Nuffield Health

Nuffield Health Tees Hospital

Quality Report

Nuffield Health Tees Hospital
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Outstanding ☆
Surgery	**Outstanding** ☆
Outpatients and diagnostic imaging	**Good** ●

Summary of findings

Letter from the Chief Inspector of Hospitals

Nuffield Health Tees Hospital is operated by Nuffied Health. We carried out an announced comprehensive inspection of the hospital on the 7th and 8th February 2017 as part of our national programme to inspect and rate all independent hospitals. We inspected the core services of surgical and outpatients services, as these incorporated the activity undertaken by the provider at this location.

Between October 2015 and September 2016, the service reported 7,060 day case or inpatient attendances. At the time of the inspection, the endoscopy service was not accredited by the Joint Advisory Group for Gastrointestinal Endoscopy (JAG). The outpatient department hosted specialities such as gastroenterology, general surgery, orthopaedic surgery and plastic surgery. Between October 2015 to September 2016, the hospital outpatient department recorded 15,978 total outpatient attendances. Of these, 8,209 were new appointments and 7,769 were follow-up appointments.

The hospital had 30 overnight beds but did not admit emergency patients. It provided some services for young people between the age of 16 and 18 years who had been risk assessed to ensure they could be nursed in an adult setting. Nuffield Health Tees Hospital had contract agreements with external providers for pathology, histopathology, blood transfusion, some diagnostic radiology and sterile services. The hospital was open 24 hours per day. However, outpatient and diagnostic appointments were available between 7.30am to 8.00pm Monday to Friday, with the additional capacity for Saturday working. Some diagnostic imaging services provided evening appointments on selected weeknights. Facilities included a pre-assessment area, two operating theatres and recovery area. There were outpatient clinic rooms, diagnostic imaging rooms and a physiotherapy gym for patients to use under staff supervision to assist rehabilitation. The majority of the work the hospital carried out was NHS (84%) compared to 16% funded by other means such as self-pay or medical insurance.

There were 29 registered nurses, 23 health care assistants or operating department practitioners and 61 other staff including radiographers and administrative staff. The hospital employed two resident medical officers (RMOs) and 112 consultants worked with practising privileges at this hospital. The senior leadership team comprises of the General Manager, Matron and Finance Manager. Experts from Nuffield Healthcare supported the hospital.

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.

During the inspection, we visited the pre assessment area, recovery bays, both theatres, three clinic rooms and waiting areas. We spoke with 54 staff including; registered nurses, health care assistants, reception staff, medical staff, pharmacy staff, operating department practitioners, and senior managers. We spoke with 22 patients. During our inspection, we reviewed 28 sets of patient records. We held focus groups with staff to allow them time to talk to inspectors and share their experiences of working in Nuffield Health Tees Hospital. We also interviewed the members of the management team and the chair of the Medical Advisory Committee (MAC). We reviewed all complaints from 2016/17. We reviewed 10 practising privileges consultant personnel files. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

There were no breaches of regulations, however there were areas where the provider should:

- Ensure that all ward based stock items are in date in the store room and resuscitation trolley and subject to stock rotation (using the oldest first).
- Ensure all corporate policies and guidelines on the hospital intranet are in date.
- Ensure all corporate policies which are being reviewed have a nominated lead and timescale for completion.
- Ensure that a long term solution to the theatre sterilising machine is in place as soon as possible.

Services we rate

Summary of findings

We rated this hospital as Outstanding overall.

We rated it good for being safe and effective and outstanding for being caring, responsive and well led. This was because:

- Referral to treatment times were consistently good for both privately funded and NHS patients. Managers monitored waiting times for appointments, treatment and cancellations to ensure that waiting time targets were met. Service complaints were low and staff responded to these in a timely manner.
- All patients we spoke with told us they were treated courteously and respectfully and their privacy and dignity was maintained. The organisation had a strong patient focussed culture and this was clearly visible in the way that staff spoke with and supported patients.
- Staff recognised the need to approach patient treatment and care from a holistic perspective. The whole surgical pathway was integrated and coordinated to maximise benefit for the patient. There were examples where staff had gone the extra mile to ensure this. Feedback from patients using the service was consistently very positive.
- The leadership, governance and culture within the service were excellent. There was a vision and strategy that all staff adhered to closely. Governance arrangements were robust.
- Staff were proud to work for the organisation and staff morale was high. Managers at all levels were visible, approachable and available at all times to all staff regardless of discipline. Staff satisfaction survey results were good.
- Patient care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice recommendations. Outcomes for patients were good. Patients confirmed pain relief and nutritional standards met their needs.
- Staff reported incidents and there were robust incident reporting systems in place. We saw incidents were fully investigated and lessons learnt were shared with all staff across the hospital.
- Infection prevention and control practices were good, and departments were clean and well equipped. Record keeping, including risk assessments and safety checks were very good and policies for medicines management followed recognised guidelines.
- Staffing levels were planned and monitored to keep patients safe at all times. Staffing levels across departments were good. There were good processes in place to monitor signs of deteriorating health and respond to medical emergencies. Overall, mandatory training figures were very good and attendance was well managed. Staff had an awareness of safeguarding procedures and where to refer for additional support and guidance.
- Staff received annual appraisals and were supported with revalidation and worked together proactively to ensure best care and treatment was delivered to patients. Consent to care and treatment processes were good and patients were able to make informed decisions.
- The service made reasonable adjustments to support vulnerable patient groups and was working towards becoming a more dementia friendly service.

There were no breaches of regulations, however there were areas where the provider should:

- Ensure that all ward based stock items are in date in the store room and resuscitation trolley and subject to stock rotation (using the oldest first).
- Ensure all corporate policies and guidelines on the hospital intranet are in date.
- Ensure all corporate policies which are being reviewed have a nominated lead and timescale for completion.
- Ensure that a long term solution for the theatre sterilising machinery breakdowns is in place as soon as possible.

We found good practice in relation to outpatient care:

- There were audits of clinical practice undertaken regularly.
- Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R audits were undertaken in line with regulatory requirements. Results indicated the service performance was in line with national standards.
- Staff informed patients about their care and treatment, and spent time with patients to discuss concerns and answer questions.

Summary of findings

- Staff gave patients appropriate support and information to cope emotionally with their care, treatment or condition.
- Staff made adjustments to accommodate patients' individual needs, for example, patients with dementia, learning disabilities physical disabilities or for those whose first language was not English.
- Patients were able to be seen quickly for urgent appointments, if required and clinics were only rarely cancelled at short notice.
- There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed.
- The department supported staff who wanted to learn, be innovative, and try new services and treatments.
- The hospital engaged with staff and there was an annual Leadership MOT carried out.
- The service managed staffing effectively and services always had enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs.

We found areas of outstanding practice in surgery:

- Staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.
- The hospital had a fully integrated and coordinated pathway for surgical patients that spanned outpatients, diagnostic imaging, preparation for surgery, pharmacy, surgery, post-surgery therapy and follow up appointments.
- Patients were prescribed take out medication prior to surgery to ensure that discharge was not delayed due to waiting for medication.

Services we do not rate

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. We did not issue the provider with any requirement notices.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Outstanding ☆	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as outstanding because it was caring, responsive and well-led. It was rated as good for being safe and being responsive to people's needs.
Outpatients and diagnostic imaging	Good ●	Outpatients and diagnostic imaging were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe and effective and caring.We rated this service as outstanding for responsive and well-led.

Nuffield Health Tees Hospital

Detailed findings

Services we looked at
Surgery; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Nuffield Health Tees Hospital

The hospital is situated in Norton in a purpose built building that opened in 1981. It provided services to patients across North and South Tees and surrounding areas. It is a modern facility for day case and inpatient surgical, diagnostic procedures and outpatient services. The centre is commissioned locally to provide elective services to NHS patients as well as private elective treatment in orthopaedics, general surgery, endoscopy, plastics, urology, gynaecology, ENT, dermatology, rheumatology and ophthalmology.

The hospital had 30 overnight beds but did not admit emergency patients. It provided some services for young people between the age of 16 and 18 years who had been risk assessed to ensure they could be nursed in an adult setting. Nuffield Health Tees Hospital had contract agreements with external providers for pathology, histopathology, blood transfusion, some diagnostic radiology and sterile services. The hospital was open 24 hours per day. However, outpatient and diagnostic appointments were available between 7.30am to 8.00pm Monday to Friday, with the additional capacity for Saturday working. Some diagnostic imaging services provided evening appointments on selected weeknights. Facilities included a pre-assessment area, two operating theatres and recovery area. There were outpatient clinic rooms, diagnostic imaging rooms and a physiotherapy gym for patients to use under staff supervision to assist rehabilitation. The hospital carried out care funded by both the NHS and by other means such as self-pay or medical insurance.

There were 36 registered nurses, 28 health care assistants or operating department practitioners and 61 other staff including radiographers and administrative staff. The hospital employed two resident medical officers (RMOs) and 112 consultants worked with practising privileges at this hospital. The senior leadership team comprises of the Hospital Director, Matron, Finance Manager and Sales and Services Manager. Experts from Nuffield Healthcare supported the hospital.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector,two further CQC inspectors, an assistant inspector and specialist advisors with expertise in governance, surgery, outpatients, theatre management, nursing and medicine. Suzanne McLeod, lead inspector, oversaw the inspection team.

How we carried out this inspection

Detailed findings

Facts and data about Nuffield Health Tees Hospital

The hospital is a single storey building open 24 hours a day, seven days a week. Facilities include two operating theatres and a recovery area plus an endoscopy suite. There were also eight outpatient consultation and treatment rooms as well as a physiotherapy suite and diagnostic radiology facilities. There were 30 beds available for patients to stay overnight.

The hospitals offered outpatient appointments in the following specialities, such as gastroenterology, general surgery, orthopaedic surgery, ENT, urology, spinal surgery, rheumatology, ophthalmology, cardiology, gynaecology, neurosurgery, respiratory medicine, dermatology and plastic surgery.

Between October 2015 to September 2016, the hospital outpatient department recorded 15,978 outpatient attendances. Of these, 8,209 were new appointments and 7,769 were follow-up appointments.

Over 7,060 surgical procedures were performed in the same time period, including elective orthopaedic, general surgery, cosmetic surgery, endoscopy and plastics. At the time of the inspection the endoscopy service was not accredited by the Joint Advisory Group for Gastrointestinal Endoscopy (JAG).

Nuffield Health Tees Hospital is registered to provide the following regulated activities:

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

There were locally outsourced services which included, pathology, histopathology, provision of blood components and sterile services.

During the inspection, we visited the pre assessment area, recovery bays, both theatres, three clinic rooms and waiting areas. We spoke with 54 staff including; registered nurses, health care assistants, reception staff, medical staff, pharmacy staff, operating department practitioners, and senior managers. We spoke with 22 patients. During our inspection, we reviewed 28 sets of patient records. We held focus groups with staff to allow them time to talk to inspectors and share their experiences of working in Nuffield Health Tees Hospital. We also interviewed the members of the management team and the chair of the Medical Advisory Committee (MAC). We reviewed all complaints from 2016/17. We reviewed 10 practising privileges consultant personnel files.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in November 2014. We did not give any ratings at that time. This is the hospital's first inspection since the introduction of CQC's new methodology where ratings are given to the five key questions. In November 2014 we found that the hospital was meeting all of our standards of quality and safety.

- In the reporting period October 2015 to September 2016, there were 7,060 inpatient and day case episodes of care recorded at the hospital. Of these 67% were NHS-funded and 33% funded by other means. The top three specialties were
- Orthopaedics (40%);
- Ophthalmology (17.6%);
- Plastic Surgery (13.1%).
- There were 15,978 outpatient total attendances in the reporting period; of these 8209 were new appointments and 7769 were follow-up appointments. Of these appointments, 16% were other funded and 84% were NHS-funded.
- There were 112 surgeons or anaesthetists working at the hospital under practising privileges. Two medical staff were employed permanently at the hospital. Within the surgery team there were 13.5 whole time equivalent (WTE) employed registered nurses and seven WTE care assistants. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- Two Never events
- Clinical incidents 216 in total of which 74% no harm, 14% low harm, 11% moderate harm, 0% severe harm, 0% death.

Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

Detailed findings

Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Zero incidences of hospital acquired Clostridium difficile (c.diff)

Zero incidences of hospital acquired E-Coli

22 complaints

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Maintenance of medical equipment
- Pathology, microbiology and histology
- RMO provision
- Medical record storage

Our ratings for this hospital

Our ratings for this hospital are:

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

Surgery

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

Information about the service

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

Summary of findings

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

Surgery

Are surgery services safe?

Good

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

We rated safe as **good.**

Incidents

- The hospital had policies for reporting incidents, near misses and adverse events. All Nursing staff were knowledgeable about reporting incidents using the electronic reporting system. Staff were encouraged to report incidents and could explain how information and findings were shared with the team.
- The hospital reported 218 clinical incidents between October 2015 and September 2016 of which 202 were related to surgery. We found that 74% (150) were reported as no harm, 14% were reported as low harm and 11% reported as moderate harm. There were no incidents reported as severe or death.
- There were two 'never events' reported between January and December 2016. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. We reviewed both root cause analysis (RCA) reports, these were found to be thorough and externally reviewed in line with Nuffield Health processes. All theatre staff we spoke with were able to inform us of changes which had come into place following the investigations to reduce the risk of these events happening again.
- Staff told us they received feedback from incidents through ward and department meetings. We reviewed minutes of these meetings that confirmed this.
- The hospital did not hold separate mortality and morbidity meetings, however, incidents and adverse events such as unplanned returns to theatre were discussed at the Medical Advisory Committee (MAC), the notes of the clinical governance sub-committee were discussed as well. We reviewed MAC meeting minutes between February and October 2016 and found cases were presented and clinical aspects of care discussed.

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

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harm that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism and falls. The surgical ward participated in the NHS safety thermometer for NHS patients only. Senior staff conducted monthly audits of patient falls, pressure ulcers, catheters and urinary tract infections. The audits showed that patients received predominantly 'harm free' care. However, information about the audits was not displayed in public areas. It is considered to be best practice to display the results of the safety thermometer audits to allow staff, patients and their relatives to assess how the wards had performed.
- From April 2016 to January 2017, 100% of NHS patients were risk assessed for venous thromboembolism (VTE). The hospital had two incidents of hospital acquired VTE during this period, these were reviewed and lessons were learnt.

Cleanliness, infection control and hygiene

- There was a clear process for the management and prevention of infection. We observed ward staff adhere to the 'bare below the elbow' policy. Bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails or nail varnish. Staff, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves.
- We found 100% of both theatre and ward staff had completed their mandatory infection prevention training by December 2016. Additionally, training records showed 30 out of 32 staff in theatres (94%) and 23 out of 24 staff on the ward (96%) had completed the infection prevention practical training. The hospital target was 85%.
- The ward area was visibly clean and well maintained. We observed domestic staff on the ward with cleaning trolleys and using a colour-coded system to minimise the risk of cross infection. We found complete cleaning and legionella water flushing schedules.

- Clean linen was stored appropriately and readily available on the ward and in theatre.
- Hand sanitiser gel was available at the entrance to the ward and theatres, along corridors, and in each of the patient's rooms.
- Staff implemented policies and procedures for the isolation of patients to minimise the spread of infections, when required. All patients were cared for in individual rooms.
- Staff used green 'I am clean' stickers to show equipment was clean and ready to use. These were clearly visible, dated and signed appropriately.
- The theatre suite was visibly clean, and there was a safe 'flow' from clean to dirty areas to minimise the risk of cross contamination of equipment. However, we were informed one of the cleaning machines broke down regularly, which caused delays in procedures and in the worst case cancellations, this also occurred during our inspection. We were informed that a business case had been submitted to replace this machine. The hospital used single use equipment where possible.
- Daily, weekly and monthly cleaning rotas were displayed in theatres. Staff were required to sign when cleaning had taken place. Senior staff monitored the completion of the cleaning tasks and the overall cleanliness of the department. We saw that these had been completed fully. In operating theatres, we saw staff following the infection control policy. Information was clearly displayed above sinks to remind staff about correct handwashing procedures. We observed staff were bare below the elbows and were seen washing their hands and using hand sanitiser appropriately.
- All patients who attended pre-assessment clinics were screened for Meticillin resistant Staphylococcus aureus (MRSA) operation. There were no incidents of MRSA, Clostridium Difficile or E.coli in the period between October 2015 and September 2016.
- There were three surgical site infections reported between October 2015 and December 2016, however, we did not see evidence of these being investigated. There were no surgical site infections resulting from orthopaedic, gynaecology, colorectal and upper gastrointestinal and vascular surgery.
- The hospital had an infection prevention and clinical outcomes nurse who monitored the implementation of policies and results of audits, provided guidance at senior nurse meetings and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital.
- Patient Led Assessments of the Care Environment (PLACE) for February to May 2016 showed the hospital scored 100% for cleanliness, which was better than the England average of 98%.
- There was carpet in the ward corridors, however, the flooring in the bedrooms met infection, protection and control requirements. The hospital recognised the carpets were an infection control risk and there was a rolling programme for removal of carpets. We observed the carpets were clean and staff signed and dated to show carpet cleaning schedules were complete.

Environment and equipment

- The ward and the theatre department had portable resuscitation trolleys. The trolleys contained medication for use in the event of a cardiac arrest. We saw daily and weekly check sheets completed for all trolleys to ensure equipment was available and in date, however, we found out of date equipment on the ward trolley, we highlighted this with senior staff and we observed equipment being replaced immediately. The ward resuscitation trolley had tamper evident tags to alert staff to any potential removal of equipment, however this was not present on the trolley in theatre. We also observed the top shelf of this trolley had a crack on the top which could be an infection control risk, we highlighted these issue with senior staff.
- We found out of date equipment in the ward treatment room, this was highlighted with senior staff and all equipment was removed and replaced immediately.
- Equipment had been safety tested, stickers showed when the equipment was next due for testing, this included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff could access the equipment they needed and said they had sufficient equipment to care for patients. There was one hoist available for the ward. Staff we spoke with said they rarely used the hoist. Patients had access to physiotherapy equipment if required.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required.
- All theatres had an adjoining anaesthetic room where patients were prepared for their operation.

- Surgical instruments were compliant with Medicines and Healthcare products Regulatory (MHRA) requirements.
- Theatre staff kept registers of implants, for example hip and knee, ensuring details could be provided to the health care product regulator if required.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Staff completed a logbook for each anaesthetic machine to record the daily pre-session check.
- A Nuffield Hospital central hub provided sterile services and supplies. Surgical instruments were readily available for use and staff reported there were no issues with supply. Instruments could be prioritised for a quick return if needed.
- Single use equipment such as syringes, needles, oxygen masks were readily available on the ward and in the operating theatre department.
- Bariatric surgery was not carried out at this hospital, however, at pre-assessment if a patient was identified as having a raised BMI but below 45, an alert was sent to the theatre so that adjustments could be made prior to the list.
- Within the theatre, there was a recovery ward, equipped with appropriate facilities to care for patients in the immediate post-operative period before they returned to the ward.
- The hospital maintained water supplies at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria colonisation.

Medicines

- The pharmacy team consisted of two part time pharmacists working five hours a day Monday to Friday, one pharmacy manager working 37.5 hours per week and one stock assistant support 3.5 hours on Tuesdays and Thursdays. The pharmacist usually visited the ward daily.
- Pharmacy services were available Monday to Friday 08.30 to 16.30. The department was not open on Saturdays. Out of hours support was available for clinical advice from another Nuffield Health Hospital 16.30 – 08.30 seven days a week. The senior nurse on the ward and Resident Medical Officer together had access to pharmacy out of hours and records were kept when access was required.
- The department used a system of advanced dispensing where a pharmacist reviews all completed care records prior to admission with the exception of patients undergoing cataract, gastroscopy and colonoscopy procedures. To take out (TTO) medications were arranged for each patient between the pharmacy and the Resident Medical Officer prior to admission. Staff informed us that this was a very good system and reduced the risk of delayed discharge.
- We looked at the prescription and medicine administration records for eight patients on the ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them and as prescribed. However, there was no place on the prescription chart for the prescriber to print their name.
- Controlled drugs (CDs) require special storage arrangements. We saw that there were suitable arrangements in place on the ward to store and administer CDs. Stock levels were appropriate and monitored. When a patient had their own CDs, they were stored in the CD cupboard and returned to the patient on discharge.
- CDs were audited quarterly, the most recent audit (October 2016) showed 100% compliance with the Nuffield Heath policy for the storage and distribution of CDs.
- Fridge temperatures were monitored daily and we found records complete. All staff we spoke with were aware of what to do if fridge temperatures went out of range.
- Emergency medicines including oxygen were available for use and expiry dates checked on a weekly basis. There were piped medical gases on the ward and in the theatre. Portable oxygen cylinders were available for the transfer of patients from the theatre to the ward.
- Appropriately packaged and labelled medication was available for patients to take home after their surgery. To take Out (TTO) packs were available for patients, if discharged when the pharmacy was closed.
- Staff recorded allergies in the patients' care records and on patients' individual drug charts.

Surgery

Records

- The hospital used specific Nuffield Health care records, which contained all information regarding patients' pre-admission, admission, treatment, post-operative care and discharge information. There were four versions of the care record; one for long stay care (more than 24 hours), one for day and overnight care (less than 24 hours), one for day case surgery without general anaesthetic and one for a surgical outpatient procedure. We looked at eight patients' care records and saw information was clear, factual and organised. Each entry was dated and signed by staff.
- The care records included the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist. There were pages to complete with details of the patient's care during anaesthesia, surgery and recovery as well as their discharge arrangements. Records were comprehensive, fully completed, accurate and up to date.
- We saw the theatre records section of care plans were clear and documented checks to ensure safe surgery and treatment was undertaken. Following each patient's surgical treatment, daily multidisciplinary records were maintained of all care and treatment provided. All health care professionals including consultants, nursing staff and physiotherapists documented care and treatment in the health record.
- Records were paper-based. Nursing records were stored in the patient's room. Medical notes were stored securely in a locked room next to the ward reception, which ensured they were kept confidential.
- Staff maintained an operating theatre register, that contained all the information needed to ensure an accurate record was kept.
- A record keeping standards audit was completed in March, June and September 2016. Each audit reviewed 25 records. They showed overall audit compliance scores of 82% in March 2016 to 91% in September 2016. We saw evidence of documentation audit and action plans being discussed in ward and board meeting minutes.
- Records that we reviewed had a signed signatory list contained within them.

Safeguarding

- Safeguarding policies and procedures were in place to ensure that staff understood their responsibilities to protect vulnerable adults and children. We reviewed this policy and it was within date and had been reviewed.
- The hospital director, matron were jointly responsible for leading on all safeguarding for the hospital. Both were trained to level three safeguarding as were the resident medical officers (RMOs).
- All staff had access to flow charts in each department detailing the actions to be taken and who to contact in the event of adult safeguarding issues arising. Staff demonstrated an understanding of their safeguarding responsibilities and an understanding of safeguarding procedures. Safeguarding training was part of staff mandatory training, this included training about female genital mutilation (FGM). All members of staff had to complete level one and two safeguarding children and young adults training. We found that 100% of staff on the ward had received safeguarding vulnerable adults level one training and 100% had received safeguarding children and young adults level one training and 80% of staff have received safeguarding children level two training against a hospital target of 85%.

Mandatory training

- Mandatory training at the hospital included, consent, fire safety, Mental Capacity Act 2005, safer blood transfusions and health record keeping. Staff could access training on line and face to face training was available for basic life support, intermediate life support, manual handling and aseptic technique.
- The induction programme for new staff, including bank staff, covered all the key statutory and mandatory training.
- An external specialist trainer provided resuscitation training, this included basic life support and immediate life support.
- The hospital compliance target for mandatory training was 85%. Compliance with training was good. Pre-assessment staff had 100% compliance with all required training, however, information provided to us up to October 2016 showed ward staff were below the target for aseptic technique (42%), medical devices in practice (67%), basic life support (79%), deprivation of liberty safeguards (79%), information governance (84%) and moving and handling practical (80%). Theatre staff

were below target on aseptic technique (59%), immediate life support (77%) and manual handling practical (59%) Plans were in place to ensure that all staff reached the 85% target by the end of the year.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital system but the medical advisory committee checked assurance of mandatory training. The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced. They showed us evidence of when this had happened.
- The RMOs received mandatory training via their agency, however, staff we spoke with advised us they did not have access to the hospital's on-line training systems.

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

- Patients' risks were assessed and monitored at surgical pre-assessment, and checked again before treatment. These included risks about mobility, medical history including testing for pregnancy, skin damage and venous thromboembolism (VTE). Patients had to meet certain criteria before they were accepted for surgery, these minimised risks to their health and wellbeing.
- All anaesthetic staff remained in the department until the last patient had left the recovery bay.
- Patients were required to complete a comprehensive preadmission questionnaire to assess if there were any health risks, which may compromise their treatment. Nurses discussed the health questionnaires with patients in the pre-admission clinics or via the telephone. If staff identified a patient as being at risk, they referred them by email to the anaesthetist responsible for the operating list, this was an additional step to increase the safety of the patient.
- The pre assessment team had developed an alert form to be completed and sent to the theatre team. This would give additional information about the patient for example raised body mass index, or any other special requirements prior to the commencement of the operation list.
- Day case patients underwent the same pre-assessment key health questionnaire and risk assessments, reviewed on the day of surgery.
- The care records included pre-admission assessments and investigative tests that ensured patients met the admissions criteria and were suitable for treatment at the hospital.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example, all care records contained risk assessments for venous thromboembolism (VTE). Patients who needed to stay overnight or for longer periods also had manual handling, pressure ulcer risk and nutritional assessments. Patient's length of stay was, in the majority of cases, no longer than four days.
- The cosmetic surgeon carried out psychological screening for cosmetic surgery patients. The surgeon identified if the patient needed additional psychological assessment in advance of agreeing to surgery.
- Ward nurses met for a handover at the start of their shift to discuss all patients on the ward, this was done on a room by room basis which protected, patient confidentiality. We observed thorough and patient-centred handovers and staff handed over changes in patients' conditions which ensured that actions were taken to minimise any potential risk to patients.
- Staff used the Modified Early Warning System (MEWS) to monitor patients and identify deterioration in health. This is a series of physiological observations, which produce an overall score. The increase in score would note deterioration in a patient's condition. A plan was available in each patient's records for staff to follow if the scores were to increase. The hospital management were planning to change the MEWS to the National Early Warning Score. We checked MEWS scores and found them all to be complete.
- On the wards, patients with a known risk of falls were allocated a health care assistant to allow for one to one care and observation.
- In theatre, staff used the World Health Organisation (WHO) "Five Steps to Safer Surgery" checklist. This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. These checks included a team brief at the beginning of each theatre list and the WHO surgical safety checklist (a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications).

- Staff completed an observational audit of the WHO "Five Steps to Safer Surgery". We reviewed these audits from October 2015 to September 2016 and found between 95% and 99% compliance.
- Regular simulated cardiac arrest scenarios were carried out so staff could respond quickly and be rehearsed should a real life cardiac arrest occur. Feedback was given to individuals on their performance.
- In the event that a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. From October 2015 to September 2016 there were 13 patients who had an unplanned transfer to another hospital. Staff gave us an example of a patient who had deteriorated during the night and had been transferred to the local NHS trust within twenty minutes.
- An RMO was on site at all times. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support (ALS) and Paediatric Advance Life Support (PALS) trained. They held a bleep for immediate response e.g. in the case of cardiac arrest and for non-urgent queries.

Nursing and support staffing

- Staffing levels on the wards were sufficient to support safe care. The hospital's ward staffing levels were set using the guidance from the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidelines, a ratio of five or six patients to one registered nurse in the daytime and a maximum of one registered nurse to eight patients overnight. During the day there were two health care assistants allocated, possibly three in the morning depending on workload.
- Staffing levels were calculated on a weekly basis, then checked and adjusted daily depending on changes and or patient requirements.
- There was a better nurse to patient ratio for those patients requiring a higher level of care.
- The nurse in charge of each shift had a zero or minimal patient caseload to allow them to support staff in the event of unpredictable or unplanned events.
- Staff worked flexibly, and said there were enough staff to provide safe care. The night shift was always staffed with at least two registered nurses, this included when patient occupancy levels were low. This enabled staff to respond to emergency situations.
- The hospital used a bank of nurses, who regularly worked in the hospital.
- Handovers were conducted on a room by room basis, we observed that these were concise, and protected patient confidentiality.

Medical staffing

- There were 112 consultants with practising privileges at the hospital. All had their status reviewed every two years by the Hospital Director and then ratified by the Medical Advisory Committee to check they continued to be suitable to work at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector.
- There were strict guidelines in place with regard to privileges, if a consultant had not treated in the hospital in six months their privilege was removed.
- The hospital director met with each consultant annually, each consultant was required to provide assurance of training, revalidation and appraisal, if the consultant was unable to provide this their practicing privileges would be suspended. We were provided with examples of consultants privileges having been suspended.
- All consultants awarded practising privileges agreed to abide by the Nuffield Health practising privileges policy, and provided the organisation with standard information showing they fulfilled the criteria. All consultants maintained registration with the general medical council (GMC) and were on the specialist register.
- Consultants were required as part of the practising privileges hospital policy to remain available (both by phone and in person) or arrange appropriate alternative named cover if unavailable when they had inpatients in the hospital.
- A member of the nursing staff told us that medical cover was good and consultants were always obtainable. They said they would return to see their patients if necessary and always provided cover arrangements when not accessible. There was an on call anaesthetist and resident medical officers to provide support.

Surgery

- The hospital employed two RMO through an agency, they worked one week on and one week off. The RMO was based on-site and was available 24 hours a day, seven days a week. The role of the RMO was to review patients on a daily basis, prescribe additional medication and liaise with the consultants responsible for individual patient care.
- We were told handovers between RMOs were effective. The RMO also attended the handover from the night shift. This ensured that the RMO had an understanding of the patients' needs on the ward overnight.
- All patients were admitted under a named consultant who had clinical responsibility for their patient during their entire stay. Staff we spoke with advised that consultants were approachable and part of the team.
- There was a senior management on call rota in place seven days per week. This rota was circulated and all staff were aware of the senior contact for the hospital each week.

Emergency awareness and training

- The hospital had a major incident plan, which identified roles and responsibilities of the senior management team and staff. Theatres had their own on-call rota to ensure adequate back up and cover was available to deal with emergencies or incidents. The hospital recognised the importance of external major incidents however, as a private healthcare provider its capabilities fell outside the areas of services that would normally respond to an external major incident.
- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Hospital-wide unannounced fire drills took place quarterly to test staff knowledge of the evacuation plan, we were informed the last one conducted was out of hours. All staff understood their responsibilities if there was a fire within the building.
- The staff we spoke with were aware of where to find local guidance and procedures to follow in the event of a major incident.
- Business continuity plans for surgery were in place. These included the risks specific to each clinical area and the actions and resources required to support a return to normal services.

Are surgery services effective?

Good

We rated effective as **good.**

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example the modified early warning system (MEWS) was used to assess and respond to any change in a patient's condition. This was in line with NICE clinical guideline 50.
- The hospital completed a monthly gap analysis of new National Institute for Health and Care Excellence (NICE) guidelines, assessed whether these were relevant to the services offered by the hospital and action they needed to take to implement them.
- Adherence to policies and national guidelines was discussed at management and departmental meetings to ensure care and treatment offered was up to date.
- Staff completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline [CG92] 'Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism)' in patients admitted to hospital.
- Patients' temperatures were measured and documented in accordance with 'Inadvertent perioperative hypothermia', NICE guidance clinical guideline [CG65].
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines [CG74].
- In line with professional guidance, the hospital had a process in place for the recording and management of medical device implants.
- There was an on-going audit programme to evaluate care and review clinical practice. These included audits such as, care record and VTE audits. Clinical staff achieved 98%, which was above 95% target for venous thromboembolism screening rate in the reporting period (March to September 2016).
- The hospital monitored performance using a local audit known as 'Gov 14'. Audit of the health records including: manual handling, slips, trips and falls, consent, the

World Health Organisation (WHO) five steps to safer surgery checklist, infection prevention, medicines management, discharge, documentation and clinical handover. We reviewed meeting minutes that evidenced the findings of the local audits and resulting action plans were discussed.

- We found all local policies and standard operating procedures were within the review date. However, we found a large number of Nuffield Health corporate policies on the hospital intranet page were not current. There were 61 policy documents on the intranet page and 33%(21 policies) were under review, yet, there was no allocated reviewer or expected date These policies included management of dropped instruments in theatre. Of the policies reviewed 41% (25 policies) had been assigned a reviewer, however the expected date had lapsed.

Pain relief

- Pain relief was discussed pre-operatively, in theatre and on the ward. Staff using a recognised one to ten scoring system assessed post-operative pain and action taken as needed. Whilst in recovery pain levels were constantly monitored and the patient was only moved back to the ward when pain was under control. Recovery staff gave intravenous opiates according to the patient's pain score.
- Patients we spoke with confirmed they were comfortable and pain relief was managed. All patients post-surgery told us they received pain relief as and when needed.
- The hospital had an enhanced recovery pathway for orthopaedic procedures, using defined pain medication pre –operatively, peri-operatively and post-operatively. Staff we spoke with informed us that patients were able to mobilise much more quickly which led to greater independence and earlier discharge.
- Nurses within pre-assessment discussed pain relief with elective patients and provided information leaflets about pain control and anaesthesia. This included information about different types of pain relief and pain scoring.

Nutrition and hydration

- Instructions about fasting times were given during the patients' pre-admission visit. Information included when they could have their last meal and how long they were able to drink water prior to their operation. All patients we spoke with confirmed they had received this information.
- We observed staff checking as part of pre procedure checks when the patient had last eaten or drank and this was recorded in the patients' care record.
- The hospital offered light snacks and drinks for daycase patients before discharge home.
- All patients were provided with hydration information in their pre-assessment appointment, this was to improve patients post-operative outcomes.
- Patients had nutritional screening undertaken at pre-operative assessment or on admission. Clinical staff used the five-step National malnutrition universal screening tool (MUST) to identify adults who were malnourished and followed guidelines to improve food intake. We saw correctly completed MUST assessments to assess nutritional risk were recorded in patient notes.
- We saw that patients who required special diets for example diabetic diet and allergy information was recorded on a white board in the kitchen for all staff to be aware.
- All patients we spoke with were positive about the food they had been served during their stay.

Patient outcomes

- There were 14 cases of recorded unplanned readmissions to hospital within 28 days of discharge from October 2015 to September 2016. Four patients had unplanned returns to theatre from July 2015 to June 2016. There were 13 cases of unplanned transfer of a patient to another hospital between October 2015 and September 2016. We were told all cases of readmissions, transfers and returns to theatre were monitored and reviewed for learning.
- NHS funded patients participated in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement or inguinal hernia repair. PROMS measures the quality of care and health gain received from the patient's perspective. Between April 2015 and March 2016 data from PROMS showed the hospital was within the expected range for primary hip replacement surgery, primary knee replacement surgery and groin hernia repair.

- The hospital uploaded data to the National Joint and Ligament Registries, Breast Implant Register and Public Health England Surveillance, meeting the national requirements.
- The hospital was working towards Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation, however, at the time of inspection this was on hold due to the concerns surrounding the machine used to deep clean equipment used in endoscopy.
- Outcomes were reported through the hospital dashboard and compared nationally against other Nuffield hospitals on a quarterly basis.

Competent staff

- A senior nurse or manager was on duty each shift to provide expert advice and support for more junior theatre staff and this was also the case on the wards.
- All new staff underwent a corporate induction, which included a departmental orientation programme. As part of this process, staff were allocated a mentor who was a senior member of staff. There was also a comprehensive preceptorship programme for new staff.
- Senior theatre recovery staff had training with the North East critical care network and provide updates and support for staff.
- Agency and bank nurses received orientation and induction to the ward area. This included use of resuscitation equipment and medicines management.
- Ward and theatre staff confirmed that appraisals took place and staff told us they had received an annual appraisal. Records showed 100% of staff had had an appraisal in 2016, including administrative and clerical staff. Staff we spoke with told us the appraisal system was effective as it formalised individual competencies achieved and identified training needs for the next year.
- Staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their skills and knowledge through training relevant to their role.
- The theatre and ward managers maintained a system of competency updates using a spread sheet and alert system, all records of yearly assessment and training certificates were stored securely. This also supported revalidation of staff, we reviewed one random record and found it to be very thorough.
- The hospital undertook robust procedures which ensured surgeons who worked under practising privileges had the necessary skills and competencies and that surgeons received supervision and appraisals. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.
- For consultants who were granted 'practising privileges' to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's name.
- Any clinical practice concerns arising in relation to a consultant would be discussed at the Medical Advisory Committee meetings. Actions were created and completed before the consultant could practice at the hospital again.
- The RMO who was employed through an agency underwent an additional recruitment process before they commenced employment. This involved checking their suitability to work at the hospital and checks on their qualification. The MAC chair provided mentoring to the RMOs where required.
- There was a system to ensure qualified doctors and nurses' registration status had been renewed on an annual basis. Data provided to us by the hospital showed a 100% completion rate of verification of registration for all staff groups working in inpatient departments and theatres.
- Staff were positive about access to further training and development courses. Courses were available externally or 'on-line' via the Nuffield Academy.

Multidisciplinary working

- The surgical service demonstrated multidisciplinary teamwork with informative handovers, good record keeping and good communication. Patients' individual needs were considered during pre-admission discussions, with treatments and therapies planned.
- We saw that medical and nursing staff, therapists and pharmacy staff worked in partnership on the ward.
- Our review of records confirmed there were effective multidisciplinary (MDT) working practices which involved nurses, doctors, pharmacists and physiotherapists. For example, we saw physiotherapists had followed therapy guidelines documented by consultants.
- There were service level agreements in place with the local NHS trust in the event a patient required rapid transportation to an NHS hospital.

- Discharge letters were sent to the patient's general practitioner (GP) and a copy of the letter provided to the patient. We reviewed three discharge records and spoke with patients ready for discharge which confirmed this.

Seven-day services

- The hospital provided elective surgery Monday to Friday from 8am to 8pm and Saturday 8am to 3.30pm. The type of surgery was dependant on which consultant was booked in for which day. Staff were aware of the patient lists in advance to enable staffing levels and rooms to be available.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. Consultants provided 24 hour on-call (off site) cover for their patients, if they were unavailable at any time they organised a consultant colleague with practicing privileges to provide cover in their absence.
- There was an out of hours on call theatre rota which included a registered nurse, operating department practitioner, a theatre support worker, an anaesthetist and recovery nurse should a patient need to return to theatre. This team were available within a 30 minute timescale to enable urgent return to theatre.
- Nursing staff and the RMO were available to provide routine or urgent medical and nursing treatment 24 hours a day. A member of senior management was available to support staff as part of an on call rota.
- Radiographers were on call out of hours to provide imaging in case of an emergency.
- The physiotherapy service provided care to inpatients seven days a week, plus an on-call service out of hours.
- The pharmacy was accessible out of hours. The ward co-ordinator and RMO could access the pharmacy to ensure medication was available at all times with the exception of controlled medication. However, there were no alternative arrangements in place to supply controlled drugs out of hours. There was no pharmacy on call service, but the pharmacist had been called out on occasions when controlled drugs had been required.

Access to information

- Staff confirmed patient records were accessible to staff across the service.
- Discharge summaries were faxed to GPs when patients were discharged from the hospital. These were also given to patients on discharge.
- All patients we spoke with felt staff had given them sufficient information about their procedure, and were able to discuss it with their consultant and nursing staff. Staff gave patients information about their procedure at pre-assessment.
- Staff discussed their care in detail and explained what to expect post-operatively including length of stay, and involved patients in their plans for discharge. Ward staff gave patients a discharge pack with specific post-operative instructions.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgeons gained consent from patients for surgery. Information about the procedure was given to patients at their initial visit for assessment. On the day of the procedure the surgeon conducting the procedure recorded formal consent, this met the two part consent guidance.
- A consent audit was conducted quarterly, results for December 2016 showed a 91% compliance. Due to the timing of this audit and our inspection we did not see evidence of actions taken from the audit.
- Staff told us they very rarely saw patients who may lack capacity to make an informed decision about surgery. They were aware of the assessment criteria needed to assess if someone had capacity and understood the decision making processes for people lacking capacity to be in their best interests.
- Records provided by the hospital showed 98% of hospital staff had received Mental Capacity Act and deprivation of libery safeguards (DOLS) training, against a target of 85%.
- There were no DOLS applications made by the hospital on record, however DOLS assessments and application forms would have been completed by consultants.
- The hospital had a policy of not admitting patients with advanced dementia although patients with mild dementia could be admitted for surgery and their care planned so their individual needs were met. Pre-assessment information showed planning took place to accommodate patients with mild confusion. A multidisciplinary team approach was undertaken which included family or carers. A room near to the nurse's

station was provided and staffing levels increased if one to one care was required. At the time of inspection the hospital was in the process of applying to become a dementia friendly hospital.
- The policies for the resuscitation of patients and 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decisions were clear. Unless otherwise requested, all patients who had a cardiac arrest were to be resuscitated. We did not see any DNACPR forms during our inspection. Staff advised us it was rare for a DNACPR form to be in place.

Are surgery services caring?

Outstanding ☆

We rated caring as **outstanding.**

Compassionate care

- Throughout our inspection, we observed care being provided by nursing staff. We saw examples of staff being friendly, approachable and professional. We witnessed a holistic approach to patient care, with patients and their relatives being spoken to with respect at all times and in a manner they could understand.
- We saw people's privacy and dignity was maintained at all times we found staff were highly motivated to maintain patients' dignity at all times. This was achieved with the use of privacy curtains in theatre recovery and single patient rooms on the ward, utilising a coloured light system to identify when patients were receiving personal care.
- We found relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships are highly valued by staff and promoted by leaders.
- We spoke with 22 patients during our inspection and looked at recent patient satisfaction survey results. Feedback was overwhelmingly positive.
- One patient told us that the staff were, "Marvellous" and that they could not fault any aspect of their care, this patient had had one joint replaced previously at the hospital had just undergone another joint replacement.
- A second patient commented, "Every member of staff has the time to talk to you, despite being in a single room I don't feel lonely because the staff are always checking on me."
- A patient who responded to the patient satisfaction survey in November 2016, stated, "From walking in the hospital I was treated with respect and dignity". Another patient commented, "You feel so relaxed in this hospital with the staff, doctors, everyone. It takes the fear of hospitals away".
- Friends and Family Test (FFT) results for the period July 2016 to December 2016 demonstrated an average of 99% of patients would recommend the hospital.

Understanding and involvement of patients and those close to them

- The pre assessment team had implemented a system where patients would attend outpatients for assessment prior to eye surgery and would undertake a pre assessment to save the patient having to return to the hospital following a telephone assessment. Staff we spoke with told us that patient feedback was very positive.
- All patients we engaged with felt well informed and included in the entire decision making process in relation to their care and treatment.
- We reviewed a patient satisfaction survey and again responses were overwhelmingly positive with patients confirming they had been provided with written and other information about what to expect, including treatments and support that was available in the hospital.
- We saw that a wide range of patient information leaflets were available to patients accessing this service and when required, staff talked them through the leaflet for example for patients who had poor eyesight.
- Each patient who attended a pre-assessment appointment was given information about appropriate hydration prior to surgery in an aim to improve recovery.
- Patients who were assessed as high risk for falls were provided one to one care. Staff were committed to working with patients and their family to ensure care was appropriate to the needs of the individual.
- Patients were given written information about different ways to contact the hospital and its staff, including consultants, during and outside of normal working hours.

Emotional support

Surgery

- Sufficient time was allocated for the pre assessment appointment to allow patients time to discuss any fears or anxieties.
- Hospital visiting hours were unrestricted, which meant patients could have access to their family and friends for support if they chose to do so.
- A patient we spoke with told us they did not, "…feel there was a rush to discharge…", as she had not been well following surgery, this, they said was very reassuring.
- We were given examples of pre-assessment cases where patients had been identified as not suitable for surgery at the hospital. On one occasion, the patient was identified during pre-assessment to have some concerning features on assessment which had previously gone undetected. The patient was transferred to the local NHS hospital. Staff at pre assessment called the patient and their relative the following day and again a week later to check how they were.
- There was a non-clinical patient advocate who visited the patients in their rooms to see if everything was ok for them, this included emotional and practical support. Any points raised by patients were immediately taken to the senior nurse in charge of the ward. We were provided with an example where a patient had identified that there was no clothes hook in their en-suite, this resulted in all rooms having a clothes hook installed on the bathroom door.

Are surgery services responsive?

Outstanding ☆

We rated responsive as **outstanding.**

Service planning and delivery to meet the needs of local people

- The hospital worked with the local Clinical Commissioning Group (CCG) in planning services for NHS patients. Operating sessions were made up of a variety of patients who had selected the hospital through NHS e-Referral Service and private patients.
- All admissions were pre-planned so staff could assess patients' individual needs before treatment. This allowed staff to plan patients' care to meet their specific requirements, including cultural, linguistic, mental or physical needs.
- The hospital used admission criteria for patients and only accepted patients for treatments with low risks of complication and whose post-surgical needs could be met through ward-based nursing care.
- The hospital provided elective surgery to NHS and private patients for a variety of the specialities which included orthopaedics, ophthalmology, general surgery, gynaecology and cosmetic surgery.
- Patients had an initial consultation to determine whether they needed surgery, followed by pre-operative assessment. Where a patient was identified as needing surgery, staff were able to plan for the patient in advance so they did not experience delays in their treatment when admitted to the hospital. This ensured that patients could access services in a way and at a time which suited them.
- The hospital had introduced "The Nuffield Health Promise" for self-funded patients. This enabled patients to have further care and follow ups at no extra cost if their expectations had not been reasonably met.
- Should a consultant request an additional theatre slot, the theatre manager was consulted to identify if there was sufficient capacity and was safe to do so, prior to patients being booked.

Access and flow

- The two laminar flow operating theatres were open from 8am to 8pm, Monday to Friday and Saturday 8am to 3.30pm. The non-laminar flow theatre operated 8am to 5pm Monday to Friday. The department would extend the hours if cases required it. This meant there was a planned programme of activity.
- Between October 2015 and September 2016 between 97% and 100% of patients were admitted for treatment within 18 weeks, one patient we spoke with had been referred, seen in outpatients and had their operation in the space of one month.
- The hospital was a provider of NHS e-Referral Service which is a national electronic referral service for the NHS in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Dates for surgery were discussed with patients at their initial outpatients' appointment. Patients were able to choose to have their operations at times suitable for them.

Surgery

- All of the patients we spoke with told us they had short waits for their surgery. We were given an example that a patient had waited two weeks from referral to procedure.
- We were not informed of any delay in the commencement of theatre lists.
- The admission process, care pathways and treatment plans were the same for private and NHS patients.
- The staff in the operating theatres provided an on-call service to ensure that the department was appropriately staffed if there was a need for a patient to return to theatre urgently.
- Patients undergoing cataract surgery received staggered appointment times to reduce patients fasting pre-operatively for long periods before their surgery.
- Healthcare assistants had received extra training to allow them to admit and discharge patients, although a registered nurse remained ultimately responsible for the patients care. This meant patients had timely access to care and treatment and action had been taken to minimise the time they had to wait.
- Records showed that in the 12 months prior to our inspection 60 procedures were cancelled for non-clinical reasons. Of these 100% (60 patients) were offered another appointment within 28 days of the cancelled appointment. We reviewed operational team meeting minutes and found all cancellations were discussed and actions/outcomes were documented.
- Discharge planning commenced at the pre-assessment stage. Planning for discharge continued during admission with specialists such as social services being identified and arranged while the patient was in the hospital. This included medications to take home.

Meeting people's individual needs

- Staff informed us patients' individual needs were assessed at pre-assessment clinic and patients who required extra care, such as those living with mild dementia, would be assisted by ensuring there was extra staff available and arrangements were made for their carers to help if required.
- Pre-assessment was used effectively to ensure the hospital only treated patients if they could meet their needs. The pre-assessment nurse confirmed that all patients were pre-assessed for surgery in advance. If the nurse identified any concerns, they had good communication links with the surgeons and the theatre team for advice and discussion.
- Discharge booklets were given to patients with advice on post-operative care, venous thromboembolism, care of the skin post cannula removal, and ward contact information. Patients who had undergone larger procedures received a telephone follow up call the day after discharge. Patients who had undergone hip and knee surgeries were also followed up 30 days post procedure.
- The physiotherapy team carried out pre-operative exercise sessions for those patients due to under go hip or knee replacement surgery. These sessions gave patients an awareness of the types of exercise that would be required following surgery to improve their mobility and success of the procedure. These sessions were not included in the NHS contract, however, the hospital ensured all patients regardless of funding received the same opportunities.
- Patients were discharged from the hospital when they felt able to be discharged and not just when they were declared medically fit, we observed such an occasion during our inspection.
- The service did not treat complex patients or those with multiple co-morbidity due to not having a level two care facility (High Dependency Unit).
- For patients whose first language was not English, telephone translation facilities were available. In preoperative assessment, staff could change the size of the lettering of patient leaflets if patients had eye sight problems.
- Information that covered a wide variety of topics was displayed throughout the areas we visited. Information for surgical procedures for example, colonoscopy and arthroscopy was also available in Arabic, Bengali, Mandarin, Polish and Punjabi.
- All patients were cared for in individual rooms with private en-suite facilities, which helped maintain their privacy and dignity.
- There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets, for example, diabetic and gluten free diets.

Learning from complaints and concerns

- The hospital had an up to date complaints policy with a clear process to investigate, report and learn from a complaint. There had been nine formal complaints about clinical care between January and December 2016. We saw from minutes of the operational team

meetings that complaints were discussed, for example, the machine used to deep clean equipment used in endoscopy had broken down and the operation list needed to be cancelled.
- The hospital director and matron oversaw complaint investigations.
- The hospital had a patient advocate who carried out patient interviews and acted on any areas of concern. Daily senior staff ward rounds also took place, should any matters arise these were documented in the patient notes and also rectified as soon as possible.
- Arrangements were in place for staff to learn from complaints or patient experiences in order to improve care. These were communicated through team and department meetings and one to one discussions However, at the time of our inspection staff were unable to recount any occasion this had occurred as there had not been any formal complaints recently.

Are surgery services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership / culture of service related to this core service

- An established senior management team (SMT) was in place at the hospital which included the hospital director, the matron, the finance manager and the sales and service manager. The ward and theatres had managers in post who received support directly from the SMT.
- The hospital was managed by a dedicated and proactive leadership team, who had an inspiring shared purpose and aimed to motivated staff to succeed. Staff told us how the hospital director and matron were routinely visible and approachable.
- Staff felt they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- There was an open and transparent culture within the hospital, improvements were made through learning and staff were encouraged to report when things went wrong.
- Two healthcare assistants in the ward area told us that they worked in a "lovely team, everyone gets on well, it is like a family".
- All staff members we spoke with said they felt proud to work at the hospital. One staff member said they liked working at the hospital and that the team was good. All staff reported good working relationships with consultants.
- One staff member in theatre told us that the theatre manager was visible every day and gave them timely information relating to the service; also if it was required the theatre manager would work clinically. The staff member also said that both the matron and hospital director was visible and knew everybody by name.
- One staff member said they felt the senior management team had an open door policy. Another said the senior management team were supportive and provided good leadership.
- Staff we spoke with informed us that they saw the hospital director at the end of each day on the ward asking how the day had gone, and supporting staff as required when the ward was very busy.
- The Nuffield Health Group have a whistleblowing policy in place, which staff were aware of when asked. Staff felt happy and open to raising concerns and speaking up to their local leaders or senior leaders for things that they were not happy with.
- The RMOs were positive about the culture and commented that all staff worked well together.
- The hospital worked with the local university and took nursing students. We spoke with two students who both told us they had a lot of support and had always worked shifts with their named mentor of co-mentor.
- We observed that the hospital support staff development and aimed to retain staff they had trained, for example the pre-assessment team had employed an apprentice as a health care support worker once their apprenticeship was completed.

Vision and strategy for this core service

- The hospital was part of the wider Nuffield health organisation, and shared in the organisation's four values. These values were to be enterprising, passionate, independent and caring. All staff we spoke with during the inspection were aware of these.
- The hospital had a clear strategy for future development, which was innovative and achievable.

- Staff demonstrated the hospital values and behaviours in the care they delivered. All staff we spoke with were passionate about the service they provided and believed they consistently put the patient first.
- Staff spoke positively about the changes that were due to take place in the hospital and how this would improve patients care and the working environment.

Governance, risk management and quality measurement

- The service had a robust structured process in place for the MAC. We reviewed the meeting minutes of meetings held in February to July 2016. These were detailed, comprehensive and covered all services within the hospital. Topics discussed included risk, learning, practicing privileges, quality dashboards and visions for the future.
- We spoke with the hospital director and MAC chair about the process of the committee and sign off. Both were articulate about the running of the service and MAC and had a clear understanding about the quality of service to be provided.
- Practicing privileges were routinely discussed as part of the MAC. Privileges are to be renewed and reviewed every three years as a minimum. There were 112 consultants who had practicing privileges at the hospital and all privilege renewals would be discussed at MAC, as well as new appointments.
- We also reviewed the risk register for the hospital dated November 2016. We could see clear progression and monitoring of risks, with detailed updates and actions taken to mitigate risks where possible. This included clear reasons to downgrade and close risks on the register. The risk register was a standard agenda item on the senior team meeting agenda, and risks were discussed at the clinical governance meeting and head of department meetings. We saw minutes of these meetings, which took place during 2016, which demonstrated that risk was a focal point for the leadership team. We also saw the risk register was displayed in the Ward and theatre managers offices. We found that staff turnover was negligible
- Managers within theatre and the wards were aware of the specific risks to their areas of work. There was a clear governance structure in place with committees, such as infection prevention, medicines management and medical devices, these reported to the senior management team who in turn reported to the medical advisory committee. A clinical governance report was compiled each quarter. This was presented and discussed at the governance committee and MAC meetings.
- The clinical governance committee met monthly; the minutes showed evidence that discussion on findings from audits, reported incidents and complaints took place. We saw clear evidence of action points proposed and improvement plans from agreed outcomes and decisions reached.
- Team meetings were held on the ward and theatres. These were used for the passing of two-way information.
- Senior members of staff from each department met every morning on the ward to discuss any concerns within the hospital, such as staffing, power surges and theatre schedules. We observed this meeting and found it informative and concise.

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

- Staff encouraged patients to complete a patient satisfaction survey before discharge. The hospital used this with the 'Friends and Family test' feedback to evaluate the service provided to the patient.
- Staff were encouraged to identify areas of improvement and implement processes to try. For example health care support workers in the pre-assessment team had identified an opportunity to pre-assess patients when they attended visual field assessments. This reduced the number of missed pre-assessment phone contacts and repeat attendances at the hospital for screening.

Innovation, improvement and sustainability

- The pre-assessment team had developed an alert which was completed during the pre-assessment appointment if the patient had a raised body mass index or latex allergy. This alerted the theatre staff that the theatre would need to be specially prepared for the patient.
- Staff we spoke with told us they felt encouraged to learn and improve. The appraisal system was linked to the hospital's strategy. For example, staff objectives were set to encourage continuous learning, improvement and to focus on quality patient care.

Outpatients and diagnostic imaging

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

Information about the service

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

Summary of findings

We rated this service as good because it was safe and responsive and caring. We rated this service as outstanding for well-led. We currently do not rate effective.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as **good.**

Incidents

- Staff reported incidents electronically in line with Nuffield policy and there were robust systems to report and investigate incidents. Incidents were discussed within clinical governance committee meetings and we saw examples of this within the minutes.
- Clinical incidents were investigated through the Clinical Governance Committee and Medical Advisory Committee and we saw the process to cascade lessons learnt and inform current practice in order to make improvements.
- Staff and heads of departments were able to explain duty of candour in depth and gave good examples of its use.
- Staff informed us of types of incidents they would report such as patient safety matters and radiological incidents. All staff we spoke with told us they felt confident to report incidents. There were two clinical incidents in outpatients and diagnostic imaging between October 2015 and September 2016. These incidents were classified as no harm or low harm.
- The departments had reported no never events in the last 12 months. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- Staff were confident they knew how to report an incident on the electronic incident management system, and could give examples of what to report.
- There was a weekly meeting attended by all heads of departments where incidents were discussed and learning shared. Learning was cascaded to teams at regular staff meetings.
- There were two radiation incidents reported within the reporting period, both of which were referred to the hospital's medical physics expert who graded them as low or no harm. Therefore, these incidents were not classed as reportable under IR(ME)R regulations.
- Staff we spoke with were clear about the reporting process and described how they would report onto the electronic reporting system and inform one of the Radiation Protection Supervisors (RPS) at the earliest opportunity. They told us that near misses were also recorded and brought to the attention of the wider hospital team in weekly meetings. Heads of each department attended these daily meetings and then circulated the notes to wider teams.
- The head of pharmacy received medical and health regulatory (MHRA) safety alerts relating to drugs. These were disseminated to heads of departments and noted in the minutes of the clinical governance meetings.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents. Staff were aware of the principles of duty of candour and could give examples of when DoC was triggered and a patient would need to be approached such as when an x-ray had to be repeated.

Cleanliness, infection control and hygiene

- Outpatient areas were clean and clutter-free. Policies and procedures for the prevention and control of infection were in place. Staff understood them and could describe their role in managing and preventing the spread of infection.
- Signed cleaning schedules were in place for treatment rooms and all consulting rooms.
- Hand sanitiser points were widely available throughout the outpatient department including the waiting areas to encourage good hand hygiene practice.
- Staff labelled clean equipment to indicate it was ready for use, for example, blood pressure monitors.
- The infection control lead nurse carried out regular handwashing and environmental audits. This was part of the hospital wide infection control audits and monitored compliance with key hospital policies such as hand hygiene. We saw that handwashing audits

completed in throughout 2016 achieved a consistently high compliance score of and the most recent result for December was 100%. Results were shared at infection control meetings and shared with staff.

- Personal protective equipment (PPE) such as gloves and aprons was used correctly and available for use in the departments. Once used, it was disposed of safely and correctly. We saw PPE being worn when staff were treating patients and during cleaning or decontamination of equipment or areas. All areas had stocks of hand gel and paper towels.
- We saw all consulting rooms had handwashing facilities.
- The provider participated in the Patient Led Assessments for the Care Environment (PLACE) scores for cleanliness between the periods of February 2016 to June 2016 showed a score of 100% for the hospital. Overall, the hospital scored the same or better than the England average for cleanliness (98%).
- Patient waiting areas, including toilets and were clean and tidy.

Environment and equipment

- The outpatient areas and departments were well signposted, uncluttered, and well maintained.
- Toilets were clean with a daily record signed by the cleaner.
- Staff we spoke with knew the procedure to follow if they identified faulty or broken equipment.
- All new equipment was risk assessed and applications training carried before use.
- A resuscitation trolley was located in the main corridor near the treatment room. Staff told us that there was easy access to this emergency equipment. All equipment including suction and oxygen lines were checked and found to be in date.
- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments.
- Clinical specimens were collated and stored safely within the pathology reception area in preparation for transport to the laboratories.
- There was an appropriate secure storage area for waste and we saw that this was well organised and free of clutter.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained.
- We found that electrical equipment testing and calibration stickers were in place on fridges and scales.
- The reception area of the outpatients department was light and airy. Staff were friendly and personable which promoted a friendly and open environment.
- We saw, and staff confirmed that, there was enough equipment to meet the needs of patients within the outpatients departments.
- Specific equipment required such as bariatric examination tables were provided.
- Results from PLACE audit in February 2016 to June 2016 and local environmental audits were good. In the PLACE audit the hospital scored 100% for cleanliness and 95% for condition appearance and maintenance, against the England average of 98% and 93% respectively.
- In radiology, we observed a small but clean waiting area. We observed that patients were greeted by radiographers almost immediately so few patients used the seating there. There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- Radiation signs were visible outside each room.
- X -ray equipment was serviced via a new multivendor contract as part of a national contract across all Nuffield sites. Staff told us it was too early to judge the efficiency of the service. However managers had fed back that response times for the first few months had not met operational need. Staff told us they hoped they would see an improvement in the months to come.
- A radiation protection advisor (RPA) from an external organisation undertook equipment and paperwork audits. They attended staff meetings
- The annual RPA audit against ionising radiation (medical exposure) regulations IR(ME)R 2008 and the ionising radiation regulations (IRR) 1999 took place in 2016. The RPA report showed that the hospital radiology department was fully compliant with all appropriate policies and procedures in place. No improvements were required.

Medicines

- Medicines were stored safely. Staff locked all medicines cupboards and the lead nurse on duty held the keys. Fridges were centrally locked and alarmed and temperatures checked daily and logged to ensure medicines were stored at the correct temperature.
- Outpatient prescribing was on private prescription pads, which were held securely in the outpatients department and usage was tracked and monitored.
- Staff ensured medicines that required refrigeration were stored within safe temperature ranges. We saw that

fridge temperature checks were completed on a daily basis and staff told us they knew how to report temperatures when they were outside of the required safe range.
- No controlled drugs were stored within the outpatient departments.
- Medicines management was audited by the pharmacy service, who completed safety and secure storage checks.
- For our detailed findings on medicines please see the Safe section in the [main service] report.

Records

- Records in the outpatient department were a combination of paper and electronic information, which contained specific information regarding the patient's past medical history.
- Patient records were kept on site, or recalled from a medical records store in time for outpatient appointments. The administration team prepared records ahead of clinics and there was no evidence that patients were seen without adequate clinical information.
- Staff told us all patients attending an outpatient appointment would have available either an accompanying GP referral letter, or their current records from a previous appointment or admission to the hospital.
- Staff we spoke with in outpatients, radiology and physiotherapy could not recall an instance where medical records had not been available for a clinic, or where a patient could not be seen because their records were not available. However, staff told us that if patient information or paperwork were missing, the staff would take a proactive approach by obtaining the data from either the patient or consultant in advance of an appointment.
- The picture archiving and communications system (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.
- At the time of inspection we saw patient personal information and medical records were managed safely and securely.
- We reviewed 12 sets of medical records across the outpatients and radiology departments. They were all fully completed and contained sufficient up to date information about patients including referral forms and letters, medical and nursing notes including patient care pathways, operation and anaesthetic records, discharge documentation and post-procedure care.
- The hospital had a policy in place that no patient records were taken off site. Staff were required to complete mandatory on-line training, which included aspects of patient safety and Information Governance and the consequences of any breach. In the event of any breach, staff understood their "Duty of Candour". All members of staff, internally, at the off-site facility, consultants and their secretaries were fully aware of the Group Health Records Standards Policy and Practising Privileges Policy.

Safeguarding

- There were no safeguarding concerns related to the outpatients department from September 2015 to the time of our inspection. Staff had raised no safeguarding concerns about people in their care or those close to them.
- The hospital had systems and policies in place for the identification and management of adults and children at risk of abuse. There was a safeguarding children, young people and adults policy and procedure, which included flowcharts for identifying concerns, safeguarding procedures and guidance on female genital mutilation (FGM).
- All staff we spoke with were fully aware of safeguarding policies and procedures and felt confident when raising concerns. Staff told us they were able to seek advice from their manager when needed.
- Policies and procedures were available on the intranet and staff were able to demonstrate how to access them. All staff had access to a simple flowchart to aid with decision making and reporting concerns regarding vulnerable adults.
- The Matron was the designated lead for safeguarding. Both the matron and Outpatients Manager had completed level three adult safeguarding training. Nurses had completed level two and administrative staff completed level one training.
- The Nuffield Tees Mandatory training matrix for October 2016 showed 100% compliance in Radiology for levels 1 and 2 safeguarding vulnerable adults and safeguarding

children training. Outpatients staff had achieved 92% for level 1 and 100% for level 2. Safeguarding training was mandatory for all staff and staff were booked onto courses to complete this training by the end of the year.

Mandatory training

- The hospital mandatory training matrix included training requirements for staff dependent on their role. For example, information governance, health safety and welfare, and fire safety was applicable to all staff whereas infection prevention, deprivation of liberty safeguards (DoLs), and medical gas cylinder safety training was only for staff that required the necessary skills in these areas. Most training was done by e-learning with the Nuffield on-line academy, in some cases followed by workshops and assessments. Staff completed their training during their work time when possible or they could access their e-learning accounts from home if they preferred.
- Regular bank staff were also expected to complete mandatory training and if they completed it at their NHS workplace, the hospital manager checked this.
- An automated system alerted managers and individual staff members when they were due for training.
- Mandatory training for the out-patients department staff was over 95%% compliant overall at the time of our visit (the hospital target was 85%.) The department had achieved 100% in several of the elements of the mandatory training programme.
- The radiology staff were 100% compliant for all mandatory training.
- We saw a robust induction programme for all staff which included on-going support from an experienced mentor.
- Medical staff completed mandatory training at their employing NHS trust. There were assurance systems in place to ensure compliance. Managers advised that any failure to meet mandatory training requirements would potentially lead to a suspension in practising privileges. The management provided examples when this had happened until the evidence had been provided.
- There was a mandatory competency programme in place for staff throughout the radiology department on all equipment including for plain film processes, interventional radiology, and CT scanning.
- Healthcare Assistants had awareness training in local rules for IR(ME)R to ensure they understood the safety elements of working in an environment where radiation is used.
- Annual IR(ME)R updates were provided by the radiation protection advisor (RPA) for all staff in line with current regulations.

Nursing staffing

- We looked at the staffing levels within the outpatient department. Staffing levels were planned in accordance with the number of clinics operating on each day and the nature of the clinics. For example we saw during our inspection that an additional nurse was present to assist with patient pre-assessments.
- The outpatient department had a team of five part time registered nurses, (making up 3.2 full time equivalent (FTE) posts), three (1.6 FTE) healthcare assistants, receptionists and administration staff. The hospital employed no agency nurses or health care assistants between October 2015 and September 2016. The staff provided clinic cover Monday to Friday, generally between 8am to 8pm, with a morning clinic held on a Saturday. This varied to accommodate specific patient requests and consultant working arrangements.
- Staff in the outpatients department told us that workload varied depending upon the number of clinics and the number of patients attending.
- A lead nurse managed outpatients and divided the clinical time between the ward and the outpatient department. Staff told us that the lead nurse was very supportive and always available for advice.
- The service used no agency nurses but could use bank staff to cover clinics if required.
- There were no vacancies within the nursing and health care assistant staff in the outpatient department at the time of inspection. Senior staff told us there was negligible staff turnover across all departments.
- Sickness levels for outpatient staff between the period of October 2015 to September 2016 were very low and for the majority of months the rate was 0%.

Physiotherapy staffing

- The superintendent physiotherapist managed a team of staff. A new member of staff was undergoing induction and training. The team included an assistant who also undertook administrative duties and an occupational therapy practitioner.

Radiography staffing

- The superintendent in the diagnostic imaging department had a core staff of 12 part time

radiographers, four of whom were regular bank staff, and two part time health care assistants. During our inspection we observed there were sufficient staff to provide adequate cover and no patient waited more than a minute. Staff told us there was always a minimum of two radiographers on duty during the day.
- Some bank staff also held NHS staff posts and maintained their competence and special interests, providing additional and current knowledge and experience for the team.
- Radiographers were available to undertake mobile imaging in the theatres and wards.

Medical staffing

- There were 112 consultants with practising privileges at the hospital. However 21 had been removed after not providing a service for more than 6 months. All had their status reviewed every two years by the hospital Medical Advisory Committee to check they continued to be suitable to work at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is given permission to work within the independent sector.
- The hospital employed two resident medical officers (RMOs). They worked alternate weeks and were on call 24 hours per day during their working week. This was standard practice across all Nuffield Health hospitals.
- Physiotherapists worked closely with consultants to develop bespoke treatment plans for patients.
- Radiographers reported there were no difficulties with availability or contacting consultants in the imaging department.
- Nursing and radiography staff called on the RMO when required and said they were very responsive.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams. Within the outpatient department, consultants covered all specialities for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.

Emergency awareness and training

- The hospital had a business continuity plan in place for use in the event of disruption caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage, or due to external circumstances beyond the control of the hospital (e.g., bomb threat). The hospital senior management team held overall responsibility for initiation of any action and formed emergency response teams, which were contactable at all times.
- Staff we spoke with were aware of the major incident policy and could describe how they would access this in an emergency.

Are outpatient and diagnostic imaging services effective?

We currently do not rate effective.

Evidence-based care and treatment

- Staff in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- Care and treatment within the outpatient department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as NICE.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited; Nuffield Health had an IR(ME)R audit proforma in place, which the lead radiographer completed as part of clinical self-audit against procedures on an annual basis. They shared the outcomes with staff and any non-compliance was addressed with an action plan.
- Staff followed Royal College of Radiology guidelines for administration of contrast media and we saw that guidelines were available in folders in the viewing room and fluoroscopy room.
- Radiation Exposure/diagnostic reference levels were audited every six months and evidence of the audits were seen during inspection. Diagnostic reference levels are intended for use as a simple test for identifying situations where the level of patient dose is unusually high. If it is found that procedures are consistently causing the relevant diagnostic reference level to be exceeded, there should be a local review of procedures and the equipment in order to determine whether the protection has been adequately optimized. If not, measures aimed at reduction of doses should be taken.

Outpatients and diagnostic imaging

- Radiographers checked all referrals to ensure patients were booked for the correct imaging tests and the requesting information was fully completed.
- The radiographer manager undertook clinical audits in diagnostic imaging. For example, audits were carried out on records of patients who had received intravenous injections, request forms, and image reject analysis.
- Patients' needs were assessed according to their physical, clinical and mental health.
- Discrimination on grounds of age, disability, gender, gender reassignment, race, religion or belief and sexual orientation was not a factor when considering care and treatment decisions.
- Data was regularly submitted and contributed to the private healthcare information network (PHIN) as part of benchmarking its practice.

Pain relief

- Staff discussed options for pain relief with patients before they performed any procedure. Minor operations and procedures were undertaken by consultants with the use of local anaesthetic in outpatient treatment rooms, which enabled patients to go home the same day.
- Staff gave patients written advice on any pain relief medicines they may need to use at home, during their recovery from their outpatient procedure.
- Patients' records demonstrated pain relief was discussed when local anaesthesia was used for minor procedures.
- Patients we spoke with during the inspection had not needed pain relief during their attendance at the outpatient department.

Nutrition and hydration

- The departments provided cold water dispensing machines within the waiting areas, and hot drinks were provided for outpatients. Patients waiting told us the hot drinks were popular and very good.

Patient outcomes

- Between October 2015 and September 2016 the hospital outpatient department saw 13,357 patients. Of these, 8,209 were new appointments and 7769 were follow-up appointments. Of all patients, 84% were NHS referrals and 16% were self-funding.
- The hospital compared survey results and activity with other locations within the region and other regions across locations in the Nuffield group.
- Nuffield Health Tees Hospital reported participation in positive patient feedback and monitoring of variances in care pathways as part of overall monitoring of patient outcomes.
- A senior manager told us that the numbers of cancelled appointments were low. We reviewed data submitted by the provider, which showed that no appointments were cancelled on the day of consultation during the period of October 2015 to September 2016.
- Radiology reports were audited for compliance with reporting times. The radiology manager oversaw this process, and discussed the audit results with the radiologists. This ensured that a system was in place to prevent unverified reports causing delays to patient care. We saw the report for January 2016, which showed that radiologists completed 92% of reports within 48 hours and none took longer than two weeks. Royal college of Radiologist guidelines state that non-urgent outpatient images should be reported within four weeks. Therefore the hospital consistently met this target.

Competent staff

- We saw that all staff completed a robust induction programme before commencing their role. New staff were supported by a mentor. We observed staff completing competency checks in physiotherapy.
- Nurses were supported with revalidation and several support sessions had been provided by the general manager to guide staff through the process.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Managers supported staff to maintain and further develop their professional skills and experience.
- The hospital undertook robust procedures which ensured medical staff who worked under practising privileges had the necessary skills and competencies and that consultants received supervision and appraisals. Practicing privileges is authority granted to a physician by a hospital governing board to allow them

to provide patient care within that hospital. Senior managers ensured the relevant checks against professional registers, and information from the Disclosure and Barring Service (DBS) were completed.

- A consultant told us that their practising privileges were granted when evidence of their indemnity, general medical council registration, NHS appraisal and (DBS) checks were produced and this was reviewed annually.
- For consultants who were granted practising privileges to work at the hospital, in line with legal requirements, the registered manager kept a record of their employing NHS trust together with the responsible officer's name. There was a process in place to ensure all consultants were up to date with the revalidation process.
- Staff said they were supported to develop their learning and progress. For example, the hospital had provided funding for healthcare assistants to study nursing at a local university. Nursing staff were encouraged to take on more responsibility, including enrolment onto a management course.
- All staff had annual performance reviews; they told us that the Nuffield organisation was supportive of staff development.
- Radiographers had to complete a set of competencies for all pieces of equipment, and the line manager reviewed their progress against these at appraisal. We saw evidence of this during our inspection.
- All staff we spoke with had received a formal annual appraisal and mid-term appraisal every six months. We reviewed an appraisal compliance audit that confirmed 100% of staff had undergone an annual appraisal in this service.
- Appraisals and mid-term objectives were linked to the hospital and Nuffield vision and values. Staff told us personal objectives were encouraged and supported.

Multidisciplinary working

- We observed there was effective team working between all staff groups. All clinical and non-clinical staff we spoke with told us the team worked well together and enjoyed the busy working environment. Departments worked closely to ensure patients did not have to make unnecessary visits. For example, radiographers offered patients x-rays on the same day as their clinic appointment, if needed and results were available electronically for consultants to view in the clinic.
- Staff told us that all the consultants worked well together in specialist teams and provided cover for each other's absences.
- Staff told us that medical staff were supportive and could be approached for advice when needed.

Access to information

- We saw that staff had access to policies and procedures through the Nuffield group intranet. NICE guidance and e-learning modules were available.
- Patient records were in paper format. Staff told us that records were brought to clinic in advance of the patient appointments. Missing records were very rare but we saw procedures if patient records were not available at the time of appointment. Staff had access to previous clinic letters electronically.
- Staff in outpatients and diagnostic imaging held daily meetings to plan the day's activities, inform teams of any patients with complex needs or changes to routine.
- Staff we spoke with reported timely access to blood test results and diagnostic imaging. This enabled prompt discussion with the patient on the findings and treatment plan.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated in conversations an understanding about their role with regard to the Mental Capacity Act (MCA), although no staff recalled its formal use.
- Patients gave written consent for general x-ray procedures, outpatient procedures and physiotherapy treatments carried out.
- Patients signed written consent forms for all minor surgical procedures.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

Outpatients and diagnostic imaging

- Staff treated patients with dignity and respect and patient confidentiality was maintained at all times. Patients were treated in private consultation rooms and staff kept doors closed during consultations
- We observed staff within the outpatients department. Staff at all times were caring and compassionate to patients. We observed staff had a good rapport with staff putting patients at ease.
- The main outpatient department reception desk was situated in the corridor, near to patients in the waiting area, it was possible for other patients to overhear conversations between staff and patient, particularly if the patient spoke loudly. For more private conversations, a quiet room could be accessed at any time for patient use.
- All patients we spoke with told us that staff were very kind and spoke with them in a caring manner. They told us that staff had respected their privacy and dignity when delivering care.
- Consultant names were displayed rather than clinic names. This protected patients' privacy because it meant other patients and visitors were not aware of the type of clinics people were attending. The department maintained patients' privacy and dignity wherever possible.
- The outpatients department provided a chaperone service during intimate personal care. Signs offering chaperone services were clearly displayed in the main waiting areas and in all consultation rooms.
- The results of the Friends and Family Test (FFT) for the period of July to December 2016 showed 99% of patients would be 'likely' or 'extremely likely' to recommend the hospital to their friends and family.
- Staff told us that families were invited into the consulting room as long as the patient was agreeable.
- We observed doctors coming out to meet their next patient due into their clinics and introducing themselves to them before helping them to the consultation room.

Understanding and involvement of patients and those close to them

- Patients felt fully informed about their care and treatment. All the patients we spoke with had a good understanding of their condition and proposed treatment plan, as well as where to find further information. Staff provided patients with guidance regarding their treatment and care.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.
- Appointments were not rushed and staff spent time with patients to discuss concerns and answer questions.
- Patients told us they understood why they were attending the hospital and had been involved in discussions about their care and treatment. Patients confirmed they were given time to make decisions and staff had made sure they understood the treatment options available to them.
- Staff ensured patients understood how they would book their next appointment and who to contact if they had any concerns following treatment.

Emotional support

- Although few patients with complex needs or learning disabilities accessed the service, staff showed a clear understanding about the importance of supporting patients, emotionally and socially, who were in distress.
- Radiology staff told us how they could support patients, allowing additional time for those who were anxious or worried about a procedure.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service planning and delivery to meet the needs of local people

- Staff within the outpatients department worked flexibly to meet capacity demands. We saw that nurses were allocated to the department to meet clinic times and patient numbers.
- There was a range of outpatient clinics offered including services such as a variety of surgical specialties, endoscopy, dermatology, and plastic surgery.
- Digital dictation was used by the consultants within the department to enable a swift turnaround for letters and appointments.
- Clinics tended to run in to a similar daily or weekly routine and the busier time periods were staffed accordingly.

Outpatients and diagnostic imaging

- Plans were in place to develop a purpose built diagnostics wing at the back of the hospital, which would support the increase in referral numbers and enable greater numbers and a wider range of imaging and procedures to be carried out.
- Physiotherapy, radiology and outpatients offered later evening appointments on weekdays to meet the needs of working people.
- Radiology services were planned around outpatient and theatre activity including extended hours in the evenings and on Saturday mornings.

Access and flow

- Referral to treatment times (RTT) were all better than national targets. RTT waiting times for outpatients was 100% for non- admitted pathways between October 2015 to April 2016. May reported a slight decrease to 99%; however 100% was consistently achieved up to the point of inspection.
- Patients entered the hospital via the main entrance and were greeted at the main reception desk where they were directed to the appropriate waiting area.
- Most patients who used the hospital, were referred by their GP.
- Self-funding patients could access mammography and physiotherapy by self-referral. Patients who had self-referred underwent a telephone assessment prior to being seen in the department.
- The hospital ran NHS clinics and clinics for private patients.
- There was capacity within the service to see patients urgently if necessary. Staff told us the department would flex to manage patient numbers on a weekly basis.
- The hospital had very low 'Did not attend' (DNA) rates and staff told us that very few patients failed to attend their appointments. Administrators told us they telephoned all patients who missed their appointment and would make another appointment if required.
- Radiologist reporting times were recorded and comparisons made against national guidelines and previous year's results to aid planning and risk management.
- Two patients told us the main reason they were using this hospital was for peace of mind and stability. They knew they would be seen quickly and enjoyed the calm atmosphere.
- The hospital did not formally advertise waiting times in waiting areas however; reception and nursing staff monitored them. During inspection we saw that clinic times were met and there were no delays. However, staff told us that when there were delays of 15 minutes or more then patients waiting would be informed of the waiting time and offered a new appointment. This would be flagged to ensure the patient was seen promptly at the next visit.
- We saw that appointment times were booked around the needs of the patient and requests to re-arrange appointments due to personal circumstances were largely met.
- Staff told us clinics were rarely cancelled and if this did occur, consultants would provide cover for each other where possible.
- Patients told us, and we saw, they were provided with full information regarding their appointment in an appointment letter detailing location, directions, consultant information, specific requirements for the appointment and contact details for the department.
- We observed that radiographers x-rayed patients almost as soon as they arrived. There were no waiting lists.

Meeting people's individual needs

- Staff told us they were able to access interpreting and translation services if they needed to. However, staff we spoke with identified this was rarely required.
- A range of information leaflets were available, which provided patients with details about their clinical condition and treatment or surgical intervention.
- Staff told us they used leaflets as supportive literature to reinforce their physiotherapy treatment and exercise regimes.
- Some patient information leaflets were available in large print for patients with visual impairment. However, they were not available in alternative languages but staff explained they would ensure the patient fully understood what they needed to, before they left the department.
- Staff told us when patients living with learning disabilities or dementia attended the departments; they allowed carers to remain with the patient if this was what the patient wanted. They also ensured that patients were seen quickly to minimise the possibility of distress to them. Staff told us they would use a common sense approach and dealt with each person and situation individually.

Outpatients and diagnostic imaging

- Information signage was appropriate to patients' needs within outpatients and diagnostic imaging and patients made their way around both departments easily.
- The patient waiting area was tidy with sufficient comfortable seating for patients visiting the department. There was access to water and magazines for patients who were waiting and staff served hot drinks on request.
- The department was located on the ground floor and there were toilet facilities available for patients including toilets with disabled access within the hospital. There was sufficient space in all areas to manoeuver a wheelchair. However, the changing rooms in radiology were very small. Staff helped patients who needed more space by taking them straight to the x-ray room and allowing them time to change into a gown or helping them remove the minimum amount of clothing to allow the procedure to be performed.
- The radiologist-led ultrasound service had a dedicated toilet with direct access from the scanning room. This provided enhanced patient privacy and dignity.

Learning from complaints and concerns

- The hospital received 22 complaints between the period of October 2015 and September 2016. We saw clear lessons were learned and changes in practices occurred as a result of complaints. However, only one complaint was directly attributable to outpatient care and this involved a complaint about clinical care. Consultant practising privileges reviews included complaints regarding clinical care. No trends or concerns about individual consultants were identified.
- Staff told us and we saw minutes to show complaints and comments were reviewed and discussed by teams at monthly staff meetings.
- The hospital had a complaints policy in place and the overall management of complaints in outpatients and diagnostic imaging sat with the Outpatients Manager. Complaints and investigations were escalated and discussed at monthly Clinical governance meetings.
- Staff were aware of the complaints procedure and felt confident raising concerns as they arose. Staff told us they engaged with patients immediately a concern was raised, but would escalate to senior staff if necessary.

Are outpatient and diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as **outstanding.**

Leadership and culture of service

- All staff we spoke with described managers as approachable and effective. There was very strong leadership of the service and managers were role models for an efficient and caring service. All managers had an open door policy. Managers were known on first name terms, were approachable and encouraged questions and suggestions from all staff.
- The leadership structure was clear and staff told us they were supported clinically, professionally, and personally by the department heads.
- We saw that staff had positive working relationships and staff told us they received support from all grades of management. The hospital director in particular was praised by every member of staff we spoke with for their attitude and care for the welfare of staff.
- Staff told us that the hospital director undertook a daily morning round to ensure that the planned day ran smoothly and address any anticipated risks or issues. The matron was accessible and supportive of staff. As a team, they discussed activities for the day ahead and any issues that arose from this round were discussed and actioned together with the team.
- Staff felt there was a positive working culture and they were passionate about their patients and the standards of services that they provide.
- Staff told us they were actively encouraged to identify training needs, in addition to the mandatory training programme. Staff we spoke with gave examples of external training courses they had attended and cascaded information to their teams.
- Staff believed the culture of the outpatients' service encouraged openness, honesty and quality patient care.
- All staff we spoke with felt proud to work for the organisation. Staff told us that there was a strong sense of team work and everyone 'pulled together'.
- Managers encouraged an open and transparent culture and staff were encouraged to report incidents and complaints. A member of staff told us that complaints

were rare in the department and 'everyone ensured problems were put right'. Staff told us they were encouraged to take action when a patient raised a concern rather than wait for it to become a complaint and felt empowered to do so.
- Staff told us managers were open to comments and suggestions for improvements from staff. Staff were encouraged to take responsibility and to make decisions.
- Vacancy rates were extremely low and staff retention was good.
- We observed communication between staff and saw that is was friendly, open and supportive.

Vision and strategy for this core service

- A senior manager told us a company quality goal was 'Get it right first time'. All staff we spoke with told us that patient care was the most important part everything that they did.
- Staff spoke with pride about the hospital's vision and this was embedded in the care and culture of the staff. The objectives for the outpatient department were aligned to hospitals values, including for example aiming to provide compassionate care to patients.
- The department managers demonstrated a vision for the future of services. They were aware of the challenges faced by the departments they managed and had action plans in place to address these challenges.
- The local strategy for the departments included plans to expand and improve the diagnostic imaging service with a new wing to be built. This would require some reinvestment of funds and would provide more imaging equipment and space for an improved patient experience and larger changing facilities.
- Staff were aware of the Nuffield vision and strategy and we observed all staff displayed the behaviours expected of them. The appraisal process incorporated organisational, local and departmental vision, strategy, goals into individual staff objectives.

Governance, risk management and quality measurement

- We saw governance structures which staff were aware of and participated in such as team meetings, department meetings, and clinical governance meetings were managed and had effective processes to communicate decisions with staff.
- Senior managers held regular clinical governance meetings and team meetings. Heads of Departments (HODs) and Operational Team meetings were held to discuss incidents and items for the risk register. We reviewed the minutes of these meetings are saw that they were comprehensive and covered issues such as incidents, clinical guidelines, audits, and complaints. Outcomes of audits and action plans were discussed and monitored in clinical governance meetings.
- Incident reporting data was reported to monthly governance meetings and staff produced and monitored action plans where trends were identified.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints.
- The organisation used a system to appraised guidance from the National Institute for Health and Care Excellence (NICE) to ensure any relevant guidance was implemented into practice.
- The hospital had a risk register in place and managers had ownership and updated this accordingly. Managers were aware of the risks within their departments and were managing them appropriately. For example, radiology had identified risks associated with their new equipment management contract and response times. This had been escalated to the national team.
- We noted a structured audit calendar for planned audits in radiology. We saw evidence of regular audit activity and action plans where improvements were required.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire. Staff told us they regularly spoke with patients to gather their feedback. Patient feedback was discussed at team meetings.
- The hospital had a continuous cycle of patient surveys as well as taking part in the friends and family test and results were shared with all staff. There was an action plan in place to address issues raised by patient feedback which demonstrated that patient experience was taken very seriously.
- Radiology staff had gathered patient feedback on a new method and position used to improve patient comfort for a knee x-ray. Patients had reported a good experience.
- Staff provided feedback to management at all levels through informal discussions and formal meetings. Staff

gave examples of how they could approach managers to put forward suggestions or raise concerns. Staff told us all managers were open to ideas and suggestions and ideas could be piloted. Staff told us that sometimes small changes could make a big difference to patient care.

- The hospital's Friends and family test (FFT) scores were 99% across the period of July to December 2016.

Innovation, improvement and sustainability

- We saw that senior managers reviewed the hospital business plans regularly to reflect the local commissioning needs. The planned new diagnostics wing would enable reinvestment of funds, sustainability, and provide a better overall service to patients and consultants.
- Staff were encouraged to suggest ways to make departments run more effectively and efficiently.
- In radiology, a radiographer had made patient access for a procedure safer and easier by using a different imaging position and method . They explained the way the image used to be taken involved the patient holding the x-ray cassette. The new method was safer and more comfortable for patients. The imaging technique was discussed and shared with all staff in the department. Feedback from staff and patients was good.

Outstanding practice and areas for improvement

Outstanding practice

The hospital had a fully integrated and coordinated pathway for surgical patients that spanned outpatients, diagnostic imaging, preparation for surgery, pharmacy, surgery, post-surgery therapy and follow up appointments.

Patients were prescribed take out medication prior to surgery to ensure that discharge was not delayed due to waiting for medication.

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure that all ward based stock items are in date in the store room and resuscitation trolley and subject to stock rotation (using the oldest first).
- Ensure all corporate policies and guidelines on the hospital intranet are in date.
- Ensure all corporate policies which are being reviewed have a nominated lead and timescale for completion.
- Ensure that a long term solution to the sterilising machine is in place as soon as possible.