One Hatfield Hospital Limited

Quality Report

3 Hatfield Avenue
Hatfield
Hertfordshire
AL10 9UA
Tel: 01707 817541
Website: www.onehealthcare.co.uk

Date of inspection visit: 28 June, 2 to 3 and 15 July 2019
Date of publication: 12/09/2019

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

One Hatfield Hospital is operated by One Ashford Healthcare Limited, who have one other hospital site. The hospital has 34 beds; 18 inpatient beds, 13 day case beds and three extended recovery beds. Facilities include three operating theatres, a dedicated endoscopy suite, outpatient and diagnostic imaging services.

The hospital provides surgery, services for children and young people, outpatients, diagnostic imaging and endoscopy services. We inspected and rated all of these services.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 28 June, 2 and 3 July 2019. We gave staff two days' notice that we were coming to inspect. We also carried out an unannounced visit on 15 July 2019 where we revisited surgery, children and young people, outpatients and endoscopy services.

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

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

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

See the surgery section for main findings.

Services we rate

We rated this hospital as **Good** overall.

We found good practice in relation to:

- The provider had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and mostly managed safety well. The provider controlled infection risk well. Staff generally assessed risks to patients and acted on them. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The provider planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access services when they needed them and did not have to wait long for treatment.

Summary of findings

- Leaders ran services well using reliable information systems and generally supported staff to develop their skills. Staff understood the provider's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The provider engaged well with patients and staff. All staff were committed to continually improving services.

We found areas of outstanding practice:

- Catering department staff went above and beyond to ensure patients' nutritional needs and preferences were met. They spoke to patients' to check if they had any food allergies and/or specific dietary requirements. They had developed a wide range of menus to meet patients' religious, cultural and health needs, as well as individual preferences including halal, kosher, vegan, African Caribbean, gluten free, low-residue and fork mashable. The department also supported staff to lead healthier lives by producing low-calorie, healthy meals for them to support those trying to lose weight.

We found areas of practice that require improvement:

- Staff working in the outpatients and diagnostic imaging services did not always keep detailed records of patients' care and treatment. We found outpatient records were not always signed and dated in accordance with best practice, or in line with hospital policy. However, records were generally clear, up-to-date and easily available to all staff providing care.
- Staff in the diagnostic service did not robustly complete risk assessments for each patient and remove or minimise risks.
- We were not assured the surgery, diagnostic imaging and endoscopy services always prescribed, gave and recorded medicines well, and that patients always received medicines at the right time. Prescriptions were not always correctly completed. Furthermore, we found medicine errors and omissions were not always promptly fed back to staff. We raised these concerns and found immediate action was taken to address them. We found improvements had been made in the surgery and endoscopy services when we returned on our unannounced inspection.
- We were not assured all staff in the outpatients service knew how to use blood glucose monitoring equipment. We raised this as a concern and when we returned on our unannounced inspection, we saw additional training was planned.
- While patients and their families were informed when an investigation was being undertaken, we were not assured they were always involved in them investigations.
- It was unclear if staff in the diagnostic imaging service provided care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. However, following our inspection we were sent up-to-date policies.
- Patients and parents were not always given a copy of their consent form. Senior staff took immediate action to address this concern. When we returned on our unannounced inspection, we saw consent forms were sent to patients' following their appointment.
- There was limited evidence to demonstrate staff in the diagnostic imaging service used audit findings to make improvements and achieve good outcomes for patients.
- At the time of our inspection, the endoscopy service did not collect patient outcomes but were planning to do so once endoscopy reporting software was in place.

Summary of findings

- There were limited facilities for children, young people and adolescents attending the outpatient and diagnostic imaging departments.
- Effective local governance processes were yet to be embedded throughout the diagnostic imaging service to monitor and assess performance. Regular opportunities to meet, discuss and learn from the performance of the service had yet to commence.
- The diagnostic imaging service did not collect reliable data and analyse it. Staff could not always find the data they needed. These were not in easily accessible formats, to understand performance, make decisions and improvements.
- There was no leadership development programme available for staff.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notices. Details are at the end of the report.

Heidi Smoult
Deputy Chief Inspector of Hospitals (East)

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Services for children & young people	Good	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.
Outpatients	Good	Outpatients services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, caring, responsive and well-led. Although some elements in the safe domain require improvement, the overall standard of service provided outweighs those concerns. Therefore, we have deviated from our aggregation rating of the safe key question to rate this service in a way that properly reflects our findings and avoids unfairness. We do not rate effective for outpatients.
Diagnostic imaging	Requires improvement	Diagnostic imaging services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as requires improvement because safety and leadership require improvement, although we found the service was caring and responsive. We do not rate effective for diagnostic imaging.
Endoscopy	Good	Endoscopy services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We rated this service as good because it was safe, responsive and well-led. We do not rate effective for independent endoscopy services. We did not have enough evidence to rate caring.

Summary of findings

Contents

Summary of this inspection

Page

Background to One Hatfield Hospital Limited 9

Our inspection team 9

Information about One Hatfield Hospital Limited 9

The five questions we ask about services and what we found 11

Detailed findings from this inspection

Outstanding practice 104

Areas for improvement 104

Action we have told the provider to take 105

Good

One Hatfield Hospital Limited

Services we looked at:
Surgery; Services for children & young people; Outpatients; Diagnostic imaging; Endoscopy

Summary of this inspection

Background to One Hatfield Hospital Limited

One Hatfield Hospital is operated by One Ashford Healthcare Limited. The hospital was purpose built and opened in December 2017. It is a private hospital in Hatfield and primarily serves the communities of Hertfordshire. It also accepts patient referrals from outside this area. The hospital provides services for adults, as well as children and young people from the age of 0 to 17 years.

The hospital is registered to provide the following regulated activities:

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

The hospital has had a registered manager in post since registering with the Care Quality Commission (CQC) in December 2017.

The registered manager is the hospital's accountable officer for controlled drugs.

The hospital offers services to NHS patients, self-pay funded patients and privately insured patients.

Our inspection team

The team that inspected the service comprised of a Head of Hospital Inspection, four CQC inspectors, one CQC assistant inspector and seven specialist advisors with expertise in surgery, anaesthetics, endoscopy, paediatrics, outpatients, diagnostic imaging and governance. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection, and Martine Pringle, Inspection Manager.

Information about One Hatfield Hospital Limited

One Hatfield Hospital provides inpatient and day case elective (planned) surgery, diagnostic imaging and outpatient services for various specialties both to private and NHS patients. This includes, but is not limited to, ear, nose and throat (ENT), general surgery, gynaecology, orthopaedics, pain management, plastic surgery, spine and urology. It has 18 inpatient beds all with ensuite facilities and a further 13 day case beds. The hospital has three operating theatres, all of which have laminar flow (a system that circulates filtered air to reduce the risk of airborne contamination). The third theatre is used for the provision of endoscopy if patients required anaesthesia or sedation. The hospital also has a three-bedded extended recovery unit and three minor treatment/ investigation rooms, 10 consulting rooms and diagnostic imaging facilities, which include magnetic resonance imaging (MRI), X-ray and ultrasound scanning. Physiotherapy facilities include one treatment room, a two-bedded bay and gym area.

During the inspection, we visited all departments. We spoke with 65 members of staff including nurses, consultants, healthcare assistants, operating department practitioners and senior managers. We observed the environment and care provided to patients and spoke with 15 patients and relatives. We reviewed 63 patient records and 29 prescription charts. We also looked at a range of performance data and documents including policies, meeting minutes, audits and action plans.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital's first inspection since registration with CQC, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (March 2018 to February 2019):

Summary of this inspection

- In the reporting period March 2018 to February 2019, there were 1,352 total inpatient and day case episodes of care recorded at the hospital; of these 20% were NHS-funded and 80% other funded.
- 32 inpatient and day case episodes of care (2%) were recorded at the hospital for children and young people; of these, 0% seen were aged 0 to 2 years, 50% were aged 3 to 15 years and 50% were aged 16 to 17 years.
- 8% of all NHS-funded patients and 92% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 11,828 outpatient total attendances in the reporting period; of these, 3% were NHS-funded and 97% were other funded.
- 640 outpatient attendances (5%) were for children and young people; of these, 12% seen were aged 0 to 2 years, 54% were aged 3 to 15 years and 34% were aged 16 to 17 years.
- The percentage of outpatient attendances by speciality during the reporting period were:
- 60% orthopaedics
- 7% ENT and audiology
- 5% gynaecology
- 5% general surgery
- 3% plastic surgery
- 3% dermatology
- 2% cardiology
- 2% urology
- 13% other (gastroenterology, neurology, nephrology, pain management, endocrinology, maxillofacial, rheumatology and podiatry)

As of March 2019, 212 doctors including surgeons, anaesthetists, physicians and radiologists worked at the hospital under practising privileges. Three regular resident medical officers (RMO) worked on a weekly or fortnightly rota. The hospital employed 16 full-time equivalent (FTE) registered nurses, 7.78 FTE operating department practitioners and health care assistants and 38 FTE other hospital support staff, and the provider had its own team of bank staff.

Track record on safety (January to December 2018):

- Zero never events
- 190 clinical incidents; 177 (93.2%) no harm, 10 (5.3%) low harm, 3 (1.6%) moderate harm, zero severe harm, zero death
- Two serious injuries
- One incidence of hospital acquired venous thrombosis and/or pulmonary embolism
- Zero incidences of hospital acquired MRSA, MSSA, C. difficile or E-coli
- From April 2018 to March 2019, the hospital received five complaints, none of which were referred to the Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS)

Services accredited by a national body:

- The hospital received the maximum rating of five from the Food Standards Agency for food hygiene in July 2018.
- Building Research Establishment Environmental Assessment Method (BREEAM) certified and rated the hospital 'excellent' in January 2018.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Facilities maintenance and support
- Radiation protection
- Laundry
- Maintenance of medical equipment
- Pathology, histology and microbiology
- RMO provision
- Theatre sterile services and cleaning
- Occupational health services
- Blood transfusion
- Critical care transfer

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

- The hospital provided mandatory training in key skills to all staff and made sure staff completed it. Overall compliance with mandatory training across the hospital was better than the hospital target of 95%.
- Staff understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The hospital controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. The surgery service used systems to identify and prevent surgical site infections
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- The service had enough staff with the right qualifications, skills and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave new and bank staff a full induction.
- Staff in all services, except diagnostic imaging, generally completed and updated risk assessments for each patient so they were supported to stay safe. Where we found vital observation charts and safer surgery checklists were not fully completed, senior staff took immediate action to address this and improvements were seen on the unannounced inspection. Staff identified and quickly acted upon patients at risk of deterioration.
- The provider generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff used monitoring results well to improve safety. Staff collected safety information and generally shared it with staff, patients, families and visitors.

However:

Summary of this inspection

- Staff working in the outpatients and diagnostic imaging services did not always keep detailed records of patients' care and treatment. We found outpatient records were not always signed and dated in accordance with best practice, or in line with hospital policy. However, records were generally clear, up-to-date and easily available to all staff providing care.
- Staff in the diagnostic service did not robustly complete risk assessments for each patient and remove or minimise risks.
- We were not assured the surgery, diagnostic imaging and endoscopy services always prescribed, gave and recorded medicines well, and that patients always received medicines at the right time. Prescriptions were not always correctly completed. Furthermore, we found medicine errors and omissions were not always promptly fed back to staff. We raised these concerns and found immediate action was taken to address them. We found improvements had been made in the surgery and endoscopy services when we returned on our unannounced inspection.
- We were not assured all staff in the outpatients service knew how to use blood glucose monitoring equipment. We raised this as a concern and when we returned on our unannounced inspection, we saw additional training was planned.
- Some staff in the outpatients service regularly worked more than their contracted hours to cover the service.
- While patients and their families were informed when an investigation was being undertaken, we were not assured they were always invited to be involved in them.

Are services effective?

Good

We rated it as **Good** because:

- Except for the diagnostic imaging service, care and treatment provided was based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff generally monitored the effectiveness of care and treatment. Except for diagnostic imaging and endoscopy services, they used the findings to make improvements and achieved good outcomes for patients.

Summary of this inspection

- The provider made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing ill health.

However:

- It was unclear if the diagnostic imaging service provided care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. However, following our inspection we were sent up-to-date policies.
- Patients and parents were not always given a copy of their consent form. Senior staff took immediate action to address this concern. When we returned on our unannounced inspection, we saw consent forms were sent to patients' following their appointment.
- There was limited evidence to demonstrate staff in the diagnostic imaging service used audit findings to make improvements where needed.
- At the time of our inspection, the endoscopy service did not collect patient outcomes but were planning to do so once endoscopy reporting software was in place.

Are services caring?

Good

We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from patients was overwhelmingly positive about their care and treatment. We saw staff were friendly, kind and caring and responded quickly and compassionately when patients called for assistance.

Summary of this inspection

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. We saw staff interacted with patients in a supportive manner and provided reassurance if they were upset or worried.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Children and young people's services ensured a family centred approach. Staff spoke with patients, including children and young people, and families in a way they could understand.

Are services responsive?

Good

We rated it as **Good** because:

- Services were planned, and care provided in a way that met the needs of local people. The services provided ensured flexibility, choice and continuity of care.
- Services were inclusive and took account of patients' individual needs and preferences, including patients with dementia, hearing impairment, and children and young people. Staff made reasonable adjustments to help patients access services and adapted them when needed.
- People could access services when they needed them and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge for NHS patients were better than national standards. Waiting times for private patients were minimal.
- It was easy for people to give feedback and raise concerns about care received. Concerns and complaints were treated seriously, investigated and lessons learned were shared with all staff and used to improve services.

However:

- There were limited facilities for children, young people and adolescents attending the outpatient and diagnostic imaging departments.

Are services well-led?

Good

We rated it as **Good** because:

- The hospital had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the

wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. Staff within each service had developed their own objectives for their service which were aligned to the hospital's vision, values and strategy.

- Leaders had the skills and abilities to run services. They understood and managed the priorities and issues faced. They were visible and approachable for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Equality and diversity were promoted in daily work and opportunities for career development were provided. The hospital had an open culture where patients, their families and staff could raise concerns without fear. Staff were proud to work at the hospital.
- Except for the diagnostic imaging service, leaders operated effective governance processes throughout services and with partner organisations. Staff had regular opportunities to meet, discuss and learn from the performance of their service.
- Staff at all levels were clear about their roles and accountabilities.
- Except for the diagnostic imaging service, leaders and teams used systems to manage performance effectively.
- Leaders and staff identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Staff in all services, except diagnostic imaging and endoscopy, collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Information systems were secure, and most were integrated. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services, which leaders encouraged. They had a good understanding of quality improvement methods and the skills to use them.

However:

Summary of this inspection

- Effective local governance processes were yet to be embedded throughout the diagnostic imaging service to monitor and assess performance. Regular opportunities to meet, discuss and learn from the performance of the service had yet to commence.
- We were not assured leaders and staff in the diagnostic imaging service used systems to manage performance effectively.
- The diagnostic imaging service did not collect reliable data and analyse it. Staff could not always find the data they needed. These were not in easily accessible formats, to understand performance, make decisions and improvements.
- There was no leadership development programme available for staff.

Good

Surgery

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

Are surgery services safe?

Good

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

In this section, we also cover hospital-wide arrangements such as how they deal with risks that might affect the hospital's ability to provide services (such as staffing problems, power cuts, fire and flood), the management of medicines and incidents, in the relevant sub-headings within the safety section. The information applies to all services unless we mention an exception.

We rated it as **good.**

Mandatory training

- **The hospital provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The hospital's mandatory training programme was comprehensive and met the needs of patients and staff. Training was primarily provided via e-learning courses, with some face-to-face sessions such as manual handling and life support training. The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. For example, clinical staff received training in adult immediate life support and non-clinical staff completed basic adult life support training.
- Staff could view their individual training needs, current compliance and access e-learning courses through the hospital's electronic training system. The system also alerted staff when mandatory training was due for completion.
- As of April 2019, the hospital's overall mandatory training completion rate was 95%. This was in line with the hospital's completion target of 95%. Staff compliance per e-learning mandatory course was:
- Blood transfusion – 100%
- Communication - 95%
- Consent – 98%
- Display screen equipment – 98%
- Conflict resolution – 99%
- Equality and diversity (general) – 99%
- Equality and diversity (understanding/promoting) – 98%
- Fire safety – 99%
- Infection prevention (clinical staff) – 100%
- Infection prevention (non-clinical staff) – 97%
- Information governance – 98%
- Moving and handling – 99%
- Patient moving and handling – 98%
- Privacy and dignity – 92%
- Health, safety and welfare – 98%
- Fluids and nutrition – 100%
- Food safety – 100%
- Medical gas safety (nurse) – 98%
- Medical gas safety (porter) – 100%
- Staff compliance per face-to-face mandatory course was:
- Mandatory induction – 98%
- Manual handling – 98%
- Patient manual handling – 94%
- Hand hygiene – 98%
- Sepsis – 94%

- Datix (electronic incident reporting) – 98%
- Adult advanced life support (ALS) – 100%
- Adult intermediate life support (ILS) – 94%
- Paediatric intermediate life support (PILS) – 94%
- Paediatric basic life support (PBLS) – 86%

(Source: Provider Information Request (PIR), D14 – Mandatory training and compliance)

- At the time of our inspection, the overall mandatory training completion rate was 100% for clinical ward staff and 97% for theatre staff.
- All staff received training to make them aware of the needs of people with mental health conditions, dementia and learning disability. As of April 2019, 98% of staff had completed dementia awareness training, 96% had completed mental health awareness training and 92% had completed learning disability awareness training (Source: PIR, D14 – Mandatory training and compliance).
- Managers also ensured all bank staff completed mandatory training. As of June 2019, the overall mandatory training completion rate for bank staff was 97% for both face-to-face and e-learning training modules (Source: Additional Evidence Request, DR13).
- Managers monitored mandatory training and alerted staff when they needed to update their training. The head of each department was responsible for ensuring staff completed mandatory training. Compliance was discussed daily at the operations meeting, which was attended by the senior management team and heads of department. During our inspection, we saw overall mandatory training compliance for the hospital remained at 95%. Action was taken to improve compliance when indicated, with additional face-to-face training sessions held.
- Staff within the service understood their responsibility to complete training and told us training was relevant to their roles.
- The registered medical officers (RMOs) employed at the hospital completed mandatory training with their agency. This included advanced life support (ALS), European paediatric advanced life support (EPALS), blood transfusion, infection prevention and control, safeguarding children level three, safeguarding adults, safer dispensing and prescribing, equality and diversity, manual handling, fire safety and information governance. We reviewed the training files and all RMOs had completed their mandatory training.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- The hospital had clear systems, processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements. Safeguarding adults and children policies were in-date and accessible to all staff. They included contact details for the local authority safeguarding teams and referral forms (Source: PIR, P7 – Safeguarding Adults Policy; Safeguarding Children Policy). The children's policy detailed the mandatory reporting duty for female genital mutilation (FGM) as per national guidance (Department of Health and NHS England, FGM mandatory reporting duty, October 2015). Safeguarding information was displayed in all clinical areas. This included a flowchart of actions and referral processes to complete.
- Staff we spoke with demonstrated a good understanding of their responsibilities in relation to safeguarding children and adults in vulnerable circumstances. They told us what steps they would take if they were concerned about the potential abuse of a patient or visitor.
- The director of clinical services was the hospital's designated lead for safeguarding adults and children. They had completed safeguarding adults and children training up to level five, which was appropriate to their role and in line with national guidance (Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health Care Staff (August 2018); Intercollegiate Document, Safeguarding children and young people: roles and competences for health care staff (March 2014)). The safeguarding lead was available to provide advice and support to staff on any safeguarding related matter. Staff knew who the safeguarding lead was and said they were accessible. Each department also had safeguarding resource folders and safeguarding link workers, who were responsible for championing good practice and providing support and advice to staff as needed.

- Staff liaised with other professionals and agencies such as GPs, the police and local authority safeguarding leads, as needed. The director of clinical services also attended the local safeguarding children's board, which met quarterly.
- The hospital was compliant with key safeguarding recommendations identified in the Lampard Review (2015), following the Savile inquiry (Source: PIR, Prov 5 – Lampard Recommendations Assurance template).
- Staff received training appropriate for their role on how to recognise and report abuse. All staff were required to complete safeguarding adults and children training at level two, and clinical staff were also required to complete safeguarding children training at level three. Safeguarding training was provided via e-learning courses. Training covered all aspects of safeguarding adults and children, including professional responsibilities, the Mental Capacity Act, categories of abuse, safeguarding processes, child protection, FGM and the Prevent strategy, aimed at reducing the risk of radicalisation and terrorism. As of April 2019, completion rates for safeguarding training exceeded the hospital target. Overall staff compliance per safeguarding module was:
- Safeguarding adults level one – 98%
- Safeguarding adults level two – 99%
- Safeguarding children level one – 99%
- Safeguarding children level two – 99%
- Safeguarding children level three – 98%
- Prevent – 99%

(Source: PIR, D14 – Mandatory training and compliance)

- At the time of our inspection, 100% of ward and theatre staff had completed safeguarding children training at the level required for their role, and 99% had completed safeguarding adults training.
- Safety was promoted through recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could work at the hospital. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.
- There had been no safeguarding concerns reported to the CQC in the reporting period, from March 2018 to February 2019.
- The hospital had a chaperoning policy and staff knew how to access it. Nursing staff accompanied patients while they were having procedures or were being examined by consultants.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- There were effective systems to prevent and protect people from a health-care associated infection and ensure standards of hygiene and cleanliness were maintained. This was in line with current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 61: Infection Prevention and Control (April 2014). Non-touch handwashing facilities were in place and hand sanitiser gel dispensers were available in corridors, ward areas, bedrooms and clinical areas. The hospital completed monthly hand hygiene audits, where 10 members of staff were observed to check they washed their hands in accordance with the World Health Organisation (WHO) Five Moments for Hand Hygiene. From April 2018 to April 2019, monthly hand hygiene compliance was generally 100% in all departments. Where compliance did not meet the hospital target of 95%, the department was re-audited to ensure there was a return to required standards (Source: PIR, D23 – Board governance dashboard). We observed staff washing their hands before and/or after patient contact. We spoke to four patients on the ward and all said staff were diligent with handwashing prior to any contact.
- The hand hygiene audit also checked whether staff were 'arms bare below the elbow'. This is an infection, prevention and control (IPC) strategy to prevent the transmission of infection from contaminated clothing and enables clinicians to thoroughly wash their hands and wrists. In April 2019, the audit showed 100% of staff in theatres and 80% of staff on the ward were arms bare below the elbow. The two members of staff who were non-compliant were consultants. Action was taken to address this. A consultant posed for photograph's to

demonstrate 'arms bare below the elbow' and posters were displayed in consultation rooms to remind staff to adhere to this. We saw staff were arms bare below the elbow during our inspection.

- We saw the correct use of personal protective equipment (PPE) such as disposable gloves and aprons. PPE was available in all clinical areas. Staff in theatres wore appropriate theatre clothing (scrubs) and designated theatre shoes were worn. This was in line with best practice (Association for Perioperative Practice (AfPP), Theatre Attire (2011)).
- All patients underwent a detailed pre-operative assessment, either face-to-face or via the telephone, prior to surgery. This included questions regarding infection risks such as whether the patient was a healthcare worker, any history of MRSA infection and whether the patient had travelled abroad within the last 12 months. This meant the pre-operative team could identify any high-risk patients and make necessary IPC arrangements prior to the patient's admission. All inpatients were screened for MRSA (a bacterium that is resistant to widely used antibiotics). Patients who underwent joint replacement surgery were given a five-day course of decolonisation treatment. This included washing with an antiseptic solution daily and using a nasal ointment three times a day. This was to reduce the risk of infection during their operation.
- From January 2018 to April 2019, zero incidences of hospital acquired MRSA, MSSA (a skin infection that may cause pneumonia), E-Coli (a bacterium that can cause severe abdominal cramps, bloody diarrhoea and vomiting) and C. difficile (a bacterium which infects the gut and causes acute diarrhoea) were reported.
- There were effective systems to ensure standards of hygiene and cleanliness were maintained. Standards of cleanliness were regularly monitored, and results were used to improve IPC practices where needed. There was a regular programme of IPC audits to ensure good practice was embedded in all departments. These included monthly environmental hygiene, sharps bin and waste audits, and quarterly mattress audits. From April 2018 to April 2019, monthly compliance with environmental hygiene, sharps, waste management and quarterly mattress audits consistently exceeded the hospital target of 90% and was mostly 98% to 100% (Source: PIR, D23 – Board governance dashboard). The IPC lead also undertook monthly spot audits to ensure IPC standards were maintained. Findings were fed back to staff and actions were taken where indicated.
- All ward areas and theatres were clean, tidy and free from clutter. Furnishings were suitable, clean and well-maintained. One patient said the ward "exceeded expectations in terms of cleanliness".
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The hospital had housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. The daily cleaning checklists were completed in 100% of the records we reviewed.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am clean' stickers were used in all areas, which were all up-to-date.
- All reusable equipment was decontaminated off site. There was a service level agreement in place with an accredited decontamination unit. Clean and dirty equipment was managed well within the theatre and there was no cross contamination of equipment.
- Staff worked effectively to prevent, identify and treat surgical site infections. The service had appropriate facilities and systems to meet national recommendations regarding surgical site infections (NICE, Surgical site infections: prevention and treatment [NG125] (April 2019)). Theatre staff cleaned each theatre between cases and deep cleaned them weekly. They were also deep cleaned by an external cleaning company on a six-monthly basis, or sooner if indicated. All three theatres had laminar air flow ventilation systems. This was compliant with national recommendations (Department of Health, Heating and ventilation systems. Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises (November 2007)). This meant there was an adequate number of air changes in theatres per hour, which reduced the risk to patients of infection. This was serviced on a six-monthly basis and the filters were changed.
- The hospital was unable to report surgical site infection (SSI) performance directly to Public Health England (PHE) because PHE had suspended new independent service providers from registering with them for SSI data submission. However, the hospital captured and recorded the same data as part of their governance

processes. All patients were followed up at two and 30-days post-discharge, during which staff asked questions in line with PHE SSI monitoring. If a patient raised any wound infection concerns this was reported through the incident reporting system and investigated. From January to December 2018, the hospital reported one surgical site infection (Source: PIR, D5 – OHH IPC Annual Report, January 2019). We saw this was investigated and no root cause was identified. However, learning from the incident was identified. This included the development of a standard operating procedure for checking wound swab results.

- The service had a 0% infection rate for patients who underwent hip and knee replacements and spinal surgery. On discharge, all patients were given an information leaflet about how to recognise the signs of infection.
- There were clear lines of responsibility and accountability for IPC. The director of clinical services was the hospital's director of infection prevention and control (DIPC). They were supported by the lead nurse for IPC and an external consultant microbiologist. The microbiologist's role was to advise on all matters related to infection control and attend infection control committee meetings. They were generally available to advise staff remotely, by telephone or email. Each department, including administration and facilities, had an IPC link worker. They were responsible for championing good practice, collating audit data, and providing IPC support and advice to staff.
- The IPC lead nurse attended the local sustainability and transformation partnership (STP) IPC group meetings, which were held quarterly. This group was attended by local IPC leads from NHS acute trusts and the independent sector, as well as the chief nurse for the clinical commissioning group (CCG). It provided a forum to network with other IPC leads and enabled good practice, IPC initiatives and learning to be shared across local health care providers.
- Staff maintained an infection prevention and control (IPC) governance dashboard. This was used to monitor IPC compliance and performance against a range of quality indicators at department and hospital-wide level, such as hand hygiene, surgical site and health-care associated infections, and IPC audit compliance. Action was taken to improve performance when indicated. For example, a staff awareness day was held to improve compliance with hand hygiene.
- Bi-monthly infection control committee meetings were held. Meeting minutes we reviewed showed these were well attended by the DIPC, IPC lead, external microbiologist and IPC link workers. A standing agenda was followed which included review of IPC action plans, IPC surveillance and dashboard, incidents and/or surgical site infection cases, training compliance, audits, antibiotic stewardship, policies and incidents. Meeting minutes were detailed and included copies of relevant reports where appropriate (Source: PIR, D6 – Minutes IPC Dec 18, Feb 19). The infection control committee reported to the hospital board through the clinical governance and medical advisory committees. The DIPC produced an annual IPC report. This detailed the programme of activities implemented to prevent and control healthcare associated infections across the hospital, and an overview of IPC performance for the year (Source: PIR, D5 – OHH IPC Annual Report January 2019). An action plan for the following year was also included to ensure IPC standards were maintained. This was reviewed quarterly at IPC committee meetings to ensure actions were addressed and completed within set deadlines.
- All staff were required to complete IPC training during their induction and then annually at the level appropriate to their role. As of April 2019, the overall hospital completion rate was 100% for clinical staff and 97% for non-clinical staff (Source: PIR, D14 – Mandatory training and compliance). Theatre staff had completed additional training in 'scrub technique' and the handling of surgical instruments. Staff competencies we reviewed confirmed this.
- The hospital had up-to-date policies for IPC and related topics such as decontamination, isolation precautions and aseptic non-touch technique (ANTT). Staff could access these for guidance through the hospital's electronic system

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**
- The design of the environment followed national guidance. The hospital was recently purpose built (December 2017). The ward and theatres were spacious, and patient centred. Inpatient rooms were well-appointed, with ensuite wet rooms and air conditioning.

- There was a three bedded extended recovery unit for patients who required higher dependency care and monitoring. This had not been used at the time of the inspection, but there were plans in place for this to be used at the end of summer.
- The day care unit had 13 private patient pods and complied with national guidance for the provision of same sex facilities, such as toilets. All patients were cared for on a trolley and the pods were fully equipped for an emergency. For example, they had oxygen, suction and emergency buzzers. We were told the day care unit was only being used when the ward did not have enough rooms to accommodate day case patients or if there were six or more patients on the day case list to warrant opening it.
- The service had enough suitable equipment to help them to safely care for patients. This included anaesthetic equipment, theatre instruments, vital sign monitors and commodes. The hospital had three main operating theatres and three minor procedure rooms. All had the appropriate anaesthetic equipment in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. There was appropriate resuscitation equipment available in the case of an emergency. Resuscitation trolleys were situated in the theatre, ward and day care unit. They were all well organised and had tamper evident seals in place. The ward had a sepsis trolley which was easily accessible if a patient developed sepsis. Sepsis is a potentially life-threatening illness, where the body's response to infection injures its own tissues and organs. Theatres also had a difficult airway trolley, transfer bag and malignant hyperthermia kit. Malignant hyperthermia is a type of severe reaction that occurs to particular medications used during general anaesthesia.
- Staff carried out regular safety checks of specialist equipment. We saw that all anaesthetic equipment was checked daily prior to use. Records also indicated that the emergency trolleys and their contents were checked daily in line with hospital policy.
- Patients could reach call bells and staff responded quickly when called. Each patient room and bathroom had emergency call bells to alert staff when urgent assistance was required. These were tested daily to ensure they worked. All staff carried communication devices which alerted them to a patient call bell or emergency bell. These could also be used to phone staff in different departments. The emergency call bell system was also linked to all emergency bleeps, which were carried by senior staff such as the director of clinical services and RMO. They sounded loudly across the ward and theatre areas.
- A sensor mat was available on the ward for patient at risk of falls. This was connected to the pager system and alerted staff if a patient got out of bed.
- There was a regular planned maintenance and equipment replacement programme. An external maintenance provider attended the hospital annually to service and safety test the electrical equipment, or when needed. The equipment had been purchased new when the hospital opened in December 2017. All equipment we reviewed had been serviced and safety tested within the date indicated.
- The storage of instruments and equipment within the theatre department was well organised, bar coded and regularly topped up. All equipment checked including single use items were in date and stored well.
- Patients who needed implants, such as hip prosthesis, had this clearly recorded in their notes. This included the device number and size. This meant all implanted devices could be tracked in case any faults developed. Implants were also stored in a designated store room, which was well organised and reduced the risk of the wrong implant being used. The hospital also recorded implants used on national registers, such as the breast implant register and national joint register (NJR). This showed which patient received which type of implant and when, to allow tracking if needed.
- Flammable products deemed hazardous to health were locked in metal cupboards. This was in accordance with control of substances hazardous to health (COSHH) guidance.
- There was limited bariatric equipment available on site. However, all rooms were spacious, and doorways were wide. There was one bariatric chair on the ward but no commode. Staff in pre-operative assessment clinics assessed a patient's weight and calculated their body mass index (BMI).
- Physiotherapists had access to patient walking aids and were able to source further equipment as required, such as raised toilet seats.
- All staff were trained on the medical devices used in their department. We saw comprehensive competency booklets in theatres which confirmed this. Equipment representatives had attended theatres and the ward to deliver medical device training.

- The director of clinical services received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA regulates all medical devices and medicines and reports faults to providers. The director of clinical services disseminated any relevant alerts via the hospital's electronic system. Staff checked the relevant equipment against alerts received and followed the recommended action by the MHRA.
- Staff disposed of clinical waste safely. There were separate colour coded arrangements for general waste, clinical waste and sharps. Theatres had an effective clean and dirty flow for the disposal of clinical waste and used instruments. The hospital had up-to-date policies to support staff with the correct disposal of waste. Sharps containers were labelled with the hospital's details for traceability purposes. This was in line with national guidance (Health and Safety Executive (HSE), Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

Assessing and responding to patient risk

- **Staff mostly completed and updated risk assessments for each patient so they were supported to stay safe. However, we found vital observation charts and safer surgery checklists were not always completed. Senior staff took immediate action to address this and improvements were seen on the unannounced inspection.**
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, we found some NEWS2 charts were not calculated correctly; we saw no risk to patients with incorrect NEWS2 scores. Senior staff took immediate action to address this. The 'National Early Warning Score (NEWS) 2' was used to identify deteriorating patients. This was in accordance with national guidance (NICE, Acutely ill adults in hospital: recognising and responding to deterioration [CG50] (July 2007)). Staff used NEWS2 to record routine physiological observations, such as blood pressure, temperature and heart rate. The NEWS2 prompted staff to take further action where appropriate, such as increased monitoring of vital signs and review from the resident medical officer (RMO). We saw good documentation in the records of a patient with a high NEWS2 score. The records showed the patient was promptly escalated and reviewed by the RMO. NEWS2 was reviewed daily by the director of clinical services during their ward round. NEWS2 completion was audited monthly as part of the hospital's medical records audit. Data for April 2019 showed compliance was 100%. We reviewed 10 patient NEWS charts and found six had been calculated correctly. We raised this and immediate action was taken to address our concern. Actions taken to improve compliance included competency assessments for all staff. Senior staff were also required to check and countersign NEWS2 charts completed by junior staff, until they had been signed off as competent. We reviewed a further five sets of notes on our unannounced inspection. We found all NEWS2 scores were calculated and escalated correctly. Staff told us they had received further training and competency assessments on NEWS2, spot checks were completed daily by the ward manager. The ward manager had also completed an audit of the notes, including NEWS2 scores, and compliance was 100%.
- The service used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist. This was in line with National Patient Safety Agency (NPSA) guidance (NPSA, Patient Safety Alert: WHO Surgical Safety Checklist (January 2009)). We observed staff followed the WHO checklist and there was no distraction while this was undertaken. Theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the process. The service audited WHO checklist compliance by observing 10 patients each month through their theatre journey. From January to April 2019, data showed compliance with the WHO checklist was consistently 100%. The service also audited patient records for compliance with the WHO checklist. For the same period, overall compliance was between 96.7% and 100%. These results were displayed in theatres for staff to see. We reviewed 10 patient records and found the 'sign out' section was left blank in two records, and the 'sign in' section had not been signed in another two records. We raised this concern with staff at the time of inspection. We checked a further six WHO checklists on our unannounced inspection. We found five out of six were fully completed; one sign out was blank for a patient who returned to theatre. We also looked at completion of the 'brief' and 'debrief'; steps one and five

of the safer surgery checklist. Out of 33 records reviewed, the brief was completed in all, while the debrief was not completed in four records. We highlighted this to staff at the time.

- Staff completed risk assessments for each patient on admission to the service and updated them when necessary. Nursing staff used nationally recognised tools to assess patients' risk of, for example, developing pressure ulcers (Waterlow), malnutrition (MUST), falls, infection control, and risks associated with moving and handling. We reviewed 10 patient records, all risk assessments were completed post-operatively. The completion of post-operative risk assessments was regularly checked as part of the medical records audit. Compliance for April 2019 was 100%.
- Staff knew about and dealt with specific risk issues. National guidance states all surgical patients should be assessed for risk of venous thromboembolism (VTE) (a condition in which a blood clot forms most often in the deep veins of the leg, groin, arm, or lungs) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Reassessment of VTE and bleeding risk should be undertaken at the point of consultant review or if the patients' clinical condition changes (NICE, Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism [NG89] (March 2018)). VTE risk assessments were regularly audited for completion. From January to December 2018, results showed compliance was between 99% and 100%. We reviewed 10 medical records and found VTE risk assessments were completed daily and correctly for all patients. From January to December 2018, the hospital reported one case of hospital-acquired VTE. A root cause analysis investigation was completed and the VTE was found to be unavoidable. The patient had received appropriate thromboprophylaxis (strategies used to prevent blood clots from forming).
- There was a screening tool and pathway for the management of sepsis. Sepsis is a serious complication of infection. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. The service had implemented the sepsis six pathway in line with guidance from the Sepsis Trust. This is the name given to a bundle of medical interventions designed to reduce the death rates in patients with sepsis. The pathway consists of three diagnostic and three therapeutic steps; all should be delivered within the first hour of recognition. The ward had a sepsis trolley, which contained the equipment and medicines staff needed to promptly initiate the sepsis six bundle. This was kept unlocked which meant there was a risk items could go missing, including the medicines. We raised this and immediate action was taken to address our concern. We saw on our unannounced inspection the trolley was locked and the key was kept in a locked key safe above the trolley. This meant it was easily accessible in an emergency. Patients' suspected of having sepsis were transferred to the local acute NHS hospital for ongoing monitoring and treatment. As of April 2019, 94% of staff had completed sepsis training.
- Each inpatient room had a whiteboard which was used to display key patient information such as up-to-date NEWS2 and pain scores, and allergy status. We saw these were all completed and updated regularly by ward staff. This meant any member of staff could see key patient information at a glance, including when vital observations were last completed.
- Patients for elective (planned) surgery underwent a nurse led pre-operative assessment before their operation. These were conducted via telephone appointment for low risk patients who needed a minor procedure. Questions included the patient's past medical history, allergies, current medication, and previous anaesthetic and/or infection risk. Patients who had any risk factors or were undergoing major surgery had a face-to-face appointment. A 'red flag' assessment was completed for patients who were high risk. This highlighted to ward staff why the patient was high risk and/or had any alerts, such as allergies or food intolerances. It included any relevant information they needed to be aware of, such as complex medical needs, blood transfusion requirements and if a patient was taking more than four medications. This risk assessment was completed on red paper and was secured within the patients' record so ward staff could easily see them. We did not see any completed at the time of our inspection; all patient notes we checked did not require them. All required tests were undertaken at the pre-operative assessment, including MRSA screening and routine blood tests such as group and save. This was in line with national guidance (NICE, Routine preoperative tests for elective surgery [NG45] (April 2016)).

- Anaesthetists held clinics every Thursday. They reviewed patients who were classed as high risk for anaesthesia or had medical conditions that deemed them at risk of developing complications after surgery.
- The service used the American Society of Anaesthesiologists (ASA) classification system to grade the patients' level of risk before surgery. For example, patients classified as ASA1 were low risk and healthy, while ASA3 patients were higher risk, with severe systemic disease. ASA grades were recorded on admission for surgery by the anaesthetist in the patient record. Any patients who were identified as high risk by the pre-operative nursing team were referred to an anaesthetist prior to their admission. Patients identified as high risk or had potential complications diagnosed following test results, for example uncontrolled diabetes, were referred to the consultant for further review before surgery was undertaken. The hospital only accepted patients classed as ASA1, ASA2 or stable ASA3.
- Patients classed as ASA3 were monitored post-operatively in one of the wards three monitored beds if required. These bedrooms were equipped for patients who needed higher levels of care and observation, such as continuous monitoring. These were situated next to the nursing station to enable increased visibility. The service also had a three-bedded extended recovery unit (ERU). This had not been used since the hospital opened, but there were plans to undertake complex breast reconstruction surgery which would require patient monitoring in the ERU. We were told they planned to start providing this surgery in August 2019, once staff had received training and all necessary equipment had been obtained.
- The service complied with the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas. This included ward admission, anaesthesia, surgery and recovery. There were enough staff on duty during the patient's surgical procedure, which included surgeons, anaesthetists and operating department practitioners. This was in line with AfPP guidance and meant the service had assessed the risk to patient's undergoing surgery.
- Staff shared key information to keep patients safe when handing over their care to others. The theatre team held a '5 to 8 at the gate' meeting at the beginning of every day. All members of the theatre team attended to review the cases booked for the day. They discussed the operations, equipment needed, on call and emergency team cover, including ALS and PILS providers. These meetings were recorded for staff to refer to if needed. Any changes to the operating list were reprinted on different coloured paper, which we observed during our inspection. This was in line with best practice guidance.
- Shift changes and handovers included all necessary key information to keep patients safe. Nursing handovers occurred twice a day at the change of each shift. These were recorded with a dictaphone and included discussion of each patients' needs, medication, NEWS2, pain and plan of care. The handover was deleted once all staff had listened to it. Staff would then speak with handover staff if they had any further questions regarding patient care. This meant nurses could continue to care for patients during handover.
- Patients were given the ward telephone number to ring in the event of any issues or to ask questions. All patients were phoned two days and 30 days post-surgery to check on their progress. Telephone enquiries were documented and filed in the patient's notes and further appointments were made if required. Staff told us of a wound check appointment that was brought forward due to concerns picked up from the two-day post-operative call.
- Staff were supported by an RMO if a patient's health deteriorated. The RMO was on duty 24 hours a day and was available on site to attend any emergencies. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care. The RMO and staff told us consultants were responsive and supportive. In an emergency, staff would request an ambulance to transfer the patient to the local acute NHS emergency department.
- The hospital had a transfer agreement in place with the local acute NHS trust should a patient require a higher level of care. A consultant, anaesthetist and/or nurse would escort the patient during transfer if indicated. Transfer arrangements were determined by the consultant and anaesthetist. From January to December 2018, the hospital reported three unplanned transfers to the local acute NHS trust. We saw detailed root cause analysis investigations were completed for the unplanned transfers, with learning identified and actions taken where indicated, to minimise the risk of recurrence and enhance patient safety.
- The hospital undertook practice emergency scenarios on both the ward and theatres. These were run by

resuscitation officers. For example, the management of major haemorrhage had been practised, following which changes to improve the process had been made. These included increasing the number of blood units held on site and a regular courier to transfer the blood from the NHS provider to reduce time. The regular courier attended the hospital three times a day. This action had significantly improved the time it took to obtain blood from two hours to 45 minutes. Staff had instigated the major haemorrhage policy for a patient since this practice incident. They told us it was managed smoothly and efficiently, and all staff worked well together. They had also practiced an anaphylaxis scenario, where they found too many staff attended. Following this, it was decided that only bleep holders should attend in an emergency. If further staff were needed, this would be arranged by the staff allocated as the runner.

- The hospital's resuscitation team was reviewed at the daily operational meeting. We observed each member of the team was allocated a specific role such as leader, airway management, defibrillation, recorder and runner. This was in line with best practice guidance (Resuscitation Council (UK), Quality standards for cardiopulmonary resuscitation practice and training (May 2017)). Each member of the team carried a communication device, so they could be contacted immediately in the event of an emergency. Following the meeting, the daily resuscitation team list was distributed to each department. We saw this was documented on boards in staff areas.
- The hospital had a service level agreement for the provision of blood and blood products. Staff had access to blood in the event of an emergency, with six units of universal blood stored in theatres. Patient specific blood was obtained in advance of surgery when indicated, such as if the patient was at risk of bleeding or had blood antibodies. The blood fridge and stock were checked daily to ensure it was safe for patient use.
- National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. NatSSIPs provide a framework to produce Local Safety Standards for Invasive Procedures (LocSSIPs). Theatre staff were aware of national and local safety standards. Theatre staff had updated their department operation policy in February 2019 to ensure they were NatSSIPs and LocSSIPs compliant. For example, the policy included specific procedures within the local area such as the five steps to safer surgery, prosthesis verification, surgical site marking and patient handover between areas in the department. We saw this information displayed on a notice board within theatres for staff to refer to. The ward had also adapted this process to apply a LocSSIPs policy for their department. This included guidance for staff around the admissions process, receiving a patient from recovery and safe care of the post-operative patient.

Nursing and support staffing

- **The hospital had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**
- The service had enough nursing staff of all grades to keep patients safe. Data we reviewed, and observations made during our inspection confirmed there was sufficient staff to provide the right care and treatment.
- Managers accurately calculated and reviewed the number and grade of nurses, healthcare assistants (HCAs) and operating department practitioners (ODPs) needed for each shift, in accordance with national guidance. The service did not use a safer nursing care tool to measure patient acuity as patients were of similar dependency. They did however, use a safer staffing standard operating procedure which detailed the staffing levels required to provide safe and effective care. The hospital's baseline target for inpatients was a ratio of one nurse to five patients (1:5). Better patient outcomes have often been associated with higher staffing levels and ratios of 1:7 and lower (NHS Improvement, Safe staffing for adult inpatients in acute care: evidence review (January 2017)). Flexible staffing rosters were completed a month in advance. Planned activity for the hospital was reviewed by managers on a weekly basis so that substantive and bank staff could be flexed according to activity and patient acuity when needed. The next day's staffing levels and activity was reviewed daily by senior staff. This included the number of theatre cases booked and whether they were major or minor procedures. This helped to assess the correct

number of nurses required for each shift. Hospital-wide staffing was reviewed at the daily operational meeting and could be adjusted according to patients' individual needs.

- The operating department used guidance set out by the Association for Perioperative Practice (AfPP) in 2015 related to safe staffing levels; 'Safe Staffing Levels for the Peri-operative Environment as a staffing tool (2015)'. Theatre staffing levels were also based on nationally recognised guidelines such as the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Anaesthetic Recovery Nurses Association (BARNA). They used the AfPP safe staffing tool to ensure the department was adequately staff. Each theatre was staffed with one team leader, two qualified and one unqualified member of staff. There were enough staff in the department to cover the lists that were scheduled at present, but they were seeing an incremental growth in activity levels since opening which meant there was potential in the future for recruiting more staff.
- The number of nurses, HCAs and ODPs in each department matched the planned numbers. From January to March 2019, the hospital reported 100% of shifts were filled (Source: Pre-Inspection Document) and staffing rota's from April to June 2019 also confirmed 100% of shifts were filled. Bank staff were offered unfilled shifts to ensure planned staffing requirements were met. From August 2018 to April 2019, the average bank usage rate for nursing staff was 10.4% and for HCAs/ODPs it was 4.1% (Source: Additional Evidence, DR12).
- Managers made sure all bank staff had a full induction and understood the service. Bank staff had completed mandatory training and received an induction before they commenced duties. This was confirmed by bank staff we spoke with. They told us they regularly worked at the hospital and were familiar with local working practices. The hospital did not use agency staff.
- The service had low vacancy rates. As of March 2019, the service employed seven whole-time equivalent (WTE) registered nurses and two WTE HCAs for inpatients (the ward), and six WTE nurses and 3.78 WTE ODPs and/or HCAs for theatres. This equated to a vacancy rate of:
- 0% nursing staff – inpatients
- 0% nursing staff – theatres
- 0% HCAs – inpatients
- 20.92% (one WTE) ODPs/HCAs – theatres

(Source: Pre-Inspection Document)

- At the time of our inspection we were told there were no staffing vacancies. They were however, recruiting for additional staff. This was because the hospital opened in December 2017 with minimal patient activity at this time. As activity grew, additional nursing and support staff were recruited to ensure the needs of patients were met. Patient activity was expected to increase in September 2019, therefore additional staff were being recruited.
- The service had low turnover rates. From April 2018 to March 2019, the average turnover rate for nursing staff was 2% for inpatients and 0% for theatres. For HCAs/ODPs it was 0% for both inpatients and theatres (Source: Pre-Inspection Document). This was lower (better) than the hospital target of 10%.
- The hospital had low turnover rates. From April 2018 to March 2019, the average turnover rate for all staff was 1.8% (Source: PIR, D23 – Board Governance Dashboard). This was lower (better) than the hospital target of 10%.
- The service had low sickness rates. From April 2018 to March 2019, the average sickness rate for nursing staff was 1.12% for inpatients and 0.84% for theatres. For HCAs/ODPs it was 0.3% for inpatients and 0.66% for theatres (Source: Routine Provider Information Request - Staffing tab). This was lower (better) than the hospital target of 5%.
- The hospital's sickness rate was variable. From April 2018 to March 2019, the average sickness rate for all staff was 8.15%, with variances from 1.9% in July and August 2018 to a high of 24% in November 2018 (Source: PIR, D23 – Board Governance Dashboard). This was higher (worse) than the hospital target of 5%. An electronic system was used to manage sickness absence and annual leave.
- The ward had a mobile messenger application ('app') group for staffing. The ward manager said staff were very flexible with swapping shifts and covered each other where required.

Medical staffing

- **The hospital had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- Patient care was consultant-led. Consultants were available for advice and/or to review admitted patients.

They provided 24-hour on-call cover for patients post-operatively and were required to be within a 30-minute drive of the hospital when off site. It was mandatory for all admitting consultants to visit their patients at least once per day, or more frequently if the patient was receiving a higher level of care, or at the request of the hospital director, the director of clinical services or the resident medical officer (RMO) (Source: PIR, P14 – Practising Privileges Policy). If the named consultant was unavailable at any time while they had patients admitted to the hospital, they arranged appropriate alternative named cover by another consultant in the same specialty. There was a buddy system in place which was found to be effective. While on inspection, we observed a consultant informing the nursing staff of cover arrangements as they were due to go on leave.

- All consultants who worked at the hospital did so under practising privileges. This is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital or clinic. As of March 2019, 212 doctors had been granted practising privileges to work at the hospital. The hospital had a medical advisory committee (MAC) whose responsibilities included, ensuring new consultants were only granted practising privileges if deemed competent and safe to practice. All consultants carried out procedures within their scope of practice within their substantive post in the NHS.
- From April 2018 to March 2019, there were no consultants who had their practising privileges removed or on supervised practice.
- Anaesthetists were expected to be available for 48 hours after surgical procedures in case a patient, whom they had anaesthetised, became unwell. The service used an independent anaesthetic group who provided on call cover 24-hours a day, seven days a week in the event of an emergency.
- Immediate medical support was available 24 hours a day, seven days a week. This was provided by registered medical officers (RMOs) who were employed through an external agency. The RMO slept on site and worked a shift pattern of either one or two weeks on, one or two weeks off. There were arrangements to call in additional support or replace the RMO if the RMO was unable to rest or sleep sufficiently. The RMO generally worked eight-hours per 24-hour shift and was only contacted overnight in the event of an emergency. The RMO we spoke with said they were contacted overnight on average once a week. The hospital had mostly used the same three RMOs since it opened in December 2017. Additional RMOs were used to cover annual leave or sickness, when needed.
- A handover took place between RMOs at the start/end of each week and/or fortnight. Handover included a structured discussion of each patient and details of any work outstanding. They also attended daily nurse handovers and the ward round. The RMO said they felt well supported by nursing and medical staff and could contact a patients' named consultant or anaesthetist if they needed further advice or support. They could also access clinical and non-clinical advice and support 24 hours a day, seven days a week through their agency.
- Managers made sure RMOs had a full induction to the hospital before they started work. This was confirmed by the RMO we spoke with and the training records we reviewed.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**
- Records were stored securely. The hospital used a paper-based system for recording patient care and treatment. We saw these were stored securely to protect confidential patient information.
- Patient notes were comprehensive, and all staff could access them easily. We reviewed 15 sets of patient records and found they were generally legible, up-to-date and contained all relevant information regarding patients' care and treatment. The service completed a monthly audit of 10 sets of patient records. Data for April 2019 showed overall compliance for record completion was 100%. The audit included risk assessments, VTE assessment, pain management, consent and infection control.
- Clear pathway documents were used throughout the patient pathway. Risk assessments were completed from the start of the patient's pathway in pre-operative assessment through to admission.
- There were surgical pathways which included preoperative assessments. The assessments were carried out in line with NICE guidance. We reviewed a sample of these and found they were completed thoroughly.

- Nursing staff completed a discharge summary letter for the patient's GP. This gave details of the operation performed, any medication required as a continuation of their care and any follow-up requirements. Consultant contact details were provided to GPs, so they could contact them for further advice if required. These letters were given to the patient to take to their GP.
- Staff completed and recorded intentional care rounding. Intentional care rounding is a structured process where staff performed regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients to check that call bells and drinks were within reach and they asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records we reviewed.

Medicines

- **The service did not always prescribe, give and record medicines well. We were not assured patients always received medicines at the right time. However, senior staff took immediate action to address our concerns and we found improvements had been made when we returned on our unannounced inspection. Medicines were stored well.**
- Staff did not always prescribe, give and record medicines in line with national standards. We reviewed 10 medicine charts and found errors on four of them. These errors included missed doses or 'blank boxes' (one missed dose was for an antibiotic), missing prescriber signatures and no indication and duration for a prescribed antibiotic. Each of these charts had been checked by the pharmacist and we were told they were reviewed daily on the ward round. We raised our concerns with the ward manager who took immediate action to address our concerns and produced an improvement action plan while we were still on site. Actions included re-education of nursing staff, reassessment of medicine management competencies, escalation of identified missed doses and discussion at the medical advisory committee (MAC). We also raised these issues with the lead pharmacist, who told us that missed doses and missing prescriber signatures had been found in audits completed in May and June 2019. However, these errors were not escalated immediately to ward staff when they were identified, instead they were reported and discussed at the bi-monthly governance meeting. Two nurses we spoke to were not aware of these audit findings. Therefore, we were not assured these errors were being fed back to all staff at ward level. This meant corrective actions were not promptly taken and there was a risk that errors would be repeated.
- The hospital's antibiotic prescribing guidelines were in line with national guidance. However, we were not assured guidance was consistently used. One consultant told us there was varying usage of antibiotics compared to the policy. This issue had been identified through audit of compliance with prescribing antibiotics, which commenced in June 2019. The audit result showed compliance was 12%. Senior staff told this was because the surgeons came from three different local NHS acute trusts, with differing prophylactic regimes. The pharmacist had spoken to the lead microbiologist and we were told this issue would be discussed at the next MAC meeting and would be re-audited monthly. Furthermore, relevant staff were reviewing the antibiotic policy which all consultants would be required to adhere to. The medication charts had a specific antibiotic prescribing section, which only allowed an antibiotic to be prescribed for three days and then prompted a review. During our inspection, we saw one occasion when this had not been used; there was no review date for the medication and no indication. This meant there was a risk the patient would take the antibiotics for longer than needed.
- During our unannounced inspection, we saw the service had made several changes in response to the concerns we raised. These included:
- Implementation of a check of each medicine chart at handover times with the nurses from both shifts to ensure no errors.
- Regular spot checks by the ward manager and pharmacist.
- Implementation of a daily checklist for the pharmacist or nurse to complete for each medicine chart where a patient stayed overnight. This included checking for missed doses, antibiotic prescriptions, allergies documented, and each prescription was legally prescribed. We saw that this had been completed for an overnight stay patient.
- The pharmacist met with the RMO after the ward round to discuss each patient and their medicines. They felt this was working well and ensured they could make appropriate medicine recommendations for the patient.

- Medicine training completed for all nursing staff.
- Completion of an ad hoc audit of the medicine charts; compliance was 100%.
- We reviewed 14 medicine charts on our unannounced inspection and found all were fully completed. There were no omissions or missed doses.
- The pharmacy department was open Monday to Friday, from 9am to 5pm. It was led by the chief pharmacist, who was also responsible for the other hospital site. The chief pharmacist attended the hospital at least once a week. Day-to-day activities were managed by a clinical pharmacist and pharmacy assistant technical officer, who were on-site during the department's opening hours. If medication was required out of hours, the RMO and a registered nurse would enter pharmacy together; the RMO had a code for access. They both signed a register to confirm what medication was removed, which pharmacy staff reconciled the following day. The clinical pharmacist told us the pharmacy team were happy to be contacted out of hours if needed. However, there was no formal arrangement for out of hours pharmacy support and this was dependent on a member of the team being available. We were told this had rarely happened. Senior staff planned to review the need for an on-call service when activity increased.
- The hospital had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We observed a strong reporting culture within the pharmacy department and saw that incidents, including near misses, were routinely reported. Pharmacy staff described examples of incidents they had reported, and actions taken to minimise the risk to patients. Medicine incidents were reported through the hospital's electronic reporting system. From January to April 2019, the hospital reported eight medication incidents, which were graded as having caused 'no harm'. We saw action was taken because of incidents reported and learning was shared with staff.
- Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Pharmacy staff attended the ward daily, Monday to Friday, and counselled patients' on their medicines prior to discharge. The pharmacist also attended the daily ward round to ensure they were aware of patient discharges. This meant they could prepare any medications in advance for discharge. In addition, they were prepared on a Friday for any weekend discharges. The ward held a number of pre-packed medicines. These were mostly analgesia or antibiotics. Each of these medications given on discharge were recorded, checked and signed for by two nurses.
- We saw regular audits were carried out to ensure medicines were reconciled, prescribed, administered and stored in line with national guidance and hospital policy. Pharmacy staff completed monthly audits of 10 medication charts. For example, the monthly 'drug chart audit' monitored compliance against standards for medicine reconciliation (10 standards), prescribing (eight standards) and administration (four standards). The service generally scored well with an average compliance of 98.8% from October 2018 to March 2019. Action plans were seen for improving compliance. These included 'reminder to all pharmacists including locums and bank to always use a minimum of two sources to confirm drug history'.
- Pharmacy staff also audited the storage of medicines, including controlled drugs, quarterly. The 'safe and secure audit' monitored compliance against 27 standards to ensure medicines and prescription pads were stored securely and in line with best practice. Results of the audit completed in March 2019 were consistently high across all departments. The ward, day surgery unit, imaging and endoscopy departments scored 100% compliance, theatres and recovery scored 95% compliance and the outpatient department scored 91% compliance. Theatres and recovery fridges were found to be unlocked. The action plan for this showed theatre and recovery leads had been spoken to and reminded to keep the fridge locked when not in use. The overall compliance score for the hospital was 97%. This was an improvement from the previous quarter when the overall compliance score for the hospital was 94% (Source: PIR, A10 – Safe and secure audit, September – December 2018; January – March 2019).
- The pharmacy manager conducted controlled drug (CD) audits and submitted a quarterly controlled drugs occurrence report to the local intelligence network (LIN). This was in accordance with national requirements (Department of Health, The Controlled Drugs (Supervision of management and use) Regulations 2013, February 2013). The audit completed in quarter four (January to March 2019) showed compliance was met (100%) for five of the 10 standards monitored. For the remaining five standards, compliance ranged from

50% to 83%. The findings were shared with staff by the heads of department, including recommendations and actions required to improve compliance (Source: PIR, A13 – Controlled Drug Quarterly Report, January to March 2019). Key recommendations included results to be disseminated to all staff and pharmacy staff to collaborate with the controlled drugs champions to remind staff on compliance. Ward staff told us there were previous issues regarding the documentation of errors within the CD book. The pharmacist had completed medicines management training for staff and laminated a reference guide for them. They had found no further issues. We saw evidence that the medicine management training had taken place in June 2019. We also saw a reminder regarding the completion of the CD register in the theatre newsletter for January 2019. We inspected the theatres CD book and found no errors.

- Staff stored and managed medicines in line with local policy and national standards. Medicines, including controlled drugs, were stored safely and securely in theatres and on the ward. We observed no medication was left unattended. Staff carried out daily checks on CDs and medication stocks to ensure medicines were reconciled appropriately. CD destruction kits were available, and staff could describe how they would destroy them.
- Staff monitored, and recorded temperatures where medicines were stored to ensure they were effective and safe for patient use. Medicines that needed to be kept below a certain temperature were stored in locked fridges. The treatment rooms where medicines were stored were air-conditioned, which meant the temperature could be maintained within the recommended range (below 25°C). Ambient and fridge temperatures were checked daily and stored within the correct temperature range. Staff knew what to do if temperatures were out of range.
- All medication checked was in date and the controlled drug balances were correct. Emergency medications were stored in secure containers on the resuscitation trolleys. These were all in date.
- Anaesthetic drugs were drawn up in syringes and prepared ready for use on each patient. All syringes were labelled as per hospital policy.
- The chief pharmacist was the hospital's antibiotic steward. An antibiotic steward seeks to achieve the optimal clinical outcome related to antibiotic use, to minimise toxicity and other adverse events and limit the selection for antimicrobial restraint strains. This reduces the risk of antibiotics becoming less effective.

Incidents

- **The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, we were not assured patients and families were always involved in investigations. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- All staff knew what incidents to report, how to report them and reported all incidents that they should report. The hospital used an electronic reporting system to report all incidents. Staff told us they were encouraged to report incidents and felt confident to do so. Results from the staff survey in June 2019 showed 92.4% of staff agreed or strongly agreed that they were encouraged to report errors, near misses or incidents. No staff disagreed with this statement.
- From January to December 2018, 127 clinical incidents and 35 non-clinical incidents were reported by theatres and the ward. Each incident had been reported and investigated in accordance with the hospital's policy for incident management. All clinical incidents were categorised according to their level of harm; three incidents were graded as having caused moderate harm and all the others were graded as low or no harm.
- For the same period, the hospital reported a total of 190 clinical and 147 non-clinical incidents. Of the 190 clinical incidents, 187 were graded as having caused no or low harm (93.2% and 5.3% respectively), and three (1.6%) were graded as having caused moderate harm.
- From January to December 2018, the hospital had no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened

for an incident to be a never event. We saw the theatres staff newsletter for February 2019 had a reminder for staff on what a never event was and how to reduce the risk of them occurring.

- Staff reported serious incidents clearly and in line with hospital policy. From April 2018 to January 2019, the hospital notified the Care Quality Commission (CQC) of six serious injuries.
- Reported incidents were reviewed and investigated by the ward and theatre managers. Serious incidents were investigated by staff with the appropriate level of seniority, such as the director of clinical services. Lessons were learned from serious incidents and changes were made to the service. Any immediate learning points for staff in theatres were raised at the daily '5-8 at the gate' meeting.
- Managers investigated incidents thoroughly. However, while patients and their families were informed when an investigation was being undertaken, we were not assured they were always invited to be invited in them. We reviewed the investigation reports for the six serious injuries reported and found comprehensive root cause analysis investigations were completed. Good practice, lessons learned, recommendations and action plans to minimise recurrence and enhance patient safety were included. However, it was not evident whether the patient and/or their family was invited to inform the terms of reference for the investigation nor whether they had the opportunity to respond and/or comment on the findings and recommendations made in the final report. This was not in accordance with national guidance (NHS England, Serious Incident Framework: Supporting learning to prevent recurrence (March 2015)).
- Managers debriefed and supported staff after any serious incident. This was evident from the investigation reports we reviewed and conversations we had with staff.
- Staff received feedback from investigation of incidents both internal and external to the service. Results from the staff survey in June 2019 showed 89.4% of staff agreed or strongly agreed that action was taken, and feedback was given when errors, near misses or incidents were reported to ensure they did not happen again. Information was shared in a variety of means including; the daily operations meeting, safety briefs, emails, governance and team meetings, newsletters and noticeboards. When there was a serious incident which required a root cause analysis (RCA) investigation, the completed RCA was displayed for staff to see on the ward and in theatres. Minutes of team meetings we reviewed confirmed incidents were discussed. We saw feedback of an incident of a patient who had to return to theatre displayed within the ward area. The ward manager had detailed the incident and also highlighted that there had been outstanding teamwork and communication, and the consultant was impressed with the competence of the staff. Key learning summaries of incidents that had occurred at One Hatfield and the other One Healthcare hospital site were distributed to staff quarterly. We reviewed a sample of these from April 2018 to March 2019 and saw lessons learned and actions taken to minimise recurrence were clearly summarised for staff.
- Staff could discuss incidents they had reported and gave examples of how they received feedback. For example, there was a patient who had a bleed intra-operatively and staff activated the major haemorrhage policy. Staff said this went well but they learned that they needed to formally stand down the local acute NHS trust once the patient was stable, which meant the trust were made aware no further blood would be needed. The service had formalised this learning within an algorithm displayed for theatre staff to see.
- There was evidence that changes had been made because of incident investigations. For example, the ward had learned from an incident where a patient developed diabetic ketoacidosis. This is a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones. Staff realised they did not have the appropriate equipment for testing for ketones, which had subsequently been purchased. A consultant we spoke to was also aware of this incident and had also produced a pocket-sized guide on the management of diabetic ketoacidosis for staff.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. They all received annual training from the director of clinical services. 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, under Regulation 20 of the Health and Social

Good

Surgery

Care Act 2008 (Regulated Activities) Regulations 2014. The six investigation reports we reviewed showed duty of candour had been applied verbally but did not include how this had been followed up in writing. However, we were provided with additional evidence which showed duty of candour letters were sent to patients. These included an apology. Each patient was offered a meeting to discuss the outcome of the investigation with the hospital director and director of clinical services. They also included any actions planned to minimise recurrence and evidence of further support given to the patient, where applicable. The investigation report was shared with the patient, family, and/or representatives on completion. Following our inspection, senior leaders took immediate action and assured us duty of candour letters would be included in investigation reports and patients' medical records.

- Managers ensured that actions from patient safety alerts were implemented and monitored. The hospital used an electronic system which alerted staff when safety alerts were issued by the Medicines and Healthcare Products Regulatory Agency (MHRA) central alerting system (CAS). A monthly CAS report was sent to all departments and action was taken where applicable. Compliance was monitored through the governance dashboard. According to the governance dashboard, 100% of CAS alerts had been actioned from January 2018 to April 2019.

Safety Thermometer (or equivalent)

- **The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**
- While the hospital did not submit safety information to the NHS Safety Thermometer, staff did collect, monitor and report safety performance data such as the number of patient falls, catheter-acquired urinary tract infections, pressure ulcers and venous thromboembolisms. We saw this information displayed publicly in the day surgery unit and ward.
- Most patients received harm-free care. From January 2018 to April 2019, the hospital reported three patient falls and two venous thromboembolisms. There were zero incidences of pressure ulcers (grade one to four) and catheter-acquired urinary tract infections.

Are surgery services effective?

Good

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

In this section, we also cover hospital-wide arrangements such as the use of current-evidence based guidance and how they ensure staff are competent to carry out their duties, in the relevant sub-headings within the effective section. The information applies to all services unless we mention an exception.

We rated it as **good.**

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies seen were up-to-date and contained current national guidelines and relevant evidence. Policies were stored on an online system which all staff had access to. In theatres, we saw the 'policy of the month' displayed for staff to read and sign to say they had read it. Meeting minutes showed that updated policies were discussed in departmental team meetings. For example, minutes of the ward team meeting held in February 2019, showed staff were asked to read the new fasting protocol. The following month, minutes showed staff discussed the protocol again and that it was working well. Staff had to sign a monthly policy document to say they had read updated policies. Staff were also informed of new or amended policies at the daily operational meeting. During our inspection we observed all staff were asked to read all HR policies as these had recently been revised.
- There was an effective system to ensure policies, standard operating procedures and clinical pathways were up-to-date and reflected national guidance. The hospital used an electronic system which alerted staff when a policy was due for review. We reviewed 25 policies and found all were within the review date. All

policies were reviewed at least every three years, or when national guidance was published. The hospital's electronic system also alerted staff when new National Institute for Health and Care Excellence (NICE) guidance and quality standards were published. A monthly report was sent to all departments with updated NICE guidance and action was taken if applicable. Compliance with the implementation of NICE guidance was monitored through the governance dashboard. We saw all required actions had been completed.

- Hospital policies and standard operating procedures such as complaints, incident management, safeguarding adults and children, transfer of care, consultant cover, access and sepsis, had been approved by the local clinical commissioning group (CCG) before the hospital was granted an NHS contract.
- Hospital policies were equality impact assessed to ensure guidance did not discriminate against those with protected characteristics as set out in the Equality Act 2010.
- The service used evidence-based guidance and quality standards to inform the delivery of care and treatment. For example, the pre-operative assessment clinic assessed patients in accordance with National Institute for Heath and Care Excellence (NICE) guidance (NICE, Routine pre-operative tests for elective surgery [NG45] (April 2016)).
- Staff followed guidance regarding the recording and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database. We saw evidence of this in the notes we reviewed. Relevant paperwork was completed at time of insertion of implant and was documented in the National Joint Register (NJR) by theatre staff within 24 hours of the procedure. The service also participated in the national spine and breast registries. However, the NJR submission data showed the hospital was worse than expected for patient consent to have their personal details stored on the NJR alongside their operation information, with only 12.5% recorded. This was well below the national expectation of 85%. We raised these findings with senior staff who took immediate action to investigate. The records of patients who underwent joint replacement surgery from April to June 2019 were audited. The findings indicated data was being incorrectly entered on the NJR. In response, the theatre lead has requested the hospital's NJR data is 'unlocked' so it can be reviewed and entered correctly. The audit showed 100% of patients were provided with the NJR patient consent form at their pre-assessment appointment.
- Staff used surgical pathways which were in line with national guidance. This included for example, integrated care pathways specific for a day case procedure. The day case pathway included the predicted American Society of Anaesthesiologists (ASA) classification. Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. Our review of patient records, guidelines and clinical pathways, and discussions with staff confirmed care was delivered in line with national guidance and standards.
- The service used Orthopaedic Data Evaluation Panel (ODEP) rated prosthesis for all joints. Implant manufacturers are invited to submit data regarding their products to ODEP. The panel rated the strength of the evidence provided and gave the implants an award of an ODEP rating. All implants used in this service were rated as 10A. This meant there was 10 years of strong evidence, which was fully compliant with the NICE benchmark.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.
- Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patients' nutrition and hydration needs. This was in line with national guidance (NICE, Patient experience in adult NHS services [QS15] (February 2012)).
- Staff fully and accurately completed patients' fluid and nutrition charts where needed. We observed MUST assessments were completed in all the records we reviewed. These were routinely updated as required. Staff used fluid balance charts to monitor patients' fluid intake. Patient records were audited for compliance with nutrition and hydration requirements. From April 2018 to March 2019, compliance was 99.75%

- Patients waiting to have surgery were not left nil by mouth for long periods. Patients waiting to have surgery were kept 'nil by mouth' in accordance with national safety guidance. This was to reduce the risk of aspiration during general anaesthesia. Patients having elective surgery were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing. Admission times were generally staggered so that patients were fasted for the minimum amount of time. Patients nutrition status was discussed during the daily safety briefing and anaesthetists requested 'pre-operative nutritional drinks' for patients who would be waiting over two hours for their surgery. We observed this happened during team briefs.
- Patients recovering from surgery had jugs of water within reach. These were regularly refilled. Staff completed hourly care rounds for each patient and checked they had a drink.
- Patients who experienced nausea or vomiting were prescribed antiemetic medicine (used to minimise vomiting and nausea). Patients were given antiemetic's intravenously (via a vein) in the recovery area if they complained of nausea post-operatively. We saw antiemetic medicines were regularly prescribed in the prescription charts we reviewed.
- Specialist support from staff such as dietitians was available for patients who needed it. We were told that if a patient needed to see a dietitan, the service would contact the local NHS trust for a dietitian to visit. The chef had links with a community dietitian service if required. All patients we spoke with said the food was excellent and there was a good choice available. The patients we spoke to confirmed they were asked if they had any dietary requirements.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The surgical care pathway used, prompted staff to assess, record and manage pain effectively. We reviewed 10 patient records which showed pain was assessed with the NEWS2 pain scale and hourly on intentional care rounds, high pain scores were acted on promptly. A monthly medical record audit was completed which looked at assessment of patients' pain and use of the pain score, compliance was 100% in April 2019. Each patient had a whiteboard within their room which the staff used to update their pain score, which was scored out of ten. We saw that these were regularly updated.
- We attended the daily ward round and observed each patient was asked about their pain. The team discussed the analgesia they were taking to ensure the patients' pain was well managed. One patient on the ward round said to the resident medical officer (RMO), "you are a very nice man as you have taken my pain away".
- Patients received pain relief promptly and told us staff effectively managed their pain. For example, one patient said, "yesterday I was in lots of pain and the staff kept coming in and got it under control".
- The service had recently developed a pain management group ran by pharmacy staff, a recovery nurse and an anaesthetist. The aim was to review and assure staff that patients' pain was well managed; the group was still in its infancy stage at the time of our inspection. A student nurse attended the meeting as part of their development, they told us they had learned a lot about analgesia and opioids.
- All patients were given an information leaflet on discharge about their pain relief. This included information about the different types of analgesia to take depending on the amount of pain the patient had.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- The service participated in some relevant national clinical audits, which they generally performed well in. Managers used the results to improve services further. The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. Clinical audits and risk assessments were carried out to facilitate this. The hospital participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) programme and the National Joint Registry (NJR).

- There was a local audit programme for the hospital. The programme ensured different aspects of care and treatment within the service were checked during each audit. Audits included; medical records, infection prevention and WHO safer surgical checklists. Audit results were discussed at governance meetings, where all clinical leads were present. They then shared this information with their teams.
- The service commenced activity for NHS patients and started to participate in PROMs from March 2019. Therefore, at the time of our inspection there was no data to share; this was expected in August 2019.
- Managers used information from audits to improve care and treatment. All PROMs data was discussed at the hospital and cross-site governance meetings. A summary of any key action points was then shared at the medical advisory committee (MAC) and actions for improvement were developed if indicated.
- The hospital participated in the national joint registry (NJR). Patient outcome data showed that for both hip and knee replacements, patients' outcomes were as expected and in line with the national average (Data source: National Joint Registry, April 2017 to March 2018: http://njrsurgeonhospitalprofile.org.uk/HospitalProfile?hospitalName=One%20Hatfield%20Hospital
- From March 2018 to February 2019, there were three unplanned returns to the operating theatre. For the same reporting period, the hospital had three unplanned transfers to the local NHS trust. All incidents of unplanned transfer were reported and investigated for any trends by the senior management team. Actions were taken to improve patient where indicated, such as daily checks of the blood gas analyser to reduce the risk of cartridge failure.
- From March 2018 to February 2019, the hospital reported no unplanned readmissions, to either an acute hospital or One Hatfield, within 28 days of discharge. Unplanned readmissions were reported as incidents and investigated.
- The service had low surgical site infection (SSI) rates. From March 2018 to February 2019, the service recorded one SSI out of 1,320 procedures. This equated to a 0.07% SSI rate.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed 18 staff files and found they all contained relevant information, such as up-to-date disclosure and barring service (DBS) check, references, curriculum vitae and evidence of registration with the Nursing and Midwifery Council (NMC). Health and care Professions Council (HCPC) or General Medical Council (GMC). Data submitted showed 100% of eligible staff had completed revalidation with their professional body. Staff completed a variety of mandatory and role specific training through an e-learning system and face-to-face training. Competencies were required for each role and included drug administration, wound care and use of ward equipment. The competencies were recorded in a booklet, scored, with space for reflective assessment, which was completed prior to sign off. We saw evidence of completed competencies for staff in the service.
- Senior managers made sure consultants working under practising privileges were experienced, qualified and had the right skills and knowledge to meet the needs of patients. From January 2018 to April 2019, 100% of consultants were compliant with the required evidence for practising privileges (Source: PIR, D23 – Board Governance Dashboard). Practising privileges for consultants were reviewed annually. The review included all aspects of a consultant's performance such as appraisal, revalidation, volume and scope of practice, examples of continuing practice development, any adverse occurrences involving the consultant and any areas of concerns brought to the attention of the Medical Advisory Committee (MAC). In addition, the MAC advised the hospital about continuation of practising privileges. Senior managers used an electronic system to check when privileges were due to expire. We reviewed 10 consultant files and found they contained all required information such as up-to-date DBS, scope of practice, professional registration, appraisal and indemnity insurance.
- RMOs had their competencies assessed, and mandatory training provided and updated by their external agency provider. They worked in line with guidelines and a handbook to ensure they were working within their sphere of knowledge. They had a yearly appraisal

completed by their external agency provider and a clinical mentor supported them. The clinical mentor could be contacted for telephone advice when needed. We reviewed the three RMO staff files and found they contained all required information and evidence of up-to-date training and competencies.

- Managers arranged for all new staff to have a full induction tailored to their role and a local orientation to their department before they started work. Dependant on their role, some new staff worked initially in a supernumerary capacity. This allowed them to understand their new environment before having full responsibility for their role. For example, ward nurses were classed as supernumerary for at least the first two weeks of their employment. New theatre staff were assigned a mentor to support them.
- Managers supported staff to develop through yearly, constructive appraisals of their work. As of April 2019, 100% of ward staff and 99.5% of theatres staff received an appraisal. The ward manager tried to do bi-annual appraisals to assist with competency completion and to ensure staff felt supported. Overall, 95% of hospital staff had received an annual appraisal. This was higher (better) than the hospital's target of 90% (Source: PIR, D23 – Board Governance Dashboard). Staff told us that they found the appraisal process helpful
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers discussed competencies and training needs with staff at their appraisal. Staff we spoke with confirmed this. For example, one member of staff told us how they were really interested in a new surgical procedure the service was looking to undertake. They had been sent to the local NHS trust, along with two scrub nurses, for training and been asked to become the lead for this. Another member of staff had recently been supported to undertake mentorship training, which would enable them to teach and supervise students undertaking a clinical placement at the hospital.
- The service had recently provided placements for student nurses from the local university. They had developed an induction booklet and learning programme for them. We spoke to a student nurse who said the booklet was very informative. They had learned a lot on the placement and felt very supported in the ward environment.
- Managers identified poor staff performance promptly and supported staff to improve. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and meetings with their managers. There were no formal one-to-one's documented however, staff told us that managers had an open-door policy and felt they addressed any issues promptly.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- We observed effective multidisciplinary working, and communication between staff in theatres and the ward. All staff carried a communication device and were able to speak to each other through this.
- All staff told us they had good working relationships with consultants and the RMO. We saw good interactions between all members of the team. The RMO, director of clinical services, pharmacist and physiotherapists were present on the ward daily and reviewed patients' together as a team. Staff said they were all approachable and they worked well as a team. Patient records we reviewed confirmed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw evidence of effective team communication across the service. The hospital held a daily operational meeting. This took place at 9.30am every morning. It was attended by the senior management team and a representative from each department, including theatres, ward, pharmacy, outpatients, physiotherapy, catering, facilities and patient services. We observed a brief overview of hospital activity, utilisation, staffing, incidents, patient feedback, mandatory training compliance, staff on call for emergencies and potential risks to services were discussed. This information was documented on a whiteboard in the staff dining area for all staff to review and was updated daily. Information was then cascaded to staff in each department.
- The service had links with the local NHS trust. Nurse specialists from the local trust attended the ward to provide advice, when needed. For example, the ward

manager told us a specialist nurse in gender reassignment had attended the ward to provide support to ensure a patient had the care they needed following gender reassignment surgery.
- Information about the treatment a patient had received during their admission was communicated to the referring GP by letter, once the patient had been discharged.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- The hospital only undertook elective surgery, and operations were planned in advance. The exception to this was if a patient was required to return to theatre due to complications following a procedure.
- Theatre sessions were held between 8am and 8.30pm, Monday to Friday. We saw effective theatre list scheduling which ensured the surgeon had finished operating on the last patient by 8.30pm. Theatre lists for elective surgery were planned with the theatre manager and bookings team. There was an on-call rota for theatre staff for out of hour's requirements, a weekly on-call rota was circulated. The rota included details of on-call arrangements for all clinical areas and the on-call senior manager. On-call arrangements were also discussed at the daily '5 to 8 at the gate' meeting.
- Staff could call for support from doctors 24 hours a day, seven days a week; consultants were always on-call for patients under their care. Patients were seen daily by their consultant, including weekends. If the consultant was not available, they arranged cover by another consultant. We saw this communicated to ward staff. This was a requirement of their practising privileges. The RMO and ward staff had a list of contacts for all consultants and anaesthetists for each patient. Staff told us medical staff could be easily contacted when needed. Anaesthetists were available via an on-call rota if a patient needed to return to theatre. There was 24-hour RMO cover in the hospital to provide clinical support to patients, consultants and staff.
- A senior nurse was always available for advice and support during working hours. Furthermore, the management team operated a 24-hour, seven days a week on-call rota system. Staff could access a senior nurse for advice and support as needed. We saw evidence in a patient's notes where staff had called the management team for advice out of hours.
- The ward accommodated overnight patients seven days a week.
- The pharmacy was open from 9am to 5pm, Monday to Friday. If a patient required medicines out of hours, the RMO and a registered nurse went to the pharmacy department and checked out the medicines.
- Pathology services were provided offsite. There was a service level agreement in place for this. Ward staff told us they could get results urgently by phone when needed.
- The physiotherapy department was staffed from 8am to 6pm, Monday to Friday. However, physiotherapy staff told us they would stay later if needed. The weekend service was provided on a rota and was only able to support inpatients. There was physiotherapy on call cover out of hours.
- Pre-operative assessment was offered Monday to Friday, 8am till 8pm. There were no plans for this service to be available at the weekends. The director of clinical services said that this would be reviewed and considered if there was an increase in demand.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- Staff assessed each patient's health and provided support and advice to help patients lead healthier lives. Patients attended pre-operative assessment appointments where their fitness for surgery was checked. Staff asked patients a series of questions about their lifestyle such as smoking and drinking status. Patients were given advice about smoking cessation when required. The service had a standard operating procedure for smoking cessation. It contained information regarding different ways to support a patient giving up smoking. For example, nicotine patches and different doses to prescribe. The hospital was also a non-smoking site therefore staff and patients were all encouraged not to smoke.
- A wide range of leaflets were available for patients regarding their care and health. Patients received leaflets on patient safety which included how to reduce the risk of developing a VTE, falls prevention, pressure ulcer prevention and recognition of sepsis.
- The hospital produced a quarterly newsletter for patients and visitors, which included health promotion advice. Copies were available in the main reception

area. The Summer 2019 edition included advice on the easy way to check moles, prevention and treatment of sports injuries and a consultant respiratory paediatrician's top tips for managing childhood asthma.
- A range of leaflets from Dementia UK were available, including advice on eating and drinking to help people living with dementia be healthier.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and knew who to contact for advice. There was an effective up-to-date consent policy for staff to follow. Patient records we reviewed showed consent was obtained in accordance with hospital policy. We observed consent being obtained for one patient prior to their surgical procedure. The consultant explained all the risks, gave the patient time to ask questions and spoke in non-medical jargon. However, we found nine out of the 10 records we reviewed contained the patients' copy of the consent form. This was not in line with hospital policy which stated a hard copy of the consent form must be given to the patient. This meant we were not assured staff gave patients a copy of their consent for surgery. We raised this with staff who told us patients' often declined a copy of their consent form. Following our concerns, we were told all patients' would be sent a copy of their consent form. On our unannounced inspection, we checked a further five patient records; three patients' had not had a copy of the consent form. We were told that these would be posted out by the administration team when filing the discharged patients records.
- Staff made sure patients consented to treatment based on all the information available. Patients were given information about their proposed treatment both verbally and written, to enable them to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.
- Managers monitored consent processes. Consent audits were part of the hospital's medical records audit data provided showed 100% compliance. We reviewed 10 sets of records and consent was completed fully in all of them.
- Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients. Staff were aware of the legal requirements of the MCA and Deprivation of Liberties Safeguards (DoLS).
- We were told patients who were booked for cosmetic surgery were given a two-week cooling off period before undergoing the procedure, in case they wanted to change their mind. This was in line with national guidance.
- When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They would involve the patients' representative(s) and other healthcare professionals. Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process, where it was determined whether they could be admitted for treatment at the hospital.
- All staff completed training on the MCA and DoLS. At the time of our inspection, 100% of ward and theatres staff were compliant with this training.

Are surgery services caring?

Good

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

We rated it as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We observed staff were caring and compassionate with patients and their relatives throughout our inspection. Staff promoted privacy and patients were treated with dignity and respect. For example, we saw a consultant respect a patient's dignity while marking them for surgery. We observed staff spoke with patients discreetly to maintain confidentiality.
- Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff talking with patients, explaining what was happening and what actions were being taken or planned. We were told the nurse in charge of the ward also did a regular 'compassionate care' round, they spoke with patients and checked how they were feeling and if they had any concerns or compliments.
- Patients said staff treated them well and with kindness. We spoke with four patients, all four told us staff were kind and caring, they could not fault the service. They said that they had received excellent care and their hospital experience had been positive.
- Patient feedback also confirmed that staff treated patients with compassion, kindness, dignity and respect. Patient feedback was gathered through various means, such as. the Friends and Family Test (FFT), 'One Loves to Listen' cards and 'iWantGreatCare' reviews. Patients were asked to complete a satisfaction survey; the results were published and shared monthly. Feedback for March 2019 showed 98.5% of patients would recommend the service and 100% felt they were treated with dignity and respect.
- Patient feedback from the FFT was positive for all services. From October 2018 to March 2019, the hospital's overall FFT performance (% recommended) was 98.6%. The only two months the hospital did not score 100% were January and March 2019, when the % recommended was 93% and 99% respectively (Source: Pre-Inspection Pack).
- The ward displayed many 'thank you' cards, which staff had received from patients and relatives. Comments from the cards included, "Just wanted to express my thanks and appreciation for the wonderful treatment and care you all showed me. All staff were second to none." One patient wrote, "All of you showed kindness and support together with professionalism, a winning formula." Another wrote, "Just a note to let you all know how much I appreciated your care and assistance during my recent stay."

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us they had time to spend with patients to reassure them and provide emotional support.
- Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "I love it here. It is exactly what I would want. It is better for my husband knowing I am being very well cared for." Patients also said that staff were "brilliant" and "nothing was too much trouble."
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. For example, we saw staff supported patients who were anxious or distressed while they were being prepared for surgery. Staff were reassuring and maintained a calm, relaxed environment.
- Pre-admission assessments included consideration of patient's emotional well-being. One patient told us that the pre-operative assessment with the nurse was very thorough and everything was explained in detail.
- Spiritual care and religious support could be arranged for patients when needed. Chaplaincy services were provided by the local acute NHS trust. Multi-faith options were available.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff made sure patients and those close to them understood their care and treatment. Patients told us nurses explained what they were doing and asked for

permission before they did anything. Patients said medical staff explained plans for their treatment and provided opportunities to for them and/or their family members to ask questions when needed.
- Patients told us they were given choices regarding their treatment options. We observed the team discussing medicine choices with a patient to ensure they were on medicines that were right for them. Physiotherapists discussed post-operative care needs with patients and relatives to ensure a smooth and safe discharge home.
- Staff supported patients to make informed decisions about their care. Patients told us staff clearly explained the risks and benefits of treatment to them before admission. In May 2019, the patient feedback report showed 97.6% of patients felt they were involved as much as they wanted in decisions about their care and treatment.
- All patients were complimentary about the way they had been treated by staff. We observed staff introduce themselves to patients and explain to them and their relatives, care and treatment options.
- Patients who paid for their treatment privately, told us costs and payment methods had been discussed with them before their admission.
- Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment.

Are surgery services responsive?

Good

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

In this section, we also cover hospital-wide arrangements such as service planning and learning from complaints, in the relevant sub-headings within the responsive section. The information applies to all services unless we mention an exception.

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people.**
- Managers planned and organised services so they met the needs of the local population. The services provided ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including orthopaedic, cosmetic and general surgery. Services were also being developed to meet the needs of local people and the wider health economy. For example, the service had recently commenced gender reassignment surgery and was hoping to commence breast reconstructive surgery soon.
- The hospital was committed to providing high-quality services to private patients and had agreements with local commissioners to provide some services for NHS patients. Quality visits had been undertaken by the local clinical commissioning group (CCG) to ensure NHS services commissioned at the hospital were safe and of a high-quality. All patients were treated equally whether they were self-funded, privately insured or NHS.
- The service only received planned admissions. Patients' with specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre-assessment. This meant appropriate arrangements could be made to meet individual needs prior to admission.
- The hospital had service level agreements with a local acute NHS hospital to provide additional services they were unable to provide themselves. This included the supply of blood products and pathology services.
- There were photo boards of staff in each department. This meant patients and visitors could easily identify staff and their roles within each area.
- The hospital provided free Wi-Fi access which meant patients could keep in contact with their friends and relatives via social media while in hospital.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.**
- Patients with mobility difficulties accessed theatres and the ward via a lift. The corridors and doors were wide, which meant wheelchair users could get through easily.

- The service accessed interpreting services for patients whose first language was not English. A telephone line was available, and staff accessed this to support patients where required.
- Patients with complex needs had their discharge planned in advance. In the pre-operative assessment, patients were asked about their home situation. Staff could arrange extra support for a patient's discharge when needed, such as social care at home.
- Staff answered call bells promptly. Patients' told us staff responded quickly to their needs, for example to help them to the toilet. Relatives' needs were considered, and they were offered food and drinks when they visited patients.
- Patient rooms had individual whiteboards which contained information such as their named nurse. Staff also wore name badges with 'hello, my name is' on them. This meant patients knew the name of the staff caring for them.
- Staff provided information leaflets for a range of conditions and to support care given. These were written in English but could be obtained in other languages and different formats, such as easy read when needed.
- Hearing loop was installed for hearing impaired patients and visitors in the main waiting area and ward. Furthermore, following the admission of a deaf patient, the hospital had ordered an additional hearing loop that could be placed in the patient's bedroom or worn by staff. This was to aid hearing for profoundly deaf patients and ensure they were able to communicate with staff.
- The service had open visiting times which meant that patients could see relatives at a time that suited them.
- The service recently started performing gender reassignment surgery. Prior to this, all staff were given psychological training to ensure they understood the needs of these patients. The consultant who performed this surgery brought a specialist nurse with them who was available daily for support and advice while the patient was in hospital.
- As of April 2019, 98% of staff had completed dementia awareness training, 96% had completed mental health awareness training and 92% had completed learning disability awareness training (Source: D14 – Mandatory training and compliance).
- The service had not treated any patients with learning disabilities, although staff could describe how they would support them. For example, the hospital would use 'patient passports' which would provide important information to staff about the patient, such as what was integral to their individual care needs. These would be completed prior to their admission. The patient would also be accompanied to theatre with their carer(s) who could stay with them in the recovery area to offer support and a familiar face for the patient.
- All patients who were over the age of 75 had a dementia screening assessment completed at their pre-operative assessment. If this was found to be positive, the nurse would feed this back to the patients GP and together they would decide the best place for the patient to receive care and treatment. This was also documented on their 'red flag' assessment, which was attached to their medical record.
- There was a dementia champion nurse for the hospital who held teaching sessions for staff. The hospital also had a consultant geriatrician who was available to provide advice and support on the care and treatment needs of patients living with dementia. The ward had set up a dementia box which contained items to make patients' stay on the ward easier. This included an easy to read clock, crockery and cutlery. Staff had access to 'This is me' booklets if required. There were a variety of leaflets available for patients living with dementia including topics such as continence, falls and pressure ulcer care. The dementia champion had created a booklet for patients and carers which identified the option for overnight stays for family members and adaptations made in the hospital for patients living with dementia. Since November 2018, there was 100% compliance with completion of the dementia risk assessment. Staff told us about a patient who had dementia who was cared for on the ward. Staff were able to spend time with the patient and put them in one of the rooms close to the nurse's station. Staff were aware that the patient liked dogs and found a television show about dogs for the patient to watch. Colouring pens from the children's area were obtained and the healthcare assistant sat and coloured with the patient.
- The hospital catered for patients' with specific dietary requirements, including religious and cultural needs. Catering staff spoke to patients' to check if they had any food allergies and/or specific dietary requirements. Menus were coded to indicate meals that were gluten free, foods that were easier to chew, vegetarian options, or meals suitable as part of a healthy balanced diet.

There was a large variety of hot food options available. This encouraged patients to eat and ensured their nutritional needs were met. The ward was able to supply food out of hours if required, which included sandwiches, toast, fruit and biscuits.

Access and flow

- **People could access the service when they needed it. Waiting times from referral to treatment for NHS patients exceeded national targets. Waiting times for private patients were minimal.**
- Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Monthly diagnostic waiting times and activity reports were submitted. One Hatfield kept a detailed spreadsheet of all NHS patients and their 18-week breach deadline. We saw that no patients breached this target. Any patients that were approaching a breach, had steps taken to expedite their admission dates. We saw that most patients were nowhere near their breach date when they were seen at the hospital. In 2019, up to the time of our inspection, the service had seen 185 NHS patients, 64 of which had surgery at the hospital well within the 18-week target.
- There was no formal mechanism similar to the NHS RTT targets for private patients. However, we saw there were no waiting lists and patients were generally seen within one to two weeks from their referral.
- Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning started at the pre-operative assessment stage. Length of the patient's expected stay was discussed. This helped patients plan for any additional support they might require at home. Patient records showed staff completed discharge checklists, which covered take home medicines, communication provided to the patient and other healthcare professionals, such as GPs. This ensured patients were discharged in a planned and organised manner.
- Managers and staff worked to keep the number of cancelled procedures to a minimum. When patients had their procedure cancelled at the last minute, staff made sure they were rearranged as soon as possible. The service monitored the number of cancellations and procedures were only delayed or cancelled when necessary. From January to December 2018, two procedures were cancelled for non-clinical reasons, both patients were rescheduled within 28 days of the cancellation. Staff told us they had learned from cancellations. For example, a patient who was having a procedure under local anaesthesia was cancelled on the day of surgery. They had been told they could eat and drink which was in line with national guidelines. However, the consultant did not want this for their patients. The team learned from this and no longer advise that consultant's patients to eat and drink as normal, prior to their procedure.
- Staff did not move patients at night. All inpatients were admitted to their own, private room.
- The ward operated seven days a week, 24 hours a day. The day surgery unit was open dependent on patient need and activity, which we were told was increasing. The number of admissions and patient numbers was reduced at weekends because theatres were not currently opened at weekends.
- The service did not formally monitor theatre utilisation. The theatre manager completed a monthly spreadsheet which contained data regarding utilised hours in theatre including start and finish times and surgeon specifics. This was sent to the finance team but was not analysed to ensure efficient theatre utilisation. Following the inspection, we asked for data regarding theatre utilisation. It showed utilisation was increasing monthly and had increased within the last year from 17.4% in July 2018 to 41% in June 2019. This was based on two operating sessions a day. However, as the service was new, there had been ad hoc use of the theatres rather than regular slots. This meant there was not over-utilisation of the services at the time of our inspection. The service was starting to get regular slots from consultants and managers hoped to increase usage in theatres to 80% by December 2020.
- Managers did not formally monitor theatre delays and overruns. The theatre manager said they did not have any concerns with theatre delays or overruns.
- NHS patients were referred to the service by their GP via the NHS e-referral system (ERS). These referrals were screened to ensure patients were appropriate for the services and facilities provided at the hospital.
- Patients were given a choice of dates for their planned surgery. Patients we spoke with confirmed they were given a choice of appointment times and could schedule procedures at a time convenient to them.

- An on-call theatre team was available to attend any emergency readmissions to theatre. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust via ambulance.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff. The service included patients in the investigation of their complaint.**
- The hospital clearly displayed information about how to raise a concern or complaint in public and patient areas. Feedback concerns and complaints could be made in a variety of ways including in person, by telephone, letter, email, text, patient survey and social media. All patients received a 'patient guide' which had details of how to make a formal complaint.
- One patient we spoke with was unaware of how to make a complaint. They said this information could be detailed in the literature they had been given but they had not yet had a chance to read through it all.
- All patients who stayed overnight were telephoned two days and 30 days after their procedure to ensure they were recovering well and were asked for feedback about the service. If any issues were raised during these phone calls, staff would attempt to resolve them. If they were unable to, they would escalate the concerns to the senior team to manage.
- Staff understood the complaints policy and knew how to handle them. They told us that where possible, concerns were resolved immediately. The head of department for the specific area was notified, and details of the concern were logged on the electronic reporting system. If any concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint.
- Managers investigated complaints and identified themes. The hospital director had overall responsibility for the management of complaints. Complaints were acknowledged within two days of receipt and a senior member of staff was assigned to investigate the complaint. The investigating officer contacted the complainant to confirm their understanding of the complaint, advise when the investigation would be completed, and discuss the complainant's desired outcome. Complaints were investigated and responded to within 20 working days. Where this was not possible, a letter was sent to the complainant explaining the reason for the delay. All complainants were invited to a face-to-face meeting with staff involved at the hospital. If the complainant was dissatisfied with the hospital's response, stage two of the complaints process was instigated and the chief executive for One Healthcare Limited would review the complaint. If the complainant remained dissatisfied they were signposted to independent external adjudicators, such as the Independent Sector Complaints Adjudication Service (ISCAS).
- From June 2018 to April 2019, the hospital received 10 complaints, none of which were referred to the Ombudsman or ISCAS (Source: PIR, D13 – Complaints Summary Report). Most complaints received were about patient care which included clinical treatment and communication from staff. We reviewed three complaint responses and found they were investigated and resolved in line with hospital policy. An apology was given, concerns outlined in the complaint were addressed, learning and/or changes made because of the complaint were included, and gestures of goodwill were made where appropriate.
- Managers shared feedback from complaints with staff and learning was used to improve the service. Learning was shared with staff through a variety of means such as the daily operational meeting, departmental meetings, governance committee and medical advisory committee. Meeting minutes we reviewed, and observations made during our inspection confirmed this. For example, minutes of the theatres team meeting held in April 2019 showed a complaint received regarding outpatients was discussed. A patient's tourniquet had been left on too long and staff were reminded to be vigilant not to do this.
- Action was taken in response to complaints and feedback received, to improve patient experience and care provision. For example, the introduction of a discharge information pack to support patients post-discharge, television screens were installed in the main reception area to provide a range of performance information, a 'light menu' was introduced for post-operative patients or those wanting meals with

fewer calories. A patient who underwent spinal surgery complained they were unable to use the glasses to drink from. Subsequently, the service purchased some beakers which received positive feedback.

- Staff gave us examples of complaints received and what they had learned from them. For example, when the service started, patients' had their pre-operative assessment close to their operation date. This meant some patients were cancelled because results were not available, several patients complained. In response, the service scheduled patients for their pre-operative assessment early enough to ensure all test results were available prior to their planned operation date.

Are surgery services well-led?

Good

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

In this section, we also cover hospital-wide arrangements such as, leadership, the management of risks and governance processes, in the relevant sub-headings within the well-led section. The information applies to all services unless we mention an exception.

We rated it as **good.**

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- There was a clear management structure with defining lines of responsibility and accountability. The hospital's senior management team consisted of the hospital director, who had overall responsibility for the hospital, and the director of clinical services. The medical advisory committee (MAC) chair and heads of department supported the senior management team. Each head of department reported to one of the senior managers. For example, heads of department in the surgery service reported to the director of clinical services.
- Staff told us leaders were well respected, very visible, approachable and supportive. Departmental managers worked clinically and provided clinical cover for sickness when required. Ward and theatre staff worked together effectively. All departmental managers had been with the service since the hospital opened, which meant there was leadership consistency across the service.
- The managers understood the service and had developed their team from the start. Senior managers told us they had chosen to have their offices situated by reception, so staff could 'drop-in' whenever they liked. We observed staff frequently came to speak to the senior managers during our inspection.
- The consultants we spoke with felt the hospital was very well run, and managers were responsive.
- Heads of department attended a monthly meeting with the senior leadership team. They received an update on the hospital, audits, complaints and all gave an update on their areas. For example, minutes of the meeting held in March 2019, showed theatre staff advised there was a new National safety Standards for Invasive Procedures (NatSSIPs) standard operating procedure which would be circulated at the next governance meeting.
- There was no leadership programme available for staff to attend. However, managers at service level had management experience. The ward manager had completed a leadership course in a previous role. We were told staff would be supported to undertake any training courses relevant to their role. The director of clinical services held weekly one-to-one's with heads of department to discuss any issues, concerns or improvement ideas they had and to provide coaching and development support, where needed.
- The chief executive of the One Healthcare group had spent a day in theatres. Staff told us this made them feel valued and they felt their needs were listened to. For example, following their visit, theatres were given a dedicated supplies department, the CEO agreed this was required to run theatres efficiently.
- The leaders understood and managed the priorities and issues the hospital faced. The hospital director and director of clinical services had previous experience of setting up independent hospitals from new. Both had been with One Hatfield from day one and recruited all

the staff to the organisation. The corporate team appointed staff into senior roles. We saw robust recruitment processes and appropriate checks of qualifications and experience evidenced in staff personnel files.

- The hospital director and director of clinical services attended regular meetings with their counterparts at the other hospital site and One Healthcare executive team. They told us there was effective working relationships across sites and corporate support was readily available.
- The staff survey completed June 2019 showed, 81.8% of staff agreed or strongly agreed that senior managers tried to involve staff in important decisions and acted on feedback; 4.5% of staff disagreed with this statement.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The hospital had a clear mission, vision and values which were focused on patient safety and the quality of services provided. The hospital mission was, "To be recognised as the private hospital of choice in Hertfordshire and the surrounding area". The vision for the hospital was, "To continually develop and grow One Hatfield Hospital by delivering excellence in clinical quality and patient experience". The vision was displayed in all areas of the service. Staff within each service helped develop a vision, values and objectives for their department, which were aligned to the hospital's. For example, the ward vision was, 'To provide a safe and effective service, above and beyond expectations, from admissions to discharge'. The vision for theatres was, 'To be dedicated in the promotion of excellence in perioperative care, to be safe, caring, competent and compassionate practitioners. As perioperative practitioners, we follow NatSSIPs guidance by providing standardised key elements of care ensuring that the care is harmonised and consistent'. Staff confirmed they were involved in developing their service's vision and objectives.
- The hospital's values were collectively known as 'The One Hatfield Way' and formed the acronym PEACE which stood for:
- **P**atient-centred
- **E**mpowered
- **A**ccountable
- **C**ollaborative
- **E**xceptional
- The values had been translated into seven objectives for 2019/20, which were:

  1: To be rated as 'outstanding' by the Care Quality Commission.

  2: To continually grow our business in terms of the number of patients we look after and our revenues.

  3: To be an outstanding hospital that is acknowledged for patient safety and the quality of service and experience that we deliver to our patients.

  4: To be acknowledged for collecting and publishing our clinical outcomes.

  5: To be a leading provider in cardiology, imaging, men's and women's health, musculoskeletal services and outpatient and ambulatory-based treatments.

  6: To be recognised for our approach in developing the capabilities and competencies of our staff.

  7: To be recognised and recommended as a great place to work (Source: PIR, D15 – Vision and strategy 2019 objectives).

- Measurable objectives had been set under key headings in the strategy such as regulatory compliance, governance, patient experience, staff engagement and clinical outcomes. Progress against achieving the objectives was reviewed and monitored at various committee meetings, including governance, heads of department, medical advisory committee (MAC) and hospital board. Senior staff told us planned hospital activity and revenue was as expected.
- The objectives for the surgery service were, 'To encourage patients who had been for day surgery and required further surgery to return to One Hatfield for their treatment' and, 'To ensure patients were aware of all services provided'.

- Staff we spoke with knew and understood the vision, values and objectives for their service and the hospital, and their role in achieving them.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff we met with, were welcoming, friendly and passionate. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.
- The service had a caring culture. Staff told us that they enjoyed working in the department and felt supported by their departmental managers. Department managers told us that they had an open-door policy and they were proud of their staff and their departments.
- All staff told us that they enjoyed their job because they liked their teams and they were described as a "family". We were told by some staff that there was "nothing" they would change about the hospital and they were proud of the way it was run.
- When asked what they were most proud of, the senior leadership team told us it was their staff and how they had grown since the hospital opened. They said it was, "a privilege to work at the hospital".
- There were cooperative, supportive and appreciative relationships among staff. They worked collaboratively, shared responsibility and resolved conflict quickly and constructively. The director of clinical services held regular meetings with department managers. They felt that this kept them well informed. They discussed the risk register, staffing levels and any feedback from audits and meetings. The managers in turn held meetings with their staff groups. Staff felt they were kept up-to-date and were made aware of changes needed within practice. We observed positive and supportive relationships between the leaders, consultants and staff at all levels and from all departments.
- The hospital culture encouraged openness and honesty at all levels. Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. Processes and procedures were in place to meet the duty of candour. Where errors had been made or where a patients' experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised. When incidents had caused harm, the duty of candour was applied in accordance with the regulation. Staff confirmed there was a culture of openness and honesty and they felt they could raise concerns without fear of blame. The hospital had a freedom to speak up guardian and staff were aware of who it was. All staff said they felt that the senior leadership team and their managers were very approachable and felt they could raise any concerns.
- Most staff felt valued and supported to deliver care to the best of their ability. Quotes from staff, were, "lovely team and everyone works well together", "everyone is friendly", and "I love working here." A student nurse told us staff had approached her and made her feel welcome, they also offered learning opportunities within their departments. Staff also said they enjoyed caring for their patients and we observed positive interactions during our inspection.
- Staff felt empowered in their roles as they were given areas to focus on that they were interested in, for example, becoming a link nurse for infection control. We met the infection control link nurse in theatres, who was very enthusiastic about their role and felt very supported by their manager.
- The safety and wellbeing of staff was promoted. There was a spiritual service available for staff if required to support their wellbeing. A member of the theatre team told us there had been a bereavement in theatres that had affected a number of staff. The management team arranged for the spiritual service from the local acute NHS trust to attend theatres to support them. They felt this was really beneficial to the whole team. A confidential telephone-based counselling service was available to staff, 24-hours a day, seven days a week. There was 'free food Friday', where every fortnight staff were given a free meal. The catering department supported staff to lead healthier lives. We were told they were supporting several staff to lose weight by producing low-calorie, healthy meals for them.
- Staff success was celebrated. The theatres had a praise board which displayed compliments and positive messages for staff. For example, we saw an email from the hospital director thanking staff for 'showing them the ropes'.

- The hospital had recently introduced staff excellence awards, to recognise an individual and/or team who had gone above and beyond. Winners were displayed publicly in the main waiting area. The ward manager nominated one of her staff nurses who was mentioned a lot in patients' feedback as having given excellent care.
- Equality and diversity were promoted in the hospital. Hospital policies were assessed to ensure guidance and standard operating procedures did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.
- Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. We were given examples of when this had occurred. The staff survey completed in June 2019 showed, 89.4% of staff agreed or strongly agreed that they felt secure raising concerns about unsafe clinical practice and confident the organisation would address their concern; 1.5% disagreed with this statement.
- The hospital was compliant with the Competitions and Marketing Authority (CMA) Order regarding the prohibition of inducing a clinician to refer private patients to the hospital.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. The hospital's governance and assurance framework were supported by a site and cross site governance committee and associated sub-committees, such as medicines management, infection control, and health and safety. Each committee had terms of reference which were reviewed annually. The committees met regularly and fed to the hospital board, corporate quality governance board and corporate partners board.
- Governance meetings were attended by heads of department. We reviewed four sets of governance meeting minutes and saw they were well attended by the senior management team, heads of department and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks. There was evidence of actions taken to address compliance within the surgical service. The ward manager told us that because it was a small hospital, issues were often dealt with immediately rather than waiting for the next clinical governance meeting.
- All levels of governance and management functioned effectively and interacted with each other appropriately. The director for clinical services was the hospital lead for governance and attended cross-site governance meetings. The hospital committee structure was used to monitor performance and provide assurance of safe practice. There were a range of other systems and processes of accountability which supported the delivery of safe and high-quality services. These included daily operational meetings, team meetings and daily walk rounds by the senior leadership team. Staff at all levels were clear about their roles and understood what they were accountable for and to whom.
- The director of clinical services held meetings with the heads of each department every week. They then held departmental meetings on the ward and theatres. Meetings were structured and minuted. We reviewed team meeting minutes for both theatres and the ward and they all showed discussions around improving the service delivered. We were told that the hospital director occasionally attended ward meetings which gave staff an opportunity to voice any issues or hear updates on developments in the hospital.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and patient pathways. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Results were shared at relevant meetings such as governance meetings.
- The service participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMs) and Friends and Family Test (FFT).
- Managers maintained a governance dashboard which reported on clinical activity, workforce and compliance with a wide range of safety and quality indicators covering incidents, audit outcomes, infection prevention and control, patient experience and medicines management. The dashboard tracked monthly performance against locally agreed thresholds

and national targets, where available. A traffic light system was used to flag performance against agreed thresholds. A 'red flag' indicated areas that required action to ensure safety and quality was maintained. Exceptions (red flags) were reviewed at heads of department and governance meetings and action was taken to address performance issues when indicated. This was confirmed in the meeting minutes we reviewed and staff we spoke with. From April 2018 to April 2019, the dashboard showed most key performance indicators met the hospital's agreed thresholds.

- Roles and responsibilities of the medical advisory committee (MAC) were set out and available. The MAC was responsible for providing assurance and advice to the senior management team on medical and operational matters, including practitioners' accreditation. It also provided a forum for discussion between doctors and effective liaison between doctors and the senior management team. The MAC met bi-monthly and was attended by consultants from a range of specialties, as well as members of the senior management team and corporate board.
- Arrangements with partners and third-party providers were governed and managed effectively. We saw contracts were in place which detailed the scope of work to be provided. These were reviewed annually. Senior staff told us they worked collaboratively with third-party providers to ensure services met the needs of patients. For example, they had liaised with the local acute NHS trust to ensure pathology services met the needs of patients. Practise emergency scenarios had been carried out to ensure blood products could be delivered within an acceptable timeframe and there were systems to ensure pathology results were available to staff.
- Staff working under practising privileges had appropriate indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 and their professional body. Staff personnel records we reviewed confirmed this.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- There were clear and effective processes for identifying, recording and managing risks. Each department had a local risk register, alongside a hospital-wide risk register. These were managed through the electronic assurance system. We found each risk was adequately described, with mitigating actions and controls in place. An assessment of the likelihood of the risk materialising, its possible impact and the lead person responsible for review and monitoring was also detailed. Risks were reviewed regularly at bi-monthly governance meetings.
- The heads of theatres and the ward recorded identified risks onto a local department risk register. These were up-to-date and included current mitigations in place that reduced the risks. For example, the highest risk on their register was the risk of manual handling patients who were overweight (bariatric). They identified that they needed to invest in further equipment that was suitable for patients with a high body mass index.
- Risks were displayed on staff boards and staff were aware of the main risks within the service and hospital. For example, anaphylaxis and malignant hyperthermia were risks in the theatre department. Staff had attended a practice emergency scenario on anaphylaxis to ensure staff felt comfortable dealing with this.
- There were local safety standards for invasive procedures in place within theatre in line with national guidance. These were displayed on the notice board for staff to see and detailed in the standard operating procedure document.
- The hospital planned well for emergencies and staff understood their role if one should occur. Up-to-date policies, such as fire safety and transfer to a higher level of care, were accessible and detailed what action staff should take in the event of a major incident. The hospital's business continuity plan policy included action cards for a range of major incidents, such as fire, electricity failure, chemical spillage, bomb threat, loss of medical gas and loss of communication. The action cards detailed staff authority and responsibilities for each major incident. Useful contacts and a guide as to how essential services might be maintained and/or recovered was also detailed in the policy. An emergency box was held at the main reception which included

copies of the action cards and equipment such as high-visibility vests, communication devices, lights and a megaphone. Simulation exercises were held to ensure staff knew what to do in the event of a major incident.
- The fire alarm system was checked weekly and all other fire safety equipment was checked annually. A fire co-ordinator for the hospital was allocated at the daily operational meeting.
- There were clear processes to manage performance effectively. The hospital had an annual audit programme to monitor performance across departments. Outcomes of audits were used to benchmark performance against the other hospital in the One Healthcare group. Results were also used to highlight any areas where standards were not being met and corrective actions were implemented to ensure a return to expected standards.
- Staff told us they received feedback on risk, incidents, performance and complaints in a variety of ways, such as the daily operational meeting, noticeboards, social medial platforms and newsletters. The director of clinical services, for example, produced a quarterly newsletter regarding lessons learned from adverse events. We reviewed a sample of these which contained a summary of incidents reported and the lessons learned. These included incidents that had occurred at the other hospital site. They also produced a bi-monthly performance review report for the medical advisory committee. This included a summary of performance data for patient experience, complaints, incidents, audits, and the top risks in the hospital.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were secure, and most were integrated. Data or notifications were consistently submitted to external organisations as required.**
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The service used paper records. Nursing and medical patient records were combined within the same record. This meant all health care professionals could follow the patient pathway clearly.
- The hospital's lack of integrated pathology reporting system was on the hospital's risk register. Pathology services were provided by the local acute NHS trust, who had been unable to provide an electronic reporting system. Actions were in place to mitigate this risk, which had been graded as 'low risk'. Results were emailed to the hospital which staff could access. Senior staff had been liaising with the local acute NHS trust to fix this and we saw electronic access had been granted to the director of clinical services.
- Theatre one had an integrated iTheatre camera system. This meant they could live stream operations and images. At the time of our inspection, this system had not been used during an operation, but had been used for teaching staff.
- Staff across the hospital described information technology (IT) systems as fit for purpose. A range of IT systems were used to monitor the quality of care. There was a risk management system for incident and complaints recording, and an online governance and assurance system to report on quality standards, safety alerts and risks.
- There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN). They also collected PROMs data for certain surgical procedures, such as hip and knee replacements, and submitted data to the National Joint Registry (NJR). In the submission year 2017 to 2018, data was submitted to the NJR for 18 hip replacements and 19 knee replacements. Data submitted showed the hospital performed better than expected for providing a valid NHS number and as expected for time taken to enter data. However, it performed significantly worse than expected for submitting whether records had the corresponding 'patient consent', with only 12.5% recorded. This was significantly lower than the national expectation of 85%. In response to these findings, the records of half the patients who underwent a hip or knee joint replacement from April to June 2019 were audited. The results showed 100% compliance for patient consent to NJR submission. We saw evidence senior staff were working with NJR to correct this and to ensure all data was entered correctly (Source: Additional Evidence Request, DR43).
- Staff were aware of how to use and store confidential information. During our inspection, we found computer terminals were locked when not in use and medical

records trolleys were locked. This prevented unauthorised persons from accessing confidential patient information. Staff had completed information governance training.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- People's views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the Friends and Family Test (FFT), 'One Loves to Listen' feedback cards, daily director of clinical services ward rounds and compassionate care rounds. Patients' were encouraged to give feedback on the quality of service they received. From October 2018 to March 2019, the average monthly response rate for the hospital was 16.2%. Senior staff told us they had taken action to improve this, with competitions held for which department could get the highest FFT response rate. The winning department was given a free lunch. We saw this had been effective. The response rate increased from 11% in February 2019 to 40% in March 2019.
- The director of clinical services joined the daily ward rounds for inpatients, to gain feedback. Patients reported this was effective and appreciated this personal engagement. We saw a relative speak to the director of clinical services straight after the ward round. This meant they were able to resolve any potential issues immediately.
- The service undertook a formal patient satisfaction survey. The results were analysed by an external company and monthly performance reports were provided. Results were compared with the other hospital in the group. The March 2019 report showed, 98.5% of patients would recommend the ward or the day surgery unit and 100% of patients were treated with dignity and respect. These results were discussed at clinical governance meetings and actions were taken to improve where indicated. For example, the question, 'Were patients told about medication side effects?' was continuously scoring low. The ward changed their process to ensure patients were given their medication prior to their discharge paperwork being completed and the side effects were explained to them. These results were displayed publicly on television screens located in the main reception area and on the hospital's website, as well as all 'I want great care' reviews. Patients were given a 'One Loves to Listen" card to complete. Staff invited patients' to complete these and we saw they were displayed in areas around the hospital.
- Patient feedback was obtained daily through their words of thanks, appreciation and compliments. Staff told us feedback from complaints and compliments received were seen as an effective way to improve services for patients. All feedback was recorded on the hospital's electronic reporting system. This enabled themes and trends to be identified. Patient feedback was discussed at governance and team meetings. The service acted on feedback they received from patients. For example, patients asked for newspapers to be available, which the service introduced.
- Leaders launched a strategic objective to improve patient engagement, through setting up of a patient forum. Patients would be invited to share their experiences, views and suggestions for how services could be improved. At the time of our inspection, they had written to patients and the first patient forum was planned for July 2019.
- Staff reported that there was good engagement from their managers and from the senior leadership team, which we observed during our inspection. From the conversations we had with staff, it was evident staff were engaged in the service and hospital development. Staff told us they felt confident to raise concerns and were encouraged to come up with ways in which the service could be improved.
- A baseline staff survey was completed in June 2019; an objective linked to the hospital's strategy. We saw the results were mostly positive. For example, 87.8% of staff said they would recommend the hospital as a place to work and 98.5% would recommend the hospital as a place to have treatment or investigation.
- The infection prevention and control (IPC) lead staged some 'staff awareness days'. These were designed to get staff engaged with IPC and promote best practice. At the time of our inspection, awareness days for hand hygiene and aseptic non-touch technique had been held. These were well attended by staff and included practical demonstrations and quizzes. Further IPC awareness days were scheduled.
- Leaders and staff collaborated with partner organisations, such as staff from the local acute NHS

trust to help improve service for patients. For example, a specialist nurse in gender reassignment had attended the hospital to provide support and advice to ensure a patient received the care they needed following surgery. Practise emergency scenarios had been carried out with staff from the local acute NHS trust and courier service to ensure blood products could be delivered within an acceptable timeframe.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services, which leaders encouraged. They had a good understanding of quality improvement methods and the skills to use them.**
- There was a focus on continuous improvement and quality. Leaders were responsive to concerns raised and performance issues and sought to learn from them and improve services. Senior staff took immediate and effective actions to address some of the concerns we raised during our inspection. Staff we spoke with were all aware of feedback following the inspection and improvements needed. According to the staff survey, 92.4% of staff said they were able to make suggestions and improvements to improve the work of my team and 90.9% said they had received training, learning or development in the last year.
- The service was still developing. They had the facilities to do more complex surgery and use the extended recovery unit (ERU) for high dependency care. The service planned to start using the ERU at the end of Summer 2019, for breast reconstructive surgeries.
- We saw the hospital provided care in a new, environmentally friendly building with the patient at the centre of the design. There was plenty of natural light and space and all the patients commented on the person-centred design. The hospital was certified and rated 'excellent' by the Building Research Establishment Environmental Assessment Method (BREEAM) in January 2018. This is the methodology which has set the world standard for rating systems of building and works as an environmental assessment method and has helped to create a greener built environment.
- In July 2018, the hospital received the maximum rating of five from the Food Standards Agency for food hygiene. This meant they were rated 'very good' for the handling, storage and preparation of food, cleanliness of facilities and how food safety was managed.

Good

Services for children & young people

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

Are services for children & young people safe?

Good

We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The hospital provided mandatory training in key skills to all staff and made sure everyone completed it. The service target for mandatory training was 95%. We saw compliance generally met the target of 95%. Paediatric immediate life support (PILS) was just below the target at 94%. Staff completed PILS annually.
- Staff in the service completed a number of mandatory training modules. Mandatory training was provided as face-to-face and through online learning packages. Examples of face-to-face training included; manual handling, sepsis, incident reporting, advanced life support (ALS) and PILS. Electronic online learning included consent, infection prevention and control, safeguarding, privacy and dignity, and fluids and nutrition.
- Managers monitored mandatory training compliance and alerted staff when their mandatory training was due to be updated.
- The resident medical officers (RMOs), paediatricians, paediatric anaesthetists, lead paediatric nurse and a recovery nurse had advanced paediatric life support (APLS) which was completed face-to-face. The service had planned for three operating department practitioners (ODPs) to undertake APLS by August 2019. This meant more staff would be available within the hospital in the event of a paediatric emergency.
- For our detailed findings on mandatory training, please see the corresponding sub-heading in the surgery report.

Safeguarding

- **Staff understood how to protect children, young people and families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- The service had systems in place to identify children at risk. All children and young people were clearly identified in the electronic records system. During our inspection we saw appropriate arrangements to ensure patients were kept safe from avoidable harm. The hospital had a Safeguarding Children Policy (2019) and a child protection flowchart for referral (2019) including out of hours contact details for hospital staff. The policy reflected relevant legislation and local requirements for safeguarding. The policy identified how to seek advice from the safeguarding team, clear definitions of abuse and the mandatory reporting duty for female genital mutilation (FGM). The lead paediatric nurse was the named safeguarding lead for children and young people and the director of clinical services was the hospital safeguarding lead for adult and children's safeguarding and both were trained to safeguarding level five.
- The service had a separate policy for children and young people who "were not brought" (WNB) to appointments. There was a clear process for following up children who were not brought to appointments and a flowchart to

follow within the policy. All families received a follow-up call for all procedures at 48 hours post procedure. If there was no response, this was followed up by the named safeguarding lead and escalated if necessary. There had been no children who were not brought to appointments within the last 18 months of our inspection.

- The service had a child protection and safeguarding committee which covered the local authority area. The service held regular paediatric user group meetings which contributed to promoting the care and welfare of children and young people by inter-agency working.
- Staff attendance at training for safeguarding children and young people met national guidelines as set out in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Intercollegiate Document (January 2019). All clinical staff received level three safeguarding training. Compliance was 98% which was above the service target. Compliance with safeguarding adults training level two was 99%. The director of clinical services had level five training.
- Staff were able to explain safeguarding arrangements and said they would raise any queries with the lead paediatric nurse. Staff were able to describe when they might be required to report issues to protect the safety of vulnerable patients.Staff could name the children's safeguarding lead and the hospital safeguarding lead for the organisation. Safeguarding flowcharts and information were publicly displayed on the ward and in the outpatients department. These highlighted the actions to take in the event of a safeguarding concern.
- The paediatric lead and director of clinical services received children's and adults safeguarding supervision from the local authority adults and children safeguarding leads. This meant they were kept up-to-date with safeguarding issues, processes and trends.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.**
- At the time of the inspection all areas in children's services were seen to be visibly clean, dust and clutter free. There were no reported cases of MRSA, MSSA, C. difficile or E. coli in the previous 12 months in children and young people's services.
- There were handwashing facilities, hand sanitising dispensers and personal protective equipment (PPE) at entrances and throughout departments. We observed staff using PPE appropriately. Staff received annual training on infection prevention and control (IPC) as part of their mandatory training. Staff were observed to be 'arms bare below the elbows', in line with the hospital infection policy.
- There were signs to remind staff to use PPE in all clinical areas. The signage included lists of things to consider, for example to be arms bare below the elbows, not to wear stoned rings, nail varnish or false nails, to have ties tucked in, and no lanyards.
- There were cleaning schedules displayed in the area for children and young people. We noted they were all signed and dated to evidence regular cleaning took place. We noted that 'I am clean' stickers were used to indicate equipment had been cleaned and these stated the date the equipment had last been cleaned.
- We saw the weekly toy cleaning log; in addition, toys were cleaned after use and before being put away.
- We noted PPE such as gloves and aprons were readily available in consulting and children and young people's rooms through the use of wall dispensers.
- The clinical area was deep cleaned every six months and curtains were routinely changed six monthly. We saw that curtains had been changed six monthly.If there was an outbreak of an infection staff told us the area would be deep cleaned.
- The hospital's Patient-Led Assessment of the Care Environment (PLACE) audit for February 2019 identified a cleaning schedule of toys was required for the service. During our inspection we saw this had been implemented.
- For our detailed findings on cleanliness, infection control and hygiene, please see the corresponding sub-heading in the surgery report.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**

- Specialist equipment for all age ranges cared for in the hospital, including that required for resuscitation was available and fit for purpose. Where children were anaesthetised, resuscitation drugs and equipment including an appropriate defibrillator were available. The paediatric resuscitation equipment was stored in the outpatient department and taken to theatre when children and young people were undergoing procedures. Staff told us they did not see children in outpatients at the same time as they were in theatre.
- There was a dedicated area for children in the recovery area. This was child friendly with a map of the world with animal figures painted on the wall. The theatre curtains were coloured and had pictures of dolphins, elephants and tigers on them. When children were in the recovery area no adults were recovered at the same time. Theatre trolleys used for children had decorated cot bumpers attached.
- Emergency paediatric resuscitation equipment was checked and seen to be 'sealed, tagged and clean'. We saw that daily checks were undertaken, the numbered tag was checked and changed monthly unless the trolley was used. Additional equipment was available if a child was difficult to intubate (have a breathing tube inserted into their airway).
- Consideration had been given regarding risks to children by sharing the same facilities as adults. Children were seen in the day surgery department, there were no other patients in the department during this time. Children and young people were cared for in single rooms with facilities for parents to stay with them. Young children were treated as day cases only and did not stay overnight.
- Following our inspection, we requested information about safety checks to rooms that would be used by children and young people. The lead paediatric nurse undertook a risk assessment of the paediatric environment. This included ensuring radiator covers were in situ, hot water temperatures were monitored, doors and windows were secure with restraints, plug sockets were covered, all non-essential equipment was removed, and essential equipment was supervised. This ensured the environment was safe and age appropriate for children and young people.
- There were electronic security operated doors at the entry to areas where designated rooms for children and young people were sited. The hospital had met Department of Health guidance (HBN 23 Hospital accommodation for children and young people (2004) states, "Door control systems should be provided to all entrance/exit doors to prevent accidental egress"). Signage was evident, informing parents of their responsibilities to supervise their children at all times.
- Children and young people were seen in the main outpatients department. There was a designated area for young children with appropriate furniture. The toilets contained raised toilet seats, steps and a potty. There was a baby changing area which was also available to be used for breastfeeding. A high chair was also available. Doors had soft hinges to prevent slamming, and emergency pull bells were evident in the toilets. However, although the emergency pull bell appeared to be pressure breakable for safety, it did not break when tried. We raised this with managers who took immediate action to ensure this was safe. There were no specific facilities for adolescents within the outpatients department.
- There were systems to maintain and service equipment as required. Equipment had undergone safety testing to ensure it was safe to use. All equipment we checked had been electronically tested and was in date.
- Cleaning materials which could be hazardous to children were stored in locked rooms. Sharps boxes were labelled, dated and were not overfilled.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each child and young person and took action to remove or minimise risks. Staff identified and quickly acted upon children and young people at risk of deterioration. Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately.**
- During our inspection we saw systems and procedures to assess, monitor and manage risks to patients. For example, the service used a Paediatric Early Warning Score (PEWS) system to alert if a child or young person's clinical condition deteriorated. Nursing staff we spoke with were aware of the appropriate actions to take if the patient's score was higher than expected. Age appropriate PEWS charts were used. We reviewed three PEWS charts and saw they were completed correctly. We requested data for PEWS audits following our inspection. Monthly audits from February 2019 to June 2019 demonstrated compliance with PEWS completion and escalation where a patient deteriorated was 100%.

Good

Services for children & young people

- The service did not undertake acute or emergency surgical admissions for children and young people. All surgical interventions were undertaken as day cases. Children and young people were screened at pre-assessment to ensure the hospital had suitable facilities to treat them. A service level agreement was in place with the children's acute transport service (CATS), if the condition of a child or young person deteriorated and they required an urgent transfer to an NHS acute hospital.
- The service had strict admission criteria. Children were seen from 0 to 18 years of age, no children under three were operated on. Children with additional medical needs, for example those with cardiac illness were referred to the appropriate hospital NHS trust for treatment. The children and young people's lead nurse oversaw the pre-assessment and booking arrangements for any procedure planned for children under 16 years of age.
- Children who were 16 to 18 years old were pre-assessed to ensure they could follow an adult pathway unless issues were detected at pre-assessment which identified them as requiring children and young people's services. If an older child required overnight care they were nursed on the adult surgical ward, in a single room close to the operating theatre. Parents stayed overnight with their child. A paediatric trained nurse was always available for advice and support. Children under 12 years old were accompanied by an adult at all times.
- There was a comprehensive pre-operative assessment for children and young people which was face-to-face and undertaken by a paediatric trained nurse. This was being developed further and was to be implemented when the updated paperwork had been printed. This included more detailed data about safeguarding, a pain assessment score, information about age appropriate play and development, whether the child was Gillick competent and had capacity to consent to treatment, and the WETFLAG framework. WETFLAG is a framework to help reduce the risk of error in a stressful situation and applies to children between the ages of one and 10. It stands for weight, energy/electricity, tube (endotracheal), fluids, adrenaline and glucose. We saw that the WETFLAG was written on white boards in the anaesthetic room and patient rooms and staff had been trained in its use. This meant nursing staff (child branch) were able to respond promptly to children whose condition suddenly deteriorated.
- Pre-assessment forms were colour coded according to weight. This meant it was clear to clinicians which weight range a child was in. This was an additional safety tool to ensure the correct dosage of fluids and medicines were prescribed according to weight. We saw there were colour coded pre-assessment forms in the children's records. Depending on their weight, the child was designated a paediatric emergency colour; blue, green, yellow or red. The colour indicated the emergency drug doses that should be administered in the event of any emergency. All children and young people were offered a visit to the hospital before admission as part of the pre-assessment pathway. This could also include a visit to the operating theatres.
- Staff in the service had received sepsis awareness training and knew how to escalate the sepsis screening tool if PEWS did not trigger it. The service had an up-to-date policy about paediatric sepsis which included full assessment information and the use of the sepsis six bundle. The sepsis six bundle is a resuscitation bundle of investigations and treatment designed to offer basic intervention within the first hour. Posters from the UK Sepsis Trust were displayed throughout the hospital.
- There were emergency procedures in place including call bells to alert other staff in the case of a deteriorating patient or in an emergency. The service always had access to an RMO who was trained in APLS. Each clinical area where children were seen had details clearly written on a white board of who was on duty that day who was APLS and PILS trained, what action specific staff members would take in the event of an emergency, and who was the duty lead nurse on call for the hospital.
- The RMO provided support to the children and young people's service if a patient became unwell. Patients who became medically unwell were transferred to a local NHS acute trust using the children's acute transport service (CATS) in line with the emergency transfer policy.
- The service used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. We observed three WHO surgical safety checklists were fully completed and signed in theatre.

We saw the use of the checklist being carried out efficiently and effectively. Following surgery, the patient handover from theatre staff to recovery staff was thorough. Children and young people did not leave the recovery area until they were awake, talking, pain controlled, and observations were within normal parameters.

- National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Theatre staff were aware of national and local safety standards. The theatres department operation policy was updated in February 2019 to ensure it was NatSSIPs and LocSSIPs compliant. For example, it discussed specific procedures within the local area including the five steps to safer surgery, resuscitation provision which included having one member of staff trained in PILS per theatre and two in the recovery area on days when paediatric surgery took place.
- Staff in the imaging department maintained a 'holding record' to capture the details of all parents who held their child during x-ray. This was a check to ensure parents or carers were not repeatedly exposed to radiation. Parents and carers were also given suitable protection such as lead aprons. There was a chaperone exposure form which included the name, type of radiation, apron and doses given and a carers and comforters policy in place. The service had undertaken risk assessments for imaging children and young people. Additional care was taken with children and young people to keep their x-ray exposure to a minimum (Source: IRMER Procedure 14. Providing Information Risk and Benefit of Radiation Exposures).
- The service held a daily communication meeting to identify, for example, activity within the hospital, daily risks, mandatory training updates and visitors to the hospital. The heads of department, lead paediatric nurse and any other available staff attended the daily communication meeting, updated local safety and information boards and shared this information with clinical staff.
- The anaesthetic consultant remained in the hospital until children and young people were discharged from recovery and had been reviewed on the ward.

Nurse staffing

- **The service had enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.**
- The service had recruited a part time lead paediatric nurse who managed the service. At the time of inspection there were two other paediatric nurses in post and general nurses who had undertaken paediatric competencies. This meant the service was meeting the Royal College of Nursing guidance on 'Defining staffing levels for children and young people's services' (2013) which states, 'for dedicated children's wards there is a minimum of 70%: 30% registered (child branch) to unregistered staff with a higher proportion of registered nurses (child branch).
- There was always at least one paediatric registered nurse on duty for children over 12 years of age and two nurses if the child was younger. The paediatric lead nurse was always available for advice if necessary over a 24-hour period. If it became necessary for a child to remain in the hospital overnight staff told us a paediatric nurse would be rostered on duty.
- Managers reviewed the electronic data base of forthcoming admissions to review when children were being admitted to the service. Staff rotas were arranged on a weekly basis in accordance with this to ensure paediatric nurses were on duty. Safeguarding level three trained staff were on duty and on site in compliance with safety and standards of care.
- There was always a paediatric nurse per shift trained in APLS when a child was at the hospital. We saw this was clearly documented on white boards in each clinical area, so all staff knew who to contact if necessary.
- The service did not use any bank or agency staff.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.**

- There was a corporate "One Healthcare" practising privileges policy including consultants and medical and dental practitioners' which was reviewed in November 2017. Practicing privileges is a term used when doctors have been granted the right to practice at an independent hospital. The policy included the granting of practising privileges, and roles and responsibilities. The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in MAC meeting minutes of discussion about renewing or granting of practising privileges. Most consultants also worked at other NHS trusts in the area.
- Consultants were granted practicing privileges following review of their credentials by the hospital's MAC. This review included an assessment of expertise in their specialist field and recommendations from their consultant colleagues. The MAC committee and senior management team monitored performance through a robust governance framework, including clinical indicators, complaints and feedback from staff and other consultant colleagues.
- There were 23 consultants employed under practising privileges who treated children and young people from three to 18 years of age. They had all completed safeguarding level three training and provided evidence of updates for paediatric life support training. This included paediatric basic life support (PBLS), paediatric immediate life support (PILS) and advanced paediatric life support (APLS). It was a requirement for practitioners to be included on both the General Medical Council (GMC) general, and the GMC specialist registers. All anaesthetists who saw children specialised in paediatrics.
- The hospital had three resident medical officers (RMOs) who provided a 24-hour a day, seven days a week service on a rotational basis. The RMO provided support to the clinical team and in the event of an emergency or with patients requiring additional medical support. During our inspection we saw the RMOs had undertaken paediatric resuscitation training and were supported by the lead professional nurse and a recovery nurse who were trained in advanced paediatric life support (APLS).
- The service was supported by a named paediatric consultant. The named paediatrician was a member of the paediatric user group (PUG) which formed part of the overall paediatric governance process. There were five additional consultant paediatricians with practising privileges if additional support was required.

Records

- **Staff kept detailed records of children and young peoples' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, not all records contained details of height and weight.**
- The service used paper records. We saw these were locked securely in the day surgery unit and the outpatients department. Patient records contained information of the patients' pathway through the service including pre-assessment, investigations, test results, treatment and care provided. Theatre records included the five steps to safer surgery checklist. We saw these were completed fully and appropriately.
- We reviewed 11 sets of records and saw evidence of clear pathways. They were legible and up-to-date, with signatory lists included. However, in five historical patient records reviewed there were no heights and weights recorded. We saw weights recorded in anaesthetic records. Heights, weights and allergy status were documented on prescription charts. This meant treatment could be accurately prescribed in accordance with the patients size. Records were audited monthly. Following our inspection, we requested specific audit data for children and young people's records. Record keeping audits for children and young people from February 2019 to June 2019 indicated 100% compliance. However, there was no specific question relating to the measurement of height and weight. Therefore, we were not assured these were always measured for all patients.
- There was an electronic database for patients, so staff had oversight of who was in the hospital and who was being admitted. We saw paediatric patients were flagged yellow. This meant all staff could identify they were aged 0 to 18 years.
- Discharge letters were sent to the patients' GP immediately after discharge, with details of the treatment, including follow-up care and medications provided.

Medicines

Good

Services for children & young people

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The service prescribed, gave, recorded and stored medicines well. Pharmacists provided support when required and reviewed medicines.
- Children and young people's weights were recorded on the anaesthetic record and prescription chart. This enabled correct calculations to be made and appropriate medication to be given. We saw the weight and allergy status recorded in the three records reviewed of the children and young people attending theatre on the day of our inspection. During an unannounced inspection on 15 July 2019 a further five prescription charts were reviewed. All charts reviewed included details of the child or young person's allergy status, height and weight, and were appropriately signed.
- Medicines to be given in theatre were drawn up and labelled by the anaesthetist when children were called to theatre. There were always staff in theatre supervising the use of medicines.
- Parents were provided with discharge information which included pain relief and management. Medicines to take out (TTO's) when children and young people were discharged were discussed with parents and recorded in the patient record.
- Pharmacy support was available. A pharmacist was available to speak with children and their parents as appropriate and counsel them about their medicines.
- Private prescription pads were stored securely in consultation rooms and robust monitoring systems were in place to ensure all prescriptions were accounted for.
- We saw treatment room and fridge temperatures were checked and recorded daily to ensure medicines were kept at the correct temperature. Staff understood the procedures to follow if temperatures were not correct.
- For our detailed findings on medicines, please see the corresponding sub-heading in the surgery report.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- During our inspection we observed staff understood their responsibilities for reporting incidents and to inform patients if things went wrong. In the event of an incident the lead paediatric nurse would investigate, undertake a review and share learning with staff. No incidents had been reported for the service.
- The service had an electronic system for reporting incidents. All staff were able to report incidents and staff we spoke with described how they would report an incident. Staff told us learning from incidents within the hospital was shared at team meetings, through emails and during the safety huddle. If necessary learning would be shared on a one to one basis. Minutes of meetings confirmed incidents were discussed. Following a medicines management incident within the hospital staff told us medicines management was nominated as "policy of the month" to raise awareness and share learning of good practice.
- Staff described the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by an event where something unexpected or unintentional had happened.
- For our detailed findings on incidents, please see the corresponding sub-heading in the surgery report.

Safety Thermometer (or equivalent)

- **The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, children, young people, their families and visitors.**
- The service monitored and displayed information in the clinical areas to monitor safety compliance.
- Information displayed included data and audit results for:
- Monthly record keeping audit
- Cleaning rotas
- Hand hygiene audits
- MRSA swabbing and protocol changes

- Sharps bins audits
- COSHH audits (control of substances hazardous to health)
- Details of incidents reported

Are services for children & young people effective?

Good

We rated it as **good.**

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.**
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Policies and standard operating procedures were discussed at heads of department, medical advisory committee (MAC) and paediatric user group (PUG) meetings. For example, we saw the paediatric access policy was discussed and ratified at the October 2018 meeting. Discussions were held in March 2019 regarding the development of standard operating procedures for allergy testing before this service could be delivered.
- Corporate policies and standard operating procedures were assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief or sexual orientation or age and were up-to-date. Child specific policies were in place including a paediatric medication standard operating procedure which was monitored through audit processes. However, the service had a policy for the use of topical cream to numb the skin before blood was taken or a cannula was inserted (a cannula is a small tube that is inserted into a vein to allow fluid to be given). The policy specifically mentioned the use of a specific brand while staff told us a different preparation was used. Following our inspection, we requested clarification. Managers provided updated information and had amended the policy. A policy had been implemented for both preparations.
- Staff were able to access policies on the hospitals intranet system. We saw policies and audit processes were regularly discussed at the paediatric user group and heads of department meetings.
- There was a clinical audit schedule which identified when specific audits were due to be undertaken. We saw this included hand hygiene, controlled drugs, and the theatre WHO five-point audit. The service undertook specific clinical audits for children and young people which included audit of the day surgery unit, outpatient department and the paediatric 48-hour follow-up call. These were led and completed by the paediatric lead.
- Anaesthetists undertaking procedures on children worked within the Royal College of Anaesthetists "Guidance on the Provision of Paediatric Anaesthesia Services," 2013.
- Staff in the service understood the rights of children and young people under the Mental Health Act 1983. Children and young people were screened during the pre-operative assessment process for mental health issues. Staff told us there had not been any children admitted with mental health issues.

Nutrition and hydration

- **Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**
- The service had standard operating procedures in place which identified how long children and young people should be kept nil by mouth before surgery. Procedures clearly identified age appropriate fasting times and included guidance for children who were breast fed or formula fed. These had been reviewed in February 2019.
- Children and young people's nutrition and hydration needs were assessed at the pre-assessment appointment and documented on their care record. Where children and young people had specific dietary requirements, appropriate arrangements were put in place.
- The service used the STAMP nutritional screening tool. STAMP is a screening tool for the assessment of malnutrition in paediatrics and is a validated nutrition screening tool for use in hospitalised children aged two to 16 years. We saw assessments had been undertaken and were recorded in the records we reviewed.
- Menus had been created that were suitable for all dietary requirements and there were links with the

community dietitian service if required. There was a specific menu for children and young people. They could also request food that was not detailed on the menu. Additional food or drinks could be ordered as required.

- We saw that post operatively a child was provided with their choice of ice cream as soon as it was safe for them to eat. This was given within a few minutes of the request being made. Patients and their relatives told us they were provided with sufficient food and drink.

Pain relief

- **Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Pain was monitored from surgery through to discharge. Both the surgeon and anaesthetist were available in the hospital until the child left hospital should there be any issues with pain before discharge. We saw clear handovers were given to recovery staff about pain relief given in theatre and pain assessments were undertaken.
- Pain assessment charts were embedded into the paediatric pathway. The assessment tool used 'smiley faces' where children were asked to choose the face that best described how comfortable or uncomfortable they were feeling.
- Parents told us their child's pain had been managed well. We saw topical anaesthetic cream was used before blood was taken or cannula were inserted (a small tube inserted into a vein to give medicine or fluid).
- A pain management team was being developed within the hospital. Staff said children and young people would also have access to this service as necessary.
- Preparations of medicines were available in a suitable format for young children, for example pain relief was available in suspension form.
- The audit schedule did not clearly identify whether a pain audit was undertaken for children and young people. Following our inspection, we requested this information and saw pain was audited within the day case and paediatric inpatient audit tool. Compliance from April 2019 to June 2019 was 100%.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- No national audits were undertaken by the hospital involving children and young people. Changes in practice were implemented to promote positive patient outcomes for children and young people. For example, all children and young people attended a face-to-face pre-assessment to assess their suitability for surgery. The pre-assessment paperwork was being further developed to provide a more detailed assessment of health and social care issues and risk assessments. The lead paediatric nurse told us the new forms would also be colour coded according to the child's weight.
- The service had a local audit programme which was incorporated into the hospital audit schedule. This included an audit of the 48-hour post discharge telephone call and acute pain management.
- We did not see any evidence of monitoring for post-operative complications, although there was also no evidence that complications had occurred. However, information was provided to families on discharge of who to contact in the event of an emergency. Written and verbal information was provided on the signs and symptoms of VTE (venous thromboembolism); a life-threatening blood clot in a vein.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- All new staff to the service had an induction, this included a corporate induction and a local orientation. Staff confirmed they had completed all mandatory training and received reminders by email and from their managers if they were due to update their training. Staff told us they were given time to complete their electronic or face-to-face learning. New starters received induction information in hard copy format. Managers were planning to convert this to an e-book as a more effective and efficient approach.
- There were three paediatric trained nursing staff within the department. All nursing staff who saw children were paediatric trained or had completed paediatric competencies. We saw competencies were completed

and assessed. The paediatric lead nurse assessed staff competencies, these included communication skills, assessing health needs, developing care plans and safeguarding. Assessment processes included discussion and observation of practice.

- The service worked with an external training provider to provide education and training for staff who were undertaking paediatric competencies. The lead nurse for paediatrics told us staff who were new to the organisation or newly qualified would not undertake paediatric competencies until they had gained experience in the hospital. Minutes from the paediatric user group (PUG) in January 2019 confirmed paediatric competencies had been reviewed to support the paediatric pathway. These were to be rolled out across the hospital for staff who were eligible to complete them.
- Staff were supported to undertake additional training and education. Minutes of PUG meetings confirmed education, training and development were discussed. Developments included the addition of paediatric holding techniques to chaperone training, a paediatric module for manual handling, and cannulation and venepuncture for any paediatric staff who required this skill.
- The service was developing children's champions. Children's champions were nurses who had undertaken training to gain greater understanding of children and young people's expectations, needs and wishes. Course content included developing an understanding of teenage communication strategies, recognising anxiety, stress and distress, early recognition of the deteriorating child, the use of the PEWS assessment tool, paediatric basic life support (PBLS) and simulated or actual assessment of the Royal College of Nursing (RCN) paediatric competencies.
- All staff received a six-monthly appraisal and monthly one to one meetings with the paediatric lead nurse. Staff were notified when appraisals were due. Staff we spoke with told us they found the appraisal process useful and were able to identify their individual learning and development needs through the appraisal process.
- The paediatric lead received bi-monthly clinical supervision from an external facilitator. Clinical supervision included the development of learning outcomes and action plans. The paediatric lead also received monthly one to one session's with the director of clinical services. However, no formal leadership and development courses were provided to enable staff to develop their leadership skills.
- All staff in the recovery area were undertaking a two-day paediatric recovery course which was run by an external provider. Three operating department practitioners (ODPs) were due to complete paediatric advanced life support training (PALS) within the next two months.
- There was always a paediatric nurse on duty when children were seen in the hospital. Managers reviewed the electronic database of forthcoming admissions to review when children were being admitted or seen in the outpatient department. Staff rotas were arranged in accordance with this to ensure paediatric nurses were on duty.
- It was a requirement of the practising privileges contract for practitioners to be included on both the General Medical Council (GMC) general and GMC specialist registers. All anaesthetists who saw children specialised in paediatrics. All resident medical officers had PALS and experience of working with children and young people.
- Student nurses were allocated placements within the service. Staff within the department had undertaken mentorship training to support them in practice. Staff told us they liaised with and received support from the university tutors.
- For our detailed findings on competent staff, please see the corresponding sub-heading in the surgery report.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.**
- There was a strong multidisciplinary (MDT) approach across all areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. Staff reported effective multidisciplinary working with access to medical staff and audiology staff as required.
- Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. The PUG meeting was chaired by a consultant surgeon who was also the chair of the medical advisory committee (MAC). Meetings were held quarterly and attended by team leaders from across the

hospital. These included the paediatric lead, theatre and outpatient department leads, paediatricians, audiologist, RMO and an independent trainer and paediatric advisor.
- The lead paediatric nurse was developing relationships with all heads of department, medical staff, nurses and clerical staff to develop the service.
- Patient records we reviewed showed GPs were kept informed of treatments provided, follow-up appointments and medicines to take home on discharge.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- Resident medical officers (RMOs) provided a 24-hour a day, seven days a week service on a rotational basis. The RMOs were paediatric resuscitation trained and had undertaken level three safeguarding training.
- Children's surgery was planned and took place on the last Friday morning of each month.
- Parents, children and young people were able to access clinics outside of working hours. Outpatient appointments were held in the evenings and on Saturday mornings. A paediatric respiratory consultant held regular Saturday morning clinics.
- There was an on-call radiographer available from Monday to Sunday in the event of a child requiring this service.

Health promotion

- **Staff gave children, young people and their families practical support and advice to lead healthier lives.**
- Admission criteria were in place for children and young people undergoing a day surgery procedure. This was to ensure children and young people with additional pre-existing conditions for example cardiac issues, were not operated on.
- Staff assessed each child and young person's health when they were admitted and provided support to enable individuals to lead healthier lives.
- Parents were given a booklet when their child was discharged with information about post anaesthetic care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and families who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. We saw consent forms were fully completed, signed and dated by the consultant and patient/parent. The planned procedure was identified, the associated risks, benefits and intent of treatment was described. In addition, the patients had been assessed as having capacity to consent for treatment. Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. However, we saw the top copy of the consent form was not given to the parents but remained in the child's record.
- Staff clearly recorded consent in the 11 records we reviewed.
- There was an up-to-date consent policy which included consent for the examination and treatment of children and young people. Staff were aware of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- Staff understood Gillick competence and Fraser guidelines. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser guidelines relate to contraception and sexual health and addresses the specific issue of giving contraceptive advice and treatment to those under 16 without parental consent.
- Staff received Mental Capacity Act training as part of their induction and received annual online updates.
- Nurses were aware of the appropriate procedures in obtaining consent. They talked to children and explained procedures to them in a way they could understand. We saw examples of how nurses would seek a child's consent before doing anything.

Are services for children & young people caring?

Good

Services for children & young people

Good

We rated it as **good.**

Compassionate care

- **Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Feedback from patients and their families was positive about the way staff treated them. Staff consistently provided care that was kind and compassionate and respected children's and young people's privacy and dignity.
- Staff were discreet and responsive when caring for children, young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Children, young people and their families said staff treated them well and with kindness. We observed staff responded quickly and compassionately to patients who called for assistance.

Emotional support

- **Staff provided emotional support to children, young people and their families to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff throughout the hospital understood the need for emotional support for parents and their families. We spoke with children and their relatives who all felt staff cared for their emotional wellbeing.
- Staff were able to build relationships very quickly with children, young people and their parents and families. For example, in day surgery staff were able to support the child and parent and ensured they (both) understood the procedure.
- Staff used distraction equipment to support children who were having procedures, such as venepuncture (taking blood). Families were also encouraged to bring distraction material or toys with them to appointments.
- Children and young people requiring day surgery were accompanied by a parent to the anaesthetic room and stayed with them until they were asleep. This ensured parents were able to continue to provide emotional support for their child. Parents were able to see their children in the recovery area as soon as they were awake to provide reassurance and support.

Understanding and involvement of children and young people and those close to them

- **Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.**
- Staff made sure children, young people and families understood their care and treatment. We saw staff clearly explaining treatment and supporting parents while their child was recovering from a general anaesthetic. Parents we spoke with told us they felt very involved and supported by nursing and theatre staff.
- Staff talked with children, young people and families in a way they could understand. Staff supported them to make informed decisions about their care.
- Children, young people and their families could give feedback on the service and their treatment.
- All parents we spoke with told us how they were fully involved in the assessment, planning and delivery of the care and support to their child throughout their hospital experience. We observed medical staff visiting children and their parents post operatively to review the child and inform the parents about the operation.
- We observed nurses walking parents back from the anaesthetic room, talking to them and giving them information about how long their child was likely to be in theatre.

Are services for children & young people responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

Good

Services for children & young people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- The service provided reflected the needs of the local population. The service was flexible to meet the needs of children and young people seen. The service only saw children and young people who were privately funded. Children and young people accessed services in outpatients, pre-assessment and the day case unit.
- Processes were organised for care and treatment to be provided by the hospital in a timely way. General paediatric outpatient care assessed children from nought to 18 years of age with symptoms across the general paediatric spectrum. Commonly managed problems included, dermatology (skin rashes, lumps and bumps), respiratory complaints (asthma, chronic cough, and exercise limitation), cardiology, ear, nose and throat (ENT) including audiology, thyroid problems and tonsillectomy and orthopaedics.
- Consideration had been given to the risks of children sharing the same facilities as adults. Operating theatre lists for children and young people were held monthly. On these occasions no other patients were admitted to the day unit or were attending the operating theatre. Adolescents aged 16 to 18 years could also be nursed on the ward if necessary. They were always nursed in single en-suite rooms and their parents were able to stay with them. A paediatric nurse was always available to oversee care.
- Facilities and premises were generally appropriate for the services being delivered. However, the imaging service had limited facilities for children. There were no dressing gowns or comforters if a child required an x-ray or imaging. There was a mural on the wall and children could take toys from the waiting area into the department. The phlebotomy room in the outpatient department had three small pictures and was not child friendly if children needed to have blood sampling undertaken. However, we were told distraction equipment had been ordered for the service which would be used when procedures were being undertaken. The resident medical officer (RMO) or consultant would take bloods from a child when required.
- Children attending the day surgery unit had access to televisions in their rooms which showed children's programmes. We saw they also had some toys, colouring books and crayons. Staff also ensured duvet covers were appropriate for the child's age.
- The outpatients department had an area specifically designed for children. There was a changing area for babies, a high chair and toilet aids. There were toys for toddlers and young children, a peddle car, age appropriate books and colouring books and activities. A risk assessment had been carried out on the use of the peddle car to ensure that children and other patients remained safe. Signage indicated that parents were responsible for their children and must supervise them at all times.
- There were limited facilities for adolescents. Staff told us that adolescents would often bring electronic devices to use while they were waiting for appointments or treatment. There were no additional charging areas or a specific area for adolescents.
- All children and young people who attended the service were overseen by the lead paediatric nurse. The lead paediatric nurse ensured that children's requirements were assessed and considered before booking a child for surgery or for an outpatients appointment. A trained paediatric nurse was always on duty when children attended the service.
- Parents could accompany their children to the anaesthetic room prior to surgery. We saw parents were accompanied back to the day unit and supported while their child was anaesthetised. Recovery staff informed the day unit once surgery was complete. Ward staff escorted one parent to the recovery area, where they could stay with their child until they were fit to return to the day unit. Parents stayed with their child throughout their recovery until discharge. Reclining arm chairs were available for parents to use.
- A paediatric respiratory specialist with practising privileges held clinics on Saturday mornings. Staff told us the specialist had lengthy consultations with children and their parents to answer questions and share information.
- If mothers who brought children to appointments were breastfeeding, staff told us they would offer them the use of an empty consulting room or the baby changing area to feed their babies.

- All families were contacted 48 hours after discharge to review their condition. This provided them with the opportunity to discuss any concerns they had.
- Managers ensured that children, young people and families who did not attend appointments were contacted. There was a policy in place if a child was not brought to an appointment.
- The service had a cafeteria in the waiting area that children and their families could access to buy hot and cold drinks and snacks. Staff told us if appointments were delayed patients would be offered free drinks. This was located close to the designated children and young people's area. There was a child safety gate at the access to the kitchen area of the cafeteria.
- When children were discharged they were all given a plastic yellow duck and a badge. Ducks were given to the children because there had been a lot of ducks in the area when the hospital was being developed.

Meeting people's individual needs

- **The service was inclusive and took account of children, young people and their family's individual needs and preferences. Staff made reasonable adjustments to help patients access services.**
- The children and young people's service was newly developed and children with complex needs were not seen at the hospital. However, there were wide corridors and low access desks if a child attended and used a wheelchair.
- All children and young people attended a face-to-face pre-assessment appointment which was led by the paediatric lead nurse. The National Institute of Health and Care Excellence (NICE) guidelines were used to assess patient's anaesthetic risk at pre-assessment. The service had strict admission criteria and did not admit patients with complex co-morbidities.
- Children and young people were nursed in single rooms on the day surgery unit. There were televisions in each room where they could watch age appropriate children's programmes. Parents were able to stay in the rooms with their child and there were reclining armchairs for them to use. Up to two parents or carers were allowed to stay with their children at any time.
- Audiology appointments were always available for children who attended the ear, nose and throat (ENT) clinic. Children could be seen by the audiologist during their ENT appointment if necessary. This meant they did not need to return to the hospital for a second appointment and information was shared with the clinicians and family without delay.
- The service had hearing loop for people with hearing difficulties. This was available in the main waiting area, outpatients and ward. The hospital had also ordered an additional hearing loop that could be placed in the patient's bedroom or worn by staff, to ensure patients could communicate effectively with staff.
- We saw there were information booklets specifically designed for children. These had pictures and cartoons and were available for a variety of age groups from toddlers to adolescents.
- Patient information we saw was only available in English. However, staff told us this could be translated into other languages on request. Staff were able to access a language interpreting service for families whose first language was not English. Staff told us they could access this very easily and did not need to pre-book the service.
- Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences. We saw children had drinks and food was collected for them from the kitchen as required. Catering staff had designed a menu especially for children. The menu included healthy options as well as more traditional children's' foods.

Access and flow

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.**
- A number of surgical treatments were offered for children and teenagers over three years of age. These included ENT, ophthalmology, urology, general surgery, gastroenterology and orthopaedics. These were provided by consultant surgeons who specialised in childhood conditions. Children were seen from the age of three to 18 years unless assessed to be treated on the adult pathway (between the ages of 16 and 18 years) by the paediatric team.
- Patients' had timely access to initial assessment and treatment through a private paediatric referral pathway. Patients and parents could access care and treatment at a time that suited them. Patients and parents could

select times and dates for appointments to suit their child's family or school commitments. Appointments could be arranged after school and some were available on Saturday mornings.

- There was one surgical list per month for children and young people. A maximum of four children were placed on the operating list each session. These took place during the morning. The consultant surgeon held an outpatient clinic in the afternoon and so remained in the hospital until children had been discharged. No adults were admitted to the day unit when there were paediatric patients there. There were no adults in the recovery area when children were there.
- From April 2018 to March 2019, there were 75 children under two years of age, 348 children between the ages of three and 15 years, and 217 young people between the ages of 16 and 17 years who attended outpatient clinics. There were 27 children and young people between the ages of three and 17 years who underwent day case procedures and five inpatients aged 16 to 18 years.
- The service had a "was not brought" policy. If a child was not brought for an outpatient appointment contact would be made with the child's parent to identify the reason for non-attendance. If concerns were identified or it was not possible to contact the parent by telephone, there were processes to follow this up and ensure there were no safeguarding or other concerns identified.
- If procedures were cancelled or delayed they were rescheduled as soon as possible in discussion with the lead paediatric nurse, paediatric team, child or young person and their family.
- Managers and staff worked to make sure they started discharge planning as early as possible. We saw discharge planning began as part of the pre-assessment process.
- Staff within the imaging department told us they could not remember when children were last seen. Following our inspection, we requested information about the numbers of children seen. From April to June 2019, 24 children and young people aged 0 to 17 years had an MRI scan, 16 had an ultrasound and 16 had attended for x-ray.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place and staff we spoke to were aware of the complaints procedure. We saw information on how to make a complaint in the reception area of the hospital.
- If a child, young person, parent or carer wanted to make an informal complaint they would be directed to the lead paediatric nurse or a senior staff member. Patients would be advised to make a formal complaint if their concerns could not be resolved informally.
- From April 2018 to March 2019, there had been zero complaints in relation to children and young people.
- Managers investigated complaints and identified themes. Staff we spoke with told us they received feedback from any complaints through ward meetings, the one to one process if necessary and at the daily communication meeting. We saw complaints were discussed at the paediatric user group (PUG), medical advisory committee (MAC), heads of department and governance meetings.
- For our detailed findings on learning from complaints and concerns, please see the corresponding sub-heading in the surgery report.

Are services for children & young people well-led?

Good

We rated it as **good.**

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**
- The service had appointed a lead paediatric nurse who reported to the director of clinical services. The lead paediatric nurse liaised with leaders of theatres, outpatients and other departments to enable the effective running of the service. The lead paediatric

nurse worked clinical shifts and ensured there was sufficient paediatric nurse cover for the service. Staff of all grades and roles worked closely together within each department to provide the service.

- Staff told us they felt leaders were visible and approachable. Leaders were passionate about their roles, effective multidisciplinary working and development of the service. There was a focus on the development of the service among senior medical and nursing staff.
- Staff we spoke to told us the senior management team were visible and had an open-door policy. If staff had ideas about service development, they were able to raise these with local leaders and the senior management team. All staff felt they could be open with colleagues and managers and were able to raise concerns and felt they would be listened to.
- There was no formal leadership programme for staff or managers to access to develop their leadership roles.
- For our detailed findings on leadership, please see the corresponding sub-heading in the surgery report.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services.**
- The hospital had a vision to be acknowledged as the private hospital of choice in the area. Patient safety and quality were at the heart of services provided. The hospital had five values which were; patient centred, empowered, accountable, collaborative and exceptional. Most nursing staff were aware of the service's vision and values.
- The service had developed its own list of objectives which were displayed in the children's area of the outpatient department. These were: regulatory compliance, governance, patient experience which included the paediatric patients journey, hospital strategy, clinical outcomes and staff engagement.
- Staff told us that all staff had been involved in the development of the vision and strategy for the service.
- For our detailed findings on vision and strategy, please see the corresponding sub-heading of the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff spoke positively about working in the hospital and described a culture that was open and friendly with an emphasis on delivering high quality care to adults, children and young people.
- All staff told us the senior management team were approachable and visible and they saw the hospital director and heads of department every day. They told us there was an open-door policy and they would feel comfortable to raise any concerns or suggestions for development.
- Staff told us the culture was positive and that "it was a lovely place to work". Staff had development opportunities and told us these were identified during the appraisal process. There were opportunities for staff to develop their knowledge and skills in the care of children and young people through the completion of competencies and staff specific training. For example, all staff in the recovery area were undertaking a two-day paediatric recovery course to enhance their knowledge and skills.
- All staff involved in the care of children and young people worked collaboratively across the departments to ensure the safe and effective care of children and young people.
- For our detailed findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The service had clear governance systems in place. The hospital held meetings through which governance issues were addressed. The meetings included clinical governance, medical advisory committee (MAC), heads of departments and paediatric user group (PUG). We saw the lead paediatric nurse attended these meetings.

There was also representation from the lead consultant and paediatric consultants at PUG meetings. Strategic planning, paediatric pathways and development was discussed at these meetings.

- Managers discussed the strategic planning, assessment and delivery of the service at the monthly PUG meeting. This ensured there was robust oversight of the service to assure quality of overall care for paediatric patients and families.
- The service had a named paediatrician, who was a paediatric consultant at a local NHS trust. The named paediatrician was a member of the PUG, which formed part of the overall paediatric governance process.
- The lead paediatric nurse undertook monthly reviews and audits of the service to ensure performance was effectively managed in all areas of care.
- The service had a child protection and safeguarding committee which covered the local authority NHS and clinical commissioning group (CCG) areas. The director of clinical services was trained in safeguarding children to level five and the lead paediatric nurse was trained to level three.
- The heads of department met monthly and the minutes showed items discussed included complaints, clinical governance, audit results and key departmental feedback. These meetings also shared staff experiences and information was shared back with staff in departments.
- Heads of department identified training needs with staff through appraisal. Training needs were also discussed at the PUG and heads of department meetings.
- Children's services were audited in line with the hospitals governance policy. For example, patient documentation and infection control audits to ensure continuous monitoring and enhancement of the quality of care delivered to children and young people.
- For our detailed findings on governance, please see the corresponding sub-heading in the surgery report.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- There was a risk assessment process. Identified risks had been assessed using a standardised template which scored the risk as low, medium or high. We saw a copy of the hospital risk register and noted each risk identified had a list of associated mitigating actions to reduce the risk. In addition, a responsible person was identified against the risks.
- We saw specific risks to children and young people were identified on the risk register. Staff within the service were aware of local risks and mitigating actions. For example, a risk assessment of the children's play area being situated next to the cafeteria had been completed. Controls were in place to minimise the risk of children being scalded by hot drinks or of injury by slips, trips and falls. We observed signs asking parents and carers to supervise children at all times.
- The service participated in the hospital's annual audit programme. Audits undertaken included infection control, record keeping, medicines administration, clinical handover of care, management of the deteriorating child and 48-hour follow-up calls. Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department, clinical lead and hospital director.
- The senior management team held daily communication meetings which were attended by representatives from all departments to identify issues that could impact on the delivery of patient services. For example, staffing levels, patient dependency, availability of beds and patient safety incidents.
- For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were secure, and most were integrated. Data or notifications were consistently submitted to external organisations as required.**
- There were clinical and non-clinical information technology (IT) systems which directly contributed to the quality of patient care through the identification of themes and trends, such as incident reporting. These helped develop safer working practices.

- There were electronic systems to manage and monitor data. These included systems to monitor compliance with training, appraisal and audits. Policies and procedures were available on the hospital intranet and staff could access these easily. Minutes of meetings were also accessible electronically. We saw there were electronic systems to monitor activity within the hospital. Children and young people's patient records were flagged with a yellow marker to highlight them to staff.
- The hospital's lack of integrated pathology reporting system was on the hospital's risk register. Pathology services were provided by the local acute NHS trust, who had been unable to provide an electronic reporting system. Actions were in place to mitigate this risk, which had been graded as 'low risk'. Results were emailed to the hospital which staff could access. Senior staff had been liaising with the local acute NHS trust to fix this and we saw electronic access had been granted to the director of clinical services.
- For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- Staff were engaged in the development of the service. They told us they felt well supported by managers and were actively encouraged to share ideas for the development of the service. Staff told us senior managers had an open-door policy.
- The service actively encouraged feedback to support continual improvement. Feedback occurred in several ways, verbal, through the patient feedback form, the hospital website or through the 'One Loves to Listen' initiative. Patients were encouraged to complete the online independent 'iWantGreatCare' test, as well as local comment cards. We saw comment cards were widely available throughout the hospital. Specific comment cards were available for children and young people who had attended the hospital either as an inpatient or outpatient.
- Staff were rewarded through a system of recognition for going above and beyond their normal duties. We saw staff excellence was identified on notice boards in staff rooms and electronic notice boards in patient waiting areas.
- Staff worked closely and co-operated with partner and external services such as the local safeguarding team, to promote, safeguard and support the wellbeing of children. Members of the PUG contributed to promoting the care and welfare of children and young people by inter agency working.
- Staff told us they had a successful winter wonderland event for children at Christmas which had taken place in an enclosed outside area.
- For our detailed findings on engagement, please see the corresponding sub-heading in the surgery report.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services, which leaders encouraged. They had a good understanding of quality improvement methods and the skills to use them.**
- The service was new to the hospital and was being developed. We saw staff of all disciplines were engaged in the process and had a vision for a high-quality service.
- The paediatric lead nurse was developing systems, for example the pre-assessment forms had been improved to include more health and social information and risk assessments.
- More staff were being encouraged to undertake paediatric competencies, which meant they would be able to work with children and young people within the hospital.

Good

Outpatients

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

Are outpatients services safe?

Good

We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The service target for mandatory training was 95%. At the time of our inspection, 97% of staff in the outpatient department had completed all of their mandatory training.
- The service monitored staff's compliance to mandatory training and had recently introduced an improvement plan to ensure training was updated when required. Actions from the plan included ensuring sufficient face-to-face training sessions were available for all staff to attend, and close monitoring of attendance through regular staff meetings.
- Mandatory training was a mixture of online and face-to-face learning. Examples of face-to-face learning topics included fire safety, basic life support and immediate life support, manual handling, blood transfusion training, aseptic non-touch technique (ANTT) and hand hygiene. Online learning topics included, information on dementia, equality and diversity, health and safety and infection control.
- Nursing staff told us it was easy to access electronic training and they were given regular opportunities to complete it during their working week.
- Medical staff were not directly employed by the service and received all their mandatory training through another provider. However, the service ensured doctors provided evidence of completion of their mandatory training. Mandatory training was recorded in doctors' staff files.
- Mandatory training was comprehensive and met the needs of patients and staff. Training included recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.
- Clinical staff described the training they had received and said that it was beneficial and helped them carry out their role safely and effectively.
- New staff were booked to attend mandatory training as soon as possible and had a full local induction which included spending time in each of the hospital's departments.
- For our detailed findings on mandatory training, please see the corresponding sub-heading in the surgery report.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- Nursing staff received safeguarding training specific for their role on how to recognise and report abuse in adults and children. Staff gave us examples of abuse and told us who they would contact if they suspected abuse. Contact details of the local authority safeguarding team were available in the department.
- Medical staff received training specific for their role on how to recognise and report abuse. The resident

medical officer (RMO) received safeguarding training appropriate to their role through their agency. The service ensured they saw evidence that medical staff had completed the required training.
- Staff received online training in female genital mutilation (FGM), child sexual exploitation (CSE), domestic violence and preventing radicalisation. Staff we spoke with were aware of their mandatory duty to report all cases of FGM in women and children at risk of FGM being performed.
- Staff knew who the named safeguarding nurse for adults and children was and told us they could contact them if they needed advice and support with any safeguarding concerns.
- For our detailed findings on safeguarding, please see the corresponding sub-heading in the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- Cleaning records were up-to-date and demonstrated
- Staff followed We observed staff washing their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61, quality statement 3 (April 2014)). Hand hygiene audits carried out in April 2019 showed staff were 100% compliant with hand hygiene. We observed staff carrying out good hand hygiene practices and using PPE appropriately.
- Clinical areas and clinic rooms had hand washing facilities with sensor or elbow-operated taps. There were hand washing technique posters displayed above the sinks. Staff were observed to be arms bare below the elbow in line with the hospital infection control policy.
- Hand gel dispensers were located throughout the clinical areas.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. All equipment in the department was labelled and clean.
- Monthly infection prevention and control (IPC) audits were carried out within the service. In April 2019, the average compliance score for all outpatient areas was 97% (Source: 49 steps OPD audit form April 2019).
- Patient-Led Assessment of the Care Environment (PLACE) audits carried out in the outpatient, physiotherapy and reception areas in February 2019 scored 96% for cleanliness.
- Suitable cleaning wipes were available in each clinical room. We observed these were used to wipe down couches after each patient use. Paper roll dispensers were used to cover couches and we saw fresh paper roll was applied before each patient. All waste disposal bins in the consulting rooms and clinical areas were pedal operated. This supported the safe management of health care waste and adherence to infection control guidelines.
- Although all areas were clean and had suitable furnishings which were clean and well-maintained, clinical rooms had some fabric chairs. Fabric chairs are not recommended for clinical areas because they are difficult to clean. The service had completed a risk assessment for these chairs and told us they were deep cleaned every six months. We were told that patients coming for wound checks, dressing changes and procedures would not use the fabric chairs. They would mostly be seen in a procedure room or seated on the clinic couch.
- From March 2018 to April 2019, there had been no instances of healthcare acquired infections (Source: Routine Provider Information Request).
- Most instruments used in the service were disposable. Reusable medical devices, including flexible endoscopes, were decontaminated by an external provider and in line with national guidance (Department of Health, Health Technical Memorandum 01-06: Decontamination of flexible endoscopes (March 2016)).
- Dust covers were in place to protect some clinical equipment and keep it clean and dust free.
- Staff in the physiotherapy gymnasium told us there was a process for all equipment to be wiped down daily and this was recorded on a tick sheet. Equipment was also cleaned between each patient use.
- For our detailed findings on cleanliness, infection control and hygiene, please see the corresponding sub-heading in the surgery report.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.**

Good

Outpatients

- Access to the outpatient department was through the hospital's main entrance. Outpatient services were delivered on the ground floor of the building.
- The design of the environment followed national guidance. The waiting areas were clean and bright with adequate seating for the number of patients using the service. There was room for wheelchairs.
- The physiotherapy service was in a separate area through the outpatient corridor. All areas were accessible to patients using mobility aids.
- There was an adult and a paediatric resuscitation trolley in the outpatient department and an emergency 'grab bag', plus defibrillator, suction unit and oxygen cylinder. Daily and weekly checks were carried out and recorded on resuscitation equipment in accordance with policy.
- There was a blood glucose monitor on the resuscitation trolley and in the clinical room. Records showed both pieces of equipment had been checked and calibrated weekly. However, manufacturers guidance, stored alongside the equipment indicated these tests were required daily. Nursing staff told us the manufacturer had informed them the equipment could be checked on a weekly basis, if they carried out the safety check prior to every patient use. This was written into the department's standard operating procedure and their risk assessment. However, it was unclear from staff if checks had been carried out prior to use, as the only recorded checks we saw were weekly checks. Staff said they did not use the blood glucose monitoring equipment very often. We raised this as a concern during our inspection and the service arranged for the manufacturer to provide new training and guidance on use of the equipment in August 2019.
- Consumable equipment used in the clinics, such as wound dressings and syringes was in sealed packaging and within expiration dates.
- Sharps bins were available in each clinic room which were dated and not overfilled.
- Pathology and histopathology services were outsourced and not provided on site. Nursing staff told us there was a process for sending and tracking histopathology specimens which were sent for analysis.
- The clinical rooms were large enough to accommodate patients and their families along with clinical staff and equipment.
- Clinical rooms contained suitable specialist equipment, including adaptable couches for carrying out procedures, and equipment to carry out ear, nose and throat examinations.
- The service had enough suitable equipment to help them safely care for patients. Staff reported there was no shortage of equipment. Equipment had been safety tested and contained stickers of when safety tests were next due.
- Staff disposed of clinical waste safely.

Assessing and responding to patient risk

- **Staff working in the outpatient service assessed and responded to risk.**
- There was a hospital wide emergency call bell system, which meant if a call bell was activated in any department, a team of staff would treat it as an emergency and respond immediately. Call bell systems were tested daily.
- Staff knew how to respond to any sudden deterioration in a patient's health. There were clear processes and pathways for the assessment of people within outpatient clinics who became clinically unwell. Nurses in the outpatient department told us if a patient became unwell during their appointment, they would carry out vital signs observations and document these on a national early warning score (NEWS2) form. Deteriorating patients were assessed by the resident medical officer (RMO) who could be called from the ward. In an emergency, staff would call 999 for assistance and transfer unwell patients to the local acute NHS trust if necessary. Patients did not routinely have their observations recorded in the outpatient department unless doctors specifically requested this.
- Laboratory tests, such as blood results and wound swabs were processed by another organisation and the results were retrieved electronically by administrative staff working in the service. Senior staff told us a system of checking ensured all results were available when required and that no delays had been reported.
- There were plans in place for local implementation of the National Safety Standards for Invasive Procedures (NatSSIPs). There were NatSSIPs guidelines displayed on a poster in the treatment rooms and staff told us they followed the guidance during minor procedures. Clinical records we reviewed showed local Safety Standards for Invasive Procedures (LocSSIPs) were being followed in the outpatient department.

- There was no access to specialist mental health support services in the outpatient department. Nurses told us if they were concerned about a patient's mental health they would refer them back to their GP. The hospital's exclusion criterion included patients with an unstable psychiatric condition/disorder.
- Staff knew about and dealt with any specific risk issues. For example, staff told us they had received training on recognition of sepsis and what they would do if they suspected a patient had early signs of sepsis.
- There was an RMO on duty 24 hours a day, seven days a week. The RMO had advanced life support and advanced paediatric life support training.
- Service leads from each department met every morning to discuss any emerging risks, and to establish leads in the event of an emergency, such as fire, or cardiac arrest. Every day, there was a named individual responsible for leading on each identified risk.
- For our detailed findings on assessing and responding to patient risk, please see the corresponding sub-heading in the surgery report.

Nurse staffing

- **The service mostly had enough nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers had recently reviewed staffing levels and skill mix. Bank and agency staff were not used in the service.**
- While the service had enough nursing staff of all grades to keep patients safe, some staff regularly worked more than their contracted hours to cover the service. The department was open from 8am to 9pm weekdays and on Saturday mornings. The service employed three whole time equivalent (WTE) nurses and two WTE healthcare assistants (Source: PIR, staffing). We were told staffing had recently been increased and any shortages, due to sickness and annual leave for example could be covered by nurses from the hospital ward if required.
- The number of nurses and healthcare assistants on all shifts matched the planned numbers.
- The service had no nurse or healthcare assistant vacancies at the time of our inspection.
- The service had low turnover and low sickness rates.

Allied Health Professional staffing

- There were five WTE physiotherapists working in the department, and there were no vacancies. Physiotherapists also covered inpatients as well as the outpatient department.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.**
- There was a total of 212 medical staff working at the hospital under practising privileges. Practicing privileges were granted to consultants to carry out care and treatment they would normally carry out in their scope of practice within their substantive post in the NHS. These medical staff worked across outpatients, as well as theatres and the ward. In the outpatient department medical staff delivered clinics for specialities which included orthopaedics, urology, gynaecology, general surgery, ear nose and throat, gastroenterology, audiology, cardiology, cosmetic surgery, GP and dermatology services.
- For our detailed findings on medical staffing, please see the corresponding sub-heading in the surgery report.

Records

- **Although staff kept detailed records of patients' care and treatment, not all records were signed and dated in accordance with best practice, or in line with hospital policy. Records were clear, up-to-date and easily available to all staff providing care.**
- Medical staff did not always sign and print their name or quote their General Medical Council (GMC) registration number after writing in patient records and some records did not have dates or times recorded when the entries were made. We reviewed nine patient records which had been completed exclusively by medical staff. Four (44%), did not contain a doctor's name, signature, GMC number, date or time, of the consultation. None of the nine records contained all of the required information. This was not in line with best practice for record keeping and did not follow the hospital's own records policy (Source: Provider information request P4, Management of clinical records policy, 2017). We raised this as a concern during our inspection. When we returned on our unannounced inspection we saw six out

of eight patient records had a doctor's name, signature and GMC number. However, the six records had all been completed by the same doctor. The two records which did not have all the required information were completed by a different doctor. All eight records were dated and four included a time.
- The outpatient department audited its records, including compliance to documentation standards. Audits reported 100% compliance in April, May and June 2019 (Source: Provider information request DR8).
- Nurses and physiotherapists made entries in patient records in line with best practice and in accordance with hospital policy.
- Patient notes were comprehensive, and all staff could access them easily.
- Records were paper based and held centrally within the hospital. Staff in the records department had an electronic tracking process for when medical records left the department and were transferred to the outpatient department or the ward. Patient records were easily transferred to new teams or different departments.
- Doctors often recorded their notes on their own electronic device or laptop. Any notes recorded electronically were emailed to the hospital using secure networks. We were told most notes were emailed the day after the consultation. Emailed notes were printed off and filed in the patient's paper-based record.
- Records were stored securely in a locked trolley behind the reception desk. We did not see any unattended records during our inspection. However, we were told data security was on the service risk register. This was because out of hours, when there were no administrative staff available and when nurses were seeing patients, medical staff required access to patient records which meant the notes were not always locked away between each patient.
- From January to March 2019, no patients had been seen in the outpatient department without their notes being available. Staff told us they would contact the records department in advance of a patient's appointment if records were missing.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- Medicines were stored securely in the outpatient's department. Medicines were stored in either a locked cupboard or a locked fridge. All items we checked were found to be within their expiry date. Room and fridge temperatures were monitored and recorded. Temperatures were within range in accordance with policy.
- There was a pharmacy on site at the hospital which supported the inpatient and outpatient departments. It was open Monday to Friday, 9am to 5pm. Heads of department, the director of clinical services (matron) and the resident medical officer had access to an emergency dispensing box out of pharmacy hours.
- Prescription pads were locked away and only accessible to staff. There was an audit log of all prescriptions issued.
- For our detailed findings on medicines, please see the corresponding sub-heading in the surgery report.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**
- All staff knew what incidents to report and how to report them. Managers told us they discussed any incidents reported within their own departments at monthly staff team meetings.
- Incidents were discussed at the daily operations meeting and shared with all departments.
- Staff reported serious incidents clearly and in line with hospital policy.
- From April 2018 to March 2019, the service reported zero never events or serious incidents. However, staff knew what constituted a serious incident and said they would report these in line with hospital policy.
- Staff understood the duty of candour. From November 2014, healthcare providers were required to comply with the duty of candour 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 the person. Nurses said they were open and transparent and knew patients and families required a full explanation if things went wrong.
- Managers shared learning with their staff about never events that happened elsewhere. For example, staff were reminded of the need to always mark a patient's skin when carrying out minor operations, to avoid wrong site surgery.
- For our detailed findings on incidents, please see the corresponding sub-heading in the surgery report.

Safety Thermometer (or equivalent)

- **The service continually monitored safety performance.**
- Hand hygiene audits and environmental audits were shared with staff, although these were unavailable to patients and visitors.
- Hospital wide data showed there were zero incidents of reportable infections including MRSA, E-Coli or C. difficile during the reporting period.

Are outpatients services effective?

Not sufficient evidence to rate

We do not rate effective for outpatient services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. National Institute for Health and Care Excellence (NICE) guidelines were followed in outpatients and physiotherapy. For example, the National Safety Standards for Invasive Procedures (NatSSIPs) were displayed on a poster in the clinical area and staff told us they followed the guidance during minor procedures. There was a NatSSIP form for minor procedures which we saw had been completed for patients.
- Physiotherapy staff followed NICE guidance for the management of back pain, and rehabilitation exercises following joint replacements. Leaders made staff aware of any newly published NICE guidelines, which they then reviewed to see if any changes in clinical practice were required.
- There were clinical policies in place which had standard operating procedures (SOPs) for staff to follow to ensure policies were adhered to. The policies and SOPs we looked at were referenced to current national guidelines.
- Regular audits were undertaken to ensure compliance to processes. For example, compliance to record keeping, hand hygiene and environmental audits were done monthly.
- Audits of clinical practices were not routinely undertaken in the outpatient or physiotherapy departments.
- Processes were in place to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Policies were assessed to ensure guidance did not discriminate because of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.

Nutrition and hydration

- The outpatient waiting area had hot and cold drinks available for patients and relatives visiting the service.
- For our detailed findings on nutrition and hydration, please see the corresponding sub-heading in the surgery report.

Pain relief

- Patients attending outpatients did not routinely require analgesia unless they were undergoing minor surgical procedures. Local anaesthetics were routinely used to ensure patients did not experience unnecessary pain during minor surgery.
- There was a visual analogue scale tool used to assess pain in the physiotherapy department. Staff used this to monitor patients progress.
- For our detailed findings on pain relief, please see the corresponding sub-heading in the surgery report.

Patient outcomes

Good

Outpatients

- **Staff in the outpatients service did not routinely monitor the effectiveness of care and treatment. This was undertaken by other services within the hospital. Some patient outcomes were measured by physiotherapists.**
- Information about the outcomes of people's care and treatment was not routinely collected and monitored for patients attending outpatient clinics. Patient outcomes were generally monitored within the surgery service, such as the Patient Reported Outcome Measures (PROMs) and National Joint Registry.
- The physiotherapy department collected some outcome data. This included the neck disability index, for patients involved in accidents and which resulted in neck injuries, and back pain scores. Outcome data was used to measure patient progress following physiotherapy treatment, such as if their pain had improved. This data was shared with relevant staff if, for example, the patient was not making progress against their treatment plan or if the physiotherapist was changed for any reason. It was also shared with the patient's insurer, when required.
- For our detailed findings on patient outcomes, please see the corresponding sub-heading in the surgery report.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance although they did not hold regular supervision meetings with all of them.**
- Staff were experienced, qualified and mostly had the right skills and knowledge to meet the needs of patients. Some clinical skills were carried out by the registered medical officer (RMO) because not all nurses working in the outpatient department were able to perform them. For example, some nurses had not received training on testing a patient's blood glucose level. On our unannounced inspection we saw blood glucose training had been arranged for August 2019.
- Managers gave new staff a full induction tailored to their role before they started work.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff we spoke with told us they had received an appraisal from their manager. Additional training needs and objectives were discussed as part of the appraisal process and learning needs were identified and agreed.
- Most training was provided in-house, for example, a member of staff told us one of their objectives was to rotate into the operating theatre, to gain additional skills. Some physiotherapy staff had attended external training to develop their knowledge and skills. For example, two physiotherapists had attended shock wave therapy training.
- Formal clinical supervision meetings were not generally undertaken in the outpatient department, although the service manager met weekly with the director of clinical services for one to one discussions and ongoing support. Outpatient and physiotherapy staff told us their managers were always available and on hand to provide direct assistance and ad hoc support whenever required.
- All staff had access to their own electronic training record which listed all the training they had attended. In addition, nurses and healthcare assistants had competency booklets for skills required in the outpatient department. These books had recently been introduced and staff were progressing through each competency at the time of our inspection.
- Managers made sure all staff attended team meetings or had access to meeting minutes when they could not attend.
- There were processes to ensure medical and nursing staff were registered with their professional body and had completed their revalidation, as required.
- For our detailed findings on competent staff, please see the corresponding sub-heading in the surgery report.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- All staff we spoke with told us they worked well together as a team. Minutes from outpatient and physiotherapy meetings were stored electronically, which all staff could access and read if required.
- Representatives from each department met every morning for the daily operations meeting, this provided an opportunity to share key information.
- The medical advisory committee (MAC) meetings were held quarterly and attended by consultants from all

specialities. We saw MAC minutes from July 2018 to July 2019 which had identified issues and discussed patient care and pathways in the service to provide the best outcomes for patients.

- Staff worked across healthcare disciplines and with other agencies when required to care for patients. For example, we saw a physiotherapist networking with another professional outside of One Hatfield, to obtain a splint for a patient.
- We observed positive interactions between medical, nursing and support staff. Staff we spoke with confirmed there was effective multidisciplinary working within outpatients, theatres and the ward. Nursing and healthcare staff told us they supported each other and moved to different departments to cover any staff shortages to ensure patients were always cared for in a safe environment.
- Staff confirmed they had established links with other services and agencies to support the needs of vulnerable patients. Staff would consult with the service's safeguarding lead if needed.
- Administrative staff worked closely with medical and nursing staff to support the planning and delivery of care. Booking co-ordinators continuously managed waiting lists for outpatient services.

Seven-day services

- Outpatient and physiotherapy clinics were held between the hours of 8am and 8pm, Monday to Friday. Saturday clinics were regularly available, depending on patient need. Clinics were not held on Sundays.

Health promotion

- **Staff gave patients practical support and advice to lead healthier lives.**
- There was a range of information on muscular skeletal conditions in the physiotherapy department which promoted independence and encouraged patients with long term conditions to remain fit and active. Other leaflets provided advice on living with conditions such as arthritis symptom management and dementia.
- Physiotherapy staff provided patients with individualised exercise programmes to improve their symptoms and level of function.

Consent and Mental Capacity Act

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.**
- There was a consent policy which was in date and identified responsibilities and processes for gaining consent for procedures, including minor operations. One Hatfield Hospital had its own consent forms which staff completed.
- All of the records we reviewed had a consent form which was signed and dated by the patient and consultant. One out of the 14 consent forms did not have the risks of the procedure recorded on the One Hatfield Hospital consent form. However, the risks of the procedure had been documented on a different consent form, belonging to another healthcare provider. We highlighted this to staff during our inspection and we were told this would be addressed by the management team. On our unannounced inspection, we looked at nine consent forms and saw that each one had recorded the risks and benefits of the intended procedure on the correct consent form.
- Patients were not routinely given a copy of their consent form. We looked at 14 consent forms and saw none had had their carbon copy removed and given to the patient. Staff told us this was because patients did not want a copy of their consent form. We were concerned that patients leaving their appointment would not have a written list of the risks associated with their planned procedure. Following our inspection, we were told the service would change its policy to ensure copies of consent forms were posted to patients the following day if they had not taken a copy at the time of their appointment. On our unannounced inspection, we saw consent forms were being sent out to patients' by administrative staff following their appointment.
- Consent audits carried out from January to June 2019, showed the service was between 93% and 100% compliant with hospital policy.
- Staff we spoke with during inspection told us if there were any concerns about a patient's capacity to consent to a procedure, a mental capacity assessment would be carried out by the consultant, as nurses were not all trained to complete these. Where capacity to consent was unclear, procedures would be postponed to establish if the procedure was in the patient's best interests.
- Physiotherapy staff recorded consent every time they reviewed a patient.

Good

Outpatients

- Staff received Mental Capacity Act training as part of their induction and had annual online updates.

Are outpatients services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- We observed staff interacting with patients and relatives and saw they introduced themselves and were courteous, friendly and respectful at all times.
- In the physiotherapy department, we saw staff provide encouragement to patients and show a supportive attitude during therapy treatments.
- All patients we spoke with told us staff were friendly and helpful.
- Patients' privacy and dignity was protected. Clinic rooms were lockable and had engaged signs on doors. Privacy curtains were drawn around treatment couches when physical examinations were performed in the physiotherapy department.
- Chaperones were available, and we saw clear signage advising patients of their right to request a chaperone during appointments.
- Comments from patients included, 'incredibly helpful and caring staff', 'excellent professional service' and 'everyone is always very welcoming'.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff told us the length of appointments was flexible depending on whether it was a first appointment or follow-up. Patients told us appointments were long enough to allow them to discuss treatment options and to ask any questions they had.
- All consulting rooms were private and were suitable environments for difficult conversations, for example following a cancer diagnosis.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Relatives were able to attend appointments with patients and there was opportunity for patients and relatives to ask questions about their planned care. This meant they were involved in making shared decisions about care and treatment.
- Staff gave patients written information to help explain their condition and treatment plan. A range of patient information leaflets were available that could be downloaded and printed for use. We observed staff take time to explain the importance of following written advice and exercises that were provided by the physiotherapy department.
- Physiotherapy staff discussed and agreed treatment goals with patients, to ensure the care provided met the patient's needs. Patient goals were documented in the physiotherapy notes.
- The feedback from patients was gathered in the service using 'iWantGreatCare' and patient comment cards. All the feedback we saw was positive.

Are outpatients services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**
- Patients attending the outpatient department were mostly privately funded, although some NHS funded patients were treated in the service. NHS patients had chosen the hospital as a location for their appointment through the NHS e-referral service. The local clinical commissioning group (CCG) set criteria within their contract for NHS patients' attendance at the hospital. This meant local commissioners were involved in the planning of local services.

Good

Outpatients

- The main hospital reception area provided a manned reception desk. During our inspection there were no queues at the reception desk, and the area was large enough to accommodate the volume of patients who used the service.
- In the outpatient waiting area there was adequate and appropriate seating. Hot and cold drinks and snacks could be purchased, and a range of current magazines and patient information leaflets were available. Patients were called through for their outpatient appointments to clinic rooms by nursing and medical staff. Physiotherapy patients booked in at the main reception and were directed to a separate physiotherapy waiting area.
- There was a large free car park at the hospital for patient use.
- Outpatient clinic appointments and physiotherapy appointments were available in the early evenings Monday to Friday, and on Saturdays to provide patients with flexibility and choice of appointment times.
- For those patients who were self-funding, information about fees was sent out with appointment letters. Physiotherapy provided a menu of treatments which included prices, so patients knew at the time of booking, what costs were involved.
- Patients could not always see all the health professionals involved in their care in one-stop clinics. For example, if a patient required an anaesthetic review, this was usually not available at the time of a patient's appointment with their consultant. Physiotherapy appointments could not always be arranged on the same day post-operative reviews were carried out. However, the service tried to accommodate patients' needs and booked appointments as conveniently as possible.
- The hospital had introduced a 'one-stop' cardiology service for the investigation and diagnosis of cardiac issues. Cardiologists offered consultations, advice and a range of tests such as electrocardiogram (ECG), cardioversion or echocardiogram if needed. This meant a more efficient and timely service for patients, with prompt diagnosis and fewer appointments needed.
- Managers monitored and took action if consultants arrived late for their clinics. This was to ensure delays for patients were always kept to a minimum. Where delays were known in advance, outpatient staff contacted patients prior to their arrival to minimise their time spent unnecessarily in the department. Patients were provided with free drinks when appointments were delayed.
- Patients received copies of clinic letters sent between the hospital and the patient's GP which provided information about their care and treatment.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- The outpatients and physiotherapy departments were situated on the ground floor and were easily accessible to patients or visitors with mobility difficulties and wheelchair users.
- Chairs suitable for patients of excess weight were available in the waiting area. The hospital had exclusion criteria for patients with a high body mass index, hence such facilities were rarely required.
- There was access to interpreting services for patients whose first language was not English. This included the use of language line and face-to-face interpreter support.
- Managers told us support for people with other communication difficulties was available, such as support using British sign language for patients with hearing difficulties if required. There was a hearing loop available at the outpatient reception desk.
- Nurses and physiotherapy staff completed online dementia training. However, nurses told us they rarely worked with vulnerable patients such as those living with dementia or a learning disability. Patients with more complex needs were usually treated at the local acute NHS trust where their individual needs could more easily be accommodated.
- The service had suitable facilities to meet the needs of patients' families. There was a separate waiting area with toys suitable for small children. Various current magazines were available throughout the department.

Access and flow

Good

Outpatients

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients exceeded national standards.**
- Patients accessed outpatient appointments through the telephone booking service. Appointment times were arranged flexibly and could be arranged in less than two weeks. NHS patients were referred by their GP through the NHS e-referral system. There was a service level agreement between One Hatfield Hospital and local commissioning groups which required NHS patients to be seen within six weeks of their referral. Senior staff told us the service was able to meet this agreement.
- After their consultation, patients were given information about when to expect their next appointment. The bookings team arranged all follow-up appointments for patients and booked appointments for surgery or procedures.
- In the physiotherapy department, patients who had been on the ward and needed follow-up physiotherapy were given an appointment by the ward staff prior to being discharged home. Patients who had not been inpatients of the hospital were able to make appointments for physiotherapy over the telephone. A referral was required for patients funded through insurance companies, but for self-funded patients a referral was not required.
- Waiting times for appointments for treatment were minimised. Staff told us privately funded patients were offered an outpatient appointment usually within a week and that from initial consultation, to completion of treatment, was usually within 12 weeks (for major orthopaedic surgery, such as hip or knee replacements). For NHS appointments there was a target for patients to receive treatment within 18 weeks of their referral to treatment time (RTT). Information supplied by the service showed all NHS patients had been treated within the 18-week RTT.
- Time taken to offer outpatient clinic appointments for assessment was monitored by the bookings team on a patient by patient basis, to support achievement of RTT targets. Private patients were usually treated within two weeks of their initial outpatient appointment and NHS funded patients were usually treated within three to four weeks from the date when funding was agreed.
- Patients we spoke with told us they had been offered an appointment within a couple of weeks of referral. Physiotherapy waiting time for appointments ranged from the next day to two weeks, depending on the physiotherapist and the type of therapy required. Waiting times for acupuncture were up to three weeks as there was only one physiotherapist who provided this service.
- Outpatient appointments generally ran to time and there were minimal delays for patients. Staff told us if clinics were running late, they advised patients and apologised for the delays.
- There was a system to manage patients who did not attend (DNA) appointments. Staff told us a monthly list of DNA numbers was sent to the quality team who monitored this and reported on it at governance meetings. Average monthly DNA rates were reported as just over 1% per month since the service commenced in 2019.
- There was a standard operating policy for managing DNA's. We were told if a patient did not attend their appointment, they would be sent a letter asking them to contact the service to make another appointment. If the patient did not respond to this letter within two weeks, then they would be discharged. Managers told us patients were not currently charged for missed appointments.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. Staff in the service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- Patients, relatives and carers knew how to complain or raise concerns. From June 2018 to April 2019, there had been two complaints recorded by the outpatient department. Both complaints had been fully investigated by senior staff and had follow up actions and recommended changes to practice recorded where applicable. Patients were offered explanations and apologies. One change of practice following a complaint included offering free refreshments to patients when their appointment was delayed.
- Nurses told us they would always try to manage complaints at a local level where possible and address concerns at source as soon as they were raised.
- Feedback from concerns raised was used to learn lessons and make improvements. All serious hospital complaints were discussed at the daily operations

meeting with the multidisciplinary team. Complaints were also discussed at clinical governance meetings attended by the director of clinical services and heads of departments. Complaints and actions were discussed at the medical advisory committee with consultants, to share learning and promote reflection.

- Staff met to discuss patient feedback and looked at how to make improvements to patient care. Examples included providing free refreshments to patients who had their appointment delayed and ringing up patients to warn them if a delay was known about in advance.
- For our detailed findings on learning from complaints and concerns, please see the corresponding sub-heading in the surgery report.

Are outpatients services well-led?

Good

We rated it as **good.**

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**
- There were named and experienced leaders in the outpatients and physiotherapy departments. Each lead was passionate about the service they led and worked well with staff in their department. There was a strong sense of team working in each department and all staff worked well together, whatever their role.
- Staff we spoke with told us they felt well supported by their department leaders. They told us they were approachable and available to help, regularly working clinical shifts within the departments.
- Staff reported managers in the executive team were visible leaders and regularly visited the departments to spend time talking to staff. They told us the hospital director and director of clinical services were approachable and would listen to concerns and ideas. Staff reported the director of clinical services had an open-door policy and was always available for staff to share ideas or discuss concerns. Communication in the form of emails and newsletters were sent out by the executive team to update staff on developments within the hospital.
- There were no formal leadership development programmes routinely available to nursing and physiotherapy staff. However, the nursing lead told us they planned to start a management training course next year.
- For our detailed findings on leadership, please see the corresponding sub-heading in the surgery report.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services.**
- The hospital vision was 'to continually develop and grow One Hatfield Hospital by delivering excellence in clinical quality and patient experience'. The hospital had five values which were; patient centred, empowered, accountable, collaborative and exceptional. Most nursing staff were aware of the service vision and values. We spoke to one medical staff member who was unaware of the hospital vison and values.
- The outpatient department had its own list of objectives which were displayed in the outpatient corridor. These were; regulatory compliance, governance, patient experience, hospital strategy, clinical outcomes and staff engagement.
- For our detailed findings on vision and strategy, please see the corresponding sub-heading in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff we spoke with all told us they felt supported, respected and valued by both managers and other staff. They described having positive working relationships with peers and managers.

Good

Outpatients

- Several staff told us they enjoyed their job and felt a sense of pride in their work.
- There was a culture of openness and honesty. Staff told us they felt comfortable to raise concerns with managers and confident they would be listened to and taken seriously.
- There were mechanisms in place for staff development which included a system for setting objectives in annual appraisals. Additional learning opportunities were being made available to develop staff knowledge and skills, although some opportunities had not been formalised as this was relatively new at the time of our inspection.
- Staff in outpatients and physiotherapy worked together collaboratively in their teams to share responsibility; tasks were delegated to individuals. In outpatients, we heard how each clinic room was allocated a named nurse who then had overall responsibility for that room each day.
- For our detailed findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

- **Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and met to discuss and learn from the performance of the service through the wider multidisciplinary team.**
- There were structures and processes of accountability in place to support the delivery of good quality services. There were clear reporting structures within each department, with a named lead having individual responsibility for that department. Department leads told us they reported directly to the director of clinical services.
- There were weekly meetings between the service manager and the director of clinical services, and there were monthly meetings between the heads of each department and the hospital director. Minutes of these meetings showed they followed a standing agenda which reviewed finance, complaints, audit results and monthly performance data. There was a list of attendance and an action log to monitor progress against identified actions.
- For our detailed findings on governance, please see the corresponding sub-heading in the surgery report.

Managing risks, issues and performance

- **Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- There was a risk assessment process and identified risks had been assessed using a standardised template which scored the risk as low, medium or high risk. We saw a copy of the hospital risk register and noted each risk identified had a list of associated mitigating actions to reduce the risk. In addition, a responsible person was aligned to the risk.
- Staff working in the outpatient and physiotherapy departments were aware of their local risks and actions to mitigate them. For example, physiotherapists told us their highest outpatient risk was lone working. Actions to reduce the risks of lone working included communicating with the outpatient staff to advise them they were alone, rostering two staff on duty wherever possible and finishing clinics earlier in the evening to avoid dark nights.
- The outpatient and physiotherapy departments participated in the hospital's audit programme. This included monthly record keeping, environmental cleanliness and hand hygiene audits. Any performance issues or concerns were escalated and reviewed at monthly departmental and hospital-wide governance meetings. However, the standards of record keeping audit had not identified that consultants signing patient records in the outpatient department did not always follow best practice or hospital policy, and we were not assured that all performance issues were adequately recognised or addressed.
- For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

- **The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Although information systems were secure, some were not integrated. Data or notifications were consistently submitted to external organisations as required.**

- There were electronic systems to manage some data. This included data for training compliance, audits and meeting minutes. Some data was not electronically available to all staff and this included laboratory results for blood tests or wound swabs. This information was accessed and obtained by administrative staff daily, who printed off the results and gave them to clinical staff, so they could be stored with each patients' notes. This was on the service risk register. The nurse in charge checked each day to ensure blood and test results were available in time for each patient's outpatient appointment. Furthermore, senior staff had been liaising with the local acute NHS trust to fix this and we saw electronic access had been granted to the director of clinical services.
- For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

- **Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.**
- Patients' views on their experience of care they had received, were gathered through a variety of methods. Patients were encouraged to complete the online independent 'iWantGreatCare' test, as well as local comment cards. Most feedback highly recommended the service.
- Patients leaving positive feedback received an online response from One Hatfield Hospital thanking them for their comments. Anyone leaving a negative response was contacted and followed up further. Results were shared and reviewed at clinical governance meetings and at meetings with relevant commissioning groups. There were comment card boxes on the main reception for patients to leave feedback.
- We saw patient comments were taken seriously and feedback was used to improve services. For example, staff told us free refreshments were provided to patients when there were delays to their appointment following feedback from a patient.
- Staff were engaged in service development. They told us they were supported by managers in developing ideas for making changes to services and management had an open-door policy for staff to drop in and discuss their ideas or innovations.
- For our detailed findings on engagement, please see the corresponding sub-heading in the surgery report.

Learning, continuous improvement and innovation

- **Staff were committed to continually learning and improving services. Leaders encouraged innovation.**
- There was a culture of improvement in the outpatient and physiotherapy services. Managers told us about ongoing plans to improve their services. Physiotherapists had completed specialist training to provide shock wave therapy for their patients and sports massage therapy had also recently been introduced.
- Nurses discussed plans to increase the skills of nurses and to take on extended skills, for example in punch biopsies for dermatology patients, although this had not been agreed at the time of our inspection.
- For our detailed findings on learning, continuous improvement and innovation, please see the corresponding sub-heading in the surgery report.

Requires improvement

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received and kept up-to-date mandatory training. There were five members of staff in the department, four of whom had recently joined the team and were undertaking their induction training, which included mandatory training. Most staff had completed their induction package.
- The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was a combination of face-to-face training and eLearning. Medicines management training for most of the team had not been completed, the training session had recently been rescheduled. The provider sent us data, which included the outpatients staff, which showed all staff had received mandatory training.
- Staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All staff we spoke with could describe the special needs of the patients attending the department. They were able to give examples of when the care they provided had been adapted to meet the needs of a patient living with dementia.
- Managers monitored mandatory training and would alert staff when they needed to update their training.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- Staff received training specific to their role on how to recognise and report abuse. This was completed via eLearning. Staff in the department were trained to children's safeguarding level three and adults safeguarding level two. Staff had access to the member of staff trained to safeguarding level five, for advice and support as necessary.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. There was a policy which contained information for staff about whom they should work with if this was necessary.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to a safeguarding folder which helped them make a referral if necessary. However, no referrals had been made at the time of the inspection.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, cleaning records were not always up-to-date.**
- All areas were clean and had suitable furnishings which were visibly clean and well-maintained. Staff cleaned

the equipment appropriately between patient use. The healthcare assistant had received extra training in order to clean the ultrasound scanner probe between patients.

- Cleaning records were not always up-to-date. We saw the magnetic resonance imaging (MRI) cleaning schedule was completed only until 28 June 2019. There was no record of cleaning on the day of our inspection or the previous day. However, the department was visibly clean.
- Staff followed infection control principles including the use of personal protective equipment (PPE). We saw there was sufficient PPE for staff to use in the department.
- Hand hygiene audits demonstrated good compliance with hand hygiene. The dashboard showed between April and June 2019 compliance was between 90 and 100%. We saw staff wash their hands appropriately.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean stickers' were available and applied to most pieces of equipment we saw.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, documentation did not always show equipment had been handed back to staff following maintenance.**
- The design of the environment followed national guidance. The imaging unit was purpose-built in 2017. Although a previous radiological protection report in 2017 recommended that radiation trefoil (internal radiation) signs with the warning of radiation in progress should be placed on the doors of rooms at eye level, there were still no warning signs at eye level or evidence that this had been considered. In the MRI scanning room, the magnetic field lines were highlighted.
- The radiology lead had an understanding of the 'Control of Electro Magnetic Forces at Work' (CEMFAW) regulations but there was no written guidance on this for other staff. Staff were aware metallic objects should not be taken into the MRI scanning room and in the event of a cardiac arrest they would move the patient out into the holding area. There was no policy for preventing the cardiac arrest team from entering the MRI scanner. However, we raised our concerns and following our discussion the radiology lead introduced systems to reduce the risk of this. This consisted of the receptionist reminding the resuscitation team on arrival not to enter the MRI scanning room.
- Staff carried out daily safety checks of specialist equipment. However, we found some of the daily checks were not recorded. When equipment failed, staff completed a fault log which had actions assigned to the entries. There was no note of how these faults had been resolved. When a piece of equipment had been serviced or repaired there was a process where the engineer "handed back" the equipment to staff. We reviewed these records and found there was no handover documented on the MRI scanner in the last year. Other pieces of equipment had a documented handover to staff.
- The service had suitable facilities to meet the needs of patients. Changing rooms and toilets were available to patients including a disabled toilet.
- The service had enough suitable equipment to help them safely care for patients. The department had oxygen cylinders available but there was no mask or tubing immediately available for use.
- Staff disposed of clinical waste safely. Clinical waste bins were checked and labelled appropriately.
- The service had a radiation protection adviser and medical physics expert. The service had a contract with an external company who provided staff with medical physics advice. This company provided an annual report on the department. The report reviewed processes and gave recommendations on action required to meet national guidance.
- Lead aprons limited exposure to radiation to keep staff safe. We saw lead aprons available in all appropriate areas of the imaging department and theatre department. Lead aprons were visibly inspected and audited but there were no radiological imaging checks of lead aprons to screen for defects.
- Staff had dose badges to record radiation exposure. These were monitored, and no one had exceeded recommended doses. However, staff who were not permanent members of the radiological team were not provided with dose badges, and there was no agreement with local NHS trusts about the monitoring of surgeons exposure to radiation, who used imaging in surgical procedures.

Assessing and responding to patient risk

Requires improvement

Diagnostic imaging

- **Staff did not robustly complete risk assessments for each patient and remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration. However, there was a lack of policy for the resuscitation of patients in the MRI scanning room.**
- The hospital used the national early warning score tool to assess deteriorating patients. However, inpatients who required imaging would be seen by staff from the department on the ward. If a patient deteriorated in the department, staff used the emergency call bell to summon medical help. Staff had undertaken checks on the responsiveness of medical attention prior to our inspection and in 2017. The response time in July 2019 was one minute which was a timely response.
- There was no policy for preventing the cardiac arrest team from entering the MRI scanner. However, we raised our concerns and following our discussion the radiology lead introduced systems to reduce the risk of this. This consisted of the receptionist reminding the resuscitation team on arrival not to enter the MRI scanning room.
- Staff did not always complete risk assessments for each patient on arrival although they used recognised tools. Staff completed a five-point checklist prior to scanning or taking images. The provider sent us a dashboard of audits completed which demonstrated these checks were 100% completed (Source: Additional Evidence Request, DR1). However, we observed these five steps were not always completed. We saw three patients receiving imaging services and found one was not asked about the clinical indication for the test, one was not asked about potential pregnancy and one was not asked about previous imaging services. We reviewed the checklist which was to be completed by the referring clinician and found this was not completed.
- Staff did not always know about and dealt with any specific risk issues. For example, staff were not clear about who they would escalate a potential pregnancy to. When prompted by inspectors staff stated they would discuss this with the radiologist and the referring clinician.
- Staff shared key information to keep patients safe when handing over their care to others. Imaging reports were reviewed within 48 hours and reports sent to the referring clinician.

Radiology staffing

- **The service had enough radiographers and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.**
- The service had enough radiographers and support staff of all grades to keep patients safe. The service had appointed to all positions but were awaiting the start of a new radiographer at the time of the inspection.
- Managers accurately calculated and reviewed the number and grade of radiographers, and healthcare assistants needed for each shift. The manager reviewed the booked appointments and ensured the correct staff with the necessary skills were on duty.
- The manager could adjust staffing levels daily according to the needs of patients by using their bank staff.
- The service had reducing vacancy rates.
- The service had reducing turnover rates. There had been significant turnover in the staffing of the department with only one member having been in post more than three months at the time of inspection.
- The service had low sickness rates.
- Managers limited their use of bank staff and requested staff familiar with the service.
- Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment**.
- The service had enough medical staff to keep patients safe.
- The service had a good skill mix of medical staff available and reviewed this regularly. The service had radiologists with a variety of skills and experience to review images. The radiologists worked on a rota basis from Monday afternoon to Friday afternoon.
- The service always had a consultant on call during evenings and weekends. Staff told us they would contact the most appropriate radiologist to review images and support them outside of normal working hours.

Records

Requires improvement

Diagnostic imaging

- **Staff did not keep detailed records of patients' care and treatment. Records were not always stored securely but were easily available to all staff providing care. However, some healthcare records were missing from patient files.**
- Patient notes were not always comprehensive, but all staff could access them easily. Requests for imaging were paper based and scanned onto the electronic system. However, when we reviewed patients who had contrast injected during MRI scanning, we found only one patient out of five had records of contrast being administered because not all notes were kept or scanned onto the patient management system.
- Records were stored securely from May 2019. Staff told us that previously patient records were left in the scanning room and therefore not in a secure location. When the new radiology lead came into post they ensured these records were scanned onto the electronic record system. When we reviewed some of these previous records we found documentation was missing from the patient record. Therefore, we were not assured records had been stored securely prior to the new radiology lead coming into post.

Medicines

- **The service had systems and processes to safely administer, record and store medicines. However, we found prescriptions were not always correctly completed and temperature checklists for medicine storage were not always up-to-date.**
- Staff followed systems and processes when safely administering, recording and storing medicines. Staff monitored the stock of medicines and when administering contrast had appropriate medical supervision in place. However, we reviewed the prescription forms for contrast medication which were pre-printed. We found one prescription where the radiologist had signed the prescription form but had not indicated the medicines to be given. Staff informed us they had discussed the prescription with the radiologist prior to administration. We reviewed records of four other patients where contrast had been given, no prescription forms had been scanned into the electronic patient record system. Therefore, we could not be assured the process for prescribing imaging contrasts in the department was robust.
- Staff stored and managed all medicines in line with the provider's policy. Medicines were stored within a locked cupboard. The key was generally kept in a keypad-controlled cupboard in the department. However, on the day of our inspection the key was left unattended in the imaging room. The service did not hold any controlled drugs. Daily monitoring of temperatures where medicines were stored was not always recorded. One log showed the temperature had been checked on 26 June and again on 1 and 2 July. However, no other dates were recorded as having been checked. A further monitoring log had irregular recording during May and April but had improved in June and July 2019.
- Staff followed current national practice to check patients had the correct medicines. Staff checked with the patient and their name band when administering medicines in the imaging department.
- For our detailed findings on medicines, please see information on this sub-heading in the surgery report.

Incidents

- **The service managed patient safety incidents well. Staff knew how to recognise and report incidents and near misses**
- The department had not reported an incident in the previous three months. However, staff were knowledgeable about an incident that occurred prior to the change in personnel within the department. There was learning from this incident which the imaging lead was enacting.
- All staff knew what incidents to report and how to report them. There was a hospital wide policy for staff to refer to.
- The service had no never events in the department.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.
- Managers would debrief and support staff after any serious incident.
- Managers knew how to investigate incidents thoroughly. Patients and their families would be involved in these investigations.
- Staff had received feedback from investigation of incidents, both internal and external to the service.
- Staff met to discuss the feedback and look at improvements to patient care. This would be incorporated into further team meetings.

Requires improvement

Diagnostic imaging

- There was evidence that changes had been made as a result of feedback. Following an incident in theatre, the theatre manager had planned to undertake radiological protection training for theatre staff.

Are diagnostic imaging services effective?

Good

We do not rate effective for diagnostic imaging services.

Evidence-based care and treatment

- **It was unclear if the service provided care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Following our inspection, we were sent up-to-date policies.**
- Staff followed policies to plan and deliver high-quality care that were not up-to-date or met best practice and national guidance. During inspection we saw therefore they did not reference the most recent national guidance relating to imaging in the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER 2017) and Ionising Radiation Regulations 2017 (IRR 2017).We were concerned that although there had been an audit of the department in 2018, this failed to recognise the references had been superseded. This meant the policies we were shown were missing policies to address new guidance, such as those relating to the monitoring of radiation of carers and comforters or a record of those staff who may have to hold a patient for x-ray.
- Local rules were out-of-date and were not signed off by staff working in the department. We saw there was an IRMER 2017 employers procedures, with a list of documents for staff to review however, there were no documents attached.

Nutrition and hydration

- **Due to the nature of the service provided, the assessment of patients' nutrition and hydration needs were not formally assessed by the service.**
- Meals were not provided due to the short length of time patients spent in the department. Water was available for patients and visitors in the waiting rooms. Hot drinks and refreshments were available in the hospital's coffee shop. We heard every patient was offered a drink of water as they waited in the department.

Pain relief

- **Staff in diagnostic imaging did not provide patients with pain relief. However, they made sure patients were as comfortable as possible when undertaking imaging services.**

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. However, managers did not always use the results to improve services.**
- The service participated in all relevant local clinical audits. These included imaging errors and complications, imaging cannulation, evaluation of imaging in theatres and imaging quality assurance. From January to June 2019, the performance dashboard showed the service scored 90% or more for compliance against all quality indicators (Source: Additional Evidence Request, DR1). However, managers did not always use the results to improve services further. We saw the World Health Organisation (WHO) surgical safety checklist audit compliance in May 2019 was 57%. However, there was no plan in place to improve compliance amongst the medical staff. The department was compliant in other audits as listed in the surgery section of this report.
- Managers shared and made sure staff understood information from the audits. This was done through team meetings.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, there was limited documentation to support the assurance of competencies of staff.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Most of the staff had recently joined the team and had provided details of qualifications on application. The manager had a table of staff competencies but had no checklist

or measurement of the competencies of new staff. In particular, there were no competency assessments related to using the image intensifier, mobile x-ray or general x-ray equipment.
- Managers gave all new staff a full induction tailored to their role before they started work.
- Managers proposed to support staff to develop through yearly, constructive appraisals of their work. However, most staff had recently commenced employment at the time of our inspection and therefore their appraisal was not due.
- Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Staff spoke positively about team meetings recently undertaken. They felt well informed and able to contribute to the running of the department.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. One healthcare assistant was being developed to advance their skills within the department.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- The manager attended regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw this through the review of hospital wide minutes of meetings.
- Staff worked across health care disciplines when required to care for patients.

Seven-day services

- **Key services were available seven days a week to support timely patient care.**
- Staff could call for support from doctors and other disciplines, including mental health services, 24 hours a day, seven days a week. Although the department was only open to routine bookings Monday to Saturday mornings an on-call service was facilitated outside of these times.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed consent forms from four patients.
- Staff clearly recorded consent in the patients' records and scanned onto the patient electronic record.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff were able to describe an incident where this had occurred.
- Staff made sure patients consented to treatment based on all the information available.
- Clinical staff completed training on the Mental Capacity Act achieving the providers target.

Are diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Patients said staff treated them well and with kindness.
- Staff followed policy to keep patient care and treatment confidential.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were able to tell us about a patient living with dementia who was

anxious about their scan. They provided reassurance but when this person became distressed they rearranged the appointment, so a family member could attend. However, the patient became distressed again so in discussion with the referring clinician they decided not to undertake the scan.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- Staff made sure patients and those close to them understood their care and treatment.
- Staff talked with patients, families and carers in a way they could understand.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We reviewed patient feedback forms from May and June 2019. All were positive and would recommend the service to others. Some staff were specifically mentioned for their caring attitude.
- Staff supported patients to make informed decisions about their care.
- A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

Are diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided care in a way that met the needs of local people and the communities served.**
- Managers planned and organised services, so they met the changing needs of the local population.
- The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Staff ensured that patients who walked into the department either received their test or were given a date to attend at a more convenient time.
- Facilities and premises were appropriate for the services being delivered.
- The service had systems to help care for patients in need of additional support or specialist intervention.
- Managers took action to minimise missed appointments and ensured patients who did not attend appointments were contacted. However, there was no formal monitoring of missed appointments. During our inspection a patient did not attend an appointment and staff contacted them. They were on holiday and a future appointment was arranged.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.**
- Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We heard staff made special arrangements for a patient who was living with dementia.
- The service had information leaflets available in languages spoken by the patients and local community.
- Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed.

Access and flow

Requires improvement

Diagnostic imaging

- **People could access the service when they needed it and received the right care promptly.**
- The service was open mainly between Monday and Saturday. Magnetic resonance imaging (MRI) services were provided Monday to Friday 8am to 8pm, and Saturday mornings. However, any examinations requiring contrast were undertaken Monday to Friday 9am to 5pm. Ultrasound provided services Monday to Friday 8am to 8pm. A direct digital x-ray room was open six days per week, Monday to Friday 8am to 8pm, and Saturdays 8am to 3pm. However, there was an on-call service provided by radiographers to cover the 24-hour period seven days a week.
- Managers did not monitor waiting times to make sure patients could access services when needed. However, we found patients were not waiting for procedures and appointments were booked in a timely manner.
- Managers and staff worked to make sure patients did not stay longer than they needed to.
- Managers worked to keep the number of cancelled appointments to a minimum.
- When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff told us this rarely happened.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**
- Patients, relatives and carers knew how to complain or raise concerns.
- Staff understood the policy on complaints and knew how to handle them.
- Managers understood how to investigate complaints and identified themes.
- There had been no complaints relating to the imaging department in the previous year.

Are diagnostic imaging services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership

- **Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, they had limited understanding of the priorities and issues the service faced.**
- The radiology lead had been in post for approximately three months at the time of our inspection. It was clear they had managed immediate priorities and challenges the service faced, including the scanning of records and monitoring of issues. However, they had not reviewed all areas where we found issues, such as the completeness of records for prescribing contrast.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**
- The hospital vision was to provide outpatients and imaging services at a time that was convenient for patients. We saw this in action on the day of our inspection as patients came in to book imaging services and they were accommodated at short notice.
- For our detailed findings on vision and strategy, please see the corresponding sub-heading in the surgery report.

Culture

- **Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.**
- Staff told us they felt able and supported to speak out about issues within the department. Although most of the team had been working together for a short space of time there was an open and friendly culture amongst staff.
- Staff told us how they were being supported to develop through training on different imaging equipment.

Requires improvement

Diagnostic imaging

- For our detailed findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

- **Effective local governance processes were yet to be embedded throughout the service to monitor and assess performance. Regular opportunities to meet, discuss and learn from the performance of the service had yet to commence. However, systems were in place at an organisational level to received information from the service and staff at all levels were clear about their roles and accountabilities.**
- The manager attended the heads of department meetings in order to feed into the hospital wide governance system. They were encouraged to provide information from their department to other managers.
- Systems were in place to ensure information flowed through to senior managers. The radiology lead planned to feedback to the team through staff meetings. The imaging department completed a dashboard which recorded incidents, patient feedback, training and audit data. This demonstrated good levels of compliance with audits and low levels of incidents. However, we were not assured the results of these audits were robust as we found initial risk assessments were not always undertaken.
- We were sent the terms of reference for the ionising and non-ionising radiation safety user group. This document had been reviewed on 1 May 2019. It stated there were biannual meetings of the group. The agenda for the meeting to be held on 5 August 2019 demonstrated that the report from the radiation protection advisor had been discussed at the January 2019 meeting. However, we were not sent any minutes of the discussion had about this report by the safety user group.
- Staff had had a team meeting but minutes of these were not available. We were told the meeting agenda included staffing resources, appraisals, training requirements and other departmental issues.
- Local governance processes were in their infancy and not yet embedded. This was evidenced by the out-of-date policies and lack of completed documentation for cleaning carried out, the storage temperature of medicines, prescriptions for imaging contrasts and lack of competency checking.
- The staff radiation dose reports were incomplete and not available to staff.

Managing risks, issues and performance

- **Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making.**
- The department contributed to the hospital wide risk register. The risk register had five risks identified on it which related to the imaging department. These were all rated at '4' (low risk) apart from one relating to exposure which was rated at '6' (low risk). Risks had mitigating actions in place and were assessed, by the radiology lead, as highly effective. Staff within the department knew what these risks were.
- Staff we spoke with had ideas of how to improve the service and make it even more responsive. They felt able to discuss these with the radiology lead.
- For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

- **The service did not robustly collect reliable data and analyse it. Data was not always in easily accessible formats. This made utilisation of data to understand performance, make decisions and improvements challenging. The information systems were integrated and secure.**
- Information was available in the department however, we found this was not always robust. We were shown policies referencing out-of-date guidance but had been updated. We could not be not assured imaging staff were using the correct policies to inform their practice. Other examples included the lack of action plan in respect of the low score of compliance against the WHO checklist and the lack of minutes from the patient safety user group.
- For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

Requires improvement

Diagnostic imaging

- **Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**
- For our findings on engagement, please see the corresponding sub-heading in the surgery report.

Learning, continuous improvement and innovation

- **All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**
- For our findings on learning, continuous improvement and innovation, please see the corresponding sub-heading in the surgery report.

Good

Endoscopy

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

Are endoscopy services safe?

Good

We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- The endoscopy lead was the only member of staff within the department. They had completed all of their mandatory training.
- All other staff worked within the theatre department on a permanent basis.
- For our detailed findings on mandatory training, please see the corresponding sub-heading in the surgery report.

Safeguarding

- The endoscopy lead was 100% compliant with safeguarding adults level one and two training, and safeguarding children level one and two training.
- Children were not seen within this service.
- For our detailed findings on safeguarding, please see the corresponding sub-heading in the surgery report.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**
- The procedure room was clean and tidy. It was cleaned by the housekeepers after every list. There was a cleaning checklist displayed in the room, this was up-to-date.
- We saw personal protective equipment (PPE) such as disposable gloves and aprons were available. We saw staff were arms bare below the elbows during our inspection.
- Systems and processes were in place for the decontamination of reusable medical devices. The Department of Health (DH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. Endoscopes are lighted, flexible instruments used for the examination of inside the body. All reusable equipment was decontaminated off site. There was a service level agreement in place with an accredited decontamination unit. Clean and dirty flow was maintained well within the procedure room and there was no cross contamination of equipment.
- For our detailed findings on cleanliness, infection control and hygiene, please see the corresponding sub-heading in the surgery report.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**
- The service had four endoscopes which they used. The processes adapted at One Hatfield Hospital were in line with the Department of Health (DH) recommendations. This meant there was a clear system in place regarding the tagging and numbering of endoscopes and their

traceability. The department lead completed a traceability audit, where the notes were checked to ensure equipment stickers were in place. The results were 100% compliant from January 2019 to June 2019.

- All other consumable equipment used in the department was single use. All items that we checked were in-date.
- The endoscopy equipment was newly purchased and up-to-date with its service testing. Staff were aware of how to test the equipment and there were instructions next to the equipment. All equipment was tested prior to a procedure starting.
- All histology samples were sent to the local NHS trust for analysis or an independent laboratory. These were all tracked and traced within a register.
- Staff were trained on equipment used in the department. For example, we saw evidence there was training on a new 'stack system' in January 2019.
- The service completed a bi-annual environmental audit. This was a self-assessment of the environment to ensure it complied with the standards set out to achieve joint advisory group (JAG) accreditation. We saw the audit was completed in December 2018. This showed the service was compliant with most of the standards. They were unable to achieve accreditation as they did not have an electronic endoscopy reporting system to support the service; this was a requirement of JAG accreditation. This had since been approved and was being put into place at the time of our inspection.
- For our detailed findings on environment and equipment, please see the corresponding sub-heading in the surgery report.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient and removed or minimised risks. However, we found vital observation charts were not always completed correctly. The service had taken immediate action to improve this.**
- The hospital used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. There was a WHO 'safer endoscopy checklist' used in the endoscopy procedure room. We looked at five endoscopy patient records and saw for all patients, the WHO checklist had been fully completed.
- The National Early Warning Score (NEWS2) was used to identify deteriorating patients in accordance with National Institute for Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Staff used the NEWS2 to record routine physiological observations, such as blood pressure, temperature and heart rate. The NEWS2 prompted staff to take further action where appropriate, such as increasing the frequency of monitoring vital signs and requesting a review from the resident medical officer (RMO). We looked at five sets of patient records and found the NEWS2 was completed correctly in three out of the five notes. We raised this with the endoscopy lead at the time of inspection. On our unannounced inspection, we saw staff on the ward had received further training regarding NEWS2 completion. The endoscopy lead had also adapted the notes audit to include a monthly review of the completion of NEWS2 charts.
- There was an emergency buzzer within the endoscopy room which if pulled, would sound throughout the outpatient department.
- There was no resuscitation trolley within the room, however they had access to the resuscitation trolley which was kept within the outpatient department. The service had completed a practice emergency scenario where they pulled the emergency buzzer to ensure the team responded promptly; they were satisfied that all emergency responders arrived promptly to the endoscopy procedure room.
- All patients were recovered within the procedure room and transferred post-operatively to the ward or day surgery unit.

Nurse staffing

- **The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**
- There was one full-time registered nurse within the endoscopy department; they were the endoscopy lead. The endoscopy staffing levels for a procedure included two registered nurses, including the endoscopy lead, and one operating department practitioner (ODP). The operating list was always staffed with staff who had experience in endoscopy. One registered nurse and the ODP worked full-time in the theatre department, apart from when they were scheduled to work in endoscopy. The endoscopy lead worked alongside the theatre manager when endoscopy lists were scheduled.

- The patients who have had an endoscopy procedure were cared for post-operatively on the day surgery unit when it was open. When the unit was closed, they were cared for on the ward. The day surgery staffing was coordinated between the ward manager and the endoscopy lead. It was planned in advance during weekly activity planning meetings.
- Staffing levels were appropriate in the department due to the low activity numbers. However, the governance meeting minutes from May 2019 showed discussions around organising an endoscopy recruitment event as the endoscopy lead was the only permanent member of staff in the department. The event was to be scheduled once the activity in the department had increased and there were more regular endoscopy lists scheduled.

Medical staffing

- At the time of the inspection, there were seven consultants employed that undertook endoscopy procedures. They were all under practising privileges within the hospital. This is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital or clinic.
- For our detailed findings on medical staffing, please see the corresponding sub-heading in the surgery report.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- The hospital used a paper-based system for recording patient care and treatment.
- We looked at five sets of patient's records and saw they were generally legible, up-to-date, and stored securely.
- The service used an endoscopy pathway to record the patient journey. This included a pre-operative assessment, infection control risk assessment, dementia screening and patients' medical history.
- Patient records had stickers, which identified the equipment used. This enabled patients to be tracked and equipment identified if a problem became apparent at a later date.
- The service completed an audit of the medical records, however, it did not look at the completion of the pathway; it looked at whether there was a decontamination label present in the patient record, if the WHO checklist was completed and if a specimen had been recorded. There was no overall compliance percentage for the audit, but there was an action to take if needed. We saw that no actions were needed in the audits undertaken from January 2019 to May 2019. On our unannounced inspection, the endoscopy lead had updated the audit to include the medication chart check and NEWS2 completion.
- The endoscopy lead arranged for patient records to be sent to the NHS trust for the multidisciplinary team to review, where indicated. There were no cancer services at One Hatfield therefore the patients' care was transferred to the local NHS trust.

Medicines

- **The service did not always prescribe, give and record medicines well. We were not assured patients always received the right medicines at the right dose and at the right time. The service took immediate action to address this and we saw improvements at the unannounced inspection.**
- Staff generally followed procedures for the safe administration of medicines in line with guidance from the Royal Pharmaceutical Society (RPS), professional guidance on the safe and secure handling of medicines (2018). Staff had access to the hospital's medicines management policy on the intranet. The policy covered obtaining, recording, using, administration, and disposal of medicines.
- We looked at five medicine charts. We found errors on three out of these five. These included no documented dose for three medicines and no prescribers signature for one medicine. The medicine charts were not audited by the service or by the onsite pharmacist. This meant errors might not be picked up or escalated. We raised this with the endoscopy lead at the time of the inspection. During our unannounced inspection, the endoscopy lead informed us they had performed an audit of the medicine charts and found errors such as medicines not being recorded on the pathway correctly. The endoscopy lead had created an action plan which included, further staff training and checking of the notes prior to patient handover to the ward. We also saw the medical records audit had been updated to include a review of the medicine chart and this audit was due to commence in July 2019.
- The service generally followed the British Society of Gastroenterology (BSG) guidelines on safety and sedation for endoscopic procedures (2018). This

ensured patients were monitored throughout their procedure, and while recovering, by an appropriately qualified nurse. There were medicines available in the procedure room for the reversal of sedation.

- The endoscopy lead had identified there was a potential risk of adverse reaction to sedation; this was on the service risk register. They had undertaken a practice emergency scenario to ensure staff responded and they had the appropriate equipment and medicine available. The endoscopy lead stated the outcome was good with no further actions needed.
- We looked at the controlled drug (CD) book and found all controlled drugs were recorded appropriately. The pharmacy department audited the controlled drugs storage and administration on a quarterly basis. The safe and secure audit for March 2019 showed endoscopy compliance was 100%; the previous audit in December 2018 compliance was 96%. This was because there was no key code access to the endoscopy room which meant it could be easily accessible by patients or visitors in the day surgery unit. There was an action plan for a key code to be installed. We saw there was a key code in place.
- When the endoscopy unit was closed, the CD keys were signed in and signed out of the department. This meant there was traceability of the keys; the department was not open seven days a week. The endoscopy lead completed an audit bi-monthly which looked at the compliance. While there was no percentage for compliance documented, we saw there were no issues from the audits for January, March and May 2019.

Incidents

- The unit had an operational policy which detailed how and where to report an incident if it occurred within endoscopy.
- There had been no endoscopy incidents reported between April 2018 to June 2019. The endoscopy lead attended the monthly clinical governance meetings and daily communication meetings where lessons learned from incidents were shared. They said if they had an incident within the service, they would communicate it to all staff at these meetings and via the 'news flash'; this was a newsletter completed monthly by the endoscopy lead to ensure all staff in the hospital were aware of any changes within the department.
- For our detailed findings on incidents, please see the corresponding sub-heading in the surgery report.

Safety Thermometer (or equivalent)

- For our findings on safety thermometer, please see the corresponding sub-heading in the surgery report.

Are endoscopy services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

We do not rate the effectiveness of independent endoscopy services.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence-based care.**
- The service followed Joint Advisory Group (JAG) gastrointestinal endoscopy accreditation standards for endoscopy services. The endoscopy service was working towards JAG accreditation. This is a governing body that assess the quality and standards of endoscopy services in relation to patient care. In order to obtain JAG accreditation, they needed endoscopy reporting software (ERS); this was an essential requirement. This had been ordered by senior management and there had been a meeting with the supplier, but it was not yet in use at the time of our inspection. We saw within July 'endoscopy news flash' that the ERS had been loaded onto the hospital server and they were working out the logistics of the system.
- The service followed the British Society of Gastroenterology (BSG) guidelines for patient management. For example, they used the BSG flowcharts to determine at the pre-operative stage when to stop anticoagulation medication. These were in line with National Institute for Health and Care Excellence (NICE) guidelines.

Nutrition and hydration

- For our findings on nutrition and hydration, please see the corresponding sub-heading in the surgery report.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**

Good

Endoscopy

- All procedures were undertaken with either sedation or Entonox. Entonox is a well-established pain relieving gas mixture. It consists of two gases, 50% nitrous oxide and 50% oxygen. If a patient requested the use of Entonox, a risk assessment, prescription and checklist was completed and kept within the patient file.
- Patients' records showed pain had been assessed using the pain scale within the NEWS2 chart and analgesia was given when needed.
- For our detailed findings on pain relief, please see the corresponding sub-heading in the surgery report.

Patient outcomes

- **The service did not monitor the effectiveness of care and treatment. The service did not collect patient outcomes at present but were aiming to do so once the endoscopy reporting software was in place.**

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- The endoscopy lead had previous experience within endoscopy and had completed specialist training for the role. We saw competencies had been signed off.
- Governance meeting minutes from March 2019 detailed that endoscopy competencies had been commenced. These had been compiled jointly with another hospital within the organisation to ensure standardisation.
- The staff within the department mainly worked within the theatre setting but had previous endoscopy experience. Their appraisals were managed within the theatre department.
- The endoscopy lead was supported by the director of clinical services who held weekly meetings to discuss any support required and assistance needed within the department.
- For our detailed findings on competent staff, please see the corresponding sub-heading in the surgery report.

Multidisciplinary working

- For our findings on multidisciplinary working, please see the corresponding sub-heading in the surgery report.

Seven-day services

- The endoscopy unit was operational from Monday to Friday between the hours of 8am and 8pm. All endoscopy procedures were planned within these hours.
- There was no emergency service available out of hours. Any emergencies would be seen in the local NHS trust.

Health promotion

- For our findings on health promotion, please see the corresponding sub-heading in the surgery report.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.**
- Consent was completed by the consultant on the day of surgery. We saw five sets of patient records which evidenced informed consent had been appropriately sought from patients undergoing endoscopy procedures.
- For our detailed findings on consent and Mental Capacity Act, please see the corresponding sub-heading in the surgery report.

Are endoscopy services caring?

Not sufficient evidence to rate

We did not have enough evidence to rate caring for this service because we were unable to observe any patient care or speak with any patient's on the days we inspected.

Compassionate care

- **Staff respected patient's privacy and dignity, and took account of their individual needs.**
- We were not able to observe any care at the time of the inspection.
- The service worked to maintain privacy and dignity for their patients. As the service was very small, they often had just one patient on the list. Most patient care took place on the ward where the patient had their own room with an en-suite bathroom and they were discharged back to their room after their procedure.
- All patients who underwent a colonoscopy procedure were given 'dignity shorts'.

Good

Endoscopy

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress.**
- All patients with a confirmed or suspected diagnosis of cancer were informed, ideally with the support from an accompanying relative or carer. This would be done within a private clinical room or within the patients private bedroom on the ward. They would meet with the consultant to enable the information and diagnosis to be discussed in detail. The consultant would alert the cancer multidisciplinary team (MDT) at the hospital where they held their NHS practice and added the patient to the cancer pathway.

Understanding and involvement of patients and those close to them

- We were unable to gather any evidence for this sub-heading.

Are endoscopy services responsive to people's needs?

(for example, to feedback?)

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- For our findings on service delivery to meet the needs of local people, please see the corresponding sub-heading in the surgery report.

Meeting people's individual needs

- **The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- The service ran the pre-operative assessment clinic alongside the consultant clinic on a Tuesday evening. This meant patients could have their pre-assessment straight after seeing the consultant if required.
- We were told the service had not yet cared for any patients with dementia or learning disabilities. The endoscopy lead completed a pre-operative assessment for each endoscopy patient. Within the pathway, there was a dementia screening tool. If this was found to be positive, the patient would be asked to attend the hospital for a face-to-face assessment prior to their procedure. If required, the endoscopy lead was able to seek advice from the dementia link nurse within the hospital. If the patient was deemed appropriate for their procedure at the hospital, this would be planned in advance to ensure support the patient required was available. All departments would also be informed within the daily communication meeting.
- All patients were required to have a responsible adult at home with them after discharge from the hospital for 24 hours following intravenous sedation. This was discussed with the patients at the pre-operative appointment. If they were unable to provide an escort for the 24 hours, this would be escalated to the senior management team who would consider an overnight stay on the ward.
- Most patients were cared for pre and post-operatively on the ward within a single patient side room. This meant their privacy and dignity was preserved. This was important for certain procedures, such as colonoscopy, where patients required bowel preparation medicine.

Access and flow

- **People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**
- The hospital monitored the number of cancellations and procedures that were delayed. Any patients who were cancelled by the service were rebooked as quickly as possible. Cancellations were discussed within the clinical governance committee meetings and actions for improvements were put in place. There had been no cancellations of patients who required an endoscopy procedure.
- For our detailed findings on access and flow, please see the corresponding sub-heading in the surgery report.

Learning from complaints and concerns

- There were no complaints received for the endoscopy service at the time of inspection.
- The endoscopy lead stated they were looking to implement their own feedback survey for patients, but this was not in place at the time of our inspection.

Good

Endoscopy

- For our detailed findings on learning from complaints and concerns, please see the corresponding sub-heading in the surgery report.

Are endoscopy services well-led?

Good

We rated it as **good.**

Leadership

- **Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**
- The service was managed by the endoscopy lead. They had previous experience in endoscopy and had good knowledge of running the service. They were line managed by the director of clinical services. The endoscopy lead did not line manage any staff.
- The endoscopy lead attended a monthly meeting with the senior management team. They received an update on the hospital, clinical changes and gave an update to senior managers on the endoscopy service. For example, December 2018 minutes detailed how the first endoscopy case had taken place and it had gone well. The lead discussed a member of the theatre team who was interested in working in the endoscopy unit and gave assurance that the member of staff would be fully trained to assist.
- The endoscopy lead completed a monthly endoscopy 'news flash' which was emailed to all staff and displayed outside the endoscopy procedure room. This was to raise awareness of any changes in the department or to tell staff about procedures. For example, April 2019 'news flash' informed staff there was a new process for the dispatch of endoscopes. The process was displayed in all the sluice areas and the lead asked staff to familiarise themselves with the process.
- The service lead attended a cross site heads of department meeting. This had happened twice since the hospital had opened in December 2017. This enabled the service lead to meet with the endoscopy lead at the other hospital site and share information and ideas. For example, they were creating an endoscopy specific feedback questionnaire for patients which was going to be shared with the endoscopy service at One Hatfield.

Vision and strategy

- **The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.**
- The service had developed their own vision and strategy. It was to:
- Create brand awareness with local communities, GPs and consultants.
- Provide a safe and efficient service that meets regulatory requirements.
- Create an enjoyable working environment for our staff and consultants.
- Build a strong working relationship with our colleagues in the NHS.
- Build our patient numbers in all activities.
- The strategy was displayed outside the endoscopy procedure room. They also displayed their philosophy. This was, 'We are committed to provide the highest quality of care to our patients in a safe and friendly environment. We aim to provide an innovative, efficient, high-quality professional service based on the principles of mutual respect and compassion for each individual. We believe that every patient is a unique and special person who has the right to considerate care and safeguard their cultural, psychological and spiritual needs. We in the endoscopy department have an ethical responsibility to the patients and we service to safeguard their privacy, dignity and confidentiality'.
- For our detailed findings on vision and strategy, please see the corresponding sub-heading in the surgery report.

Culture

- For our findings on culture, please see the corresponding sub-heading in the surgery report.

Governance

Good

Endoscopy

- **Leaders operated effective governance processes, throughout the service. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**
- The endoscopy lead attended the hospital clinical governance meetings and gave an update on the department. The meeting minutes showed progression within the department. For example, in January 2019, the endoscopy lead discussed the need for an endoscopy reporting software which was essential for Joint Advisory Group (JAG) accreditation. May 2019 minutes showed this had been approved.
- In January 2019, the unit had a mock Care Quality Commission (CQC) inspection. This enabled them to look at processes and make improvements where required. We saw an action plan for the improvements needed. For example, a 'weakness' found was controlled drug (CD) checks. There was an action which said they had spoken to the chief pharmacist and were putting a more robust system in place which included recording in the CD book when the unit was closed and using a sign in and out record for the keys for traceability. We saw this had been communicated to staff via the 'news flash' and during our inspection we observed this had been implemented.
- The service displayed their objectives which included governance objectives. These were to implement any actions from annual reports, including infection prevention and control (IPC) and health and safety, to share learning from incidents and to introduce endoscopy specific quality audits. They had a specific audit of the environment in line with JAG accreditations.

Managing risks, issues and performance

- **Leaders had started to use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**
- The service had their own risk register. This was up-to-date at the time of our inspection and showed the progression of mitigating risks. For example, they had received a field safety notice for their gastroenterology scopes in relation to the pre-flushing of them and that this could be a risk to patient safety. The service immediately implemented an action which included purchasing a flushing pump. They informed the consultants of the field safety notice and the action they had taken to resolve this. The service was now fully compliant with best practice recommended flushing practices. The risk register did not rate the severity of the risks but showed clear mitigations and actions taken to reduce the risks.
- The endoscopy lead had also identified a risk of an adverse reaction to sedation. The need for a practice emergency test to ensure the emergency team were available had been identified. The service performed a live drill which showed the team were prompt in their arrival to the department and the resuscitation lead was confident with the response time of the emergency team.
- There were local safety standards for invasive procedures in place in line with national guidance. These were displayed on the notice board for staff to see and detailed in the standard operating procedure document. For example, the completion of the five steps to safer surgery.
- For our detailed findings on managing risks, issues and performance, please see the corresponding sub-heading in the surgery report.

Managing information

- **The service did not collect data and analyse it. This was being developed by the service at the time of the inspection.**
- The service had recently purchased endoscopy reporting software (ERS) which would enable staff to record and report patient outcomes to the national endoscopy database (NED). This would mean they could benchmark their service against other providers and improve quality assurance in endoscopy.
- For our detailed findings on managing information, please see the corresponding sub-heading in the surgery report.

Engagement

- Patients' views on their experience of care they had received were gathered through a variety of methods, such as the online independent 'iWantGreatCare' test and comment cards. At the time of our inspection there was no specific endoscopy patient survey. However, the endoscopy lead told us they planned to introduce one soon, when they commenced the process for JAG accreditation.

- The endoscopy lead engaged with staff by sending out a monthly 'news flash' report. This ensured staff were updated on the department changes.
- For our detailed findings on engagement, please see the corresponding sub-heading in the surgery report.

Learning, continuous improvement and innovation

- **Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.**
- Managers were focused on continuous improvement and quality. The endoscopy lead was responsive to concerns and performance issues raised and sought to learn from them and improve services. They took immediate and effective actions to address some of the concerns we raised during our inspection. For example, we found some medicines were not prescribed or given correctly during our review of patient records. At the unannounced inspection, the endoscopy lead had completed an audit and found similar issues. They were arranging further training for staff, had adapted the monthly medical records audit to include a review of the medicine chart and ensured notes were checked prior to the patient being transferred to the ward.
- The service was still developing as it had only been completing procedures since December 2018. They had plans in place to collect patient data and patient feedback in order to inform the service and make improvements where needed.

Outstanding practice and areas for improvement

Outstanding practice

- Catering department staff went above and beyond to ensure patients' nutritional needs and preferences were met. They spoke to patients' to check if they had any food allergies and/or specific dietary requirements. They had developed a wide range of specific menus to meet patients' religious, cultural and health needs, as well as individual preferences including halal, kosher, vegan, African Caribbean, gluten free, low-residue and fork mashable. The department also supported staff to lead healthier lives by producing low-calorie, healthy meals for them to support those trying to lose weight.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure diagnostic imaging staff undertake all patient risk assessments including the five-point checklist, and document that these have been completed in patient records. Regulation 12(1)(2)(a)(b).
- The provider must ensure all medicines are prescribed, given and recorded in line with best practice guidance and hospital policy. Regulation 12(1)(2)(g).
- The provider must ensure all patient records are signed, dated and stored in line with best practice and hospital policy. Regulation 17(1)(2)(c).

Action the provider SHOULD take to improve

- The provider should ensure all patients receive a copy of their consent form which clearly sets out the risks and benefits of the proposed procedure.
- The provider should ensure all patient records including vital observation charts (NEWS2) and safer surgery checklists are fully completed.
- The provider should invite the effected patient/family members to inform the terms of reference for serious incident investigations and offer them the opportunity to comment on the findings and recommendations made in the final investigation report.
- The provider should ensure medicine errors and omissions are promptly fed back to staff.
- The provider should consider improving facilities for children, young people and adolescents attending the diagnostic imaging and outpatient departments.
- The provider should ensure all staff using point of care testing, including blood glucose monitoring equipment, have appropriate training.
- The provider should ensure the standard operating procedure for checking point of care equipment, including blood glucose monitoring equipment, reflects manufacturers guidance.
- The provider should ensure there is enough resilience built into staffing levels in the outpatient department to cover all the hours required, without relying on staff working increased hours.
- The provider should consider the recommendations from the radiation protection advisor and ensure that where audits highlight deficiencies action plans are in place.
- The provider should embed local governance systems in the diagnostic imaging department.
- The provider should ensure there are clear processes for identifying risks, issues and performance in the diagnostic imaging service.
- The provider should consider introducing leadership and development programmes for staff.
- The provider should use audit results in the diagnostic imaging service to make improvements where needed.
- The provider should monitor and audit patient outcomes within the endoscopy service.
- The provider should ensure the risk register for the endoscopy service includes risk scores for the service to measure the severity and act on risks appropriately.
- The provider should ensure heights and weights are documented in the records of all children and young people who use the service.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance