Orthopaedics and Spine Specialist Hospital

Quality Report

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

Ratings

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

Overall summary

The Orthopaedics and Spine Specialist Hospital is a purpose built facility which opened in 2004, and operates as part of the NHS choice scheme where patients, referred for specialist treatment can choose where to have their treatment. The hospital has 20 beds. Facilities include one operating theatre (laminar airflow system) and outpatient and diagnostic facilities.

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

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on Wednesday 14 September 2016, along with an unannounced visit to the hospital on Monday 19 September 2016.

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

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

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

Services we rate

We rated this hospital as Good overall.

We found good practice in Surgery:

- 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.
- From April 2015 to March 2016, the service reported no never events, no clinical incidents and no non-clinical incidents. Staff knew what constituted an incident and how to report incidents.
- Theatre staff used the World Health Organisation safer surgery checklist. This is a safety checklist used to reduce the number of complications and deaths from surgery. An audit of 20% of randomly selected patient records from April 2016 to June 2016 showed that the safer surgery checklist was documented in all of the records.
- From April 2015 to March 2016, the service reported no incidents of venous thromboembolism (VTE) or pulmonary embolism and no unplanned returns to theatre or unplanned readmissions within 28 days of surgery.
- Staff worked with patients and their loved ones to make plans for discharge before surgery took place. This meant that patients were not delayed in going home after surgery.
- Medications were stored securely in all clinical areas. Staff consistently completed stock checks for controlled drugs and completed daily safety checks for emergency equipment.
- Staff completed patient records accurately. All patient records we saw contained appropriate risk assessments and management plans.
- Patients were satisfied with the service. All four patients we spoke to said that staff were caring and responsive to their needs. Results from the NHS friends and family test showed positive results; from October 2015 to March 2016, the service consistently scored 100%.
- There were few complaints about the service. The service reported three complaints in the last year. We saw evidence that managers responded to complaints appropriately and shared learning from complaints with staff.
- Leaders of the service were visible and approachable. Staff reported a good culture and working environment.

We found areas of outstanding practice in surgery:

- 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.

We found areas of practice that required improvement in Surgery:

- We found some gaps in reporting to national databases. Data on Patient Reported Outcome Measures (PROMs) was reported but outcomes were not available. Senior staff told us this was because the service did not have full access to the reporting data base and that the number of questionnaires submitted to the system was too small to be interpreted statistically.
- Some policies seen on inspection appeared to be out of date, for example, the medicines management

Summary of findings

policy was dated 2009.However, following the inspection period the provider submitted evidence that the policies had been reviewed regularly and were in date.
- Staff did not use the National Early Warning Scoring system(NEWS) to monitor patients' observations. This meant that there was no standardised system for assessing and responding to patient deterioration. However the hospital had systems in place to ensure patients were monitored.

We found good practice in outpatients and diagnostic imaging:

- The service did not report any clinical or non-clinical incidents for the period April 2015 to March 2016.
- Equipment used for outpatient appointments was in date of servicing and provision was in place for repairs.
- Medical records were well structured and recorded the patients' pathways through the service from referral to discharge.
- Ninety-two percent of staff were compliant with safeguarding training and all staff were compliant with their mandatory training.
- The hospital reduced the risk of patient deterioration by setting an admission criteria that excluded medically complex and unstable patients, which was checked in the consultation stage of care.
- Policies were underpinned by regulation and national guidance.
- Patients told us that staff were compassionate and kind, and feedback about the service was consistently good. Patients felt involved and informed about their care.
- Missed appointments were well managed and we saw an improvement in the rate of missed appointments from 2015 to 2016.

We found areas of practice that required improvement in outpatients and diagnostic imaging:

- The pregnancy status of women of child bearing age was not always checked.
- Staff were not trained in, and therefore did not have up to date knowledge, of the Mental Capacity Act or Deprivation of Liberty Safeguards.
- There was a hospital risk register, however most of the risks were generic, rather than specific risks for the hospital.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	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 Surgery as Good overall. • There were arrangements in place for staff to report incidents and staff understood their responsibilities to raise concerns. • From April 2015 to March 2016, the service reported no incidents of venous thromboembolism (VTE) or pulmonary embolism and no unplanned returns to theatre or unplanned readmissions within 28 days of surgery. • Clinical areas were visibly clean and staff complied with infection control procedures. • Staff stored medications securely and completed daily safety checks for emergency equipment. • There was enough staff to meet patients' needs. Staff involved patients in their care and supported them to make plans for discharge after their surgery. • Staff were competent in their roles. Staff compliance with training and appraisal was good. • Patients were satisfied with the service. There was a clear complaints process and we saw evidence of learning from complaints. • Leaders of the service were visible and approachable. Staff reported a positive culture and working environment. However: • Sterilisation labels for some surgical equipment were out of date. • Staff did not use the National Early Warning Scoring system (NEWS) to monitor patients' observations. This meant that there was no standardised system for responding to patient deterioration. However the hospital had systems in place to ensure patients were monitored. • Staff were not trained on the Mental Capacity Act or Deprivation of Liberty Safeguards.

Summary of findings

- There were some gaps in reporting to national databases.
- Data on Patient Reported Outcome Measures (PROMs) was reported but outcomes were not available because the service did not have full access to the reporting database.

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostics as Good overall.

- There were no clinical or non-clinical incidents reported from April 2015 to March 2016.
- The service had clear admission criteria, which reduced the risk of patient deterioration by ensuring that patients with a complex medical history were not admitted to the service.
- Equipment was serviced and maintained appropriately.
- Patient records were well-structured and reflected the patient's journey from referral through to discharge from the service.
- Staff compliance with mandatory training was good and staff were supported with re-validation and annual appraisal.
- Patients were given information to support them to make informed choices about their care. Patients felt involved in their care and gave positive feedback about the service.
- The service was well-planned. The majority of non-admitted patients received their appointment within 18 weeks of referral and there was an improvement in the rate of missed appointments from 2015 to 2016.
- Staff felt confident in their leaders. Leaders kept staff updated on governance issues through regular team meetings.

However:

- The pregnancy status of women of child bearing age was not always checked.
- Staff were not trained on the Mental Capacity Act or Deprivation of Liberty safeguards.
- There were some gaps in governance processes, for example there was a hospital risk register, however most of the risks were generic, rather than specific risks for the hospital.

Summary of findings

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Good

Orthopaedics and Spine Specialist Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Orthopaedics and Spine Specialist Hospital

The Orthopaedics and Spine Specialist Hospital is a private hospital in Stirling, Peterborough. The hospital primarily serves the communities of Peterborough. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 2004. The hospital carries out the following regulated activities: Diagnostic and screening procedures, Surgical procedures, Treatment of disease, disorder or injury, Caring for adults under 65 years, Caring for adults over 65 years.

The hospital was previously inspected in January 2014.There are no compliance actions or enforcement notices associated with this service.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on Wednesday 14 September 2016, along with an unannounced visit to the hospital on Monday 19 September 2016.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, two other CQC inspectors and two specialist advisors with expertise in orthopaedic surgery and general surgery. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Orthopaedics and Spine Specialist Hospital

The hospital had one ward and is registered to provide the following regulated activities:

Diagnostic and screening procedures, Surgical procedures, Treatment of disease, disorder or injury, Caring for adults under 65 years, Caring for adults over 65 years.

During the inspection we visited the ward, imaging and theatre. We spoke with 15 staff including; registered nurses, health care assistants, reception staff, medical staff, and senior managers. We spoke with four patients and one relative. During our inspection we reviewed eight sets of patient records.

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

Activity (April 2015 to March 2016)

· In the reporting period April 2015 to March 2016 there were 517 inpatient and day case episodes of care recorded at the Hospital; of these 93% were NHS-funded and 7% other funded.

· 42% of all NHS-funded patients and 41% of all other funded patients stayed overnight at the hospital during the same reporting period.

· There were 1,773 outpatient total attendances in the reporting period; of these 90% were NHS funded and 10% were other funded.

There was one surgeon who was also the Medical Director.Five anaesthetists and one radiologist worked at the hospital under practising privileges. One regular resident medical officer (RMO) worked from mid-day on Monday till mid day on a Wednesday. There were 3.5 whole time equivalant employed registered nurses, 1.8

Summary of this inspection

whole time equivalant care assistants and one receptionist, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There were no cases of MRSA, MSSA, E-coli or Clostridium difficile in the surgery service from April 2015 to March 2016.
- There were no surgical site infections reported from April 2015 to March 2016.
- There were no incidents of hospital acquired Venous Thromboembolism or Pulmonary Embolism from April 2016 to March 2016.
- There were no clinical or non clinical incidents reported from April 2015 to March 2016.
- There were no reported deaths from April 2015 to March 2016.

Services provided at the hospital under service level agreement:

- Equipment sterilisation services were outsourced to a local NHS trust.
- Pathology, Histology and Blood Transfusion services were outsourced to a local NHS trust.
- There was a service level agreement in place for medical engineering
- A pharmacist visited the service twice a year to complete a review of medicines management. This provided an external overview of medicines management in the service
- There was a service level agreement in place with a local NHS trust for the escalation of any patients who needed escalation of their care post-operatively.
- Service level agreements were in place for the service and maintenance of all x-ray equipment and machinery
- Service Level Agreements were in place for the decontamination of equipment and the management of clinical waste.
- A service level agreement was in place with a neighbouring NHS trust to provide a radiation protection service to the hospital

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as Good because:

- Staff were aware of the incident reporting system and duty of candour.
- Mandatory training compliance was 100%. Knowledge of safeguarding issues was good and staff knew how and who to escalate concerns to.
- Infection prevention and control measures were in place and the recent hand hygiene audit 100%. There had been no surgical site infections from April 2015 to March 2016.
- Documentation in patients records was good, and notes were contemporaneous.
- Risk assessments were completed appropriately. Staff compliance with screening patients for VTE was 100%.
- Effective system were in place for the management of medicine, and ensuring equipment and the environment was maintained.
- Staff wore dosemeters that monitored exposure to radiation and these were sent to a local NHS trust on a monthly basis for review in order to ensure that the level of staff exposure to radiation stayed within acceptable limits. The 2016 radiation protection survey report for the service showed that no doses of concern had been recorded on the dosemeters.

However:

- Staff did not use an early warning scoring system to monitor patients' observations. This meant that there was no standardised system for assessing and responding to patient deterioration. However the hospital had systems in place to ensure patients were monitored.
- The pregnancy status of women of child bearing age was not always checked.

Are services effective?

Good

We rated effective as Good because:

- Hospital policies were evidence based and used best practice guidance. An example was the change in practice for disc replacements, in which surgical technique had been changed following updated NICE guidelines.

Summary of this inspection

- Appraisal rates amongst staff were 100%. Managers had plans in place to support nurses through the process of revalidation. There was a process and policy in place for granting practicing privileges.
- Staff completed local audits to assess compliance against policies. For example audits in pain management and hand hygiene compliance.
- Patients were prescribed pain relief before surgery so that there was no delay in giving patients pain relief after surgery. Pain was also discussed as a symptom in outpatient clinic appointments.
- Patients had access to food and drink throughout their stay and dietary requirements were taken into consideration and provided for.
- Consent was taken on the day of surgery. There was opportunity for patients to consider all of the information prior to the procedure taking place, as information was provided in the outpatient consultation, a follow up letter sent after consultation and subsequent appointments booked if required.

However:

- The service did not participate in the imaging service accreditation scheme, which is a patient-focused assessment and accreditation programmer that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- Mental Capacity Act and Deprivation of Liberty training was not included in the mandatory Safeguarding Level 1 Adult training. However the Registered Manger advised that this would be included in future training sessions.

Are services caring?

Good

We rated caring as Good because:

- From October 2015 to March 2016, friends and family test scores were 100%. Response rates varied from 81% to 96% from October 2015 to March 2016. This was consistently higher than the England average for NHS patients in the independent sector, which ranged from 39% to 42% in this period.
- In April, May, July and August 2016, all patients asked had rated every aspect of the service as either 'Excellent' or 'Good'.
- Feedback left by patients on the NHS choices website was consistently positive. In November 2016 the service received a five star rating based on 70 patient ratings.

Summary of this inspection

- Patient feedback during the inspection was all positive with patients speaking highly of the care and treatment they had received.
- The operations manager or the administrative staff acted as chaperones if required in the consultant outpatient clinic. There was a 'chaperone policy' in place that set out the expectations of chaperones.

Are services responsive?

Good

We rated responsive as Good because:

- Data on referral to treatment times for admitted patients showed that from April 2015 to March 2016, there were seven months where above 90% of patients began treatment within 18 weeks of referral.
- For the period April 2016 to July 2016 each month 100% of non-admitted patients received treatment within 18 weeks, with the exception of June 2016 where 92% of patients were treated within 18 weeks.
- All staff had received an information session on dementia from a Dementia Friends Information Champion in July 2016. This meant that staff had information on the signs of dementia and how to work with patients living with dementia.
- Information could be obtained in other languages via a translation service.
- There were three complaints from April 2015 to March 2016. Learning from complaints was used to inform service improvement. One complaint for the inpatient area had resulted in a change for the pre-assessment stage of care to provide patients with more information relating to smoking and nicotine replacement during their admission.
- There was a formal process in place to monitor "Did Not Arrive" DNA, in outpatients. The process for handling DNAs was to offer another appointment after one DNA. After two or three DNAs, the case would be reviewed by the surgeon and the patient would be discharged and the referrer informed.

Are services well-led?

Requires improvement

We rated well-led as Requires Improvement because:

- Some policies seen on inspection appeared to be out of date such as the Medicines Management, Induction and Consent policies.However, following the inspection period the provider submitted evidence that demonstrated that the policies had been reviewed regularly and were in date.
- There was a hospital risk register, however most of the risks were generic, rather than specific risks for the hospital.

Summary of this inspection

- Systems for monitoring quality and effectiveness of the service were not robust. For example, the service did not report outcomes for Patient Reported Outcome Measures (PROMs).
- The hospital had decided not to adopt the National Early Warning Score (NEWS). This created a lack of consistency if patients were required to be escalated. However, the hospital had systems in place to ensure that patients were monitored.

However:

- The hospital mission statements were displayed in the staff areas. The service mission was to provide compassionate, responsive, innovative and cost efficient treatment to orthopaedic patients. Staff knew the mission statements.
- Staff were confident in the leadership, working together and service quality.
- There was a consistent approach to learning from incidents and the quality of root cause analaysis were good.
- There was a hospital risk register. Risks were rated, had clear ownership and actions required. Risks were recorded under a “generic” for example infection control or information governance.
- Updates on clinical governance issues were provided to staff every six months in staff meetings. The meetings included discussion about incidents, complaints, patient safety alerts and updates to policies.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Surgery

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

Are surgery services safe?

Good

We rated safe as Good.

Incidents

- There were no never events, serious incidents or deaths reported in the surgery service from April 2015 to March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no clinical or non-clinical incidents reported from April 2015 to March 2016. Staff knew about incident reporting and understood how to report an incident using the paper-based incident reporting form. One nurse we spoke to gave an example of a medication error as something that would be reported. Senior staff told us that if any incidents occurred, they would be discussed, evaluated for lessons learnt and shared with staff at team meetings.
- We asked two nurses on the surgery ward about duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support. Both nurses were aware of the duty of candour and one told us that staff should be "open and honest."
- We saw a duty of candour policy, which included a flow chart for staff about how to respond to an incident of patient harm.

Clinical Quality Dashboard or equivalent

- Managers reported safety outcomes to the local clinical commissioning group. We saw a quality schedule for April to June 2016, which showed targets and outcomes for a variety of measures including never events, incidents and infection rates. The outcomes for all of these measures were positive, with no never events, incidents or infections reported.
- There were no incidents of venous thromboembolism (VTE) or pulmonary embolism (PE) reported in the surgery service from April 2015 to March 2016. The hospital would be informed by the admitting hospital if a patient developed a VTE or PE post surgery. This had only occurred twice in the last 11 years.
- Staff compliance with screening patients for VTE was 100%. All five patient care records we saw contained assessment of VTE risk.
- We spoke to two nurses on the surgery ward, who told us that there had been no patient falls in the last year. Staff did not routinely carry out falls assessments.Staff said this was due to the low risk of falls in the patient group selected for treatment.
- Staff did not monitor the incidence of urinary tract infections in patients with catheters because catheters were rarely used in the service.

- We did not see any information on safety outcomes displayed in patient areas. However, the hospital website did give information on key performance indicators including MRSA rates, surgical site infections and unplanned returns to theatre.

Cleanliness, infection control and hygiene

- All of the clinical areas we visited were visibly clean. We checked the cleanliness of 13 pieces of equipment across the surgery service. All of the equipment we looked at was visibly clean and marked with green 'I am clean' stickers that had been appropriately dated.
- Cleaning of clinical areas took place daily on the three days per week where patients were in the hospital. We saw a cleaning schedule for the theatres area and checked completion of records from 27 July 2016 to 14 September 2016. We found that this had been completed on all required dates.
- We saw a cleaning schedule for clinical equipment on the ward and checked completion of records from 4 July 2016 to 19 September 2016. We found that this had been completed on all required dates.
- Alcohol gel dispensers were available in all clinical areas and staff had access to personal protective equipment such as gloves and aprons. Staff completed hand hygiene before and after treating patients and complied with 'bare below the elbows' practices. We saw a nurse wearing appropriate personal protective equipment (PPE) when treating a patient on the surgery ward. Staff in theatre wore appropriate PPE, including masks.
- All four of the patients we spoke to on the surgery ward were satisfied with the level of cleanliness. One patient commented "It's very clean everywhere" and another stated "They [staff] use the gels."
- Nursing staff completed a monthly audit of hand hygiene. We looked at results from June 2016 to August 2016. In June and July 2016, six members of staff were observed and all were compliant with hand hygiene and had used appropriate handwashing techniques. In August, three members of staff were observed but results were only documented for one member of staff, who was compliant with hand hygiene and used appropriate handwashing techniques.
- There were no cases of MRSA, MSSA, E-coli or Clostridium difficile in the surgery service from April 2015 to March 2016.
- There were no surgical site infections reported from April 2015 to March 2016.
- Equipment sterilisation services were outsourced to a local NHS trust. Equipment was sent on a weekly basis and was returned within two days. Extra surgical equipment could be loaned from the local NHS trust if it was needed while equipment was away being cleaned.
- Sterilisation labels on some surgical equipment were out of date in the theatre storeroom. We checked eight sets of surgical instruments and found that two sets were out of date, since 2007 and 2012 respectively. We also found a hip replacement that was out of date since 2012. These pieces of equipment were stored on a separate shelf to the majority of the equipment. We raised this with the provider at the time of our inspection. The provider assured us that these pieces of equipment were not used. We asked the provider to remove them. When we returned on our unannounced inspection, equipment with out of date sterilisation labels remained on the shelf. We asked the provider to remove the equipment from the storeroom to avoid any confusion, which they did immediately.

Environment and equipment

- Resuscitation equipment in the recovery area and on the surgery ward was easily accessible. We saw documentation of safety checks for the resuscitation equipment in theatre from July 2016 to September 2016. All required checks had been completed on days when surgery was performed. We saw documentation of safety checks for the resuscitation equipment on the ward from July to September and found that all required checks had been completed on days when patients were present on the ward.
- There was a service level agreement in place for medical engineering. We checked four pieces of electrical equipment across the surgery service and found that all had been electrical safety tested. For example, we looked at the anaesthetic machine, found that it had been electrical safety tested, and was within date for its next test due in November 2018.

- Senior staff showed us evidence of a difficult airway trolley in theatre. This meant that anaesthetists had appropriate equipment to manage patients with a difficult airway, in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guideline – Checking Anaesthetic Equipment 2012.
- There were six bed spaces where piped oxygen and suction equipment was available. Portable oxygen and suction equipment was also available on the ward

Medicines

- Staff stored medications securely in the anaesthetic room and on the surgery ward. In both areas, controlled drugs (CDs) were stored behind two locked doors. Other medications were stored in a locked trolley on the ward.
- We looked at registers of CDs on the surgery ward and in the anaesthetic room. These showed that staff checked the register of CDs on a daily basis to ensure that the stock of each drug was monitored and accounted for. We checked the recorded balance compared to the actual stock of three CDs on the day of our inspection and found that they matched.
- We checked the dates on a selection of four CDs in the anaesthetic room and two CDs on the surgery ward and found that all six were in date.
- Staff carried out daily checks of refrigerator temperatures. We looked at records from 20 June 2016 to 13 September 2016 for the refrigerator in the anaesthetic room and found that all checks had been completed and that the refrigerator had remained within the target temperature of four to six degrees. This meant that medicines requiring refrigeration were stored appropriately. We saw guidance for staff on what to do if the temperature fell below the recommended range.
- All five prescription charts we saw were signed and allergies were documented. This meant that there was less risk of a patient receiving a medication they were allergic to and that the prescriber of medications was clearly identifiable in case of any concerns.
- A pharmacist visited the service twice a year to complete a review of medicines management. This provided an external overview of medicines management in the service

Records

- Patient records were stored securely in a staff area on the surgery ward.
- We reviewed five sets of patient records. Patient records were kept in a single file, which included pre-operative assessments, operation notes, post-operative notes, nursing notes and prescription charts. This meant that staff had access to all relevant medical information when caring for patients.
- All the records we saw contained appropriate risk assessments, management plans and evidence of multidisciplinary working. Pre-operative assessments included smoking status, venous thromboembolism (VTE) risk, height, weight and social circumstances.
- We saw results of an audit of nursing documentation. This showed improvements in the accuracy of record keeping. From October to December 2015, 78% of notes were compliant. From January to March 2016, 86% of notes were compliant and from April to June 2016, 92% of notes were compliant.

Safeguarding

- The hospital medical director was the nominated lead for safeguarding. Staff were able to identify the medical director as the person they would go to with safeguarding concerns.
- A 'safeguarding adults policy and procedure' document was available for staff to refer to, although this policy had no date of issue or review. Therefore we were not assured that the information in the policy was in line with current practice.
- The Safeguarding Adults Policy and Procedure stated that all staff must have twice yearly safeguarding training, however when this was checked with the operational manager we were informed that this was incorrect and should state once yearly training.
- 92 percent (or 12 out of 13 staff) completed safeguarding adults level one training in the period April 2015 to March 2016.
- Reporting documentation for the period April to June 2016 showed that safeguarding training had taken place and safeguarding policies had been revised and were with the clinical commissioning group for review.
- No safeguarding incidents were reported in the period April 2015 to March 2016.

- Staff did not receive information in their safeguarding training around female genital mutilation (FGM). However, females are more at risk of FGM when they are under 18 years of age, and the hospital did not accept patients under 18 years of age

Mandatory training

- All staff completed mandatory training on a yearly basis. This included fire safety, infection control, moving and handling and basic life support training. We saw records showing that 100% of staff had attended mandatory training in December 2015.
- The medical director told us that bank staff were included in the hospital's mandatory training unless they could provide evidence that they had completed this at another organisation.
- Clinical staff received training in immediate life support. We saw records showing that three out of four nursing staff had completed immediate life support training, with the remaining nurse due to complete this in September 2016. The resident medical officer (RMO) was booked to complete immediate life support training in October 2016.
- A log was kept of all staff training including which staff had completed, or were due to complete what training throughout the year, including dates.

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

- Staff knew how to escalate concerns about deteriorating patients. A consultant and consultant anaesthetist were on site to respond to concerns between 7am and 6pm. After 6pm, concerns were escalated to the RMO. A consultant surgeon and consultant anaesthetist were on-call after 6pm.
- There was a 'close observation room' where nursing staff could provide one to one care for patients if required. However, this room was not equipped for the provision of extended post-operative care, such as organ support. There was a service level agreement in place with a local NHS trust for the escalation of any patients who needed escalation of their care post-operatively.
- Information for staff was displayed in the staff room, including a sepsis pathway and a resuscitation policy. This meant that staff had information on how to respond to a deteriorating patient.
- The surgery service admissions policy stated clear exclusion criteria for patients undergoing surgery. Staff confirmed that patients were selected carefully, based on operative risk and that patients with complex, long-term conditions were not accepted, as the service would not have the facilities to care for them appropriately.
- The World Health Organisation (WHO) safer surgery checklist was used in theatre. This is a safety checklist used to reduce the number of complications and deaths from surgery. On our unannounced inspection, we saw staff in theatre completing the safer surgery checklist. We saw records of an audit of 20% of randomly selected patient records from April to June 2016. This showed that the safer surgery checklist was documented in all of the records.
- All of the records we saw contained appropriate documentation of patient observations. However, staff did not use an early warning scoring system. This meant that there was no standardised way for staff to recognise the early signs of deterioration of a patient.

Nursing and support staffing

- The surgery service employed 3.5 whole time equivalent registered nurses. There were 2.5 whole time equivalent nurses in inpatients and one whole time equivalent nurse in theatres. The service employed 0.5 whole time equivalent non-registered support staff in inpatients and 1.3 whole time equivalent non-registered support staff in theatres.
- On the day of our announced inspection, there were two registered nurses(RN), working on the surgery ward and five patients on the ward. Staff and patients told us that this was adequate to meet patients' needs. We spoke to four patients and all of them said that there were enough staff to meet their needs.
- From April 2015 to March 2016, agency or bank RNs were used in four out of 12 months. There was no use of bank or agency health care assistants in this period. Senior staff told us that a total of three self-employed bank staff were used in theatre. These three staff members

worked for the service regularly and were included in staff mandatory training. The registered manager told us that they kept a professional registration register for bank staff, which included evidence of professional registration, indemnity insurance, copies of training certificates and DBS clearance.

- There were no staff vacancies in inpatients or theatres and there had been no staff turnover in inpatients or theatres in the last year.
- We saw a printed handover sheet used by nursing staff to feedback any concerns to the surgeon about patients' progress.

Medical staffing

- There was a total of six doctors practicing under practising privileges in the surgery service from April 2015 to March 2016. This included five anaesthetists and one radiologist.
- Medical cover was available at all times when the surgery service was in operation (Mondays to Wednesdays). A consultant surgeon and consultant anaesthetist were on the premises from 7am to 6pm on Mondays and Tuesdays. After 6pm, the RMO was on site to provide medical cover and a consultant surgeon and a consultant anaesthetist were on call (within 5 miles of the hospital). The RMO had a six hour break on a Tuesday afternoon. One of the consultants would provide medical cover during this time.
- The RMO received clinical supervision from the consultant surgeon in order to develop their learning and clinical skills.
- Staff told us that it was rare for a patient to require ongoing care beyond the service's usual operating hours of Monday to Wednesday. Staff said that if there were a clinical need for a patient to stay longer, staff would arrange amongst them for adequate staffing to continue. There was no formalised rota in place for this as it was a very uncommon occurrence.

Emergency awareness and training

• There was a Business Continuity Plan which gave clear instructions for emergency situations for example lift entrapments. The plan included staff contact details, actions that should be taken, suppliers and utilities contact numbers.

• Staff were aware of the contingency plan, and a review of the plan was completed every six months. We checked the past two years records, and the six monthly reviews had been completed between June 2014 to June 2016.

Are surgery services effective?

Good

We rated effective as Good.

Evidence-based care and treatment

- Senior staff set targets for improving the quality of care using the Commissioning for Quality and Innovation (CQUIN) scheme. This is a payment framework, which encourages care providers to share and continually improve how care is delivered. We saw evidence of a CQUIN relating to enhanced recovery after surgery. This showed improvements to pre-operative assessment and measures introduced to reduce intra-operative physical stress and promote a structured approach to post-operative management.
- Senior staff told us that they assessed whether alerts from the National Institute for Health and Care Excellence (NICE) were applicable to the service and if so devised action plans to gain compliance. An example was the change in practice for disc replacements, in which surgical technique had been changed.
- Staff completed local audits to assess compliance against policies. For example, staff completed monthly audits of handwashing and infection control procedures and quarterly audits of nursing documentation.We saw evidence of learning from audits. For example, we saw a review of nursing documentation audits which showed improvements in the standard of documentation and identified areas of further learning to be shared at the staff meeting.
- Policies in the surgery service referred to national guidance and law. For example, a nurse on the surgery ward showed us the resuscitation policy, which referenced guidelines from the Resuscitation Council. We also saw an Accident, Incident and Near Miss policy, which referenced the Health and Safety Act, 1974.

Pain relief

- A pain control audit conducted from April 2015 to March 2016 showed that 91% of patients said their pain was controlled before leaving hospital, 2% said their pain was not controlled before leaving hospital, 6% did not state whether their pain was controlled and 0.81% stated that this question was not applicable.
- Two nurses on the surgery ward told us that patients were prescribed pain relief before surgery so that there was no delay in giving patients pain relief after surgery.
- The patients we spoke to told us that they were offered pain relief regularly.

Nutrition and hydration

- Patients told us that they were satisfied with the food and drink they were offered. One patient on the surgery ward commented on the "beautiful food."
- Patients having surgery were advised to fast from midnight the night before surgery. The consultant reviewed each patient on the morning of surgery and would advise nursing staff if the patient would be having surgery later in the day so that the patient could drink water up until three hours before surgery.
- Patients having a general anaesthetic were given a preventative anti-sickness drug at the same time as the anaesthetic. This meant that patients' recovery was less likely to be delayed due to sickness.

Patient outcomes

- There were no unplanned transfers, readmissions within 28 days or returns to theatre from April 2015 to March 2016.
- There were no surgical site infections reported between April 2015 and March 2016.
- We saw an audit schedule for 2016, which included timeframes for submission of data for national benchmarking audits and local audits. For example, nursing staff completed a quarterly local audit on pain relief.
- Staff submitted data to the National Joint Registry for patients undergoing hip and knee replacements. The 2015 audit report showed a consent rate to the register of 100%, which was excellent. The report showed that there were no mortality or revision rate outliers.
- The surgery service submitted Patient Reported Outcome Measure (PROMs) questionnaires but outcomes were not available because the service did not have the I.T infrastructure to connect to the reporting database. Senior staff told us that connecting to this database was an objective for the service, although this was not highlighted on the risk register.
- Managers in the service had created an account with the Private Healthcare Information Network (PHIN) but did not submit data to PHIN at the time of our inspection because they were waiting for authentication of the account.
- The surgery service did not submit data to the British Spine Registry. This is a national database set up by the British Association of Spinal Surgeons to monitor the outcomes of spinal procedures, with the aim of improving patient safety.

Competent staff

- From September 2015 to August 2016, 100% of staff in the surgery service had completed their yearly appraisal.
- There was a process and policy in place for granting practicing privileges. The medical director and registered manager were responsible for granting practicing privileges. Appointment of new practitioners was discussed and ratified at the clinical governance committee meetings. Practicing privileges were reviewed every two years in the form of a meeting between the practitioner and the medical director. This meant that managers of the service took steps to assure themselves of the competence of doctors practicing there.
- Managers had plans in place to support nurses through the process of revalidation. A lead member of staff had been appointed to oversee the revalidation process and arrangements were in place to document nurses' continuing professional development.
- Nurses in the surgery service attended teaching sessions with the medical director. We saw minutes from a nurses meeting which showed evidence of a teaching session on post-operative shock. Nurses also completed clinical competencies on a yearly basis.

Multidisciplinary working

- Nurses worked with the physiotherapist to encourage early mobilisation of patients. Nursing staff told us how they assisted patients to mobilise out of bed two hours postoperatively. This meant that patients were ready to continue to progress their mobility with the physiotherapist on the first day postoperatively.
- We saw the multidisciplinary team of staff in theatre working effectively together.
- A nurse on the surgery ward told us how staff liaised with patients' GPs regarding postoperative weaning of pain relief and any ongoing care needs.
- Staff told us about a time when they had arranged support for a patient from the local independent living team to enable the patient's safe discharge.
- We saw a handover sheet which nurses used to update the consultant on patients' progress. There were no formalised multidisciplinary meetings but staff told us that there was good communication between medical and nursing staff.

Access to information

- Staff had access to the information they needed to provide effective care. This included the patient's past medical history, pre-operative assessments and operation notes. All notes were in paper format.
- We saw a board in theatre displaying the patient's name, operation, surgical team and numbers of surgical instruments used.
- We saw useful information displayed for staff on the surgery ward, including a sepsis pathway and advice on catheter care.
- Staff sent discharge information to each patient's GP post-operatively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The was a Consent Policy available for staff to access although this was out of date for review, which was due in January 2016.
- We saw a poster on consent and the law displayed in the staff area of the surgery ward.
- Patients gave consent to surgery on the day of surgery. However, staff explained the risks and benefits of surgery to each patient at the pre-operative outpatient appointment and sent each patient written information to consider before giving consent. If a patient had any concerns after reading the written information, an extra outpatient appointment would be booked before surgery to discuss these concerns. We saw evidence of consent in the five sets of medical records we reviewed.
- Staff did not have any specific training on mental capacity assessment. This meant that staff were not trained in how to recognise if a patient lacked the mental capacity to give consent. Staff did not receive training on deprivation of liberty safeguards. This meant that staff were not trained in the procedures for depriving a patient lacking mental capacity of their liberty in order to receive appropriate care in their best interests.

Are surgery services caring?

Good

We rated caring as Good.

Compassionate care

- The service collected and submitted data for the NHS friends and family test. Results were consistently positive. From October 2015 to March 2016, friends and family test scores were 100%, which was positive. Response rates were also high; they varied from 81% to 96% from October 2015 to March 2016. This was consistently higher than the England average for NHS patients in the independent sector, which ranged from 39% to 42% in this period.
- Results from a local patient care survey from April 2016 to August 2016 showed positive results. The survey asked patients 11 questions about their stay and asked them to rate different aspects of the service on a scale from 'Excellent' to 'Poor'. In April, May, July and August 2016, all patients asked had rated every aspect of the service as either 'Excellent' or 'Good'. In June 2016, one patient out of 37 had rated four aspects of care as 'Poor.'
- Patient comments from the local patient care survey were positive. For example, one patient said "Everything has been brilliant, we have no complaints whatsoever,

only praise…many many thanks." Another patient said "I came with complete confidence in the staff, medics and the standard of care I would receive, I was not disappointed."

- Patients left positive feedback about the service on the NHS choices website. From April 2015 to March 2016, 35 items of feedback were left on the website, all of which were rated 'extremely likely to recommend' the service. In November 2016, the service had a five star rating on the NHS choices website, based on 70 reviews.
- Patients on the ward told us that staff were kind and caring. One patient said the surgery ward was like "heaven" and another commented that it was like "a home from home."
- One patient told us that she had "no concerns" throughout her stay and now felt "ready to go home."

Understanding and involvement of patients and those close to them

- Patient records contained evidence of involvement of patients' relatives and loved ones in the planning of patients' care. For example, one set of records contained a pre-operative discussion with a patient and her granddaughter about the support she would require after surgery.
- Senior staff told us that the patient was always the focus of care and staff could give us examples of how they had supported patients individual needs. For example, senior staff told us about how they had sourced Halal meat to meet a patient's dietary requirements and how they provided a birthday cake for patients whose birthdays fell while they were in hospital.
- Patients were given information leaflets to explain procedures. One patient told us how his consultant had showed him what his surgery would involve using a model of the spine. This patient also had a leaflet explaining important steps in post-operative recovery.
- We saw patient information leaflets on surgical procedures. For example, we saw a leaflet called "Understanding Total Hip Replacement", which gave information on preparing for surgery, understanding the risks of surgery and recovery after surgery.
- Nursing staff told us how they greeted patients on arrival and explained what their stay would involve so that patients would feel less apprehensive about surgery.
- Patients on the surgery ward were allowed visitors from 9am to 8pm.

Emotional support

- A nurse on the surgery ward told us how she spent time with patients to discuss any fears they might have and to provide reassurance.
- Nursing staff telephoned patients one week postoperatively to check on their wellbeing and to follow up on any concerns the patient might have.
- Patients were referred back to their GP for any ongoing support needed.

Are surgery services responsive?

Good

We rated responsive as Good.

Service planning and delivery to meet the needs of local people

- The service provided inpatient care mainly for NHS funded patients, although 7% of inpatients funded care through insurance or self-funded.
- Staff told us that the hours the service operated were mainly predictable due to careful selection of appropriate patients and the elective nature of the procedures performed. Staff told us that if there was a need to extend the hours the service operated to meet a patient's needs that this would be organised by staff as needed

Access and flow

- There was a clear process in place to ensure that all relevant tests and scans had been completed before patients were booked for surgery. This meant that patients' operations were not delayed or cancelled on the day of surgery due to missing clinical information.
- Data on referral to treatment times for admitted patients showed that from April 2015 to March 2016, there were seven months where above 90% of patients began treatment within 18 weeks of referral.
- There was a clear admissions policy in place, with inclusion and exclusion criteria that were appropriate to the facilities available.

Good

Surgery

- Staff worked with patients and their loved ones before surgery to arrange for supported discharge home. A nurse on the surgery ward showed us a checklist that was used to ensure factors such as transport home and support following discharge were discussed. The nurse gave us an example of a patient who had been supported to arrange for a period of respite in a residential home because they did not have any relatives who could provide support.
- There were two procedures cancelled for non-clinical reasons from April 2015 to March 2016. Both patients were offered another appointment within 28 days of the cancelled appointment.

Meeting people's individual needs

- All staff in the surgery service had received an information session on dementia from a Dementia Friends Information Champion in July 2016. This meant that staff had information on the signs of dementia and how to work with patients living with dementia.
- The service had specific assessment forms for patients over 65 who may be at risk of dementia. These forms included screening questions about the patient's memory, which could be used to identify if a more detailed 'Dementia diagnostic assessment tool' needed to be completed.
- A telephone translation service was available for patients who did not speak or understand English. We saw an information poster for nurses on the surgery ward with details of how to access this service.
- Patients were cared for in individual private rooms. Each bedroom had a private wetroom for ease of access for patients. There was one room with two beds. A nurse on the surgery ward told us about how the relative of a patient with Down's syndrome was allowed to stay with the patient overnight in this room so that the patient felt comfortable and kept their normal routine as much as possible.

Learning from complaints and concerns

- There were three complaints in the surgery service from April 2015 to March 2016. The complaints related to food provided on the surgery ward, a patient who was disappointed that they were not clinically suitable to have surgery and a patient wishing to go outside to smoke following surgery.
- Managers investigated and responded to complaints appropriately. For example, we saw documentation of a complaint from a patient who was advised not to go outside to smoke following surgery. Managers had responded to the patient's complaint and apologised to the patient. We saw evidence of learning from this complaint, for example changes to advice given to patients pre-operatively about smoking and discussion with staff about how to communicate advice about smoking to patients.
- We saw minutes from a staff meeting in October 2015 where staff discussed a patient's feedback about food being cold and identified ways of improving the timing of patients' meals.
- The staff we spoke to were aware of the complaints process and could give examples of learning from complaints.
- There was a complaints policy in place. This was within date for review and contained timeframes and accountabilities for responding to complaints.
- Patients could access information on the service's complaints procedure via the hospital website and also in their room information booklet

Are surgery services well-led?

Requires improvement

We rated well-led as Requires Improvement.

Vision and strategy for this this core service

- The hospital mission statements were displayed in the staff areas. The service mission was to provide compassionate, responsive, innovative and cost efficient treatment to orthopaedic patients. The social mission was to make our services available to any patient who needs them whether they are self-funding their treatment, covered by private medical insurance or referred by the NHS locally or nationally. The business mission was to run our service on sound business principles that sustain our success and promote the professional and personal development of our staff.

- One member of nursing staff told us that the mission was to give every patient the same care whether they were private or NHS patients. This was in line with the hospital's social mission.

Governance, risk management and quality measurement

- Updates on clinical governance issues were provided to staff every six months in staff meetings. Minutes of the July 2016 meeting showed that staff received updates on a range of issues including complaints, clinical and non-clinical audits, policy updates, staff training, infection control, health and safety, and patient safety notices. Learning from incidents was an agenda item however there were no incidents to report on.
- Senior staff told us they held quarterly clinical governance meetings. We saw two sets of minutes from these meetings, from November 2015 and May 2016, which showed that the meeting was attended by the medical director, registered manager and chair of the committee. The meetings included discussion about incidents, complaints, patient safety alerts and updates to policy.
- However, meeting minutes appeared to be sparse and lacked detail or structure. We were not assured that there was robust challenge within the service. For example, whilst we were informed that "discussions" had occurred regarding not implementing NEWS, there was a lack of challenge recorded regarding this, particularly as this is a recommended guidline that standardises assessment of acute illness.
- The medical director had overall responsibility for granting practising privileges, supported by the registered manager who would monitor the application process, for example references, competency and adequate medical/indemnity insurance. Practising privileges were reviewed on a two yearly basis by the medical director.
- Some policies seen on inspection appeared to be out of date such as the Medicines Management, Induction and Consent policies. However, following the inspection period the provider submitted evidence that demonstrated that the policies had been reviewed regularly and were in date.
- There was a hospital risk register. Risks were rated, had clear ownership and actions required. Most of the risks were "generic," for example infection control or information governance. However, service specific risks were not on the register.
- Systems for measuring and improving quality were limited. For example, whilst the service submitted Patient Reported Outcome Measure (PROMs) questionnaires it did not report outcomes for Patient Reported Outcome Measures (PROMs) because the service did not have the I.T infrastructure to connect to the reporting database.
- Data was not submitted data to the British Spine Registry, which would provide the opportunity for research, audit, monitoring of Patient Reported Outcome Measurements (PROMS), and is considered best practice.
- The annual radiation protection service report 2015, identified the need to ensure that the procedure for checking pregnancy status of female patients was followed. However, the report from the 2016 showed that this check was still not consistently being done.
- The hospital had decided not to adopt the National Early Warning Score (NEWS). This created a lack of consistency if patients were required to be escalated. However, the hospital had systems in place to ensure that patients were monitored

Leadership / culture of service related to this core service

- The surgery service was led by the medical director and registered manager.
- The hospital management held personnel files for self-employed staff, inclusive of references and disclosure and barring service checks, training certificates and current mandatory training records.
- When discussing incident reporting, and the fact that no incidents had occurred in the past year, two nurses stated that this was "a very open system, we just talk to each other", that "we work so well as a team" and that the consultant surgeon "is so precise in everything, he never rushes and he is so thorough in everything"
- Staff on the surgery ward told us they felt proud to work for the service and one nurse commented that senior staff were "amazing" to work for and that the service was "one of the happiest places I've ever worked."

Good

Surgery

- Staff said that leaders were visible and approachable. One nurse said, “Managers are always there for you…you can go anytime.”
- From April 2015 to March 2016, there was 0% sickness for inpatient nurses and no sickness for inpatient health care assistants. There was no staff sickness in theatres in this period. This indicated a good level of staff wellbeing.

Public and staff engagement

- Staff and patients were involved in service improvement. For example, leaders presented all positive and negative patient comments at staff meetings and discussed areas for learning with staff.
- A nurse on the surgery ward told us that if staff had ideas for training and development they would be supported to implement these by leaders.

Innovation, improvement and sustainability

- The hospital was developing their information technology structure to be able to become “linked” with the NHS. This would mean that scans could be electronically transferred as opposed to discs being sent. The hospital was in a pilot phase with an acute trust at the time of the inspection.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as Good.

Incidents

- There was an 'accident, incident and near miss policy', in date, for the hospital. We spoke with two nurses who demonstrated a good understanding of incidents and near misses, and the process for reporting incidents.
- There had been no serious incidents and no never events for the period April 2015 to March 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- For the same period, there had been no clinical and no non-clinical incidents and no radiological incidents reported.
- The provider had a 'being open and duty of candour policy' and procedure in place for staff to refer to in the event of an incident occurring requiring the duty of candour to be exercised.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The two nursing staff we spoke with expressed an understanding of the duty of candour although there had been no incidents occurring to see evidence of this in action.

Cleanliness, infection control and hygiene

- MRSA screening for admissions took place at the pre-assessment stage of care and we saw evidence of this being recorded in the three sets of notes we reviewed.
- There had been zero cases of MRSA, methicillin resistant staphylococcus aureus (MSSA) and escherichia coli (E. coli) for the period April 2015 to March 2016.
- Daily domestic cleaning schedules for the outpatient consulting rooms and x-ray area and the ward area (where the pre-assessment clinics took place) were reviewed for the 10 week period prior to our inspection and all entries were complete.
- The two nurses we spoke to were both wearing uniform that complied with 'bare below the elbows' practice.
- One of the ward nurses who worked in the pre-assessment clinic was also the infection control link nurse for the hospital. The role of the link nurse was to utilise formal links with specialist nurses in infection control to increase their understanding of the subject and share that learning and develop good practice in their own setting. The link nurse was due to attend an annual study day in October 2016 and feedback the learning at the next staff meeting.

Environment and equipment

- The hospital had an in date 'resuscitation policy' that stated that resuscitation equipment was to be checked daily and recorded.

- There was a resuscitation trolley in the close observations room on the ward where the pre-assessment clinics took place, which was scheduled to be checked daily for the three days a week that the inpatient area was in use. We checked the log book for the three month period (June to September 2016) prior to our inspection and found that daily checks were missing on six occasions.However the hospital subsequently advised this is when the hospital had been closed.
- Lead aprons for x-ray were kept in theatre which was located on the same corridor a short walk away from the x-ray room.
- The service held a full inventory of all radiological equipment and the purchase dates.
- Service level agreements (SLA's) were in place for the service and maintenance of all x-ray equipment and machinery. Three pieces of x-ray equipment and three pieces of equipment in the close observations room were checked and all were within date of for their next service and safety checks. SLA's were also in place for the decontamination of equipment and the management of clinical waste.
- Doors to the x-ray room were lead lined. This meant that there was radiation protection in place.
- A single radiographer was contracted to provide an x-ray service to the hospital on a self-employed basis. This radiographer was the lead for ionising radiation, and completed audits to check doses and exposure to patients and staff.
- Staff in theatres had access to lead aprons to provide personal protection from radiation during use of X-rays. Thyroid shields were not included. The surgeon and circulating nurse wore dosemeters that monitored exposure to radiation and these were sent to a local NHS trust on a monthly basis for review in order to ensure that the level of staff exposure to radiation stayed within acceptable limits. The 2016 radiation protection survey report for the service showed that no doses of concern had been recorded on the dosemeters. The surgeon told us that use of x-rays in theatre was minimal and ranged from 2-5 seconds in total per operation
- Personal and protective equipment (PPE) such as aprons and gloves were available for use in the close observations room on the ward where pre-assessment patients were seen. However there were no pre-assessment clinics taking place at the time of our inspection so we did not see any compliance to good hand hygiene practice or use of PPE.

Medicines

- A 'medicines management policy' was in place for staff to access although it was out of date since December 2009. However, medicines were not used, nor stored in the outpatient clinic rooms or the x-ray room.
- Any prescriptions issued from the outpatient consulting rooms were written on headed paper by the consultant surgeon, and prescription pads were not used.

Records

- There was a 'health records policy' in place for staff to refer to although this had no date of last review so we were not assured that the guidance in the policy was current. The policy was closely linked to the hospitals' Patient Journey, Care Pathway and Service Delivery Policy. Medical records were kept in line with the Records Policy.
- Patient records were stored onsite. Records were always available to the consultant surgeon for outpatient appointments.
- We reviewed three sets of medical records. Each record contained the referral into the service, a completed pre-operative patient questionnaire, and a completed pre-assessment checklist. We saw base line observations which were all signed and dated, completed moving and handling assessments, nutritional, Waterlow (which is a risk assessment for the development of pressure ulcers), deep vein thrombosis and infection risk assessments. MRSA screening was also documented at the pre-assessment appointment.
- Follow up letters were seen in two of the three sets of records we reviewed (one had not had their follow up appointment post discharge yet). This indicates that medical records for the outpatient stage of care were thorough and contained appropriate records of risk assessment.
- Following each outpatient consultation with the consultant surgeon, a letter detailing the outcome of the consultation and suggested treatment was sent to the patient's GP or referrer. This was in line with the Patient Journey, Care Pathway and Service Delivery Policy.
- A hospital wide nursing documentation audit review for the period from April 2016 to June 2016 showed that

92% nursing notes were 100% compliant, 7% were 80% and 1% were 60% compliant. This was an improvement of 86% for the period January to March 2016, and 78% October to December 2015. Areas for improvement were the for staff to write their initials next to any amendments in their records, documentation of postoperative records and allergy sections being completed. Improvement actions were seen minuted in staff meeting records.

- Records were kept of all radiation safety notices issued by manufacturers of equipment and the actions taken, as well as recommendations of the annual audit of the service by the radiation protection service (this service provided annual reviews of the x-ray service to ensure that the risk to patients was within acceptable limits) and all regulations relating to radiology. The policies for radiology were audited by the radiation protection service and recommendations made and implemented.
- Risk assessments were completed for the x-ray room and equipment including x-ray equipment in theatres. There was evidence of risk assessments being reviewed annually.

Safeguarding

See surgery for main findings

Mandatory training

See surgery for main findings

Assessing and responding to patient risk

- The hospital had set criteria for admitting patients, which led to medically complex or unwell patients not being admitted. This meant that the risk of patients deteriorating based on pre-existing conditions was reduced.
- One example was given by the operations manager of a patient who fainted in the outpatient consulting room. The consultant surgeon called for a bed to be brought down from the ward, requested some observations be undertaken until it was clear the patient was stable, then transferred the patient to the ward until they were well enough to leave.
- A service level agreement was in place with a neighbouring NHS trust to provide a radiation protection service to the hospital. The annual reports from the radiation protection service for both 2015 and 2016 were reviewed. Overall the reports identified improvements to practice in 2016 based upon the 2015 recommendations, with the exception of checking pregnancy status.
- The annual review and associated report 2015 identified the need to ensure that the procedure for checking pregnancy status of female patients was followed. However, the report from the 2016 review showed that this check was still not consistently being done. The report was released around the time of our inspection and the provider had not had time to create an action plan to address this at the time.
- Signs were on the walls of the x-ray room advising patients about the risk of x-rays in pregnancy and the radiographer stated that all females between the ages of 18 and 60 years would be asked their pregnancy status.

Nursing staffing

- There was no dedicated nursing establishment for the outpatients' service. The consultant surgeon clinics were not supported by nursing staff. Two nurses from the ward provided the twice weekly pre-assessment clinics as part of their roles.
- One nurse with the competence to take blood held one of the pre-assessment clinics for patients requiring blood tests for their admission. Another nurse provided the second pre-assessment clinic for swab-only patients, where blood tests were not required.
- In the event of unexpected absence of the nurse providing the pre-assessment clinic where patients required blood tests, the consultant surgeon provided clinic cover. In the event of unexpected absence of the nurse providing the swab-only pre-assessment clinic, another ward nurse would provide clinic cover.
- There was an 'induction policy' in place that outlined the induction processes and expectations for new permanent staff. However this policy was out of date since December 2012.

Medical staffing

- The consultant surgeon was the only member of medical staff seeing patients in the outpatient clinic. The surgeon was employed by the hospital and was therefore not performing under practicing privileges.

Major incident awareness and training

See surgery for main findings.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We rated effective as: Inspected but not rated.

Evidence-based care and treatment

- Policies were underpinned by regulation and national guidance. For example, the Resuscitation Policy referenced guidelines from the Resuscitation Council and the Accident, Incident and Near Miss policy referenced the Health and Safety Act, 1974.
- Radiology policies and procedures were reviewed annually as part of the review performed by the radiation protection service. This ensured that up to date clinical guidelines were being incorporated into the policies.

Pain relief

- Pain was discussed as a symptom in outpatient clinic appointments but was not scored. Pain was treated by the patients' surgical treatment and associated pain relief post-surgery. Pain was discussed at the follow up appointment.

Patient outcomes

- The service did not participate in the imaging service accreditation scheme, which is a patient-focused assessment and accreditation programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- Patient outcomes were not measured for the outpatients and diagnostic service, but rather for admitted patients.

Competent staff

- The registered manager was the hospital lead for revalidation. The two nurses we spoke to confirmed that they were supported in their revalidation processes. The clinical commissioning group had set the hospital a CQUIN, which is a payment framework to encourage continuous improvement in healthcare, for nurse revalidation which had been achieved.
- The radiographer provided supervision in theatre to the surgeon when using x-ray. We saw notes for June 2016 which show the radiographer's observations of the x-ray procedure performed in theatre.
- The consultant surgeon delivered educational talks to staff before each staff meeting with the aim of preventing or reducing the risk of incidents. Minutes of the staff meeting in July 2016 showed that a talk was given on pre-operative objectives and shock, which supported nurses who perform pre-assessment clinics in the patient checks they perform.
- 100% of staff were within date of their annual appraisal.
- Two nurses told us that should they wish to attend a course or partake in professional development of any kind, they would make a request to the consultant surgeon who would support them if he agreed it was appropriate.

Multidisciplinary working

- The outpatients and diagnostic imaging service at the hospital was supported by the consultant surgeon, two ward nurses and the radiographer.
- X-ray investigations were available to both inpatients and outpatients on Wednesdays.
- The diagnostics service worked with the regional radiation protection service to ensure continuous safety and effectiveness of the service by undergoing an annual review.

Seven-day services

- The outpatients and diagnostic service was not a seven day service.
- The outpatient service, including the consultant clinics and the pre-assessment nursing clinics, ran from Tuesday to Friday every week.
- The radiology service was available on Wednesdays although the radiographer was available to be contacted in the event of an x-ray being required urgently on the other week days.

Access to information

- Information systems were paper based at the hospital. Referrals received were in letter format and any imaging scans accompanying referral letters were on computer discs. Computer discs containing scans for patients being referred from one specific geographical area were arriving later than the referral letters. This had been raised with head of radiology where the referrals were

Good

Outpatients and diagnostic imaging

originating, as well as with the commissioners. The delay in receiving the computer scans did not lead to patients waiting beyond the 18 week target. One patient we spoke with confirmed that they had to wait for their first appointment until their scan results arrived, but that they did not find the wait excessive and they were seen quickly once all the information was available to the consultant.

- Referrals contained past medical histories, details of presenting complaints, and scan images and results on disc. Any referrals received without scans performed were sent, by the administrative team, back to the referrer to request the appropriate examinations.
- Outpatient letters were transcribed and sent to patients and referrers within three working days of the appointment taking place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See surgery for main findings

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as Good.

Compassionate care

- There was a 'privacy and dignity policy' for staff to access. This was last reviewed in November 2014 and we could not ascertain when it was due for review again.
- The operations manager or the administrative staff acted as chaperones if required in the consultant outpatient clinic. There was a 'chaperone policy' in place that set out the expectations of chaperones.
- All three patients we spoke with told us that the staff were kind. One patient told us that the nurse he saw in the pre-assessment clinic was very kind and efficient and that he had every confidence in his care before he arrived for admission.

Understanding and involvement of patients and those close to them

- Feedback about the service on the NHS choices website showed that for the period April 2015 to March 2016, all 35 items of feedback rated the hospital 'extremely likely to recommend' the service. There were no outpatient and diagnostic service specific patient surveys.
- All three patients we spoke with felt informed about their care. One patient told us that everything about his care was explained to him in both his appointment with the consultant surgeon, and his pre-assessment appointment with the nurse.
- Staff gave us examples of how they engaged patients and their loved ones in their care. For example, the consultant told us that outpatient consultations always started by asking patients about themselves and asking them to share "more than what is written in the referral letter." This meant that patients could provide any information they wished and that staff could build a picture of the patient's needs and support systems.

Emotional support

- One patient told us that he felt very overwhelmed and shocked at the treatment he required, but that the consultant surgeon took his time to support the patient with advice and comfort before ending his appointment.
- A nurse on the surgery ward told us how she spent time with patients to discuss any fears they might have pre-operatively and to provide reassurance.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good.

Service planning and delivery to meet the needs of local people

- The hospital was open to outpatients between Monday and Friday of each week, with the exception of bank holidays. Pre-assessment clinics were held on Tuesdays (for patients requiring blood tests) and Thursdays (for patients only requiring pre-assessment swabs). Consultant outpatient clinics were held on Wednesdays, Thursdays and Fridays.
- In the event of the consultant surgeon or the nurses conducting the pre-assessment clinic taking planned leave, the clinics were re-arranged. In the event of a staff

member taking unexpected leave, such as sick leave, the consultant clinic would be re-arranged by the administrative team and the pre-assessment clinics would be covered by existing staff. The clinic where swabs alone were taken would be covered by another ward nurse. The clinic where bloods were taken would be covered by the consultant surgeon.

Access and flow

- For the period April 2016 to July 2016 each month 100% of non-admitted patients received treatment within 18 weeks, with the exception of June 2016 where 92% of patients were treated within 18 weeks. This equated to one patient in June waiting beyond 18 weeks.
- The provider told us that the reason any patient would wait beyond the expected time was when the hospital received referrals when the patient was already quite a way through their referral to treatment pathway.
- Patients did not have to wait long to be seen once they arrived at the hospital for their appointment. One patient told us that he waited between four and five minutes from arriving to being called in by the consultant.
- Access to the outpatient clinic was well coordinated. Referrals were received from the NHS e-referral service, which allows patients to choose online what hospital they wish to attend. Referrals would also come from GP's. Patients would be offered an appointment once the associated radiology results had been received. This meant that the patient had more time with the surgeon in their appointment, as the surgeon was able to review results before the patient attended. Admission dates were agreed between the surgeon and the patient in the outpatient clinic.
- A radiographer was on site to perform x-ray investigations on Wednesdays, at the same time as the consultant outpatient clinic. If required, patients could be x-rayed at the same time as their initial appointment. This was in line with the hospital's Patient Journey, Care Pathway and Service Delivery Policy.
- If emergency x-rays were required the operational manager told us that the radiographer would be contacted to attend the hospital outside of their normal working hours. The hospital's surgeon was competent in taking x-rays and was able to use the portable x-ray equipment.
- The hospital monitored the rate at which patients did not attend (DNA) their outpatient appointments. For the period April 2015 to September 2016, there were 34 appointments not attended. For the period April 2016 to September 2016, there were 21 appointments not attended. The process for handling DNAs was to offer another appointment after one DNA. After two or three DNAs, the case would be reviewed by the surgeon and the patient would be discharged and the referrer informed.
- Nurses explained to the patient at the pre-assessment stage of care that they would require someone with them at home once they were discharged. If a patient lived alone then the service linked with a local team that was part of the community services which offers up to six weeks of support post operatively. This process was started at the pre-assessment stage of care.

Meeting people's individual needs

- Staff had access to a telephone translation service for patients who did not speak English.
- The consulting rooms and x-ray room were based on the ground floor of the hospital close to the entrance. There was a lift in place to the first floor where the close observation room was based on the ward, for patients attending the pre-assessment clinic. This supported patients living with a physical disability. The hospital was compliant with the Disability Discrimination Act 2005.
- Drinks and water machines were available for patients waiting to be called in for their outpatient appointments.
- Patients were provided with information and advice at the pre-assessment stage of care relating to their condition and treatment or procedure. This informed the patient of what to expect about the procedure, their stay, recovery and the environment they would be staying in whilst an inpatient. Comprehensive patient leaflets were seen for hip replacement and spinal surgeries.

Learning from complaints and concerns

- There had been zero complaints relating to the outpatients or x-ray departments in the 12 months prior to our inspection.
- Learning from complaints was used to inform service improvement. One complaint for the inpatient area had

Good

Outpatients and diagnostic imaging

resulted in a change for the pre-assessment stage of care to provide patients with more information relating to smoking and nicotine replacement during their admission.

- A Complaints Policy was available for staff to access. The policy was within date for its next review although the policy contained spelling and grammatical errors.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as Requires Improvement.

Vision and strategy for this this core service

See Surgery for main findings

Governance, risk management and quality measurement for this core service

See surgery for main findings

Leadership / culture of service

See surgery for main findings.

Public and staff engagement

See surgery for main findings.

Innovation, improvement and sustainability

See surgery for main findings

Outstanding practice and areas for improvement

Outstanding practice

We found areas of outstanding practice in surgery:

- 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 well being after they were discharged from the hospital.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all surgical equipment sterilisation labels are in date.
- The provider should ensure that staff are trained in mental capacity assessment and deprivation of liberty safeguards.
- The provider should ensure that there is a standardised tool (National Early Warning Score) for assessing and escalating deteriorating patients.
- The provider should consider submitting data to the British Spine Registry.
- The provider should consider gaining access to the secondary user service to enable patient reported outcome measures (PROMs) to be interpreted and benchmarked.
- The provider should consider applying to join the Imaging Services Accreditation Scheme (ISAS).