents were caring and appropriate for their age and understanding.
- Young people were assessed for their suitability to attend this hospital before an appointment was offered.
- Privacy and dignity of young people was respected and there were flexible waiting areas.
- Steps had been taken to provide leadership of the service but senior managers misunderstood Nuffield Group Policy about leadership of children's services.

However:

- Consultants arranged for records to be available for patients who were attending their clinics. The patient notes were retained by the consultant and not usually available for outpatient nursing staff to view. This meant that records of consultations were not available for staff to reference if a patient should call the hospital outside of the consultation.

Are services for children and young people safe?

Good

We rated services as good for protecting children and young people from avoidable harm because:

- Senior managers monitored staff competency to ensure that only appropriately qualified staff provided care for children and young people.
- All outpatient nursing staff and physiotherapists had completed basic life support for children and paediatric equipment was available for use in an emergency.
- Systems were in place to report incidents for adults and children. Infection control procedures were monitored with provision of hand sanitising gel for use by staff, patients and visitors to the hospital.
- The pharmacy service had no expertise relating to medicines for children or young people but children and young people had no medicines administered at the hospital.

However

- Level two safeguarding children training had not been completed by all staff who were in contact with children and young people. There had previously been no level two training available within the Nuffield Group. We were told by staff and the advisor for children's services that additional safeguarding training had been developed and added to training profiles for relevant staff.

Incidents

- A process was in place to report incidents and untoward events to the senior management of the hospital which was used for all parts of the hospital including children's' services.
- There were no serious incidents involving children or young people reported between October 2014 and September 2015.
- Quarterly governance meetings were held which were attended by representatives of each department and reported incidents were discussed. Staff had identified an incident when investigating a parent's complaint. This was reported at the clinical governance meeting of 25 August 2015 but no completion date or action had

been recorded. Senior managers described changes they had made following the investigation. The booking process was altered to ensure staff were acting within their agreed contract. Before allocating an appointment, booking staff used a reference document which detailed which professionals could see children and young people.
- No morbidity and mortality meetings were held at this hospital as there were no unexpected deaths

Cleanliness, infection control and hygiene

- The hospital had processes in place to protect all patients including children and young people, from acquiring infections in the hospital.
- There were infection prevention and control meetings monthly with representation from all departments of the hospital included a hospital board member, microbiologist, ward link nurses, infection prevention co-ordinator, and allied health professionals, housekeeping and catering staff. Infection control issues were discussed as a standing item at hospital board meetings.
- There were no reported infections involving children and young people.
- Hand sanitising gel was available at entrances to all departments for staff, patients and visitors to use.
- All staff we saw followed hospital protocol and ensured they were bare below the elbow in clinical areas. We observed staff using hand washing techniques between patient contact and using hand sanitising gel hands appropriately. All areas we visited were visibly clean.

Environment and equipment

- A system was in place and followed to ensure that the environment and equipment were in good order to reduce the risk of harm to patients and visitors to the hospital.
- Resuscitation equipment was available for children and young people of all ages in the outpatient department and on the ward area. We saw records of daily and weekly checks that were signed and dated by staff to ensure the equipment was ready for use in an emergency.
- Coffee and tea making facilities in the reception area were at a height that would prevent access by young children visiting the department.
- Adequate seating areas were available for young people attending the outpatient and physiotherapy department.

Medicines

- Pharmacy services were available in the hospital with processes in place for safe storage and administration of medicines.
- Dispensing services were not offered to young people at the hospital. If a child or young person needed a prescription for medications, this would be provided by the consultant caring for the patient who could then collect their medications from an alternative pharmacy outlet. Paediatric British National Formularies were available in outpatients should medical staff need to refer to them.
- Medicines were kept out of the reach of children in locked cupboards and fridges where appropriate.
- Medication incidents were monitored and reported to the leadership team. Between September and December 2015 there were no incidents reported that involved children or young people.
- Emergency medication was available for children who may suffer anaphylactic shock whilst at the hospital. Anaphylaxis is a severe allergic reaction that is life threatening. No invasive procedures or immunisations, or allergy testing was undertaken for children or young people meaning this would be unlikely to occur. The hospital had made a decision to make this available for any children attending the hospital as patients or visitors.

Records

- Consultants arranged for records to be available for patients who were attending their clinics. The patient notes were retained by the consultant and not usually available for outpatient nursing staff to view. This meant that records of consultations were not available for staff to reference if a patient should call the hospital outside of the consultation. However, nursing staff did not administer any treatment for a child or young person and responded to the verbal request of the consultant.
- Physiotherapy services maintained their own records electronically for patients they treated. When a course of treatment was completed physiotherapists ensured a letter was sent to the child or young person's GP detailing treatment and outcomes.

Good

Services for children and young people

Safeguarding

- Safeguarding training was in place to inform staff when and how to recognise and report safeguarding concerns.
- The hospital director and matron were identified as the leads for safeguarding children and young people. No safeguarding children concerns were reported between October 2014 and September 2015.
- The hospital took steps to ensure they met the standards for level one and three safeguarding children as set out in the intercollegiate document - Safeguarding children and young people: roles and competences for health care staff, March 2014. There was a hospital target for staff attendance at the level one training of 85%.The training records of 6 January 2016 showed all areas met the target except for two. These two areas had new staff (three in total) who were planning to attend the next available session which was planned for June 2016. The intercollegiate document recommends level two safeguarding children and young people training should be completed by non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers. The hospital did not meet this standard. This was because level two training had not been available within the Nuffield Group until January 2016. There had been some technical difficulties with placing this training on the profiles of staff but this had been rectified by Nuffield Group.
- Flow charts were displayed for staff to view and refresh their knowledge on appropriate actions if they suspected there was a safeguarding concern. Staff we spoke with were able to tell us what would alert them to a safeguarding concern and what action they would take.
- No formal safeguarding supervision was available although opportunities were used to update knowledge. For example, a Nuffield Health Matron's meeting took place in February 2016.This was attended by matrons from Nuffield Hospitals including Cheltenham and learning from the Saville Report was presented at this time.
- There was no system to inform staff if there were existing safeguarding concerns regarding a patient attending the outpatient clinic. Staff told us they would expect to be informed by the consultant (or their secretary) who was seeing the patient.
- Hospital staff had information on how to contact local safeguarding children boards and social services if they needed to but there was no regular attendance at any safeguarding meetings or serious case reviews. This limited the learning opportunities around safeguarding issues within the local community.
- A chaperone policy was available for staff to follow and notices were displayed in the outpatient department for patients to give them the choice. Staff told us they followed hospital policy regarding dignity and privacy. A parent would be assumed as a chaperone when attending with their child who was under 16 years of age. If the child attended without a parent, a member of nursing staff would take the role of a chaperone for the consultation. Young people between 16 and 18 years of age, attending alone, were offered a chaperone for their consultation.
- Consultants were expected to demonstrate their level of safeguarding training as part of their practising privileges. We saw hospital board minutes where this was monitored and plans the hospital board had to present evidence to the medical advisory committee at their next meeting.

Mandatory training

- Mandatory training was available for all staff and monitored by senior managers. Subjects included health and safety, basic life support, infection prevention and control. Most outpatient nursing staff had completed paediatric basic life support with five new members of staff planning to attend the next available training session.

Assessing and responding to patient risk

- The hospital did not admit any children for inpatient care. Children and young people who were seen as outpatients were generally well and not at risk of deteriorating following a procedure carried out at the hospital.
- Staff were aware that the hospital policy in an emergency for a child was to administer basic life support and dial 999 for further support.
- Physiotherapists assessed their patients by asking them or their parent what they activities they could manage and if any discomfort was felt.

Nursing staffing

Good

Services for children and young people

- There were adequate nursing staff but no registered children's nurses at the hospital. Children were seen as outpatients, by consultants and with parents present. The appointments we observed had a member of nursing staff present but no specialist skills for children and young people were required.

Medical staffing

- Consultants held outpatient clinics until 7.30pm.
- Resident medical officers were present in the hospital to cover routine needs of patients. They were provided by an agency and had experience and skills in paediatric care including advanced paediatric life support. Resident medical officers were not involved in outpatient consultations with children or young people but would attend if staff had any concerns about a child or young persons condition.

Are services for children and young people effective?

Not sufficient evidence to rate

We did not have enough information to rate the effectiveness of the service offered.

- Services for children and young people were delivered on an outpatient basis only.
- Systems were in place to ensure staff were competent to care for children and young people of the age range that visited the hospital as outpatients. Guidance was available and easily accessible for staff to follow if they were unsure of procedures.

However

- No audits were completed relating specifically to children and young people.

Evidence-based care and treatment

- Policies and procedures were available for staff to view on the intranet. Some information was available for quick reference. For example, safeguarding procedures with a flow chart was displayed on the wall near the nurse's station and basic life support procedures were attached to the emergency trolley.
- Any new guidelines for children's services would be discussed at meetings of the medical advisory committee (MAC). For example, NICE guidelines were discussed at the MAC meeting of 25 August 2015 and assessed for suitability of being adopted by the hospital. Actions needed to embed the guidelines into practice were identified. This information was cascaded to staff through the heads of department meetings and team meetings for staff to be aware of changes to their practice.

Pain relief

- No invasive procedures were carried out in the outpatient department. Consultants would provide a prescription and advice for management of pain when the patient was at home.
- Physiotherapists were aware of how pain could affect a young person by discouraging them from carrying out advised exercises. If pain was a problem for a young person they would alter the therapy administered to a level that was comfortable for the child or young person.

Nutrition and hydration

- A drinks machine was available in the reception area for any patient who required hot or cold drinks.

Patient outcomes

- Children and young people were not admitted to the hospital as in patients and no outcome measures were available following their outpatient appointment. There were no audits carried out specific to children and young people's services.

Competent staff

- A system was in place to ensure that all staff delivering direct care for children and young people had appropriate competencies.
- Consultants providing services to children were required to confirm their scope of practice based on the age groups being treated. We saw an example where one of the consultants had confirmed in their safeguarding training and the age of children they would be treating. Notes from hospital board meetings and the medical advisory committee showed discussions about practising privileges and any actions taken.
- Administration staff had a list of professionals with the scope of practice that was authorised by the hospital. They would check this list before confirming any appointment for an under 18 year old.

Good

Services for children and young people

- Physiotherapists had undertaken additional training relating to children and young people which was provided by Nuffield Group. They were able to explain how their approach to treatment might differ when compared with treating adults.
- Consultants' competencies were monitored and practising privileges (authority granted by a hospital governing board to provide patient care in the hospital) were not renewed if evidence of practise was not provided by them. For example, their practice at Nuffield Cheltenham Hospital was to mirror their NHS practice. If they did not see children at their NHS practice they were not allowed to see children at Nuffield Cheltenham hospital.
- GPs followed the same rules as the consultants regarding age range of young people being seen for non-invasive procedures only in their drop in clinics at the hospital.
- Nursing staff and physiotherapists had all completed basic life support training in paediatrics. None were trained in advanced life support for paediatrics. There was always a resident medical officer available who had completed advanced paediatric life support training.
- A paediatric trained radiologist visited once a week to perform ultrasounds for young people. All young people's x-rays were checked and ultrasounds reported on by this radiologist. The remaining radiology staff had no paediatric competencies.

Multidisciplinary working (in relation to this core service)

- Multidisciplinary working was limited but this was due to the limited service that was offered to children and young people at this hospital.
- Physiotherapists were available to offer treatments for children and young people. Consultants would refer patients for treatment where it was appropriate. We saw the physiotherapy department accepting an immediate referral from a consultant who discussed the young person's needs and plan of care.
- As patients were only attending the outpatient department for a short time there were no play therapists.

Seven-day services

- The outpatient department was available for appointments until 7.30pm on a weekday. This meant that children and young people were able to attend outside of school hours.

Access to information

- A letter was sent to GPs by the consultant's secretary following each consultation with a child or young person. We were told by the consultant this was generated within two working days.
- Physiotherapists provided progress reports for GPs as well as discharge summaries when treatment was completed.
- Consultants made their own arrangements for patients' medical records to be available and kept confidential. These were not usually available for outpatient nursing staff to view and no consultant records were held by the hospital. Information was relayed to nursing staff verbally from the consultant.

Consent

- Should written consent be required regarding treatment for a child or young person generic forms were used. It included instructions on who could consent and space for signatures from the young person and their parent (or person with parental responsibility). There was no opportunity to witness written consent for procedures being completed at the time of our visit. We witnessed explanations between consultant, young person and parent for ongoing treatment plans. Understanding was checked by the consultant and referral to physiotherapy was initiated after gaining verbal consent from the young person and parent.
- Consultants were aware of assessing young people's ability to consent for treatment using Gillick competency guidelines. Staff told us parents were always present with under 16 year olds.

Are services for children and young people caring?

Good

We rated caring for children and young people as good because:

Good

Services for children and young people

- Staff cared about the patients they came into contact with and spoke in appropriate ways for their age and level of understanding.
- Parents were encouraged to accompany their child to their consultation. If for any reason young people attended the GP drop in service without a parent a chaperone would be available for all ages and encouraged for those under 16 years.

Compassionate care

- We observed interactions between staff and patients ensuring they understood their options for treatment by giving them time to ask questions and answering in a way they could understand.
- We observed interactions between staff and young people. who were spoken to appropriately for their age and with respect.
- Parents we spoke to were happy with the service they received and stated they would be happy to leave their child in the care of the hospital if they needed to.
- Friends and Family test results were available for patients but did not identify feedback from children and young people.
- Patient experience forms were available for any patient to use. There were no specially adapted feedback forms for young people.

Understanding and involvement of patients and those close to them

- Young people were able to have their parents accompany them to the consultation. We observed explanations from staff in a way that young people could understand. Time was given for patient and parent to clarify options for treatment. Explanations were given to young people using models and displaying scan results for the patient to view.

Are services for children and young people responsive?

Good

We rated the responsiveness of children and young people's services as good because:

- Facilities were provided that were suitable for young people who over the age of 12 years, to receive consultation or non-invasive treatment. For example private rooms for consultation,
- Waiting areas were arranged in a way that could segregate a young person from any adult patients.
- Appointment times were flexible and offered around school hours.
- Complaints were investigated and acted upon.

However

- There was no age appropriate format for gathering the views of young people
- There was no young person friendly information displayed to inform them of services in the community such as sexual health services or emotional support.

Service planning and delivery to meet the needs of local people

- A review of services for children and young people was undertaken in September 2015 which identified Nuffield Cheltenham could not meet the regulatory standards for treating children and young people undergoing procedures as an in-patient. This was due to a lack of registered nurses for children. Senior managers of the hospital sought advice from children's specialists and redesigned the service to reduce risks to safety and offer outpatient, non-invasive consultations to include physiotherapy and radiology.
- Feedback was available using the standard patient experience forms and comments were not identified as being from children or young people.
- Waiting areas were available for all patients with soft chairs and sofas arranged around low coffee tables. There was no specific area for young people but two other small areas that could be used if the young person needed a quieter space to wait.
- Children and young people were seen at their appointment time in individual consulting rooms which provided privacy

Access and flow

- Between October 2014 and September 2015 none of the children referred to the hospital were NHS funded. Information provided about referral to treatment times was for all ages of patient. Patients and parents we spoke with told us they had arranged their appointment within a few weeks of first contact with the hospital.

Good

Services for children and young people

- Waiting areas were available at the hospital receptions and physiotherapy department areas. There were smaller waiting areas outside consultation rooms if the young person preferred to wait in them.
- Administrators checked the age of any child before allocating an appointment and ensured that any patient under 18 years old attending for an appointment was highlighted for staff to be aware. This was to ensure the young person was seen by staff who were authorised to do so. Staff demonstrated this to us on the day's electronic clinic list.
- There was a system for allowing choice of appointment times. The patients we spoke with had been offered a choice of appointment time to fit within a school lunch time and before school started.

Meeting people's individual needs

- Before making an appointment reception staff would check if the young person had any special needs to assess whether the hospital could meet their requirements. If there was any question that needs could not be met, the reception staff would liaise with nursing staff or consultants. Nursing staff told us they would expect the consultant or their secretary to ensure Nuffield Cheltenham Hospital were aware of any special needs a young person may have.
- Radiology had facilities to perform a range of x-rays and scans which young people of 12 years and above could access. Children living with autism could have plain x-rays but no complex scan procedures. Radiology staff would work with the carer of the young person as there were no facilities for distraction of the patient. Changing rooms were available for adults and young people to use if they needed to change their clothing for an investigation. If the young person did not want to use these changing rooms they could change in the x-ray room.
- Young people waited in the general waiting areas for their appointment and could be directed to quieter areas within outpatients or alternatively the physiotherapy waiting area. There were no young person friendly publications displayed such as information on sexual health and local services available and no information on safeguarding for the public displayed.
- Translation services were available from an alternative provider and staff told us they would also use hospital staff if they were available.

Learning from complaints and concerns

- Processes were in place for complaints to be reviewed and themes identified. Progress of complaints actions were discussed at hospital board meetings and heads of department meetings.
- Between the dates of October and September 2015 there were two complaints relating to young people. One of these preceded the change to the service but complaint records showed how details were investigated and actions were recommended.

Are services for children and young people well-led?

Good

We rated services for children and young people to be good for well led because:

- Patient safety was important to the leadership team of the hospital. Children and young people's services had been reviewed and actions taken to reduce risk.
- Governance procedures were in place to monitor effectiveness and quality of service although this did not single out procedures for children and young people. Information was cascaded to staff appropriately who felt informed of any changes.
- Investment in the gym for physiotherapy had a positive effect for young people suffering sports injuries.

However

- There was no focus in gathering views of staff or patients and their families in improving the service.
- Leadership of the service had become confused since the reduction of services offered. Nuffield Group Policy was interpreted differently by the hospital director and the Nuffield Health national children's advisor.

Vision and strategy for this this core service

- The strategy was to provide services for children and young people safely. As there were no trained nurses for children in the hospital this had reduced the service that

could be provided. The hospital board members were reviewing how they could increase their service for children and young people to develop their vision for the service.

- Safety for patients was an important factor in how services were delivered. The hospital director and matron had taken steps to ensure the service provided was as safe as possible. They had completed an assessment of children and young people's services in July 2015 using regulatory guidelines. The outcome of the assessment was that they could provide outpatient consultations and non-invasive treatments for young people between 12 and 18 years of age. The service had been reviewed in January 2016 with actions and updates documented and further review planned. Senior managers informed us they would seek advice regarding planning children's services from Nuffield Health's national advisor for children. The national advisor for children informed us the decision to provide children's services lay with the hospital director.
- At a heads of department meeting 22 December 2015 Nuffield Health Chief Operating Officer stated that he "recognised some hospitals need to stop children's services for a short term in order to achieve the standard, but ambition is to offer children's services where appropriate and safe to do so".
- Staff we spoke with was clear what their responsibilities were for children and young people and were aware that the future of the service had not been decided.

Governance, risk management and quality measurement for this core service

- Governance procedures were in place at the hospital with a range of meetings being held to review processes and how the hospital was performing.
- The medical advisory committee met three monthly with attendance from senior management and clinicians at the hospital. An ENT surgeon at the hospital represented children's services at the Medical Advisory Committee.
- Minutes recorded discussions which included outcomes of infection prevention and control measures, progress on audits, appraisals and competency of professionals. The meeting held 28 July 2015 discussed the withdrawal of invasive procedures for children under the age of 16 years following an assessment of the service.
- The hospital board consisted of three members and meetings were held monthly. Notes from the September 2015 meeting showed children's services were to be added to the risk register. This was because the safety of children and young people may be compromised if they could not meet the regulatory requirements. We saw this was added to the risk register on 08 September 2015. Details were included of the areas creating the risk such as no paediatric nurse available and no paediatrician with practising privileges at the hospital. Actions were documented to mitigate the risk by suspending inpatient services or invasive procedures for patients less than 18 years old. Dates for review of the service were identified on the risk register with actions and review dates.
- Clinical governance meetings were held quarterly and attended by the hospital matron, quality manager and department managers. Notes we viewed documented discussions regarding infection prevention and control issues and audit results with required actions identified. These were communicated to hospital staff through meetings between heads of department and cascaded to teams.
- Heads of department meetings were held monthly. Minutes of September 2015 documented the reasons that children's services were to be reduced and that they were waiting for further guidance.

Leadership / culture of service

- There was some confusion about who was the lead for children's services at the hospital. The hospital director and matron's interpretation of the Nuffield Group policy was that the children's lead for the service was the Nuffield Health children's advisor. The Nuffield Group children's advisor told us that she provided advice for children's services but did not act as the lead for the hospital. The Nuffield Group Children's Services Policy stated "Hospitals with outpatient - consultation only services, may choose to have a designated lead nurse directly employed by the hospital, an agreement with another Nuffield Health hospital where that hospital's designated lead nurse acts as an adviser or has access to a registered children's nurse through a formal consultancy/service level agreement." We were not told of any agreement with another Nuffield Health hospital for leadership of the service. Staff were clear they would take any concerns to the matron or hospital director on a day to day basis.

Good

Services for children and young people

- There was a culture of putting the patient first in all areas we visited. We observed polite and caring exchanges between staff and patients.
- Staff felt informed and every member of staff we spoke with was clear of the recent changes and the ages of young people who were treated at the hospital.

Public and staff engagement

- There was limited engagement with the public and staff regarding how services were to be provided for children and young people.
- The hospital director and matron had consulted with professionals outside of their organisation. This was to determine what the regulatory expectations were and how the hospital could ensure they met those regulations for children and young people.
- Staff were informed of services offered to young people but were not engaged in the process of changing the service.
- Patient feedback forms were available for adults, children and young people but were not designed specifically to encourage a child or young person to feedback their views.

Innovation, improvement and sustainability

- A consultant with a special interest in sports injuries had recently been given practising privileges at the hospital. Some of his patients were between the ages of 12 and 18 years. The physiotherapy department informed us they worked closely together and their knowledge of treating sports injuries had been enhanced. The hospital board had financed improved gym facilities enabling sports injuries to be treated more effectively.

Good

Outpatients and diagnostic imaging

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

Information about the service

The outpatient and diagnostic imaging services at Nuffield Hospital Cheltenham consisted of equipment and rooms for consultation, treatment and pre admission clinics. There were 11 general consulting rooms, an ear, nose and throat suite (for consultation and treatment), ophthalmology room, phlebotomy room, three further treatment rooms, and two pre assessment rooms. Minor operations for procedures requiring local anaesthetics only, were undertaken in the outpatients department.

The outpatient department including the pre assessment clinic was managed by the out- patient's sister. Diagnostic imaging also had its' own Manager. It was staffed by nurses, health care assistants and administrative staff. The physiotherapists were managed by a senior physiotherapist. The diagnostic imaging staff were managed by a senior radiographer. The outpatients department was usually open 08.30-19.30 Monday to Friday however the department did open 08.00 -21.00 if patients had appointments that required it.

The radiology department performed scans and x-rays using a variety of equipment which included a magnetic resonance imaging (MRI) and computer tomography (CT) scanner, ultrasound equipment, x-ray, bone densitometry and mammography. The hospital operated its' own static MRI scanner five days per week and CT scanning was provided by an alternative provider on three days per week.The imaging services were overseen by the Nuffield Health Cheltenham diagnostic and imaging department staff and operated according to Nuffield health policies. Nuffield Health Cheltenham operated a radiology department which provided services for plain x ray, fluoroscopy, ultrasound and mammography. Laser procedures were managed under the outpatient department management but were out of the scope of the CQC registration requirements so were not part of this inspection.

There were physiotherapy treatment rooms with space and equipment for sports rehabilitation in a gymnasium including an exercise studio.

The outpatient and diagnostic imaging department and pre assessment clinic employed 41 staff. During our inspection, we spoke with 16 staff including receptionists, health care assistants, radiographers, physiotherapists, nursing staff, and doctors. We also spoke with six patients and carers and reviewed six sets of patient records.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatient and diagnostic imaging department as good overall because;

- The service had processes which staff followed to report serious and other incidents and concerns. The service demonstrated that staff learned lessons and then changed practice when required.
- The outpatient and diagnostic imaging department was clean and tidy and there were systems in place to protect patients from acquiring infection.
- Equipment was maintained and patient records were stored safely
- Nurses, radiographers, physiotherapists and others had appropriate qualifications, skills, knowledge and experience to carry out the role in outpatients and diagnostic imaging.
- Staff spoke with patients and those who attended outpatient appointments with them in a respectful and considerate manner. Patients privacy and dignity was always respected in the care we observed
- Reasonable adjustments were made so that disabled patients could access and use the outpatient and diagnostic services.
- Complaints were handled effectively and confidentially. Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care.
- There was an effective governance and management framework to support the delivery of good quality care through learning from complaints or incidents.
- Meetings were held regularly on a monthly basis for Hospital Board Meetings and Heads of Department meetings.
- Staff we spoke with described feeling part of a team and that they were respected and valued.

However:

- We saw some evidence that World Health Organisation checklist were not completed correctly in radiology.
- Some staff said they would rely on family members for translation. This could lead to situations where patients needs and wishes were not properly known
- The strategy for developing the outpatient and diagnostic imaging department and means to deliver the vision had not yet been fully developed. The strategy was not yet embedded beyond the leadership team of the outpatients department. Although there was evidence of action plans and proposed audits to monitor and improve the service and inform strategy in the department.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

We rated safety in outpatient and diagnostic imaging department as good because

- A system was in place for staff to report serious and other incidents that were unexpected or untoward. Staff were aware of the system and felt it was easy to use if needed. No serious incidents involving outpatients had been reported October 2014 to September 2015.
- Lessons from concerns and incidents were shared with team members and actions were taken to improve safety beyond the affected team or service. For example staff forums had been conducted by the hospital matron and the Quality Improvement Committee to reinforce the importance of accurately entering and checking patient identifiable information. Further training had been provided to staff.
- The outpatient and imaging department were visibly clean and tidy. Hand gel dispensers were available throughout the department and staff used them. We also saw adequate supplies of personal protective equipment such as gloves and aprons which we saw used.
- The maintenance and use of equipment protected patients from avoidable harm. The radiology manager showed us the equipment maintenance logs for a range of imaging equipment which demonstrated that maintenance was safely carried out.
- Nurses, radiographers, physiotherapists and others had appropriate qualifications, skills, knowledge and experience to carry out the role in outpatients and diagnostic imaging.
- Patients' individual care records were written and managed in a way that maintained patient privacy and confidentiality. There were arrangements for safeguarding that protected adults, children and young people from avoidable harm.
- There was adequate staffing in the outpatient and diagnostic imaging department.
- Arrangements were in place to respond to emergencies and they had been practised in outpatients and diagnostic imaging department.

However

- Audit of hand hygiene February 2016 had showed low compliance in the imaging department and an action plan was produced. An audit in March demonstrated 100% compliance. The imaging department was also lower than the other departments in the hospital for rates of attainment for some mandatory training. For example safeguarding training was incomplete.
- Arrangements were in place to respond to major incidents but they had not been practised in outpatients and diagnostic imaging department. Some staff were aware there was a need to practise and review major incident awareness although this had not happened at the time of our visit.

Incidents

- A system was in place for staff to report serious and other incidents that were unexpected or untoward. Staff were aware of the system and felt it was easy to use if needed. No serious incidents involving outpatients had been reported October 2014 to September 2015.
- Staff understood their responsibilities to raise concerns, to record safety incidents, and near misses. For example staff in outpatients had raised several incident reports for example where wounds were identified as being infected, when appointments had been delayed in outpatients or when there had been double entries for a patient made on the electronic patient identification system.
- There had been some incidents where specimens had been mislabelled or lost. These had been investigated with actions taken to improve the process. For example staff now delivered specimens immediately to the pathology department instead of them being collected.
- Lessons from concerns and incidents were shared with team members at team meetings and on a one to one basis if needed. Actions were taken to improve safety beyond the affected team or service through mandatory staff meetings. The meetings had been conducted at staff changeover by the hospital matron through the Quality Improvement Committee to reinforce the importance of accurately entering and checking patient identifiable information. Further training had been provided to staff.

Duty of candour

- Staff demonstrated an understanding of the principles related to Duty of Candour. Duty of candour is regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.. We saw evidence that relevant people or patients were told when they were affected by something that went wrong. Investigations were carried out, patients were given an apology and they were informed of any actions taken. Some staff were not familiar with the term duty of candour, however, all the staff we spoke with confirmed they informed and apologised to patients when care was not as it should have been.

Cleanliness, infection control and hygiene

- The outpatient and imaging department including the consulting and treatment rooms and gymnasium were visibly clean and tidy. Hand gel dispensers were available throughout the department and we saw staff using them appropriately. There were adequate supplies of personal protective equipment such as gloves and aprons and we saw these in use.
- The hospital had systems in place to protect patients from acquiring infections in the hospital. The recently appointed senior staff nurse in the outpatients department was the infection prevention lead for the department and worked with others in the hospital to support infection prevention control measures such as hand hygiene monitoring. Infection prevention and control in the imaging department was managed by the radiology manager.
- Precautions were taken in the outpatients and radiology departments when patients with suspected communicable diseases were seen. Staff used designated rooms and took additional precautions where necessary to prevent transmission of infection. For example staff told us of an incident where they had used a separate room to minimise chances of infection as it had hard flooring. It had been cleaned immediately afterwards following infection prevention and control policy. Staff were able to show us where infection prevention and control policies were on the intranet such as for Methicillin resistant Staphylococcus aureus (MRSA).
- There was an infection prevention and control committee with representation from all departments of the hospital. This included a hospital board member, microbiologist, ward link nurses, infection prevention co-ordinator, allied health professionals, housekeeping and catering staff. Meetings were held regularly. Infection prevention and control was a standing item at hospital board meetings.
- The strategy for 2015 was included in the Infection Prevention Annual report and included plans to increase timeliness of root cause analysis reporting, monthly Health Care Acquired Infection rates monitoring and reduction and ensuring quarterly Infection Prevention & Control meetings were well-attended and minuted with detailed action plans that were regularly reviewed.
- The minutes of the heads of department meeting held September 2015 and 22 December 2015 included information regarding review of infection prevention control.
- The hand hygiene audit carried out February 2016 indicated a low compliance in the imaging department (33.3%). Some staff were washing hands and conducting aseptic technique appropriately but in some instances the technique was incorrect. An action plan was put in place discussed with the radiology manager and staff were supported with additional training which resulted in 100% compliance at next audit. The outpatient department scored 93.33%.

Environment and equipment

- The maintenance and use of equipment helped to protect patients from avoidable harm. We saw equipment clean and ready to use with stickers showing when it was cleaned. The radiology manager showed us the equipment maintenance logs for a range of imaging equipment. The logs were completed by the appropriate person and signed and dated which demonstrated that maintenance was safely carried out.
- We saw that the arrangements for managing waste kept patients safe. Waste bins used appropriate coloured bags for classes of waste which we saw being used appropriately.

Good

Outpatients and diagnostic imaging

- Resuscitation equipment for adults and children was checked daily and staff signed demonstrating it was available for use in an emergency.
- The imaging service staff had arrangements in place to control and restrict access to non-ionising radiation premises. In particular, Magnetic Resonance Imaging scanners and lasers were in rooms which had locked doors and appropriate signage. There were folders containing information relating to risk assessments for controlled areas.
- There was adequate seating and space in the outpatients department which was well signposted.
- The hospital's Patient Led Assessment of the Care Environment scores included the outpatient and diagnostic imaging department scores. The scores were the same or higher than the England average for: cleanliness, dementia, food, privacy, dignity and wellbeing and ward food. The hospital's scores were lower than the England average for: condition, appearance and maintenance.

Medicines

- The arrangements for managing medicines, medical gases and contrast media helped to protect patients from avoidable harm. This included the safe storage, administration and disposal of medicines. We saw medical gases stored appropriately in carriers. Contrast media used to highlight parts of the body when scanned in the imaging department was stored according to manufacturer's instructions. Appropriate records were kept by the imaging staff. Drugs were checked monthly for stock dates and storage cupboards were locked.
- Medicines were supplied from an onsite pharmacy and were available Monday to Saturday 9am to 5pm. The Pharmacist was available for telephone advice and there was a service level agreement in place for out of hour's provision of medicines in the hospital. Dispensing services were not offered to young people at the hospital. If a child or young person needed a prescription for medications, this would be provided by the consultant caring for the patient who could then collect their medications from an alternative pharmacy outlet. Paediatric British National Formularies were available in outpatients should medical staff need to refer to them. Prescription pads were securely stored and a log kept of prescriptions
- An audit of secure medicines storage was planned for 31 March 2016 shortly after our inspection.
- A medicines management forum met monthly to discuss audit results, updates and changes to practice. The attendance list of 30 October 2015, included staff from all areas of the hospital and the resident medical officer. Actions relevant to the outpatients and imaging department were identified, for example the senior radiographer was to review prescribing in the imaging department and ensure the information relating to the control of substances hazardous to health or COSHH was up to date and relevant. The audit was not completed during our inspection.

Records

- We saw that patient's individual care records were written and managed in a way that maintained confidentiality.
- There was a system in place to ensure that medical records generated by staff holding practising privileges were available to staff (or other providers) who may be required to provide care or treatment to the patient.
- All of the 16 records we saw in outpatients and diagnostic imaging were completed correctly. However some incident reports recorded a range of issues with records. The incident reports showed that, some discharge information was missing. The reports also showed that nurses had needed additional information from consultants who were not on site when patients attended the outpatients department for nurse led procedures such as suture removal. Some reports showed staff had recorded incorrect details in the minor operations book and patients were incorrectly charged. However the most recent information for an occurrence was May 2015 and involved incorrect specimen labelling. The specimen was later traced and staff now delivered specimens to the pathology laboratory instead of them being collected.

Safeguarding

- The Hospital Director and the Matron were jointly responsible for leading on all safeguarding within the hospital. All members of staff were required to complete level 1 safeguarding training as part of their mandatory training and this included information on the government policy on counter terrorism.
- Overall outpatients had 12 staff (92%) that had completed Safeguarding Children and Young Adults level one. Outpatient staff had also achieved (92%) for completing Safeguarding Vulnerable Adults level one.

Staff in radiology had 10 staff (83%) that had completed both safeguarding training. The figures were low in the pre assessment clinic due to several new starters but plans were in place to address the shortfall.

- Staff in outpatient and diagnostic imaging where familiar with female genital mutilation and how they would report it if suspected. The manager and staff told us of two examples that demonstrated an awareness of safeguarding in practice. We also saw written records of referrals to local authority safeguarding teams.
- There were flow charts within each department detailing the actions to be taken and who to contact in the event of adult or child safeguarding concerns or prevent issues arising.
- No safeguarding concerns were reported to CQC in the reporting period Oct 2014 to Sep 2015.

Mandatory training

- Staff received effective mandatory training in the safety systems, processes and practices of the hospital and outpatients and diagnostic imaging department.
- Mandatory training was available for all staff and monitored by senior managers. Subjects included health and safety, basic life support, infection prevention and control. Records monitoring staff compliance were variable. At 26 January 2016, between 33% staff and 100% of staff had completed the required modules. The lowest attainment was for pre-admission clinic staff who were yet to complete their training following recent appointments.
- Staff in outpatients had achieved 100% in all modules except for fire safety where three out of thirteen staff were incomplete. There was an action plan in place to address the shortfall.
- Physiotherapist had achieved all training except for one of 12 staff for basic life support and one of 16 staff for information governance.
- We saw completed records for all radiology staff relating to their scope of entitlement or what procedures that they could carry out according to Ionising Radiation (Medical Exposure) Regulations 2000.
- However, the imaging department were incomplete in several areas of mandatory training according to hospital records. Fire safety, health safety and welfare, information governance and managing stress were at 83% compliance. Manual handling practical was at 80%. Safeguarding children, young adults and adults were also at 83% (10 out of 12 staff had completed training).
- Hospital managers were aware of the variance in attainment when we spoke and they had an action plans for staff to be compliant for March and April 2016.

Assessing and responding to patient risk

- There were clear pathways and processes for the assessment of people within outpatient clinics or radiology departments who may have been clinically unwell and required transfer to an acute hospital. There was a standard operating policy in place for inpatient wards that staff in outpatients and diagnostic imaging would follow.
- Arrangements were in place to respond to emergencies and they had been practised in outpatients and diagnostic imaging department.
- We saw evidence of the World Health Organisation surgical safety checklist implemented in outpatients and the use of the checklist adapted for radiology. However while radiographers were signing where required we found that a consultant was signing incorrectly on the wrong form. We reported this to the hospital director and we were told action would be taken to ensure compliance.
- The radiology manager ensured that the radiation protection advisor was easily accessible for providing radiation advice. While there appeared to be a strong emphasis generally on promoting the safety and wellbeing of staff in outpatients and diagnostic imaging we identified during the inspection that there had been a delay in return of results of dosimeter badges. The badges measure levels of radiation exposure for staff. We shared this with the senior management team during the inspection. While a delay was evident there is no legal requirement to monitor staff. A risk assessment was in place that showed it was unlikely that exposure to a dangerous dose of radiation would occur. The delay was evidence that the process might be prone to failure to highlight to the radiology manager when there may be a concern regarding exposure to radiation
- The radiology manager and staff in their team ensured that x-ray, magnetic resonance imaging scans and other diagnostic tests, was only made in accordance with Ionising Radiation (Medical Exposure) Regulations 2000. There were additional processes in place to ensure that the right patient got the right radiological scan at the

right time. The radiology manager had implemented an additional six point check of name, date of birth, address, part of body, correct side identified and type of imaging to be used.
- There were warning and information signs and other information displayed in the radiography department waiting area informing people about areas and rooms where radiation exposure took place.
- The imaging staff ensured through screening at referral and appointments that women using the services and female staff who were or might have been pregnant always informed a member of staff before they were exposed to any radiation. Radiographers could offer pregnancy checks before imaging occurred if patients were unsure.
- We saw evidence of risk assessment carried out for consultants who performed ultrasound guided needle biopsy so they could provide evidence of competency.
- We saw evidence of a change to practice in continuity of care for patients following monitoring by outpatient staff. The patients had undergone trans rectal ultrasound guided biopsy of their prostate gland. The actions included a change to the prescribed dose of antibiotics and an increase in number of follow up telephone calls to monitor any untoward occurrences such as raised temperature. Staff advised patients to contact further medical treatment based on the information they received.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed in a way that protected patients from avoidable harm when receiving care and treatment. The outpatients and diagnostic imaging service had experienced some problems recently with recruitment. However the service was now stable with just one vacancy in radiography. Minutes of outpatients and imaging department staffing meetings showed for example that outpatient department staffing had been discussed and also recorded that the senior radiographer was hoping to recruit soon.
- There were eight outpatients nurses including a full time manager providing 5.87 whole time equivalent (WTE) full time staff a week.
- There were four healthcare assistants providing 2.91 WTE full time equivalent staff. There was a receptionist for the outpatient department who worked 28 hours in the week.
- The pre admission clinic had recently come under the management of the outpatient department and there were two nurses providing 1.85 WTE full time staff. There was also one healthcare assistant in the pre admission clinic who worked 24 hours in the week with a receptionist who worked the same hours.
- Staffing the imaging department consisted of five radiographers providing 4.40 WTE staff. The imaging department employed five receptionists providing 2.53 full time staff.
- The physiotherapy department for outpatients included seven staff covering equivalent to 5.16 WTE.
- The outpatients department had a good ratio of experienced to newer staff with 18% of nursing staff having less than one year service in the hospital. There were 82% of staff who had been employed longer than one year in the reporting period (October 2014 to September 2015).
- Levels of sickness amongst nursing staff were moderate between October 2014 and September 2015 resulting in a consistent staff environment. Overall the staff team was stable and consistent.
- Arrangements were in place for using bank and agency staff if there was a need. There was no use of agency nursing staff in the reporting period October 2014 to September 2015 for the outpatient departments.
- The hospital had comprehensive local induction policies. Staff new to the department told us they had completed their induction which had included health and safety, basic life support and procedures for reporting incidents.
- Arrangements for handovers and shift changes in outpatients and diagnostic imaging ensured patients were safe by ensuring that enough staff were available. The outpatients department used a board system that showed what staff member was allocated to what area and consultant and who was on what duty in the day.

Medical staffing

- Consultants who held clinics were responsible for the care of their patients. Secretaries organised the clinic lists around consultant availability. If the consultant was delayed or unable to attend it was the consultant's responsibility to provide cover with an alternative appropriately skilled consultant who also had practicing privileges at the hospital.
- The resident medical officer was not involved in supporting the consultant clinics.

Good

Outpatients and diagnostic imaging

- Consultant radiologists were not always on site but there was a process for cover for the hospital and they attended the hospital at least once a day usually when viewing imaging and scan results.

Major incident awareness and training

- Outpatient staff told us there was regular testing of fire alarms. Business continuity plans had been implemented when a planned generator test had affected the electronic information systems. The information required was always planned the day before the clinic started so disruption was minimal and there were plans to use additional confidential wireless systems should it happen again. This ensured the hospital as still able to provide care and support needed
- The arrangements in place to respond to major incidents had not been practised in outpatients and diagnostic imaging department. Some staff were aware that there was a need to practise and review major incident awareness however this had not happened at the time of our visit.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to provide a rating on the outpatient and diagnostic imaging department's effectiveness.

- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice.
- We saw evidence that World Health Organisation and other checklists were carried out in the imaging department
- There were no audits for minor operations undertaken to monitor and measure outcomes.
- We saw evidence that nurses, radiographers, physiotherapists and others had appropriate qualifications, skills, knowledge and experience to carry out the role in outpatients and diagnostic imaging.

However:

- We some evidence that World Health Organisation checklist were not completed correctly in radiology.

Evidence-based care and treatment

- Radiographers followed the Ionising Radiation (Medical Exposure) Regulations 2000 for the safe use of radiological equipment. We observed that every room in radiology had written procedures which were read and signed by any staff using radiology equipment. This ensured staff were aware of safety procedures to minimise patient risk. We saw records of World Health Organisation and other checklists that were carried out in the imaging department. There was evidence of some non-compliance by consultants for World Health Organisation checklists. The consultants were signing on the prescription sheet not the checklist. All checklists had been completed correctly by radiographers.
- Care and treatment in the outpatient and diagnostic imaging department was provided with guidance from the National Institute for Health and Care Excellence. A central Nuffield team then supported all Nuffield hospitals to remain updated and informed the hospital of changes to the guidance. Policies and procedures were available for staff to view on the intranet. Some information was available for quick reference. For example, safeguarding procedures with a flow chart was displayed on the wall near the nurse's station in the outpatients department and basic life support procedures were attached to the emergency trolley. Information was cascaded to staff through the heads of department meetings and team meetings for staff to be aware of changes to their practice and when actions needed to embed the guidelines into practice were identified. National Institute for Health and Care Excellence NICE guidance forms were sent to consultants to see if they complied with the latest guidance. Consultants were responsible for replying to say they did comply or the guidance was not relevant to their practice..
- We saw a recent audit of plain films from 'x-ray' procedures. Staff had identified that February 2016 plain film reject analysis results were close to what was considered to be of unacceptable quality. They were due to new staff, patient movement and machine settings from the manufacturer that needed adjustment after installation. Actions from the audit had been taken to advise all practitioners of a technique that could assist patients to maintain minimal or no movement.
- The sister and manager of the outpatient department told us they planned to audit the care pathway

documentation used for outpatients March 2016. Other audits planned by the outpatients' sister were for identifying completion rates of the World Health Organisation surgical and radiological checklists, chaperoning and maintenance of patient's privacy and dignity. The radiology manager had the following audits planned; pregnancy status and referral compliance, the World Health Organisation radiological checklist compliance and compliance with Ionising Radiation (Medical Exposure) Regulations 2000.

Pain relief

- Nursing records included a pain assessment chart. We did not observe its use in outpatients but staff told us they asked if patients needed any pain relief following procedures carried out in the department.

Patient outcomes

- The governance framework ensured that a range of outcomes and trends overall were reviewed and discussed. Any trends or themes identified in the electronic reporting system and patient satisfaction survey results were discussed at the monthly Hospital Board and Heads of Departments meetings and actions planned. They were also included in the quarterly Quality and Safety, Clinical Governance and Medical Advisory Committee meetings.
- There were no audits for minor operations undertaken to monitor and measure outcomes. Patients who returned to the department were those who needed further, more invasive treatment. Consultants providing treatment where responsible for monitoring their own success or otherwise of treatments. We saw evidence of a change to practice in continuity of care for patients following monitoring of outcomes by outpatient staff. The patients had undergone trans rectal ultrasound guided biopsy of their prostate gland. The actions included a change to the prescribed dose of antibiotics and an increase in number of follow up telephone calls to monitor any untoward occurrences such as raised temperature. Staff advised patients to contact further medical treatment based on the information they received.
- The Nuffield Group hospitals that Cheltenham Nuffield Hospital had a strategy for continuous improvement in infection prevention and control. This involved regular meetings and actions from those meetings. As an example infection prevention and control included pre-operative screening and post-operative monitoring of infection. There were audits of urinary catheter insertion and a pharmacy led antibiotic usage audit as well as hand hygiene monitoring and surgical scrub technique monitoring.

Competent staff

- We saw evidence that nurses, radiographers, physiotherapists and others had appropriate qualifications, skills, knowledge and experience to carry out their role in outpatients and diagnostic imaging.
- Practising privileges and competencies of consultants were monitored and they would be suspended from practising in the hospital if the standards were not met. The hospital responsible officer maintained a good relationship with the medical director of the NHS organisations where the majority of consultants worked. They ensured oversight of appraisals being provided and we saw an example where the trust had been written to in regard to appraisals which were due to be completed but not yet provided. The responsible officer role was also to ensure receipt of two professional references for consultant staff in line with the policy. Where a consultant wanted to add a procedure to their practising privileges they were required to evidence they were undertaking the procedure in another hospital then meet with matron prior to submitting to the medical advisory committee for approval.
- There was a comprehensive system that ensured consultants working under practising privileges arrangements only carried out treatments, procedures or reporting that they were competent to perform. The outpatient department sister and staff were familiar with what procedures should be carried out and felt they were able to raise issues if they were concerned.
- We also saw evidence that when staff took on new responsibilities they completed the appropriate competency assessment. For example physiotherapists had to complete competencies when the gymnasium had a new piece of equipment installed to use. The senior radiographer showed us examples of Ionising Radiation (Medical Exposure) Regulations 2000 compliance. For example the scope of entitlements for operators using the equipment. We also saw competencies for healthcare assistants including skills such as limb plastering.

Good

Outpatients and diagnostic imaging

- The learning needs of staff were identified through regular appraisal. Staff were encouraged and given opportunities to develop. For example radiographers took turns to attend conferences and then feedback to team members. Some developed specialties in imaging. We spoke with one health care assistant who had recently improved their management of fractured limbs and plastering through additional competencies. One of the physiotherapists showed us their training plan for 2016 which included issues such as pain/pain physiology. Radiographers and physiotherapists met separately to discuss professional journals.
- There were arrangements for supporting and managing outpatients nursing staff through quarterly appraisal and development meetings and a plan for revalidation. We also saw evidence that senior managers and other leaders had supported managers and staff when variable performance had been identified achieving change in behaviour and staff retention. The outpatient department sister and hospital matron were clear about the process they would use and we saw evidence of positive outcomes for staff.
- Staff administering radiation were appropriately trained to do so. We spoke with the radiology manager who showed us records demonstrating that staff were competent to operate diagnostic equipment in the department.
- Staff appraisal rates had increased from 2014 for all staff working in outpatients departments. Nursing staff appraisal rates increased from 50% in October 2014 to 91% in September 2015". Health care assistants appraisal increased from 67% in October 2013 to 100% in September 2015

Multidisciplinary working (related to this core service)

- Some meetings were multidisciplinary in the hospital. For example the heads of department meeting and clinical governance had good representation from across the hospital. At the December heads of department meeting the outpatient sister thanked the ward for the loan of staff when absence had caused staffing issues.
- There were systems that managed information about patients who used services and supported staff to deliver effective care and treatment. We saw evidence of staff in different teams who were involved in assessing, planning and delivering patient care and treatment.

Seven-day services

- The outpatients department was usually open 08.30-19.30 Monday to Friday however there was provision for the department to open 08.00 -21.00 if patients had appointments that required it.
- Some diagnostic imaging was available by appointment at weekends or late in the evening by prior arrangement if consultants anticipated that patients may need it.

Access to information

- No patients were seen in outpatients without the full medical record being available.
- All the Hospital's own records were kept on site, or recalled from a medical records store in time for their outpatient appointment. The Consultants' secretaries, whether internal or external, provided the Consultant's own notes prior to any outpatient appointment.
- We were told a few consultants removed notes off the hospital site. It was a requirement of their practising privileges that they register as a data controller with the Information Commissioner's Office. As a data controller there was a responsibility to handle information in a particular way to ensure confidentiality and security. The information was held on the consultant's personnel file and checked regularly.
- The outpatient and diagnostic imaging service provided electronic access to diagnostic results to other professionals as needed and where consent was gained to do so. We were told of an instance where other conditions had been identified when patients had undergone x-rays and this information had been shared quickly with relevant professionals so that urgent treatment could begin. Staff in outpatients and diagnostics also communicated with the patient's general practitioner to ensure information was shared.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their duties in law when obtaining consent and ensured explanations were given to patients in a way they could understand. Patients we spoke with felt they were given choice and understood the information provided for their decision making.
- Nuffield group Hospital followed a strict referral process and did not provide treatment to patients who lacked capacity to consent themselves.

Good

Outpatients and diagnostic imaging

- We were told by staff that patients were supported to make decisions at their own pace and a person's mental capacity to consent to care or treatment was assessed and, where appropriate, recorded. We saw evidence that procedures by nurses, radiographers and physiotherapists in outpatient and diagnostics were consented for appropriately.
- The pre admission clinic and consent procedures were designed to identify issues such as difficulty in consenting.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring in outpatient and diagnostic imaging department as good because

- We saw staff working with patients and those who attended outpatient appointments with them in a respectful and considerate manner. Some patients had mobility issues and staff ensured that patients and those with them were not rushed when they called patients and showed them where they were to go.
- Patients privacy and dignity was always respected in the care we observed
- We witnessed staff speaking in a caring manner with patients.
- Staff told us they would ensure patients advocates were with them if needed. For example when staff knew patients who attended had a learning disability and needed support. We were also told of the arrangements for translation services provided by a third party if they were needed.
- Female and male patients who were receiving treatment and support through the breast care service were offered emotional and social support through telephone calls at home during treatment started in outpatients. We saw evidence that treatment options were discussed with patients and they were encouraged to be part of the decision making process.

However:

- Some staff said they would rely on family members for translation. This could lead to situations where patients needs and wishes were not properly known

Compassionate care

- We saw staff working with patients and those who attended outpatient appointments with them in a respectful and considerate manner. Some patients had mobility issues and staff ensured that patients and those with them were not rushed when they called patients and showed them where they were to go. All staff we observed were encouraging and demonstrated a supportive attitude to patients who used the outpatient service.
- Patient's privacy and dignity was always respected in the care we observed. The outpatients department provided an accompanying or chaperone service during physical or intimate care. The service offered same sex chaperones when intimate personal care and support was being given by a member of the opposite sex.
- We witnessed staff speaking in a caring manner with patients. On arrival at the hospital patients were greeted by a receptionist. As they approached the reception desk they were given information and completed the appointment paperwork. Most patients we spoke with understood the information they received. Any queries were dealt with when they asked the receptionist or other staff for more help. Reception staff responded in a friendly manner to patients and stopped their conversation with the inspector to speak with patients.
- The service had arrangements in place to make sure that diagnostic imaging results were always available in a timely manner. We saw imaging department staff asking radiologists for results at short notice. This was in order that staff could relieve the anxiety of patients who were waiting for results.
- While the reception area was placed away from the chairs in the waiting area it was not completely private. It was possible for other patients to hear conversations between staff at the desk and a patient. This was more obvious if a patient had difficulty hearing and reception staff had to speak louder than usual or a patient was waiting at reception also. Reception staff told us that if a more private conversation was needed staff would guide the patient to a private room.

Understanding and involvement of patients and those close to them

- The patients we saw did not require support with communication. Staff were aware that they needed to communicate with patients so that they understood

their care, treatment and condition. They gave examples of when they had communicated with patients who had difficulty understanding but might not have had a formal diagnosis of for example dementia. Some staff said they would rely on family members for translation. This could lead to situations where patients needs and wishes were not properly known

- Patients described knowing who to contact if they were worried about their condition or treatment after they left hospital. We spoke with one patient in the outpatients department who was unsure of who to contact but knew they could contact the hospital if needed.
- We spoke with six patients during the inspection of the outpatient and diagnostic imaging department. Most patients we spoke with said they were very happy with the service.
  One patient in the outpatient department was not satisfied with the care they had received whilst they were an inpatient and was meeting with matron after their appointment to discuss these, as part of the complaints process. One patient told us they felt the service was relaxed and not rushed. Another patient said that they were well informed and would choose the hospital again if they needed further investigations or treatment. All had been kept informed and were aware of their ongoing plans for care.
- We chose a random selection of ten patient satisfaction survey forms from approximately 100 available in the breast care service in outpatients. All ten were positive comments.
- 2014 Nuffield patient surveys rated the hospital as either good or excellent averaging 97%

Emotional support

- Staff understood the impact that a patient's care, treatment or condition might have on their wellbeing and on those close to them. We saw evidence that emotional and social factors were considered. Some patients were offered an additional night accommodation when staff discovered there was no one to monitor the patient at home after a procedure. We were told of circumstances where male breast cancer patients were supported by being directed to a charity that supported well-being.
- Patients who were receiving treatment and support through the breast care service were offered emotional and social support through telephone calls at home during treatment started in outpatients. We saw evidence that treatment options were discussed with patients and how they were encouraged to be part of the decision making process.
- Patients told us that when they had been an inpatient the visiting hours were reasonable and staff wanted to ensure they were happy before the patient returned home. One patient described always being treated with kindness, compassion and respect and felt that physical and mental health was supported.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive in outpatient and diagnostic imaging department as good because

- The services provided through the outpatients and diagnostic imaging service met the needs of the population it served. We saw evidence of flexibility, choice and continuity of care.
- We saw evidence that sometimes appointments were delayed due to consultations overrunning. We spoke with one patient whose appointment was delayed but did not know why when we spoke with them
- Reasonable adjustments were made so that disabled patients could access and use the outpatient and diagnostic services. Areas were wheelchair accessible; reception desks had sections that were at wheelchair height. Complaints were handled effectively and confidentially, with a regular update for the patient or person raising the complaint. Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care.

Service planning and delivery to meet the needs of local people

- The services provided through the outpatients and diagnostic imaging service met most of the needs of the population. Patients we spoke with described flexibility, choice and continuity of care. Appointment times were offered either as set times so that patients could contact the consultant and request a different one or offered a range of dates and times to suit. The hospital had

received a limited number of referrals under a contract with Gloucestershire Clinical Commissioning Group. These were either through the Choose and Book system or directly via a local Hospital and were limited to orthopaedics, gynaecology and hernia repairs. From January 2016, the Choose and Book Hernia service had been discontinued, due to lack of Consultant availability.

- The environment was appropriate and patient centred. We saw comfortable and sufficient seating, toilets and facilities accessible to people with disabilities and to parents with small children who needed changing facilities. There was no separate play area for children in the waiting areas. The hot drinks machine was at a height away from small children and was in the line of sight of the reception area.
- Free parking was available but patients told us it was sometimes difficult to park. The car park and department was clearly signposted.
- There were over 20 outpatient and diagnostic imaging specialities offered including breast care, ear, nose and throat, general medicine and surgery, gynaecology, orthopaedics. We spoke with patients who were local and others who had travelled from outside of the county and who had bypassed private hospitals with outpatient clinics that were closer to where they lived.
- The hospital offered outpatient consultation only services for oncology patients and some procedures for patients with bladder cancer on the ward on an outpatient basis. No intravenous chemotherapy or other cancer treatments were provided.

Access and flow

- Patients we spoke with told us the appointments system was easy to use. We spoke with patients in the outpatient and imaging department who told us that they were offered a choice of appointment time. We saw evidence that sometimes appointments were delayed due to consultations overrunning. We spoke with one patient whose appointment was delayed but did not know why when we spoke with them. They had spoken with the reception team and were waiting for a response.
- Radiology appointments were of sufficient length and there was provision to extend the appointments if needed. The system for ensuring information was available before the appointment enabled staff to identify those people who may need more time.
- Care and treatment was only cancelled or delayed when absolutely necessary. We saw evidence of reasons for when patients had appointments cancelled which were shared with patients for example delays in consultants attending the hospital. The cancellations were explained to people honestly and patients were supported to access care and treatment again as soon as possible.
- There were 87 NHS funded patients who attended the outpatient and diagnostic imaging department for their first appointment from October 2014 to September 2015. There were 102 NHS funded patients who attended the outpatient and diagnostic imaging department for follow up in the same period.
- There were 8036 patients who were funded from insurance or self-pay schemes who attended the outpatient and diagnostic imaging department for their first appointment from October 2014 to September 2015 There were 7336 who attended the outpatient and diagnostic imaging department for follow up in the same period.
- Between October 2014 and September 2015, there were four months when less than 95% of non-admitted patients started their treatment within 18 weeks of being referred. The target was met in the remaining months.

Meeting people's individual needs

- Reasonable adjustments were made so that disabled patients could access and use the outpatient and diagnostic services. Areas were wheelchair accessible, reception desks had sections that were at wheelchair height and there were toilet facilities for patients with disabilities. We heard all staff speaking appropriately with patients which supported meeting their needs.
- Older patients we spoke with told us their care was good.
- Radiology staff were aware of the need to identify patients who were or might be pregnant and offered pregnancy tests for those who were unsure. Patients who were attending the imaging department who were breast feeding or planning to were given appropriate advice about having an x-rays during this time.
- Staff told us how they worked with patients that needed additional time to ask questions at new appointments. We did not see any evidence of equipment or aids that might be used for support in communicating or

distraction of patients who had special sensory needs. Staff said they would take advice from the patients' carers when carrying out procedures to ensure the patient was able to engage.

- Patients with bariatric needs were not referred to outpatients and diagnostic imaging at the hospital.
- The hospital had recently employed a nurse with experience of nursing patients and people with dementia. Staff in the outpatients and diagnostic imaging department we spoke with expressed how they wanted to improve their understanding of dementia and communication difficulties.
- Staff recognised when patients who used the service and those close to them needed additional support to help them understand, access and be involved in their care and treatment. We were told of arrangements for translation services which were available from a third party. Staff told us they would ensure patients' advocates were with them if needed. For example when patients attended who they knew had a learning disability and needed additional support to communicate.

Learning from complaints and concerns

- A process was in place to deal with complaints and concerns. Hospital policy identified that a response should be provided to the patient raising a complaint within 20 working days. The replies that we saw were within these time limits. Complaints were handled effectively and confidentially, with a regular update for the complainant and we saw evidence of formal records that were kept and actions taken as a result. Complaints were acknowledged in writing within two working days of the day on which the complaint was received. In some cases the hospital director or matron would ring the patient to gain more clarity around the complaint and offer them the opportunity for a face-to-face meeting to discuss the investigation or findings.
- The Hospital Director and Matron would discuss a complaint as soon as they could after it arrived and commence an investigation. On a monthly basis complaints were discussed at the Hospital Board Meeting and Head of Departments meetings and on a quarterly basis at the Medical Advisory Committee, Quality and Safety and Clinical Governance Meetings. Themes were shared with staff in groups in meetings or individually if needed. Staff felt it was very easy to recognise developing themes and address these immediately due to the small size of the hospital and numbers of patients involved.
- The patient satisfaction survey questionnaire had a dedicated section for patients to raise concerns and the process in place ensured they would be contacted by staff within two working days of the survey company passing the form to the hospital.
- We saw patient satisfaction survey results were displayed around the hospital and these included comments about either the service or individual staff members. These were also discussed at the Hospital Board and Quality and Safety Meetings.'
- Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care. Findings were shared appropriately with hospital and Nuffield group staff as needed. We saw how a root cause analysis had identified key issues and learning such as staff being reminded to follow process correctly and consultants changing their practice following learning. Patients were also informed to take complaints further if they were not happy with the initial outcome.
- We saw evidence that some patients had complained in situations where the patient was responsible for full or partial cost of care or treatment and there had been a disagreement over a bill or misunderstanding about care. We saw evidence that hospital staff made every effort to ensure complaints were resolved in this situation and that there were appropriate discussions about the cost. We spoke with one patient who was due to have follow-up treatment and was considering pursuing a complaint regarding her inpatient stay.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led in outpatient and diagnostic imaging as good because

Good

Outpatients and diagnostic imaging

- The vision for outpatients for the leadership team was informed by the corporate vision. Most staff were able to explain they aspired to provide care of such a standard that Nuffield Cheltenham were the first choice for care with an outstanding reputation for 'patients come first'.
- We saw evidence of actions that had been taken which the hospital senior management team felt would support a strategy for achieving the local and corporate priorities and delivering good quality care.
- The senior management team were aware of the risks in the hospital and there was an effective governance framework to support the delivery of good quality care through actions from meetings.
- Staff we spoke with described feeling part of a team and that they were respected and valued.
- We saw senior managers visiting the outpatients department during our visit and we were told this was a normal daily occurrence.

However:

- The strategy for developing the outpatient and diagnostic imaging department and means to deliver the vision had not yet been fully developed. The strategy was not yet embedded beyond the leadership team of the outpatients department. Although there was evidence of action plans and proposed audits to monitor and improve the service and inform strategy in the department.

Vision and strategy for this this core service

- Outpatients was a term used to include the pre-assessment clinic and breast care service. The vision for outpatients was informed by the corporate vision which aspired to provide care of such a standard that Nuffield Cheltenham were the first choice for care with an outstanding reputation for 'patients come first' We spoke with staff who were familiar with some of the Nuffield group values of being enterprising, passionate independent and caring (EPIC). Staff we spoke with felt that the values and vision were something that was shared with them rather than designed by them.
- The strategy to deliver the vision had not yet been developed for outpatients department although there was evidence of action plans and audits from minutes of meetings to monitor and improve the service in the department. We saw evidence of actions that had been taken which the senior management team felt would support a strategy for achieving their priorities and delivering good quality care.
- The senior management team were able to identify strengths in service delivery and areas that were noted for improvement not least the dementia action plan.

Governance, risk management and quality measurement for this core service

- There was an effective governance framework to support the delivery of good quality care through actions from meetings held. For example learning from complaints or incidents was discussed on a monthly basis through the Hospital Board Meeting and Head of Departments meetings and on a quarterly basis at the Medical Advisory Committee, Quality and Safety and Clinical Governance Meetings.
- The main risks for the hospital were documented in the Board of Governors papers and the main risks within Divisions were documented in their risk registers and included in Divisional Operational Board papers. Local risks at outpatient and diagnostic imaging department level were documented in a local risk register. Risks could be escalated as appropriate to specific boards and committees for discussion and action. We saw local risk registers and actions taken to mitigate risk.
- The outpatients department sister described issues relating to the department as the refurbishment of the department, issues with the leaking roof although the roof did not affect outpatients directly. Also the processes and outcomes for trans rectal ultra sound biopsies. In particular the identification and monitoring of post-operative complications of the biopsies. The radiology manager spoke about ultrasound competencies for consultants carrying out fine needle biopsy with ultrasound and this issue was on the risk register. The hospital director had spoken about the World health organisation checklist completion and sterile equipment supplies as being a risk. The local and corporate risk registers included these issues with actions to address them.
- The senior management team were aware of the risks in the hospital. For example the structural risks relating to building condition which might affect patient

experience in a negative way and risks to service provision from administering poor quality care if staff were not trained adequately and relying on the quality assurance of their external providers.

- The medical advisory committee played a key part in the approval of practising privileges with all new applications being discussed. We saw evidence of this in minutes of the meetings along with examples where consultants wanted to undertake new procedures and these were discussed and agreed by the medical advisory committee. Once approved by the medical advisory committee consultants were sent a formal agreement to sign to agree to work within the practising privilege policy and within the scope of practice agreed.
- The working arrangements with third party providers for some imaging services were managed through service level agreements. The assurance that they followed Nuffield Cheltenham policy and procedure was with the radiology manager.
- Staff we spoke with during the inspection of outpatients and diagnostic imaging were clear about their roles and they understood what they were accountable for. The Registered Manager was clear they were accountable for ensuring that the regulated activities were delivered in accordance with the Fundamental Standards (Regulations 8 to 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).
- The sister in the outpatient department and staff ensured that consultants who invited external staff (for example their own private nurse) to work with them in the outpatients department could not work unless they had undergone appropriate checks.
- While there appeared to be a strong emphasis generally on promoting the safety and wellbeing of staff in outpatients and diagnostic imaging we identified during the inspection that there had been a delay in return of results of dosimeter badges to the radiology manager. The badges measured levels of radiation exposure for staff. We shared this with the senior management team during the inspection. While a delay was evident there is no legal requirement to monitor staff. The imaging department were engaging in voluntary personal dose monitoring. A risk assessment was in place that showed it was unlikely that exposure to a dangerous dose of radiation would occur. We saw emails relating to the radiology manager having queried the delay but no evidence of it having been escalated as a concern to the hospital director or matron.
- The quality and safety sub-committees of the relevant boards led on quality performance including: setting the required quality standards against evidence bases. They provided the support in the achievement of required standards. This included audit and measuring customer feedback. We saw evidence of completed formal audit in outpatients and imaging. We saw evidence of Investigation and actions being taken on sub-standard quality and safety performance.
- Each year a publicly available summary of the monitoring of quality and safety performance was published on the group website.

Leadership / culture of service

- Staff we spoke with described feeling part of a team and that they were respected and valued.
- We saw senior managers visiting the outpatients department during our visit and we were told this was a normal daily occurrence. Staff told us they could discuss any issues with the management team and felt they were listened to. We saw evidence that action was taken to address behaviour and performance that was inconsistent with the vision and values of the organisation which had resulted in a better sense of team working.
- Before inspection we were aware that the outpatients department had undergone some change in personnel, roles and recruitment which had impacted on some staff. During our visit the sister of the outpatients department and the team members worked well together. We were told that the sisters door 'was always open' for staff to share concerns and service development issues.
- We saw evidence that the culture of the outpatients and diagnostic imaging department was centred on the needs and experiences of patients who used the services. For example mistakes and complaints were handled openly and sensitively.
- We saw evidence that staff and the teams of nurses, healthcare assistants, therapy and imaging staff worked collaboratively to ensure services ran well. A radiologist did not always attend the multi-disciplinary meeting held on a Tuesday evening but the radiology manager sent written reports to the meeting.

Good

Outpatients and diagnostic imaging

Public and staff engagement

- Patients and others who used the service were asked their views on care they received. The breast care service had recently gathered 100 responses in a survey although all the results had yet to be audited. We randomly sampled 10 and all were positive. The interim analysis by the breast care nurse showed that 22 responses were all positive.
- Staff engaged in regular informal and minuted development meetings with the sister of the department. Radiology and physiotherapy staff met with their respective leads regularly also.
- Staff engaged at various levels in a range of meetings and views were shared on service development. Staff told us they could discuss any issues with the management team and felt they were listened to.

Innovation, improvement and sustainability

- We saw meeting notes that recorded discussions between heads of department and senior management team where reasons and supporting evidence were being considered for various improvements to the outpatient and diagnostic service. For example the staffing level in radiology was discussed and the recent inclusion of the preadmission clinic into outpatients department to improve leadership links.
- Recently staff had instigated a follow up telephone call at one week after a trans rectal ultrasound biopsy. This was to ensure patients were following after care guidelines and to monitor any signs of infection. The imaging facilities had also recently been upgraded.
- The 2016 budget included plans for upgrading the hospital as a whole to ensure the appearance of the environment was uniform and of a high standard throughout the site to enhance patient experience.
- The Hospital had established two new services in the previous 12 – 18 months. A private breast care service which included a clinical nurse specialist in breast care, a certified complementary therapist and a private multidisciplinary team to support the four breast surgeons.
- There was a musculoskeletal service which was consultant led. The service included ultrasound diagnostic capabilities, the use of a specially designed gym with state of the art equipment to help treat musculoskeletal problems for patients and immediate referral for magnetic resonance imaging scans should they be needed. It was supported by a team of physiotherapists.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure all records are stored securely and there are no risks of patient confidentiality.
- The hospital must ensure the management and recording of venous thromboembolism prophylaxis is clarified. That risks are appropriately recorded and managed and policies ensure patient safety.
- The hospital must maintain secure, accurate and contemporaneous patient records at the hospital, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided
- The hospital must ensure World Health Organisation checklists are signed correctly by all staff including consultant staff working in imaging.

Action the provider SHOULD take to improve

- The hospital should ensure sufficient WHO audit records are in place to provide reassurance that sufficient have been completed to provide an accurate measure.
- The hospital should ensure safety audits for non NHS patients are undertaken to ensure safety of all patients.
- The hospital should ensure all staff having contact with children and young people are trained as outlined in national guidance - Safeguarding children and young people: roles and competences for health care staff, March 2014.
- The hospital should consider improving links with local safeguarding children boards.
- The hospital should consider providing information suitable for young people attending as patients.
- The hospital should consider how to gather feedback from children and young people.
- The hospital should ensure regular feedback on voluntary monitoring of radiation exposure levels to staff is obtained within recommended time frame.
- The hospital should ensure required mandatory training is completed for outpatients and diagnostic imaging staff.
- The hospital should ensure major incident scenarios and practice include outpatient department and imaging staff and are held to supplement the business continuity plans.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Risk assessments for venous thromboembolism (VTE) were not consistently recorded to reflect the detail of the risk and that any identified risk had been communicated to the consultant. The provider must ensure that risks are appropriately recorded and managed. Policies and practices for VTE varied. The provider must ensure that the management and recording of venous thromboembolism prophylaxis was clarified and policies ensured patient safety. World Health Organisation safety checklists in the imaging department were carried out by two members of staff but only signed by one. The provider must ensure that risks are appropriately recorded and managed. 17(2) (c) Such systems or processes must enable the registered person, in particular, to: (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Requirement notices

Records were seen unattended by staff on the ward area of the hospital. The provider must ensure that all records are stored securely and there are no risks of patient confidentiality being compromised.

The hospital did not operate a system of retaining a complete record for each child or young person who was seen in the outpatient department. Consultants managed the records for their own patients which were not kept at the hospital. If nursing care and physiotherapy was needed records would be created and retained by the hospital for professionals' reference.