Nuffield Health Wolverhampton Hospital

Quality Report

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

Ratings

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

Overall summary

Nuffield Health Wolverhampton Hospital provides a range of clinical services including orthopaedics, ophthalmology, oncology, ear, nose and throat (ENT), gynaecology and general surgery. It has two operating theatres of which one has a laminar flow system, which is a system to control air and reduce infection during operations. There are 27 en-suite bedrooms and two

Summary of findings

chemotherapy rooms on the second floor and the hospital has a diagnostic suite offering mammography, fluoroscopy and general x-ray. It also offers 10 consulting rooms within the outpatient department.

We carried out an announced inspection visit on 14 September 2016 and an unannounced inspection on 19 September 2016. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led. Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took into account what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We conducted a comprehensive inspection at Nuffield Health Wolverhampton Hospital as part of our independent healthcare inspections programme. The inspection was conducted using the CQC's new methodology. The inspection team inspected the following core services:

• Surgery

• Outpatients and Diagnostic imaging (including chemotherapy treatment).

The hospital carried out minimal medical care service activity but had recently introduced chemotherapy treatment services. The service was small and in its infancy at the time of the inspection and did not warrant its own separate report. Therefore, chemotherapy services were inspected and reported as part of the outpatients and diagnostic imaging service.

Prior to our inspection visit, we considered a range of quality indicators captured through our monitoring processes. In addition, we sought the views of a range partners and stakeholders.

Key elements of this process were focus groups with healthcare professionals and feedback from the public.

We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection, we reviewed services provided by Nuffield Health Wolverhampton Hospital in the ward areas, operating theatres, outpatients, pharmacy and imaging departments.

We observed how people were cared for and reviewed patient records of 16 patients. We spoke with 12 patients and their relatives, 26 staff, including consultants.

We collected 69 completed comment cards by people attending the hospital. There were 68 (98.5%) positive comments recorded on the feedback. Only one negative comment was noted.

Our key findings were as follows:

Overall, we rated the hospital as Good

We saw several areas of good practice including:

- There was a good induction process for new and agency staff.
- We saw a positive incident reporting culture with good quality incident reports.
- The medicine management system and safety checklists were good.
- We saw supportive managers at all levels and staff told us they were visible and approachable.
- There was protected swipe card access in areas of the diagnostic imaging department.

However, there were areas where the provider needs to make improvements.

The provider should;

- The provider held records securely however; they had no tracking tools in place to prevent loss of patient notes when consultants took them offsite.
- Work towards recommended guidelines such as the Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises when carrying out minor procedures outside of the main theatre areas.
- Ensure mandatory training for Immediate Life Support (ILS) is kept up to date.
- The hospital had no written procedure for covering consultants when on leave or unavailable. Consultants verbalised their availability to OPD and Diagnostic Imaging staff as an informal process. We saw this arrangement as not a robust system and needed to be strengthened.

Following this inspection, we told the provider that it must take some actions to comply with the regulations

Summary of findings

and that it should make other improvements. We also issued the provider with a requirement notice that affected surgery and outpatients. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Overall, we rated surgery services at Nuffield Health Wolverhampton as good because; • There were no never events, deaths or serious incidents in the last reporting period. • All staff were committed to reporting incidents and there was shared learning from incidents across teams and other Nuffield hospitals. The hospital thoroughly investigated incidents, completing root cause analysis on incidents graded as moderate or above. • Infection rates were low; there were no incidents of Escherichia (E-Coli), Clostridium-Difficile (C-Diff) or Methicillin-Resistant Staphylococcus Aureus (MRSA) in the period leading up to inspection. • Mandatory training was ongoing and well attended. • The hospital followed a comprehensive audit programme, which included an action plan for any actions identified. • Multidisciplinary working was evident across the service. There was a person centred approach to care, with the hospital staff recognising individual needs and provision of choice. • Staffing levels kept people safe. • Patients told us they were happy with the service they received. Patients told us the hospital informed them about their treatment and told them what to expect when discharged. • Staff recognised vulnerable patients and that additional support might be required on leaving hospital. • Complaints rates at the hospital were low. When the hospital received complaints, they took them seriously, responded to them and shared them across the organisation. • Patients could access surgery in a timely manner. Ninety per cent of patients began treatment within 18 weeks of referral.

Summary of findings

- Staff told us leaders were approachable and they were happy to work at the hospital. The rate of staff turnover for nurses in theatre was low. There was a well-established Medical Advisory Committee (MAC).

The hospital had robust systems to improve performance such as regular audits and learning from complaints and incidents.

Services for children and young people

The hospital had suspended these services before the inspection.

Outpatients and diagnostic imaging

Overall, we have rated the outpatients and diagnostic imaging department as good. We rated safe, caring and responsiveness as good and well led as requires improvement. We do not have sufficient evidence to rate effectiveness.

- Infection prevention measures were in place and we saw staff adhering to 'arms bare below the elbow' guidelines.
- All areas we inspected were visibly clean and the infection prevention lead carried out regular hand hygiene audits in the department.
- The hospital regularly serviced and checked equipment within the department.
- The hospital securely stored medicines and staff checked the stock within the department.
- The department had clear processes for reporting incidents.
- The management of the department discussed incidents locally and with senior management.
- The hospital had processes in place to escalate concerns in the event of deteriorating health of a patient.
- The hospital had medical cover from a resident medical officer (RMO) 24 hours a day. In addition, staff within the department had access to on-call radiographers' out-of-hours.
- Patient feedback was very positive about the hospital environment and treatment received. Patients told us that staff were kind and caring. We witnessed good staff interactions with patients during our inspection and noted that relatives were included appropriately in consultations.

Good

Summary of findings

- A new chemotherapy service was introduced into the hospital and was in its infancy. The service was small but provided safe care and treatment to patients.
- The department had chaperone options available to all patients. A chaperone is a person who acts as a witness for both a patient and a medical practitioner and as a safeguard for both parties during a medical examination or procedure.
- The department exceeded its target for referral to treatment times (RTT) during April 2015 to March 2016.
- The hospital had a clear strategy and values, which staff embedded.

Summary of findings

Contents

Good

Nuffield Health Wolverhampton Hospital

Services we looked at

Surgery; Outpatients and diagnostic imaging (including chemotherapy treatment).

Summary of this inspection

Background to Nuffield Health Wolverhampton Hospital

Nuffield Health Wolverhampton opened in 1978 and is set on a hill within six acres of woodland. The main building was previously a Victorian mansion known as the Gables. The hospital is situated approximately five miles from the Royal Wolverhampton NHS Trust and is convenient for both consultant access and patient transfer if required. There is a main bus route into the centre of Wolverhampton and the train station is approximately a 10-minute drive away.

The hospital provides a range of clinical services including orthopaedics, ophthalmology, oncology, ear, nose and throat (ENT), gynaecology and general surgery. It has two operating theatres of which one has a laminar flow system, which is a system to control air and reduce infection during operations. There are 27 en-suite bedrooms and two chemotherapy rooms, on the second floor and the hospital has a diagnostic suite offering mammography, fluoroscopy, ultrasound and general x-ray. It also offers 10 consulting rooms within the outpatient department.

Up until August 2016, there has been mobile provision for MRI and CT scanning; however, the hospital has now installed an MRI scanner on site.

The registered manager for the hospital is Karen Pattison she had been in post for eighteen months at the time of our inspection.

Our inspection team

Our inspection team was led by a CQC Inspection Manager and a team of eight including CQC inspectors and a variety of specialists: theatre nurse, chemotherapy specialist and a governance specialist.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Nuffield Hospital, Wolverhampton.

Before visiting, we held staff forums and we reviewed a range of information that was kept about the hospital and each core service.

Information about Nuffield Health Wolverhampton Hospital

The Nuffield Health Wolverhampton Hospital is registered for the following regulated activities. The service became registered for most activities on 26 November 2010.

- Diagnostic and screening procedures (26 November 2010)
- Family planning (7 September 2015)
- Surgical procedures (26 November 2010)
- Treatment of disease, disorder, or injury (26 November 2010)

General Activity

- There were 5,475 inpatient and day case episodes of care recorded at Nuffield Health Wolverhampton in the reporting period (April 2015 to March 2016); of these 46% were NHS funded and 54% other funded.
- Thirteen per cent of all NHS funded patients and 14% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 13,124 outpatient total attendances in the reporting period (April 2015 to March 2016); of these 60% were NHS funded and 40% were other funding streams. 4% were oncology patients.

Summary of this inspection

- The chemotherapy treatment service was inspected and reported under outpatients and diagnostic imaging services and commenced August 2015. Since that time 31 patients were seen and treated in the service

Important note

In the first three months of 2016, every Nuffield hospital had a quality assurance review (QAR). A team made up of a quality care partner, a matron from another hospital and a specialist, undertook the site visit after key performance indicators (KPI's) and other data had been reviewed in advance. A resulting action plan was created for the hospital and because of this review, children's services at Nuffield Health Wolverhampton were suspended in June 2016.

The review identified three areas for consideration which were, lack of paediatric immediate life support training for some staff, no specific paediatric resuscitation trolley and no service level agreement for transfer of children to an NHS trust. The hospital is currently working towards reinstating children's services in the summer 2017.

The following services are outsourced by Nuffield Health Wolverhampton Hospital:

- Catering – private caterer
- Domestic waste disposal – local authority
- Facilities maintenance – private facilities company

Surgery

Nuffield Health Wolverhampton provides both day surgery and inpatient treatment for patients across a range of specialties. Surgical specialities and procedures include primary hip and knee arthroplasty, spinal, breast, urological, cranial and vascular surgery. The hospital currently provides care and treatment for adults over 18 years only. Between April 2015 and March 2016, the hospital had 4,006 visits to theatre and 742 inpatient admissions.

The most common procedures undertaken at the hospital are cataract operations, joint injections and diagnosis of stomach problems using endoscopic investigations.

Surgical patients are admitted to one of the ward's 27, en-suite rooms and operated on in one of the two operating theatres; the hospital also has an endoscopy suite.

Outpatients and diagnostic imaging

The outpatient department at Nuffield Health Wolverhampton Hospital consists of a diagnostic suite offering magnetic resonance imaging (MRI), computerised tomography (CT) currently being delivered by a third party as a mobile service, ultrasound, fluoroscopy, mammography and general x-rays.

There are 10 consulting rooms in the outpatient department.

Speciality consultations are available in numerous fields, including cardiology, gynaecology, breast cancer, general surgery and chemotherapy with plans to expand the oncology service. Patients have access to a minor procedures room and an ear, nose and throat (ENT) suite.

The Children and Young Person service (CYP) consisted of outpatient consultations and radiology screening only. Elective day case procedures had been suspended following a review of the service. The main specialities available for consultation only were ENT, general, urology and orthopaedics.

The Nuffield Health Wolverhampton Hospital outpatients department operates between 7.30am to 7pm Monday to Friday, with appointments offered at weekends depending on the demand.

Between April 2015 and March 2016, the outpatients department saw 13,123 patients of which 214 were children under 18–years old and 12,909 were adults. The data provided by the hospital showed that 60% of patients were NHS funded and 40% were other forms of funding.

We inspected chemotherapy care and treatment as part of outpatient and diagnostic imaging services as medical activity at this hospital was minimal and did not warrant a separate report.

Diagnostic imaging provided the following services:

• CT

Summary of this inspection

- Fluoroscopy
- General x-ray
- Mammography
- MRI
- Ultrasound

From 1 August 2016 to 31 August 2016, diagnostic imaging services saw 158 adults for MRI and 38 for CT. The service saw 11 children under the age of 18-years for MRI, 16 for ultrasound and nine for X-Ray.

The percentage breakdown of outpatient department specialties are:

- Orthopaedic 40%
- Ophthalmology 20%
- General surgery 9%
- Medical 8%
- Ear, Nose and Throat 6%
- Oncology and Haematology 4%
- Urology 4%
- Other 4%
- Gynaecology 3%
- Oral 2%
- Cosmetic 1%

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 safe as good because:

- The hospital had no never events, deaths or serious injuries in surgery from April 2015 to March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- Healthcare infection rates were low. From April 2015 to March 2016, there were no incidents of Escherichia coli (E.coli), Clostridium difficile (C.diff) or MRSA,
- Patients received MRSA screening as part of the pre-assessment process.
- All staff were committed to reporting incidents. Compliance rates for attending electronic incident training were above the hospital's target of 85%.
- Incident reporting procedures were robust. The hospital discussed incidents at team meetings, heads of department's meetings, the medical advisory committee and senior management board meetings.
- Matrons shared learning across Nuffield hospital sites as part of the Matrons Network.
- The hospital planned, implemented and reviewed staffing levels to keep people safe. Patients told us they felt safe.
- Medicines were stored and accessed securely. Audits showed compliance with the Controlled Drugs (Supervision and Management of Use) Regulations 2006.
- The endoscopy unit has been Joint Advisory Group (JAG) accredited demonstrating that it has the competency to deliver against measures in the endoscopy global rating scale.
- Safety thermometers and audits were used to measure, monitor and analyse patients care.
- The surgical safety checklists were embedded into practice.
- Mandatory training was ongoing and well attended by all staff in all departments.
- Staff were aware of duty of candour, and the requirements of being open to patients.
- Staff were following infection prevention techniques and the environment was visibly clean.
- Equipment was well maintained and in good supply throughout the hospital.
- The service held medical records securely.

Summary of this inspection

However;

- During our inspection, we saw no air-handling unit in place in the treatment room situated within the outpatients department. The document: Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises, recommends 10 air changes per hour in treatment rooms. This was highlighted to senior staff during the inspection; as a result the provider undertook to carry out all lesion removal procedures in the new diagnostic suite which is compliant.
- The hospital had no tracking tools in place to prevent consultants from misplacing patient notes when consultants took them off site. They were currently working to set up a system, an example of this was to photocopy patient's notes that were seen on site and to keep those notes for access if required.

Prior to the inspection the hospital reported there had been 11 surgical site infections (SSI) in surgery between April 2015 and March 2016 from 2,684 procedures. Nine of these infections related to breast surgery. In the weeks following the inspection, the hospital told us that this data was incorrect and following a review of the breast infection data, two patients had been identified as an infection concern. We saw data to support their findings. This was slightly higher than the rate of NHS hospitals (April 10 to March 15) which had a rate on one infection per 100 surgeries performed.

Are services effective?

Good

We have rated this service as good for effective because:

- The service followed a comprehensive audit programme identifying issues and devising actions plans when necessary.
- Staff consistently recorded consent in patients' records.
- The endoscopy department had achieved Joint Advisory Group (JAG) accreditation. This demonstrated the department had the competency to deliver against endoscopy national standards.
- Physiotherapists used a patient centred approach to support patients to meet their goals.
- Staff managed pain and recorded it well.
- Staff met patients nutrition and hydration needs.
- Multidisciplinary working was evident throughout the services.

Are services caring?

Good

We rated this service as good for caring because:

- Staff treated patients with dignity and respect.
- Patients were happy with the care they received and told us nothing was too much trouble for the staff.

Summary of this inspection

- Consultants introduced themselves to patients before treatment; they also asked for preference on how to address the patient.
- Results from the patient satisfaction survey showed an overall satisfaction score of 97%.
- Patients felt informed about their care and knew what to expect on discharge.
- Staff recognised when someone may be vulnerable and arranged for support on discharge.
- Private rooms were available to patients if they wished to discuss any concerns. Patients we spoke with were complimentary about the care staff had given them.
- We received positive comments from patients and their relatives who could not speak highly enough about the service and the staff.
- Patients who visit the hospital as an outpatient are encouraged to complete a friends and family card in the department.
- Patients often used social media to comment on their experience and the hospital regularly monitored these comments both locally and centrally.
- Senior staff discussed patient feedback at department meetings and the hospital board meetings.
- Patients told us that staff always maintained their privacy and dignity.
- Patients told us staff were polite, friendly and supportive.
- The hospital encouraged the use of chaperones and discussed additional requirements upon booking and prior to attendance at the clinic.

Are services responsive?

Good

We rated this service as good for responsive because:

- People accessed care at the right time, waiting times, delays and cancellations were minimal.
- Discharge planning started at pre-assessment stage. The hospital considered support, such as care at home and staff made contact with families or outside agencies, such as social care.
- The ward had a specific room near the nurses' station specifically for patients with dementia. A pictorial book was available for when language barriers presented and for people with communication difficulties.
- Patients accessed surgery services in a timely manner. The hospital monitored how long patients spent in the hospital prior to their appointment.

Summary of this inspection

- The outpatients department provided us with their targets for referral to treatment times for patients seen in less than 18 weeks.
- The hospital provided diagnostics imaging waiting times for Magnetic Resonance Imaging (MRI) and non-obstetric ultrasound.
- Complaints and concerns were low; when the hospital received complaints, they took them seriously, responded to them, shared them across the teams, and improvements were then made as a result.
- All departments had a good understanding on how to handle complaints.
- Patients had access to translation services if English was not their first language.
- The department had private consultation rooms, which meant people could discuss their emotional needs in confidence.

Are services well-led?

Requires improvement

We rated this service as requires improvement for well led because:

- We were not assured the hospital had a robust process in place to ensure there was a complete and up to date set of patient's records on site, which is a legal requirement.

However;

- The hospital was part of the wider Nuffield health organisation and shared in the organisation's four values. These were caring, independent, passionate and enterprising.
- The hospital's vision at a local level was to become the private hospital of choice in the West Midlands, by ensuring high quality care that is safe, effective and personalised to the individual's needs.
- Staff could tell us what the vision for the service was.
- There was a structured leadership in place and staff felt supported.
- Staff told us the leadership team were approachable, that they were happy working at the service and that it was like a family. Staff also felt they could go to a manager of any seniority for support.
- The hospital had procedures to ensure they were able to manage consultant's Practicing Privileges (PP) well.
- There were policies to support the identification and resolution of issues where doctors whose performance, conduct or health may put patients at risk.
- There was a well-established MAC in the service in addition to regular board, head of department and senior meetings.

Summary of this inspection

- The hospital had robust systems to improve performance, which included audit, learning from complaints and incidents, and the collection of national data such as patient reported outcome measures (PROMs).
- There was a proactive approach to monitoring quality and safety within surgery. The service carried out regular audits; when improvements were required; the service management developed actions and shared the learning with staff within the service.
- Innovative practice was evident in outpatient and diagnostic imaging departments

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as good.

Incidents

- The hospital reported that there were no never events, deaths or serious injuries in surgery from April 2015 to March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- There had been 159 clinical incidents within surgery and inpatients in the reporting period April 2015 to March 2016, and 44 in non-clinical incidents in the same period, non-clinical incidents included staff accidents, unacceptable behaviour of staff and staff sharps injuries.
- Staff we spoke with were aware of how to report incidents and how to use the electronic incident reporting system.
- We saw the hospital had a robust system in place to investigate, report, monitor and share learning around individual incidents. Root cause analysis was undertaken for all incidents classified as moderate or above. We reviewed an investigation report from an incident that occurred in December 2015 when a patient was able to hear voices whilst under anaesthetic. During the inspection we saw that recommendations from the investigation had been implemented. For example we saw that the anaesthetist and the practitioner had signed to say they had checked the anaesthetic machine as recommended. The practice of two practitioners checking the machine was identified learning following the root cause analysis in December 2015.
- We reviewed investigation reports, minutes and meeting notes from 2016 and found evidence that incidents and learning from incidents was shared with all staff. Senior managers told us that matrons shared learning across Nuffield hospital sites as part of the matron's network; we did not see any evidence of this at the time of our visit as the matron was new to post.
- The duty of candour is a legal duty on hospital, community and NHS trusts to inform and apologise to patients if there have been mistakes in their treatment that have led to significant harm. There had been no incidents that met the legal threshold for duty of candour at the time of our inspection, but staff were aware of their responsibilities. For example one manager we spoke with was able to give us an example of how they applied the principles of duty of candour when a surgical procedure had gone wrong. The patient received ongoing clinical support and daily telephone calls and a letter of apology. Therefore, the patient was made aware when things went wrong and provided with reasonable support.
- The hospital had no surgical related mortalities in the reporting period April 2015 to March 2016. Healthcare associated infections were discussed at infection prevention meetings that took place on a three monthly basis. Reportable infections and Information such as blood stream infections, infection prevention, and data on knees and hips were discussed in information governance meetings, head of department and Medical Advisory Committee (MAC) meetings.

- Managers told us that the trust fed any morbidity or mortality reviews undertaken into head of department meetings, information governance meetings and that they shared them with the Medical Advisory Committee (MAC).

Safety thermometer

- The Nuffield hospital (Wolverhampton) participated in the National Safety Thermometer for NHS patients and kept a record of these on safety thermometer charts. The safety thermometer is a measure of harm free care delivered to patients relating to pressure ulcers, falls, urine infections (in patients with a catheter), and venous thromboembolism (VTE).
- Harm free care for non-NHS patients was monitored through the hospital audit process. Safety thermometer results were not displayed for staff and patients to see at the time of our inspection. This meant staff and patients were unable to see up to date information as is considered best practice.
- Safety thermometer results for the period March 2016 to September 2016 showed harm free care with the exception of one VTE. The hospital conducted a root cause analysis in relation to this incident and practice was changed as a result.
- The hospital audited compliance rates in relation to assessing patients for the risk of VTE. This was in line with 'National Institute of Health and Care Excellence' (NICE) guidance venous thromboembolism in adults: reducing the risk in hospital. We reviewed an audit completed in May 2016 which showed the hospital achieved 100% compliance.
- VTE screening rates were higher than the target of 95% from April 2015 to March 2016; 95% is the target for NHS patients. We viewed risk assessments in relation to VTE in the patients' medical notes.
- Staff collected and submitted safety thermometer information on a monthly basis (last completed in September 2016), but told us they did not receive any feedback in relation to this. This meant that ward staff did not know how the unit was performing.

Cleanliness, infection control and hygiene

- Healthcare infection rates were low. There were no incidents of E-Coli bacteria, C-diff (a bacterium that can infect the bowel and cause diarrhoea) or MRSA (a type of bacteria that is resistant to a number of widely used antibiotics) from April 2015 to March 2016.Patients received MRSA screening as part of the pre-assessment process.
- The hospital carried out screening for Carbapenemase Producing Enterbacteriaceae (CPE). CPE is a bacterium that usually lives harmlessly in the gut of humans.
- Prior to the inspection the hospital reported there had been eleven surgical site infections (SSI) in surgery between April 2015 and March 2016 from a total of 2684 procedures. Nine of these infections related to breast surgery (57 procedures). In the weeks following the inspection the hospital told us that this data was incorrect and following a review of the breast infection data two patients had been identified as an infection concern. This was slightly higher than the rate of NHS hospitals (April 10 to March 15) which had a rate on one infection per 100 surgeries performed.
- Minutes from the hospital infection prevention committee showed that surgical site infections were discussed at meetings. We reviewed a sample of three root cause analysis investigations completed in relation to surgical site infections. All three identified lessons learned, recommendations and actions to be completed.
  We saw SSI's were supported with an appropriate investigation and root cause analysis and that the infection control lead generally reviewed them to identify trends and learning. However, there was confusion over breast infection numbers requiring a more in depth enquiry to extract the required information. We were therefore not assured that in this case the information had been reviewed.
- We observed and patients told us that staff regularly washed their hands, used alcohol gel and arms were bare below the elbow.
- The hospital had an infection control nurse and each department had an infection control link nurse and a health care assistant. The infection control nurse contacted patients 30 days after surgery to follow up on their wellbeing.
- The hospital had an annual infection prevention strategy in place (2016). The strategy identified key risks and recommendations of how the hospital addressed

these within Nuffield Wolverhampton. The recommendations formed the annual programme for infection prevention and control within Nuffield Health for all hospitals.

- The hospital provided us with a sample of hand hygiene competency tools that staff had completed in August and September 2016; these showed a compliance rate of above 95%. Any staff not meeting this target would have immediate retraining and be reassessed within one month. Hand hygiene compliance in theatre in September 2016 was 94%.
- Staff cared for patients in private en-suite rooms. All areas we visited were clean and well maintained. We saw green stickers on equipment to show the equipment was clean and these were all in date.
- We saw that staff had access to and used personal protective equipment such as gloves and aprons. Alcohol dispensers were readily available and stocked throughout wards, theatres and recovery rooms.
- The hospitals PLACE scores (patient led assessments of the care environment) for cleanliness were higher than the England average by 1%. PLACE is a system for assessing the quality of the patient environment.
- A cleanliness audit tool was in place. Areas audited included resuscitation trolleys, taps and sinks, water dispensers, tables and telephones. We reviewed a cleanliness report from January 2016 to March 2016 and found overall compliance with cleanliness in theatre and the ward to be 89%,this did not meet the trust target of 100%.We saw that the hospital had drawn up action plans to address any issues.
- Sharps bins were available in clinical areas. These were labelled and emptied in accordance with the Royal College of Nursing Guidance to support the implementation of the Health and Safety regulations 2013 (sharps instruments in healthcare).
- We visited the hospital endoscopy unit which was Joint Advisory Group (JAG) accredited, level 1, this meant the hospital had been assessed and the criteria for accreditation had been met. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competency to deliver against measures in the endoscopy global rating scale. The endoscopy unit cleaned and sterilised endoscopy scopes. The scopes were cleaned as part of a three-stage process in accordance with the decontamination guidance outlined in the 'Department of Health: Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. There were segregated areas for dirty and clean scopes in place. The endoscopy staff member we spoke to was knowledgeable in relation to current guidance and able to reference the hospitals decontamination procedure. We saw that staff undertook and recorded daily and weekly testing of equipment.
- The theatre and endoscopy suites appeared clean and tidy; staff told us that an external company regularly cleaned them and that every six months a deep clean took place.
- The theatre department had a clinical waste room with appropriate containers for clinical waste. External companies collected any human tissue and took it off site for incineration.

Environment and equipment

- The hospital had two theatres and one endoscopy suite, one of the theatres had laminar flow (a system for circulating air, reducing the risk of airborne contamination).
- External companies maintained equipment on a yearly basis. We saw equipment was serviced regularly; all equipment we checked had a sticker applied to confirm this. We observed that pressure-relieving equipment was available if needed. The theatre had both a utility room and a storage area. The rooms appeared well organised and clean.
- The theatre had a designated area for changing into scrubs. This was well stocked and easily accessible.
- We visited the minor treatment room as part of our inspection where procedures such as punch biopsy's and drainage of cysts took place. At the time of our visit (September 2016), we found there was no air-handling unit in place. The document: Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises, recommends an air change rate of 10 per hour in treatment rooms. Following our visit the hospital told us they had moved all procedures to a new suite, which had the correct air changes in place.

- Process sets (sterile steel trays with instruments) were prepared in advance and provided by surgery for any procedures that take place the minor treatment room.
- The hospital had a dirty utility room for transferring surgical instruments before returning to theatre for cleaning. This was in line with Department of Heath Guidance: Health Technical Memorandum 01-01: Management and decontamination of surgical instruments (medical devices) used in acute care.
- Emergency call bells were located in each bedroom, including a cardiac alarm in case of a cardiac arrest.
- Staff had access to resuscitation equipment both on the ward and in theatre. We saw that resuscitation trolleys were checked daily and had tamperproof tags on them.
- The ward had a designated medical device library for the storage of equipment still requiring servicing.
- The hospitals' PLACE scores were lower than the England average by 2% for condition, appearance and maintenance. This meant that the hospital scored slightly lower than other hospitals in the period February 2015 to June 2015.
- We read the hospitals latest available cleanliness report dated January to March 2016 in relation to surgery and the hospital ward. The report identified marked ceiling tiles and an interior that needed redecorating. An improvement programme had been initiated by the hospital which included plans for redecoration and refurbishment.

Medicines

- All areas we visited had appropriate lockable storage facilities for medicines, including lockable cabinets in bedrooms for patients.
- The hospital managed medicines safely. Daily checks took place on fridges used for the storage of drugs.
- As part of our inspection we visited an anaesthetic room, we checked the cupboards containing medications and found these were locked. Staff were aware of current guidance on best practice issued from The Royal College of Anaesthetists: Storage of Drugs in Anaesthetic Rooms 2016.The guidance recognises that drug cupboards in anaesthetic rooms containing non controlled drugs may need to remain unlocked when the room is temporarily unoccupied and the operating theatre is in use; this is because even a short delay in accessing drugs may result in an adverse patient outcome. Staff told us to ensure patient safety whilst in the theatre cupboards remained unlocked but closed. The aesthetic room was in a restricted area as it was adjoining the operating theatre. We found that medication in the anaesthetic rooms was labelled and easily accessible.
- Staff administered medicines safely. We saw two nursing staff had signed the controlled drug register for patients prescribed a controlled drug. This was in line with Nursing and Midwifery Council: standards for medication management guidance 2007.
- The patients' prescription charts clearly documented any allergies. We reviewed three medication administration charts and found staff maintained them well, they were clear about the medications prescribed and medications for administration.
- A service level agreement (SLA) was in place for the onsite pharmacy that was open from 9am until 6pm, Monday to Friday. The pharmacist checked stock levels on a daily basis. There was a locked cupboard for medications to take home for out-of-hours discharge. The pharmacist audited stock levels on the ward and in theatre, and controlled drugs in line with the controlled drugs (Supervision of Management and Uses) regulations 2006. They limited and monitored stocks of drugs kept on the ward. The resident medical officer (RMO) and a qualified nurse together could access the pharmacist out-of-hours.
- The nurse we spoke with was aware of where and how to access policies in relation to controlled drugs.
- There was an antimicrobial stewardship policy in place to assist in the administration of antibiotics. The policy provided guidelines in relation to antibiotic prescribing principles, dosages, antibiotic use and patient allergies.

Records

- Staff had written and managed patients' individual care records in a way that kept them safe. On the day of the inspection, we viewed 10 sets of patient records. Records were in paper format and completed appropriately. Records were complete and contained details from admission through to discharge. All 10 records we viewed were, legible, signed and dated.

- There were two sets of notes kept for each patient, these being clinical records and care records. Staff kept clinical records safe in a locked cabinet by the nurses' station. The hospital kept patients' care records in individual bedrooms assuring confidentiality.
- The hospital audited patient records quarterly. Audits we viewed looked at details such as if staff recorded patients' details in full and if staff had signed the entries they made in patient records. An audit completed in April 2016 looked at 13 domains within the healthcare records; the hospital scored 100% in nine of these. Areas for improvement included ensuring the use of the 24 hour clock (30%) and that the admitting consultant or deputy had written a daily entry against observation of the patient in the care or clinical record (15%).
- Allergies were appropriately recorded; we saw on one patient's notes that they were allergic to Non –steroidal anti-inflammatory drugs (NSAIDS).
- We saw a completed signature list of staff that completed observations in the clinical notes.
- Records had appropriate documentation such as, falls tools, pre-assessments, admission information, risk assessments including VTE and nutrition, pain scores, national early warning system (NEWS), pre-operative checklists, MRSA screening, post-operative care plans and notes. We also saw evidence of discharge arrangements, multidisciplinary input by nurses, and physiotherapists and pharmacists. One patient's notes we reviewed had an additional insert in relation to wound management.
- At the time of our visit, no one had a do not resuscitate plan in place.
- All records were integrated and followed the patient from admission through to discharge. We saw audits were in place to monitor the handover of patient care, ensuring it was appropriately documented when transferring between theatre, recovery and the ward.

Safeguarding

- There had been no safeguarding concerns identified at the hospital in the last 12 months. The Matron and the registered sick children's nurses were the identified safeguarding leads for children and adults. Staff knew what to do if they had safeguarding concerns. Staff advised they would speak to their manager or the Matron in the first instance.
- Staff were aware of safeguarding principles and practices. All staff had access to flow charts to aid with decision making and reporting safeguarding concerns. We saw the hospital had displayed flowcharts for safeguarding children and young people on the ward. The flow chart for safeguarding adults was not on display. Staff knew where to access the safeguarding policy and were able to show us a copy of the flow chart at our request.
- Staff had been trained to level 2 in safeguarding children and young adults and level 1 in safeguarding vulnerable adults; this met the hospitals target rate of 85%, this is in line with their mandatory training policy. The hospital had two senior staff members who had completed Level 3 safeguarding training and both were compliant.
- The hospital had one paediatric lead nurse who was developing a future service for children and young people within the hospital.

Mandatory training

- The hospital used electronic learning for the majority of their training. Nursing staff told us they felt supported in relation to training and that they could request training in a certain area if they needed to. One staff member we spoke with was making a request to their manager for further training in dementia. There was no mandatory training in relation to dementia; however, staff were trained around the Mental Capacity Act 2005.
- Mandatory training data from July 2016 showed that theatre and ward staff met their target rate of 85% compliance in all areas except intermediate life support (13% theatre, 45% ward).In the weeks prior to and following the inspection both areas showed significant improvement, achieving compliance rates of 86% in theatre and 92% on the ward.
- Compliance rates for attending electronic incident training were above the hospital's target of 85% for mandatory training. .
- Compliance rates for 'Data level one incident reporting' training in theatre were between 91% and 95%.This met the trust target of 85% or above.

- Staff received mandatory training in safety systems, processes and practice. All staff were required to complete mandatory training on an annual basis and specialised training in clinical roles, the requirements of which were set out in the Nuffield Health training policy.

Assessing and responding to patient risk

- Surgical procedures were only performed on patients who had moderate to low risk scores. Anaesthetists calculated the patients American Society of Anaesthesiologists (ASA) grade as part of their assessment of patients about to undergo a general anaesthetic. The ASA is a system used for assessing he fitness of a patient before surgery and is based on six different levels with level one being the lowest risk. The hospital also had a local admissions policy that specified the admission categories accepted. Patients who required a local anaesthetic received an assessment over the telephone. If staff identified risks at this stage, they invited the patient to a face-to-face assessment to ensure the patient was safe for surgery. The hospital invited all patients having a general anaesthetic to a face-to-face consultation.
- Qualified nurses and healthcare assistants supported patients through the pre- admission process. Patients told us that any risks were fully explained. For example one patient told us that staff had fully explained the risks in relation to bleeding.
- A service level agreement (SLA) and standard operating procedure (SOP) were in place with the local hospital for deteriorating patients needing transfer to an acute hospital setting. Nursing staff had a copy of the agreement and the policy on the ward ensuring they were easy to access. If a deteriorating patient needed a transfer the staff member coordinating the transfer contacted the ambulance service by telephone to request an ambulance.
- Sepsis is a severe infection that spreads in the bloodstream. We saw that there was a sepsis screening tool displayed in the ward area. The hospital had a standard operating procedure (SOP) in place. Staff were aware of the policy and where to locate it.
- The hospital had recently implemented the national early warning scores (NEWS) as recommended by the Royal College of Physicians (RCP). Use of the NEWS ensured staff were alerted early to any deterioration in the patient's condition.
- We observed three surgical procedures and found that theatre staff completed the five steps to safer surgery checklist appropriately. The checklist is a nationally recognised system of checks before, during and after surgery designed to prevent avoidable harm and mistakes during surgical procedures. We reviewed the latest audit on the checklist completed in April 2014, this showed 100% compliance against the target of 85%.
- Patients told us that staff answered the call bells quickly and that staff had told them how to use it. Staff told us they checked on all patients on an hourly basis. We saw staff carrying out regular patient checks during our visit.
- Nursing staff we spoke with were able to describe what they would do if a cardiac arrest took place and showed us the cardiac buzzer system. Staff told us the hospital regularly tested them on their response to cardiac alerts and gave them feedback on how they did. The lead resuscitation nurse from theatre regularly re-educated nursing staff and there was a weekly bleep rota in place if a cardiac arrest occurred. This ensured staff could contact the appropriate professional.
- The resident medical officer (RMO) was based within the hospital grounds and could provide an immediate first response in an emergency.

Nursing staffing

- The ward used a minimum staffing ratio of one registered nurse to five patients (1:5). The hospital only undertook elective surgery. This meant the number of nursing and care staff needed on a particular day could be calculated and booked in advance.
- Staff told us the hospital reassessed and adjusted staffing levels in line with the amount of patients, occupancy, needs of the patient or altered length of stay. At the time of our visit, there were two qualified nurses on duty and eight patients (2:8). Staff told us if the ward required extra staffing, the hospital used bank staff or staff from other areas of the hospital, no concerns in relation to staffing were raised during the inspection.

- There was a two-hour overlap between the morning and afternoon shift with staff handover taking place three times a day. Managers told us this was to help over lunch times and in receiving new admissions to the ward.
- New staff had a minimum of two weeks working as supernumerary, followed by a review at four and 12 weeks. The hospital gave each member of staff a mentor.
- We saw the hospital required agency staff to provide evidence of any training and competencies they had completed.
- We reviewed documentation that showed that agency staff received a thorough induction given by the nurse in charge. The induction included assessment of competencies such as using medical devices, hand hygiene techniques and the application of dressings. Managers told us that they tried to use the same bank or agency staff whenever possible to ensure continuity of patient care.
- Use of bank and agency nurses working in theatre departments was consistently lower than the average of other independent acute hospitals we hold data on: the average being 18% during the reporting period April 2015 to March 2016.
- Staff turnover was 17% for theatre nurses and 20% for theatre OPD's during the reporting period April 2015 to March 2016.
- The latest data received from the hospital showed there were 1.6 full time equivalent (FTE) nursing posts vacant as of April 2016. There were no posts vacant for staff working in theatre departments in the same time period.
- The rate of sickness for theatre nurses was higher than average of other independent acute providers we hold data for from April 2015 to July 2015, this had improved from August to September 2015 when the sickness rate fell to lower than average.

Surgical staffing

- We reviewed staffing rotas for September 2017 and a weekly bleep rota for cardiac arrest calls. The hospital used 'The Association of Perioperative Practice (AFPP) guidelines' to ensure their staffing levels and skill mix was appropriate within the operating theatre. Consultants, surgeons and anaesthetists participated in an on-call system for patients who had recently undergone surgery.
- Data from the hospital showed that there were 87 doctors or dentists practicing under rules of privileges, this included 30 anaesthetists. There were 5,475 episodes of care carried out by doctors with practicing privileges between April 2015 and March 2016.
- The hospital did not directly employ surgeons. Surgeons were licenced to undertake surgery at the hospital and the hospital granted practicing privileges in accordance with their practicing privileges policy. To apply for practicing privileges all medical practitioners must hold a General Medical Council (GMC) licence and provide evidence of insurance or indemnity cover. Most of the medical practitioners working at the hospital held a post within the NHS.
- Two Resident Medical Officers (RMO's) were employed via a third party contract and provided cover 24 hours a day, seven days a week on a rota basis. The RMO's liaised with the nursing and consultant teams and were based within the hospital grounds. Senior managers told us that the agency would provide alternative cover in the unlikely event it was required, for example if an RMO was disturbed for long periods during the night. This would ensure that RMO's were not working a 24 hour shift.
- The hospital operated a 24 hour on call system for patients who had been operated on to access consultants, anaesthetists and surgeons.

Major incident awareness and training

- The hospital had a major incident plan with the purpose to co-ordinate essential departments in the event of instances such as fire, flood, bomb and bomb threats, pandemic flu, loss of computer servers or loss of vital services. The plan identified roles and responsibilities of staff and senior managers. Each department had their own on-call rota to ensure adequate back up to deal with emergencies and incidents. In the event of loss of electricity, an oil generator automatically provided essential power. There was also uninterrupted power supply (UPS) protection for theatres. In the event the

generator failed, emergency lights had their own batteries. The cardiac alarm system also had UPS back up. Managers we spoke with were aware that the hospital had a major incident plan.

- Staff told us they participated in training for emergency scenarios such as responding to a cardiac arrest.

Are surgery services effective?

Good

We rated effective as good

Evidence-based care and treatment

- The hospital had a comprehensive audit programme in place which covered a wide range of areas such as VTE (venous thromboembolism), falls, moving and handling risk assessments, consent, deteriorating patients and the five steps to safer surgery checklist.
- The hospital shared results from audits at the medical advisory committee (MAC), clinical head of department and departmental meetings. Following the meetings, the hospital formulated and disseminated actions plans to the heads of each department to action. Nuffield Health develops their policies centrally at a corporate level and all policies at Nuffield Health Wolverhampton were corporate policies.
- Staff screened patients for their risk of developing VTE at pre-assessment and again on admission.
- The hospital endoscopy suite had achieved Joint Advisory Group (JAG) accreditation status in March 2016. This demonstrated that the endoscopy department had the competency to deliver against Endoscopy National Standards. The hospital provided care and treatment in line with NICE guidelines including Venous thromboembolism in adults: reducing the risk in hospital and acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. Other best practice guidelines included The Royal College of Anaesthetics (RCoA) and The Association of Anaesthetists of Great Britain (AAGBI) Storage of drugs in Anaesthetic rooms: Guidance on best practice.
- The hospital was in the process of registering on the Breast and Cosmetic implant registry (BCIR) however, at the time of our inspection (September, 2016), this was not yet live. The BCIR is designed to record details of any individual who has had breast implant surgery for any reason so they can be traced in the event of a product recall or safety concern. The hospital maintained an internal implant register prior to registration on the BCIR however; we did not see this as part of our inspection.

Pain relief

- Staff prescribed and gave appropriate pain relief to patients following surgery. We spoke with four patients who told us staff managed their pain well, and that staff kept on top of pain relief and regularly asked them about pain levels.
- We observed staff taking and explaining a pain score to a patient. Staff worked on a pain score of one to ten, which staff recorded in the patients' notes. A person's score helped to identify the level of intervention required to control the pain and the effectiveness of the treatment over time.
- Patients told us that staff had told them to press the call bell if they were in pain and someone would come to them.
- We saw that patients had access to appropriate pain relief on the wards. Nurses recorded pain-relieving medication on the patients' medication administration chart. Patients could speak to their consultant if their pain was not resolved; following discharge they could contact the hospital for advice or speak to their own GP.

Nutrition and hydration

- Patients we spoke to told us they had a choice over what they wanted to eat and drink. They also told us that, at a cost, relatives could order food if the kitchen were aware in advance.
- All four patients we spoke with were happy with the quality of food at the hospital.
- We saw that staff completed nutritional risk assessments and discussed dietary requirements at pre assessment and again on admission. Where required, staff used fluid balance charts to help monitor patients. None of the patients whose records we checked had

required fluid balance charts to be completed. The service did not have its own dietitian however; nursing staff made a referral to a community dietitian if required.

- The hospital had processes in place to identify food allergies at pre-assessment stage.
- The hospital catered for specific dietary requirements for example, they could arrange for a vegetarian menu or a celiac diet if someone required one.
- The hospitals place scores for food were at 98%.This was better than the England average of 93%.

Patient outcomes

- There were six cases of unplanned re-admissions within 28 days of discharge in the reporting period April 2015 to March 2016. The assessed rate of unplanned readmissions (per 100 inpatient and day case attendances) was not high, (0.145 compared to 0.24) when compared to a group of other independent acute hospitals who have submitted data to the Care Quality Commission (CQC).The hospital reported on unplanned readmissions graded at moderate or above on the electronic recording system and completed a root cause analysis.
- There were three cases of unplanned transfers to another hospital from April 2015 to March 2016. The assessed rate of unplanned transfers (per 100 inpatient and day case attendances) was not high (0.072 compared to 0.17) when compared to a group of independent acute hospitals that have submitted data to CQC.
- There were six cases of unplanned returns to the operating theatre in the reporting period April 2015 to March 2016. This was not high when compared to the average number of unplanned returns to theatre in sample data.
- The service routinely monitored outcomes about people's care and treatment. The service participated in the National Patient Reported Outcome Measures (PROMs) for primary knee replacement (NHS funded patients only). PROMs are standardised validated question sets to measure patients' perception of health and functional status and their health related quality of life.
- England adjusted average health gain for PROMs primary hip replacement is within the estimated range of the hospital's score for the following measures. Results for the EQ-5D index (generic health measure status) showed that 89.9% of 79 records reported as improved and 3.8% as worsened; for the EQ-VAS (visual analogue scale component of EQ-5D), 63.6% of 77 records reported as improved and 22.1% as worsened. Out of the 87 records on the Oxford hip score 97.7% were reported as improved and 2.3% as worsened. We did not see any actions plans on how to improve those results that had worsened at the time of our inspection.
- The service participated in the national PROMs for knee replacement. The hospital's adjusted health gain for PROMs is within the estimated range of the hospital's score. Results for the EQ-5D index showed 88.5% of 87 records reported as improved and 5.7% as worsened. In relation to EQ-VAS, 44.4% of 81 records reported as improved and 35.8% as worsened. The Oxford Knee score recorded 94.8% of 93 records as improved and 5.4% as worsened.
- Since January 2016, the hospital had commenced data collection for patients undergoing hip and knee replacement to submit to Public Health England's Surgical Site Infection Surveillance audit.
- The service was due to participate in the National Breast Implant Register however, at the time of our visit the system had not gone live. The register allows implants to be traced in the event of any safety concerns.
- The hospital submitted data to the National Joint Registry (NJR). The NJR exists to define, improve and maintain quality of care of individuals receiving joint replacement surgery across the NHS and independent healthcare sector. Since January 2016, the hospital had commenced data collection from patients undergoing hip and knee replacement to submit to the Public Health Surveillance Surgical Site infection surveillance audit. This audit was ongoing.

Competent staff

- Data showed 100% of professional validation amongst all staff who required professional registration.
- The hospital had a confident start programme in place for newly qualified nursing staff. This was a new initiative for newly qualified nurses and supported in preparation

for validation. The programme included completion of a portfolio and included nursing competencies, building relationships, team working, leading and managing self and others. During our visit, we spoke with a new member of nursing staff who told us the hospital laid the portfolio out well and how during their first two weeks the hospital had not included them in the staffing numbers.

- The service used a staff competency tracker to track compliance with medical device training. The tracker would alert managers if training was not completed, each manager was responsible for checking their own department. Ward managers reported non-compliance in head of department meetings.
- Staff told us they were able to ask for training and that the training they had was sufficient.
- The hospital reported that most staff (Above 90%) had completed an appraisal between March 16 and September 16. This met the hospitals target of 85%; the hospital appraisal year ran from March to March .We saw that staff received a formal annual appraisal and a mid-term appraisal every six months. At the time of our visit the hospital were changing from a paper based appraisal system to an electronic one.
- The hospital sent us a sample of training certificates dated July 2016, we saw training records that showed 100% of theatre and ward staff had completed training on the National Early Warning Score (NEWS). Use of the NEWS ensured staff were alerted early to any deterioration in the patient's condition.
- New staff had a minimum of two weeks working as supernumerary. The hospital reviewed staff at four and twelve weeks and they provided the staff member with a mentor.
- The hospital had a Medical Advisory Committee (MAC) whose role included ensuring that new consultants were only granted practicing privileges when they were deemed competent and safe, and to approve practicing privileges at the quarterly meeting. The MAC committee met on a quarterly basis to feed back and take advice from the consultant body for the main specialities. The MAC provided scrutiny of all applications by consultants in order to receive practicing privileges.
- The hospital had procedures in place to ensure they were able to manage consultant's Practicing Privileges (PP). These were managed electronically. We received a sample of consultant records that showed the hospital had received all the necessary compliance documentation. These records contained information such as indemnity insurance numbers, General Medical Council renewal dates, qualifications, references, last completed appraisal and renewal dates.
- We requested a sample of three consultant appraisals and found them to be comprehensive, they included discussions around honesty and integrity, communication, continuing professional development and developing and improving patient care pathways.
- The hospital reported that the service had two medical practitioners who hold practicing privileges for cosmetic surgery.

Multidisciplinary working

- A multidisciplinary team including nursing staff, pharmacists, physiotherapists, consultant surgeons and anaesthetists supported patients receiving surgery.
- We spoke with a physiotherapist who told us that there was a joint appointment taking place on the evening of our inspection with a patient, consultant and a physiotherapist.
- Staff encouraged patients to mobilise as soon as possible after surgery. Physiotherapists set and tailored goals. If a patient liked gardening, goals could be set that include gardening in the rehabilitation process.
- Staff from a variety of departments including surgery attended meetings such as MAC and in relation to infection control, demonstrating the hospital's commitment to multidisciplinary working. We saw evidence of multidisciplinary input in the patients' records.
- Staff told us they would refer patients identified as having a social care need to social services for an assessment of need.

Seven-day services

- The theatres were available from 8am to 8pm Monday to Friday and from 8am to 4pm on a Saturday; offering a six-day service.

Good

Surgery

- The theatres were also available for any patient needing to return to theatre 24-hours a day, seven days a week.
- Theatre staff operated on an on call system where three members of theatre staff were on call between the hours of 6.30pm and 8.am. There was also an X-ray on call system and a pathologist available out of hours via the telephone. A resident medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have about a patient's medical condition.
- Physiotherapists offered a seven-day service; regular physiotherapists staffed the service during the week and agency at weekends. The pharmacist operated from 9am until 6pm Monday to Friday. Out of hours the RMO accompanied by a qualified nurse could access the pharmacy if required.

Access to information

- Patients' observation records were kept in patients bedrooms; this made them easily accessible for staff and maintained a degree of privacy and security. Patients' clinical records were in paper format and easy for staff to access. This ensured staff could access documents like risk assessments, medical records and medication administration charts in a timely manner.
- Staff had access to policies and procedures on the hospitals intranet. Information of importance was portrayed to staff by managers and in email correspondence. There were sufficient computers available for staff to access a computer when needed. Service level agreements were kept in a file on the ward, this meant that they were easily accessed by staff that required them.Staff were able to access electronic patient records such as discharge letters on the computer system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had policies in place to safeguard vulnerable adults. We saw a policy in relation to The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). The policy was up to date, version controlled and that it referred to the Mental Capacity Act codes of practice. The policy refers to a Mental Capacity Act assessment form; however, staff we spoke to were unaware of this form. We saw that staff had access to a mental capacity flowchart they could follow if needed. The manager we spoke with said they had not needed to make any Deprivation of Liberty Safeguards (DoLS) applications. There were no patients on the ward at the time of our visit that had required a mental capacity assessment.
- The hospital audited consent as part of the quarterly audit system. In April 2016 out of 20 records, there was 100% compliance in relation to discussion of treatment being appropriate to the patient's level of understanding and the seriousness and likelihood of risks and adverse events.
- Staff were aware of their responsibilities to gain consent. All notes reviewed had consent forms and showed staff completed them satisfactorily. Consent was part of a two stage process which the hospital sought at consultation and again on admission this allowed a period of "cooling" off when patients could change their mind.
- Staff told us if they had any concerns about a patient's capacity, they could contact the RMO for support.
- Ward and theatre training records for July 2016 show compliance on DOLS and Mental Capacity Act training to be above 95%.

We saw records had appropriate documentation in relation to consent and that staff had access to a consent process flow chart.

Are surgery services caring?

Good

We rated caring as good

Compassionate care

- Staff treated patients with dignity and respect. Patients were happy with the care they received and told us nothing was too much trouble for the staff.
- We saw compassionate interactions between staff and patients on both our planned inspection and follow up visit. We saw staff knock on doors where patients were receiving treatment and waiting for a reply before they entered.

Good

Surgery

- We witnessed staff respecting confidentiality at all times. We observed patients treated in private treatment areas with closed doors or behind curtains. Patients told us staff respected confidentiality at all times
- Consultants introduced themselves to patients before treatment; they also asked for preference on how to address the patient.
- The hospital participated in the NHS Friends and Family Test (FFT) to capture patient feedback .The NHS created the Friends and Family test to help service providers and commissioners understand whether patients are happy with the service provided or identify areas of improvements. The hospitals FFT scores between October 2015 and March 2016 showed that 98% to 100% of patients were happy with the treatment they received and would recommend the service to their friends or family members if they required similar treatment; results were similar to the England average. The response rate of patients taking part in the test varied between 26% and 43%.The hospital's response rates were varied (sometimes better, sometimes worse) when compared to the England average of NHS patients. These rates are for independent sector NHS patients only.
- Results from the Patient Satisfaction Survey (June 2016) showed an overall satisfaction score of 97% (67 patients responded).
- One patient told us "from the physiotherapists to the nurses, everyone was great".

Understanding and involvement of patients and those close to them

- Staff provided care and explanations in a way that patients understood and appreciated. Patients we spoke to told us that they had their treatment fully explained to them.
- All the patients we spoke with said staff had spoken with them about their discharge plans, for example, staff had asked if anyone would be at home when they returned.
- Treatment costs for non NHS patients were discussed with the patient at the pre-assessment stage prior to any surgery taking place.

Emotional support

- Private rooms were available to patients if they wished to discuss any concerns**.**
- One patient told us how staff had helped relieve their anxiety as they had not left anything out when discussing the surgery.
- The hospital had no religious facilities on site; however, patients could complete prayer in their bedrooms if they wished.
- Staff were able to access a consultant psychiatrist if needed. Staff assessed patients' psychological wellbeing at pre-assessment.

Staff monitored patients' wellbeing and told us any staff highlighted any concerns about a patient's ability to manage on discharge to the patient's GP or through a referral to social care. One patient told us staff had arranged for a carer on discharge and another that staff had made sure someone would be at home.

Are surgery services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The hospital provided a number of payment options for fee paying patients and accepted patients with private medical insurance. NHS patients could access selected procedures under the choose and book patient government initiative.
- The hospital did not provide emergency care; all admissions were planned and arranged in advance and included both private and NHS patients. During the reporting period April 2015 to March 2016 13%of NHS funded patients and 14% of all other funded patients stayed overnight at the hospital. This indicated that NHS and private patients had the same level of treatment.
- Data showed that there were 5,473-inpatient and day case episodes of care recorded at the hospital during the reporting period, of these, 46% were NHS funded. During the period, 75% of patients treated fell into the age range of 18 to 74 years and 25% of patients were aged 75 years or older.

Good

Surgery

- The hospital had two theatres (one with laminar flow) and an endoscopy suite; the theatre included a recovery area, which meant they had the capacity to deal with the demand on the service.
- The hospital had a recovery plus program that was free of charge to private patients. The program was an optional enhanced recovery pathway that began following postoperative physiotherapy. This enabled patients to continue their recovery at a local Nuffield gym at no extra charge. The hospital did not have its own gym facilities so they referred patients to another local gym.

Access and flow

- Patients could be referred to the hospital via choose and book, this meant that patients could choose the most convenient time, date and place of treatment for selected services.
- Most surgery was elective other than those patients who had to return to theatre unplanned. We found theatre staff had on-call arrangements to manage any unexpected returns to theatre including weekend and night cover
- Patients accessed surgery services in a timely manner. The hospital met the standard of 90% for admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period April 15 to March16.
- Theatres were available 24 hours a day for any patient needing to return for unexpected surgery.
- For the period April 2015 to March 2016, the hospital reported 24 cancelled procedures for non-clinical reasons. The hospital offered another appointment within 28 days of the cancelled appointment for 100% of those patients affected. No data was available at the time of our inspection regarding the reason for the cancelations. None of the patients we spoke to had experienced any delays in relation to their care or treatment. We saw that cancelations were discussed at the MAC meetings however, we did not see any evidence that the MAC investigated these or that audits had been completed.
- Managers told us consultants covered leave hours with colleagues from the Nuffield hospital and that consultant's leave was booked at least six weeks in advance. The hospitals system for managing consultant leave was informal and they did not have a standard operating procedure in relation to consultant annual leave and cover. Following inspection the hospital formalised its arrangements into a standard operating procedure.
- Discharge planning started at the pre-assessment stage. The hospital considered support such as care at home and staff made contact with families and, or, outside agencies such as social care.
- Discharge only took place at an appropriate time of day, which staff told us was at the latest 9pm unless it was patient choice. Patients told us staff communicated with them around their discharge. One patient told us that the staff had ensured they had a carer in place.
- Once patients were fit for discharge, the GP was sent a discharge summary detailing their admission and a copy was provided to the patient. The hospital generated the discharge letters electronically. At the time of our visit, we saw several discharge letters ready to forward to the patients GP.
- Patients were provided with the contact details of the hospital if they needed to access advice following discharge.
- Staff gave patients the telephone number of the ward on discharge should they have any queries.

Meeting people's individual needs

- All patients had a single room with en suite toilet and shower facilities. All rooms and corridors were accessible to wheelchair users.
- We saw a variety of leaflets on different surgical procedures were on display around the hospital.
- The ward had a specific room near the nurses' station specifically for patients with dementia. The room had blue doorframes, blankets, a blue toilet seat and different coloured cutlery. A book with pictures in was available for when language became a barrier or for people with communication difficulties. Staff were able to access psychiatric support for patients if required.
- Contact details of translation services were available on the ward. Staff told us they identified language barriers and referred patients to a translation service at the

pre-assessment. Staff told us that several members of staff could speak different languages and would on occasions act as a translator; however, this was for day-to-day comfort needs only.

- Staff provided patients with a discharge brochure containing information such as post-operative care and care of the skin. Staff also provided patients with the telephone number of the ward.
- The ward manager told us they had not recently had anyone with a learning disability stay at the hospital on an inpatient basis but advised that they would liaise closely with family members to provide appropriate support if they did.
- The ward's visiting hours were from 2.30pm until 8.30pm; the ward made exceptions if needed, for example if a patient was unwell.

Learning from complaints and concerns

- At the time of our inspection in September 2016, we saw the hospital displaying leaflets titled "How to make a comment or formal complaint" on the ward. The hospital had a three-stage process for dealing with complaints including appropriate escalation routes if the hospital was not able to achieve a satisfactory outcome. If the hospital could not resolve the complaint, an independent review by the independent Sector Complaints Adjudication Service (ISCAS) would take place. The service told us that over the past year from 2015 to 2016, the hospital had resolved all complaints they received at a local level.
- We saw there were six surgical complaints in 2016. Complaints information we reviewed showed managers had investigated complaints; had put actions in place and cascaded information in staff meetings. We viewed a sample of minutes from a head of department meeting April 2016 and a MAC meeting July 2016; both showed staff present at the meetings discussed complaints. The Care Quality Commission (CQC) received no complaints about the service in the reporting period (April 15 to March 16).
- Complaints received by the hospital included staff attitude, not being happy with post-operative care, being unhappy with consultant, being unhappy with post-operative information given and being unhappy with the outcome of surgery received.

Another complaint from February 16 was in relation to a patient who was unhappy with the attitude of nursing staff. As a result, management discussed attitude and lack of communication at the departmental meeting. Management also asked staff to reflect on how their actions may affect patients, especially when they were anxious.

Are surgery services well-led?

Good

We rated well led as good

Leadership / culture of service.

- A senior management team was in place at the hospital, which included the hospital director, the matron, the finance manager and the sales and service manager. There was several long standing nursing staff and health care assistants on the ward who had worked at the service in excess of 20-years.
- Staff told us one of the reasons they liked to work at the hospital was having the time to spend with patients. Patients told us that staff answered call bells quickly, they felt safe and secure and that staff always had a smile on their face.
- A nationwide Matron Cluster group had been set up, which enabled shared learning from incidents across various hospital sites. The service had a regional theatre lead that oversaw all theatres in the Nuffield group and provided theatre staff with support and guidance.

Vision and strategy

- Staff told us that the leadership team were approachable, that they were happy working at the service and that it was like a family. Staff also felt they could go to a manager of any seniority for support.
- The hospital was part of the wider Nuffield health organisation and shared in the organisation's four values. These were caring, independent, passionate and enterprising. The hospital's vision at a local level was to become the private hospital of choice in the West Midlands by ensuring high quality care that is safe, effective and personalised to the individual's needs. Staff could tell us what the vision for the service was.

- The hospital's visions, goals and specific objectives were set under headings of safety, effectiveness, caring, responsiveness and well led. The well-led objectives included recruiting and retaining staff that shared the hospital's values and beliefs and do the right thing, to ensure employee wellbeing and to encourage staff feedback.
- Staff told us the hospital director was visible and that they saw them on a regular basis.

Managers were able to identify challenges within the service. Managers at different levels were

given administration tasks outside their own specific domain. We were told that protected time was not provided for these additional roles, which meant staff felt under pressure.

- The hospital had a disciplinary and grievance policy. Additionally there was a raising and responding to Doctor Concern's policy, the remit of the policy was to support the identification and resolution of issues where doctor's performance, conduct or health could put patients at risk.
- A business plan was in place dated 2016, this included topics such as management objectives, action plans, market analysis and financial summaries.

Governance, risk management and quality measurement

- The hospital had procedures to ensure they were able to manage consultant's practicing privileges (PP) well. We received a sample of three consultant records that showed the hospital had received all the necessary compliance documentation. These records contained information such as indemnity insurance numbers, General Medical Council renewal dates, qualifications, references, last completed appraisal and renewal dates.
- There were systems in place to improve performance across most areas which included audit, learning from complaints and incidents, and the collection of national data such as patient reported outcome measures (PROMs).
- Consultant surgeons were represented at the medical advisory committee. We reviewed the meeting minutes held on July 2015, October 2015 and January 2016 and found these to be detailed and comprehensive. They included topics around incidents and complaints, practicing privileges (PP), infection prevention and clinical outcomes such as unplanned readmissions and returns to theatre.
- The hospital held a risk register and the manager of each department was responsible for their own departmental risks. Managers we spoke with were aware of the identified risks within their department. There were two risks identified within surgery (July 2016), and management were in the process of addressing these. The risks on the register reflected the risks that were evident. The first risk related to an operating light having a temporary fix due to the on, off light not working (September 2015). The second related to the risk of a failing medical gas supply to theatres as a pump was obsolete and not repairable (October 2015). In both instances, the hospital had arrangements in place for repairing the equipment. However before the work could be completed the hospital had needed to submit a capital expenditure case. The risk register had review dates for each risk. We reviewed minutes from senior management and MAC meetings and saw evidence that the risk register was discussed.
- There was a proactive approach to monitoring quality and safety within surgery. The service carried out regular audits; when they required improvements, management identified actions and shared learning with staff within the service.
- Surgical procedures and reports were discussed at head of department and clinical governance meetings, information from these meetings were then fed into the MAC. This provided both senior managers and clinician's opportunities to review risk and take appropriate actions.
- Details of the reasons for cancellation of operations were not available to us during inspection.

Public and staff engagement

- The hospital participated in the Friends and Family Test (FFT) to capture patient feedback from NHS staff.
- Staff told us they had attempted to initiate a patient focus group but this had not been successful as there were insufficient patients who wished to engage in the process.

Good

Surgery

- The hospital conducted an annual leadership survey and invited all staff to provide feedback on their line manager and the senior management team. Such information allowed the service to review staff satisfaction levels and their engagement with their work, their manager and the company vision.
- The service held regular staff meetings and gave staff the opportunity to engage.
- The hospital had become an official partner of a local football club and had become medical sponsorship partners, providing treatment to players across a range of specialities.

Innovation, improvement and sustainability

- The most recent NHS partners Network (NHSPN) report on independent sector providers caring for NHS patients, has named the Nuffield Health Wolverhampton hospital as a top performing hospital twice. This was around the hospital performing well in scores for primary hip replacement surgery, where the report found patients had significantly improved hip functionality and reduced pain using the Oxford Hip Score technique and the ED-5DTM score.
- The endoscopy unit at Wolverhampton was the first group of 31 Nuffield hospitals to become Joint Advisory Group accredited (JAG) demonstrating that it had the competency to deliver against measures in the endoscopy global rating scale.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There had been no reported never events between April 2015 and March 2016 within the outpatient or diagnostic department. A never event is a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken.
- There had been 62 clinical incidents within outpatient and diagnostic imaging services between the period of April 2015 to March 2016 and 18 non-clinical incidents in the same period.
- None of the incidents had been categorised as death or severe.
- Nuffield Wolverhampton Hospital was aware of and complied with the requirements of the duty of candour. The duty of candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The provider encouraged a culture of openness and honesty.
- Staff we spoke with were clear on the meaning of duty of candour. Staff spoke about being open and honest with their patients.
- The hospital provided staff training for incident reporting including an explanation of what constitutes an incident. The hospital had trained the outpatient and diagnostic team, all staff within the department were compliant.
- We spoke with nurses and radiographers who were able to share an example of incident feedback their management provided to them. Management discussed incidents during team briefs which were held on a regular basis.
- Ninety-three per cent of staff within the outpatients and diagnostic imaging department were compliant in Level 1 incident reporting training.

Cleanliness, infection control and hygiene

- Aprons, gloves and hand gel were available in consulting rooms and throughout the department.
- All clinical and non-clinical areas were visibly clean. The hospital had clearly labelled containers for the disposal of sharps (needles) and staff filled these to appropriate levels.
- There was an easily identifiable system in place for disposing and administrating chemotherapy treatment. The hospital had purple lids for cytotoxic (contains chemical which are toxic to cells) waste bins and staff wore purple gloves for administrating treatment. We saw posters on display to identify the difference of each clinical and non-clinical waste bins.
- We saw a separate cupboard with cleaning equipment and protection in case of cytotoxic spillage.
- Antibacterial gel dispensers were easily available for both staff and public to use at the entrance of clinics, wards and by patient beds.
- The outpatients department had appropriate and visible signage for hand washing at the main entrance and the entrance to the ward, in line with World Health Organisation (WHO) guidance.
- We observed good hand hygiene from all staff during our inspection, we saw staff washing their hands and

applying hand gel at regular intervals. We saw six examples of hand hygiene assessment all six had achieved 100% between the period of April 2015 and March 2016.
- We spoke with five patients who all said they had seen staff washing their hands and using hand gels.
- In the outpatients department and radiology department, we observed staff following 'bare below the arms' guidelines.
- The hospital had clear processes to decontaminate areas within the outpatients department after treating a patient with an infectious disease. Staff explained if a patient had MRSA, they would see the patient last on the list and they would perform a deep clean prior to continuing with clinic. However, when we spoke with a diagnostic imaging staff member, they were not entirely sure of the process when dealing with a patient with an infectious disease.
- The infection prevention lead at the hospital carried out regular infection prevention and control audits. The infection prevention lead would feed information in to regular clinical governance meetings.
- There were no reported issues for outpatients or diagnostic imaging within the last 12 months. The department also reported no hospital infections of Clostridium difficile (C.diff), MRSA, Methicillin-sensitive staphylococcus (MSSA) or Escherichia coli (E-coli).
- The outpatients department and diagnostic imaging had a compliance rate of 97% of staff for infection and prevention practical training.

Environment and equipment

- The hospital had secure access to the diagnostic imaging department and staff accessed the department using swipe cards in all areas. The hospital displayed clear warning signs to warn of the danger of exposure to radiation and information of potential risks.
- Four weeks prior to our inspection, Nuffield Health Hospital Wolverhampton opened a stand-alone magnetic resonance imaging (MRI) suite. The suite was operated by its own staff, which were in the process of developing the diagnostic imaging department. At the time of our inspection, they were using a third party for the computerised tomography (CT) scan service.
- The department had two resuscitation grab bags, we saw they were all in date, and staff had stocked them appropriately with equipment and securely locked all resuscitation drugs away.
- Staff in the diagnostic imaging department recently undertook a resus training scenario. This was designed to identify staff strengths and weaknesses when dealing with emergencies. The scenario looked at timing when attending an emergency and how to deal with an emergency situation in a secure environment such as MRI. This was to ensure staff maintains their competencies when dealing with emergency situation and allowed staff to reflect on their performance.
- Patients and relatives had access to a spacious waiting area and comfortable seating in two locations within the outpatient department. There was one waiting room for diagnostic imaging, this was very small and staff we spoke with were not happy with the size as it affected the patient experience. There was not always room to accommodate patient relatives.
- They had a quiet room within the diagnostic imaging department to speak with patients confidentially regarding sensitive topics.
- There were two allocated en-suite rooms on the ward for patients who received chemotherapy treatment. These were visibly clean, spacious; no carpets were used and were suitably equipped.
- No clinical procedures were being performed in carpeted rooms, management only rooms had carpets.

Medicines

- The radiology department had a secure utility room with swipe card access were drugs were stored. We noted that drugs were in date and secured appropriately.
- The oncology nurse, the pharmacist and named consultant discussed patients' blood results and well-being of patients before pharmacy dispensed chemotherapy for administration. Chemotherapy was delivered by a third party. Chemotherapy was made to order, it was prepared for individual patients and ready for their next treatment.
- The consultant prescribed all chemotherapy medication including any pre-chemotherapy medication and post-chemotherapy medication. Pharmacy retained this prescription for auditing purposes. The pharmacist and supplier checked all chemotherapy medicines on delivery to ensure they were securely stored. We saw this was a robust process.

- Qualified staff double checked and signed prescriptions, including a thorough check of the expiry date, volume, the batch number, name of patient, date of birth, date of administration, the expiry date, allergies and dosage of the chemotherapy treatment.
- Appropriate licences and contingency for Administration of Radioactive Substances Council (ARSAC) (Nuclear Medicine) were in place and met national guidelines.

Records

- We reviewed six sets of adult patient notes during our inspection. Staff had completed the appropriate fields in all notes; they were legible and signed by a consultant. Staff recorded allergies and carried out risk assessments for venous thromboembolism (VTE).
- We saw the hospital stored patient records appropriately and in locked cabinets.
- Data provided by the hospital prior to our inspection reported that they saw less than one percent of patients in the department without all relevant medical records being available.
- We asked the hospital what processes were in place to mitigate risk of a patient with no records being available. We were told that if notes had not been received, staff would make enquiries with the referrer; private or NHS, in an effort to locate them. If they couldn't be located and consultants were willing to see the patient without notes, the staff documented all care on clinical notes and transferred them back to the patients' medical records when they had been located.
- Private patients' medical notes in outpatients, related only to the consultant they had come to see and these notes were usually brought on the day by the consultants themselves or delivered to the clinic by the medical secretary.
- Consultants were registered as data controllers under their practices and privileges, consultants were aware of their responsibility to ensure confidentiality and security.
- Both the chemotherapy service and the outpatient departments had a robust system in place for managing patient records. Patient records included risk assessments such as risk of falls, nutritional assessments, visual infusion phlebitis (VIP) score, venous thromboembolism (VTE).
- Staff had completed records appropriately in all the records we looked at during our inspection. They included a GP referral letter, details of health insurance where applicable and details of any procedures or investigations carried out with relevant findings, including any chemotherapy intervention. However, we saw no evidence of audits carried out on chemotherapy records of patient, which meant that senior staff had no way of ensuring quality been maintained.

Safeguarding

- The hospital had a named lead for safeguarding for both adults and children. Staff had access to safeguarding policies online.
- There had been no safeguarding incidents within outpatients or diagnostic imaging services during the reporting period April 2015 and March 2016.
- Staff were clear on how to raise safeguarding concerns for both adults and children; they told us that they had access to guidance within the department on how to raise concerns. In addition, the staff reported any concerns to their line manager who in turn would escalate to the local authority. Staff were able to describe the different types of abuse which would constitute a safeguarding issue.
- Staff said the hospital trained them to level 2 in safeguarding children and level 1 for vulnerable adults. The hospital had a target of 85% for safeguarding training. We saw that 85% of staff had completed children's safeguarding and 96% had completed adult safeguarding training level 1.
- The hospital had two senior staff members who had completed level 3 safeguarding training. They were available when children and young people had appointments.
- The hospital had one paediatric lead nurse for safeguarding who is currently developing a future service for children and young people within the hospital.
- The CYP inpatient service has now been ceased but CYP outpatient and diagnostic services continue, therefore the registered children's nurse will ensure that CYP are cared for in a safe and efficient manner whilst ensuring that their physical, psychological and spiritual needs are accommodated. They also have a duty to report, escalate and act upon in any safeguarding issues that may be identified.

- Managers informed us that they have appropriate levels of employees with safeguarding level 3 training. The Ward Manager and CYP nurse are trained to this level including the matron.

Mandatory training

- The hospital required all staff within diagnostic imaging and the outpatient department to complete mandatory training in a range of subjects. We were provided with data from their training records from March 2015 to March 2016. We saw 41 subjects were available for staff to complete depending on their role and speciality, the hospital was on track to achieve its target of 85% compliance in all but four subjects. The subjects below the hospital target were; incident management level 3 (75%) and incident reporting level 4 (75%) immediate life support (ILS) (28%), and physiotherapy medical devices (60%). Staff that had not yet completed their training were booked on to the next available date.

Assessing and responding to patient risk

- The hospital carried out cardiac arrest training scenarios in various departments to ensure staff were responding correctly and in a timely manner. A member of staff said, "It is really good as it keeps you up-to-date with basic life support". Staff told us these scenarios occurred approximately once every two months.
- The diagnostic imaging department had access to a specific medication box to treat anaphylaxis, to contrast agents used during scanning (anaphylaxis is a rare life threatening allergic reaction). This box contained adrenaline, steroids and anti-histamines to enable prompt treatment should this situation arise.
- We were advised that, should a patient become acutely unwell within the outpatient and diagnostic imaging department; staff would escalate their concerns to the resident medical officer (RMO). The radiation protection advisor was also easily accessible for advice relating to any radiation concerns.
- Staff told us that patients were questioned regarding the risk of pregnancy during consultations and prior to diagnostic imaging being carried out. In addition, signage was in place in the radiology department relating to pregnancy.
- The Five Steps to Safer Surgery safety checklist, for interventional radiology was embedded in daily practice. This is a process also recommended by the National Patient Safety Agency (NPSA) for every patient undergoing an interventional procedure. The process involves a number of safety checks before, during and after the procedure to avoid errors. For each patient's procedure, the checklists were followed and completed in full.
- We reviewed the sample audits undertaken in radiology, which included a review of the Five Steps to Safer Surgery checklist completion. We saw examples of 10 WHO form audits checks for flouro injections were 100% completed and a further 10 examples of WHO form audits checks for ultra sound injections that were 100% completed.
- Should a patient, who was undergoing chemotherapy treatment, become unwell during their treatment, the ward staff and oncology nurse would assist along with the crash team.
- Emergency assessment for oncology can be dealt with on site with 24 hours access led by the oncology lead nurse who offered advice and guidance along with the patient's named consultant.
- The diagnostic imaging department had a yearly audit schedule in place. Dose audits were conducted in line with IR(ME)R regarding the protection of patients from the risks of unnecessary exposure to x-rays.

Nursing and Radiographer staffing

- There were systems in place to request additional staff or to cover gaps in duty rotas. This system was reviewed on regular basis depending on the clinic demand from the OPD manager, Staff we spoke with in the outpatient department felt they required further staffing support. As at April 2016, the outpatients and diagnostic imaging department had a 4.4 full time equivalent (FTE) for health care assistants and 3.3 FTE for nurses. They had a ratio of nurse to health care assistant of 1.0 to 1.4 (FTE).
- Use of bank and agency for outpatient nurses was higher than the average of other independent acute hospitals for nine of the 12 months during the reporting period April 2015 to March 2016. The highest percentage of agency use was in November 2015 and was 33%, April 2015, June 2015 and July 2015 all had rates similar to the average of 7%. The agency nurses were familiar with the operational side of OPD which helped with continuity of care and knew their role when working in OPD.

Good

Outpatients and diagnostic imaging

- Use of bank and agency for outpatient health care assistants was higher than the average of other independent acute hospitals during the same period. November 2015 saw the highest rate at 31%.
- As at April 2016, the vacancy rate for outpatient nurses was 14% or 0.5 FTE. There were no vacancies for health care assistants. Management told us they were actively recruiting for permanent staff.
- The rate of sickness for nurses in outpatient departments was 0% through the reporting period of April 2015 to March 2016 and the rate of sickness for health care assistants was 0%, during the same period.
- Staff turnover was 14% during the reporting period of April 2015 to March 2016.
- At present, there was one oncology specialist nurse to administer chemotherapy, with support from the pre-assessment lead who was also oncology trained.
- Plans had been developed to expand the oncology service and further recruitment of oncology staff was agreed to meet the demands of the service as it expanded.
- Nuffield Wolverhampton Hospital had recently employed a project manager who was also the pre-assessment lead to ensure the pre assessment service was re-designed, that patient experience was on an optimum level and that patient was to be safe to continue with future planned procedures. This was put in place because the oncology lead was once the pre assessment lead but had been given the role as the oncology lead.

Medical staffing

- The hospital provided patients with a point of contact should they have concerns about their treatment or condition in between appointments. Staff reported all consultants were easily accessible when not at the hospital to give advice and to book emergency clinics should this be required.
- The hospital had no written procedure for covering consultants when on leave or unavailable. Consultants verbalised their availability to outpatients and diagnostic imaging staff as an informal process. We saw this arrangement as not a robust system and needed to be strengthened.
- The hospital had three oncology consultants with practising privileges at the time of our inspection.
- Nuffield Wolverhampton had two consultant paediatricians with practice privileges. One of these consultants has provided access to himself and the team at the local trust for help, guidance and advice. This same consultant is the CYP representative on their medical advisory committee (MAC); he also works very closely with the RSCN.

Major incident awareness and training

- The hospital had an internal emergency incident and business continuity plan in place, which described actions staff, must take in the event of a fire, flooding, loss of power or infection outbreaks.
- Equipment within the diagnostic and imaging department had mechanisms in place to stop scanning and procedures safely should the electricity fail.

Are outpatients and diagnostic imaging services effective?

At present we do not rate the effectiveness for outpatient and diagnostic imaging services in acute independent hospitals but during our inspection we noted the following good practice:

Evidence-based care and treatment

- The diagnostic imaging department had clear processes in place to report incidents. This process was structured and began with electronic incident reporting, notification to the radiation protection advisor, and then notification to IR(ME)R if appropriate. A radiographer told us that the department had no exposures greater than intended within the diagnostic imaging department within the last 12 months. IR(ME)R reports provided by the service supported this.
- Nuffield Health Hospital Wolverhampton policies and procedures were set nationally by Nuffield Health and took account of relevant best practice guidance including that issued by the National Institute for Clinical Excellence (NICE), the Department of Health and relevant royal colleges such as The Royal College of Nursing (RCN).
- The oncology service followed NICE guidelines for oncology and chemotherapy services. We saw information on breast cancer, colorectal cancer, and blood or marrow cancers. Including NICE guidance on anti-cancer medicines.

Pain relief

Good

Outpatients and diagnostic imaging

- Pain relief was not a primary service of the outpatients department. However, if pain relief was required, staff were able to access analgesia for patients.
- Patients could contact the outpatient department directly during normal operational hours to speak to a nurse if they had any issues or their consultant if they were experiencing any pain after a procedure. If the clinic was not open, patients were advised to contact their GP.
- Within the diagnostic service, staff offered pain relief to patients undergoing interventional radiology procedures. The type of pain relief they offered was dependent upon the patient and the procedure.
- The doctor undertaking the procedure would assess the need for pain relief.
- Staff asked patients to score their pain on a ladder, ranging from zero to 10 and then recorded the score on their observational clinical record. The pain score enabled staff to monitor the effectiveness of any treatment and to recognise any deterioration.

Nutrition and hydration

- Patients and relatives had access to both hot and cold drinks in all waiting areas. During our inspection, we saw staff advising patients the café was open if they wanted food and signposting patients to drinks dispensers where patients could help themselves to the water and hot drinks.
- Chemotherapy patients had access to the surgical ward catering staff that came round at regular intervals to provide meals, snacks and drinks.

Patient outcomes

- The diagnostic imaging department carried out audits in relation to the competencies of paperwork, fridge checks and checks around the risk of pregnancy. Staff told us that patients were questioned regarding the risk of pregnancy during consultations and prior to diagnostic imaging being carried out. In addition, signs were in place in the radiology department relating to pregnancy.
- Radiology service undertook annual audits on radiation exposure limits and local reference levels (DRLs). The most recent audit from March 2016 did not identify any concerns regarding patient exposures.

Competent staff

- Staff across OPD and diagnostic imaging was competent in their respective roles to provide care and treatment for patients who visited the hospital.
- All staff (100%) had completed their appraisals in the outpatients and diagnostic imaging departments for the current appraisal year from March 2016 to March 2017. The hospital had an appraisal rate target of 85%.
- Continuous professional development (CDP) was self-directed and individuals kept records. Staff were encouraged to undertake CPD.
- The hospital medical advisory committee (MAC) had primary oversight of the clinicians practicing privileges (PP's).
- The hospital had removed four doctors' practising privileges over the last 12 months, and suspended three doctors' practicing privileges. Two doctors had retired, one was removed due to lapsed paperwork and one had moved to another Nuffield Health Hospital and no longer attended the Wolverhampton hospital.
- We saw evidence and we were told by the oncology lead nurse that they were provided with on-going training in the management of oncological emergencies; based on the United Kingdom Oncology Nurse Society (UKONS) rapid triage assessment tool. In the UK all oncology nurses administrating Systemic Anticancer Therapy (SACT) are required to complete and qualify an accredited SACT module.
- The department had three radiation protection supervisors (RPS). RPS were appointed under the ionising radiation regulations 1999 (IRR) but locally oversee radiation protection under the ionising radiation (medical exposure) regulations (IRMER).
- The oncology lead nurse was involved with UKONS and attended regular oncology conferences regarding oncology.

Multidisciplinary working

- Throughout the inspection, we observed a good working relationship between the different departments and services including outpatients, diagnostic imaging, the ward, the domestic service, housekeeping service and the hospital management team.
- Patients were referred to physiotherapy, occupational therapist or dietician during their clinic and assessments. We saw physiotherapist would review patients or follow up with patients during their clinic

appointment. We also saw that Nuffield Wolverhampton hospital had access to the Nuffield gym, patients and relatives had access to the gym, with first two sessions for free.

- All consultant surgeons, oncologist and haematologist are core members of their specific groups within their trusts and they list their NHS patients for discussion. If there are any proposed changes with NHS patient's management and treatment, the hospital referred the case back to the appropriate MDT for discussion and agreement.
- All patient records we looked at included a referral from a GP and a follow up report back to the patients' GP with findings and any recommendations, Macmillan nurses or staff from the local hospices were also included if relevant to patients.
- Oncology patients received chemotherapy treatment only from the oncology trained nurse.
- If chemotherapy patients were deteriorating, they would be transferred to the local NHS Trust. Oncology consultants worked both at Nuffield Wolverhampton and an NHS Trust.

Seven-day services

- There were two RMOs working on an alternate weekly rota. One RMO was available 24-hours a day, seven days a week, with processes in place to prevent either RMO working a 24-hour shift.
- The hospital's outpatients department did not provide access to a seven-day service but services operated Monday to Friday, with appointments also offered late in the evenings. The hospital did offer Saturday morning appointments if there was demand for clinics.
- Patients attending the outpatients department had access to an on-site pharmacy during clinic opening hours.
- The oncology lead nurse carried a mobile telephone for oncology patients who required advice and support pre and post-treatment, 24-hours a day. However, there was only one oncology lead nurse running the helpline for oncology patients because at the time of the inspection, the oncology service was at its infancy and demand was relatively low.
- The oncology nurse would book her annual leave around patient's appointments; staff members told us that oncology service is very small and not yet busy. This is an area the hospital plan to expand. If the oncology lead nurse required sick leave, the identified nurse who would provide cover was the pre-assessment lead, who was trained in oncology and chemotherapy.

Access to information

- The radiology department had the ability to transfer images securely to the local NHS trust, therefore enabling continuity of care for patients receiving care at different locations.
- The radiology service used a picture archiving and communication system (PACS). Clinicians, with appropriate secure access, could view images from this central, off-site server. Imaging reports were available promptly from the radiology management computer system.
- Outpatient consultations within the hospital were consultant-led. All patients attending outpatients would either, have an accompanying GP referral letter or their current medical records from a previous appointment or admission would be available at the hospital. For NHS patients a detailed referral letter would be available prior to their initial consultation at the hospital.
- Staff had access to computers and were able to access hospital polices, training, newsletters and were kept up-to-date with Nuffield.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff gained consent prior to any procedure taking place within the outpatients and diagnostic imaging departments. Staff also had access to the policy online.
- Staff were aware of the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS 2007). The hospital had included both MCA and DoLs as part of the mandatory training.
- The compliance rate of staff completing DoLs training was 97%, which was above the hospital target of 85%. There was a compliance rate of 96% for completion of consent to examination or treatment training, and a rate of 98% of staff who completed the MCA training.
- All of the managers we spoke with were aware of consent, Mental Capacity Act and Deprivation of Liberty Safeguards requirements and we saw appropriate policies in place to support this.

Good

Outpatients and diagnostic imaging

- We spoke with two other members of staff about these requirements. One member of staff was able to describe the requirements and had a good level of understanding. However, the other member of staff was less clear and we escalated this to their line manager.
- The six patients we spoke with informed us that staff asked them for their verbal and written consent before staff provided care or any procedures were undertaken.

Staff spoke about the additional information and support available from the dementia lead nurse.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

- We observed staff to be polite and friendly towards patients and relatives.
- We spoke with four patients who were complimentary of clinic staff and the hospital. They told us the staff treated them with kindness and compassion. We observed staff interacting with patents in a professional and compassionate manner in clinics and in the waiting area.
- We saw episodes of patient care during our inspection where staff were courteous to patients. Staff introduced themselves by name prior to consultation.
- Clinic rooms in the outpatients department displayed signs indicating if the rooms were engaged or free; to prevent unnecessary access during consultations and treatment.
- The hospital encouraged all patients to complete a satisfaction survey on discharge to capture feedback. Patients have consistently scored professionalism, friendliness and helpfulness of all staff at 96% or higher in the last 12-months.
- The NHS Friends and Family Test (FFT) results demonstrated 100% of patients would recommend the hospital for most of the 12-month period with the exception of January 2016 when the result was 98%, and February 2016 with 99%. The FFT scores were very similar to the England average of NHS patients across independent sectors.
- We observed the receptionists being kind, courteous and helpful when talking to patients arriving at the clinic and collecting drink for patients with limited mobility.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us that staff discussed and explained their treatment to them in detail in a manner they were able to understand.
- The hospital welcomed relatives or carers to accompany patients in to consultation areas for support.
- We saw and patients told us that consultants provided advice and information in relation to treatment and the next steps after patient's consultations.
- The service had information on leaflets and on the hospital website regarding costs, options for payment and the processes to follow.
- Patients advised us that they understood their treatment and payment arrangements.
- Patients we spoke with said staff involved them when making decisions regarding their treatment plan.

Emotional support

- The manager showed us a small private room in the diagnostic imaging department, which was available if a patient needed some quiet time or needed a private conversation with a staff member. We heard staff offering patients the use of this room to discuss results.
- We observed staff adopting a gentle and supportive approach to patient care and treatment throughout the outpatients and diagnostic imaging department.

Patients had access and information to counselling services through the local NHS trust.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital was aiming to expand their oncology service. During our inspection, the oncology lead nurse said they have increased the amount of oncologist consultants joining the hospital meaning the service

were hoping to see an increase of patients. The hospital currently had three consultants with practising privileges and hoped to increase as the service expanded.
- The hospital had a newly built MRI suite, which had a new radiographer and other staff. The main goal, according to staff, was to eventually have their own computerised tomography (CT) equipment to provide a diagnostic imaging service from the hospital without dependency on a third party to fill the service demand.
- The outpatient department did not have a receptionist to support staff. Staff felt this impacted on their workload by trying to be a receptionist and having to leave patients mid conversation to answer the telephone.
- Staff felt the lack of receptionist had an impact on the quality of patient care, as staff were not able to give all their attention to patients. This was supported by a patient we spoke with who said, "Staff were running here there and everywhere trying to run outpatients". This was raised with management, who said they have requested a receptionist but this request had not been fulfilled.

Access and flow

- Healthcare professionals such as GP's, consultants or nurses would refer patients in order for them to access outpatient services at the hospital, prior to treatment or examination taking place.
- If NHS patients did not attend for any reason, they were discharged back to their GP via an automated process.
- Staff we spoke with reported the clinics ran on time and that the department did not subject patients to extended waits.
- The outpatient and diagnostic imaging department exceeded the standard for referral to treatment times (RTT) during April 2015 to March 2016.
- Between April 2015 and March 2016, the outpatients department saw 13,123 patients of which 214 were children under 18–years old and 12,909 were adults. The data provided by the hospital showed that 60% of patients were NHS funded and 40% were other forms of funding.
- From 1 August 2016 to 31 August 2016, diagnostic imaging services saw 158 adults for MRI and 38 for CT. The service saw 11 children under the age of 18-years for MRI, 16 for ultra sound and nine for X-Ray.
- All patients we spoke to said they were satisfied with the waiting times for the clinic.
- All patients were seen within the recommended referral to treatment of six weeks.
- Patients were seen within two weeks once seen by GP and referral made to the consultant.
- The chemotherapy treatment services commenced in August 2015. Since that time 31 patients were seen and treated in the service.
- There were no patients receiving chemotherapy treatment on the day of the inspection or when we visited on the unannounced period.
- Patients told us staff offers a choice of appointments to suit them.

Meeting people's individual needs

- When booking an initial appointment, clinic staff asked patients if they required any additional help regarding interpreters, chaperones or other help. This could then be arranged in advance of the visit.
- Staff invited patients to bring companions into consultations.
- We reviewed the policy for the use of chaperones when there are religious or cultural reasons and staff had access to this.
- In the MRI suite, the radiographer showed us how they changed the language on their computer system to speak with a patient undergoing an MRI. There were over 20 different languages available.
- Patients had access to leaflets regarding information on what to expect when arriving for their appointment within the outpatients and diagnostic imaging departments.
- Patients receiving chemotherapy had access to Macmillan information leaflets related to their cancer treatment.
- We saw the hospital had a range of literature available for staff and patients about learning disabilities and dementia.
- Staff also offered patients translation services when required.
- The oncology service also provided patients with a personalised treatment book to record their treatment

schedule, medications, blood results and any side effects. Staff advised patients to carry this book with them at all times especially when attending for their treatment or when out of the house, in case of an emergency.

- We reviewed the chaperone policy. We observed staff during the outpatient clinic sessions and through speaking with patients the option to have a chaperone.

Learning from complaints and concerns

- Nuffield Health Wolverhampton reported 20 complaints from April 2015 to March 2016.
- There were no complaints raised or received regarding the oncology service.
- The service had not received any complaints regarding fees, costs or arrangements for outpatient payment at the service. No patients or relatives raised concerns to us during our inspection.
- The hospital has referred one of the 20 complaints to the ombudsmen or Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- The hospital had a policy for dealing with complaints and the overall responsibility for complaint management lay with the hospital director who had good knowledge of all complaints past and current. If a complaint was related to clinical care, a clinical member of staff would lead the investigation.
- Senior staff discussed complaints on a monthly basis at the board meeting and head of department meetings, and on a quarterly basis at the medical advisory committee (MAC) and the clinical governance meetings, we saw minutes to support this.
- The outpatients and diagnostic imaging departments displayed complaints leaflets in reception areas, which were accessible to all patients entering the hospital.

Staff said they would initially try to deescalate and manage patient's complaints locally by apologising and taking appropriate action. If a complaint could not be resolves locally it was then escalated to the appropriate manager for further investigation. We saw all complaints were logged onto the complaints register. The hospital director was responsible for, and ensured that they acknowledge all complaints within two working days from the day in which the patient made the complaint.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated the outpatients and diagnostic imaging department as Requires Improvement for well-led.

Leadership / culture of service

- Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff spoke highly about manager's support in the outpatients and diagnostic imaging service. The manager worked to continually improve the service and made positive changes to the service, example being in diagnostic imaging with an MRI suite being opened.
- Three members of staff within the outpatients and diagnostic imaging department told us they felt the culture was open and honest. They felt that senior management in the department acted on information and provided feedback and support to staff.
- Staff morale was good and we observed staff from all specialities working well together. The team was visibly enthusiastic about the outpatient and diagnostic imaging services. Many of them had worked in the service for many years.
- Staff enjoyed working at the hospital and felt the company treated them with respect and valued their opinions
- Staff were motivated and enjoyed working at the hospital and told us they were a cohesive team and were supportive of one another.
- Staff within the outpatient department had raised their concerns to management about lack of receptionist support and how this impacted on their workload. Staff also told us this was raised in their monthly management meeting.
- Managers told us that they were aware of the lack of a specific receptionist for the OPD, but support could be made available from other areas, if required or at exceptionally busy times. Staff told us that the lack of receptionist sometimes took clinical staff away from providing patient care.

Vision and strategy for this this core service

Good

Outpatients and diagnostic imaging

- Nuffield Health is a not for profit organisation with a strategy to "help individuals to achieve, maintain and recover to the level of health and wellbeing they aspire to by being a trusted provider and partner".
- Nuffield Health has six beliefs that underpin the behaviour of their people, and four values that guide and work alongside their beliefs. Their values are to be "enterprising, passionate, independent and caring".
- At a local level, the hospital "strives to become the private hospital of choice in the West Midlands by ensuring high quality care that is safe, effective and personalised to the individual needs".
- Staff were aware of the hospital values this was reflected in their work by caring and passion to provide high quality care for patients.

Governance, risk management and quality measurement for this core service

- The hospital had procedures to ensure they were able to manage consultant's practicing privileges (PP) well. We received a sample of three consultant records that showed hospital had received all the necessary compliance documentation. These records contained information such as indemnity insurance numbers, General Medical Council renewal dates, qualifications, references, last completed appraisal and renewal dates.
- We were not assured the hospital had a robust process in place to ensure there was an up to date set of patient's records on site at all times, which is a legal requirement. This is because some consultants take away patient notes without leaving a copy on site. We advised the hospital management that this was a breach of regulations (Regulation 17 HSCA (RA) Regulations 2014) which requires that a full record is retained by the service provider. The management team were aware and explained that this process was being changed and all patients will have a Nuffield medical record. They told us this was a priority. However, there was no set date for this new system to be completed.
- The hospital had no tracking tools in place to prevent consultants misplacing patient notes when taking them off site. If patients notes were not available, the booking team would create a new record and hope that the consultant has recorded all intervention electronically, the hospital were aware this could impact on patients and this was being looked at as a matter of urgency.
- The medical advisory committee received updates on the performance of the outpatient and radiology service, including monitoring referral to treatment times. This meant senior management discussed quality of the service.
- The local senior team within outpatients and diagnostic imaging were fully aware of the risks and challenges of the department and knew when they would add items on the risk register.
- The risk register was an item on the senior team meeting agenda and the team discussed risks at the clinical governance meetings and head of department meetings.
- Issues on the risk register included, less staff that were able to complete pre-assessments, due to increase of activity with chemotherapy patients. This risk remained open although there had recently been a new pre-assessor lead nurse employed.
- Another issue identified on the risk register was the mammography equipment reaching its expected limit of usefulness. There was a manufacturer's contract to repair when it broke down and staff told us that they were waiting for a new machine. This had been discussed at MAC meetings and identified as a risk, with a plan to replace the equipment.
- An infection prevention and control lead nurse were responsible for coordinating audit, reviewing infection control incidents and providing training to staff. This was effective in monitoring clinical and the performance.

Public and staff engagement

- Patients were able to leave feedback and comments via a variety of different websites. In addition, the hospital requested feedback from patients during their visit to the clinic.
- Staff had a free membership to the hospital gym with a discount membership price for their spouse.
- The hospital also offered patients a free consultation at the hospital gym and the physiotherapy team were able to refer a patient to the gym if they felt this would be beneficial for the patient.

Good

Outpatients and diagnostic imaging

- Newsletters were produced for staff and for consultants and distributed by email and as printed copies. Both newsletters contained items on developments at the hospital, staff achievements, learning from incidents and training opportunities and requirements.

Innovation, improvement and sustainability

- The hospital had plans to expand the oncology service and provide a new chemotherapy suite.

The service has opened an MRI suite and aim to have a full CT scanning service in the near future but there was not a set date as of yet.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital MUST ensure staff have access to all necessary information, including maintaining an accurate, contemporaneous record in respect of each patient and this information is available onsite at all times.

Action the provider SHOULD take to improve

- Work towards recommended guidelines such as the Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises when carrying out minor procedures outside of the main theatre areas.
- Ensure mandatory training for Immediate Life Support (ILS) is kept up to date.
- The hospital had no written procedure for covering consultants when on leave or unavailable. Consultants verbalised their availability to staff as an informal process. We saw this arrangement as not a robust system and needed to be strengthened.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 1 2 (c)** **The Provider did not ensure that hospital staff had access to all necessary patient information on site, including maintaining an accurate, complete and contemporaneous record in respect of each patient.**