

Schoen Clinic London






Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Schoen Clinic London is operated by Schoen Clinic London Ltd. The hospital has 39 beds, although only 16 of these were in regular use at the time of our inspection, as the service opened on 15 August 2018. An additional six beds on another 14-bedded ward (which was not officially open at the time of inspection) were sometimes in use for day case surgery. Facilities include eight day-case places, three laminar flow operating theatres, five post anaesthetic care unit beds, two treatment rooms, ten consulting rooms, and a physiotherapy department with three individual treatment rooms, and one group room. Diagnostic imaging was provided by another provider via a service level agreement, although this was colocated in the same building.

There is also one satellite consulting room for initial consultations only, sublet from another provider. No diagnostic tests or interventions were carried out at this satellite site.

The hospital primarily serves patients requiring elective specialist orthopaedic surgery, on a private basis. No NHS patients are treated at the hospital. The hospital had recently started to accept some patients aged 16 or 17 years, but told us that these patients were carefully assessed on an individual basis. The hospital/service provides surgery and outpatient services. We inspected both of these core services.

We inspected this service using our comprehensive inspection methodology. We gave 48 hours notice of the inspection because evidence gathering in an unannounced inspection would be impacted by the fact that the service undertakes procedures at variable times, as it is a relatively new service. We carried out the inspection on 12 April 2019.

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.

Services we rate

This was the first time we rated this hospital. We rated it as **Good** overall because:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and quickly acted upon patients at risk of deterioration.
- **The service had enough medical and nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.** Managers regularly reviewed and adjusted staffing levels and skill mix.
- **Staff kept detailed records of patients' care and treatment.** Records were clear, up to date and easily available to all staff providing care.
- **The service used systems and processes to safely prescribe, administer, record and store medicines, on the whole.**
- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.** Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- **The service used safety monitoring results well.** Staff collected safety information and shared it. Managers used this to improve the service.
- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.

Summary of findings

- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service made adjustments for patients' religious, cultural and other needs.
- **Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**
- **Staff monitored the effectiveness of care and treatment.** They used the findings to make improvements and achieved good outcomes for patients. Data so far was limited as the service had only opened in August 2018.
- **The service made sure staff were competent for their roles.**
- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- **Staff supported patients to make informed decisions about their care and treatment.** They followed national guidance to gain patients' consent.
- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- **Staff provided emotional support to patients to minimise their distress.**
- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**
- **The service planned and provided services in a way that met the needs of the patients it provided services to.**
- **The service was inclusive and took account of patients' individual needs and preferences.**
- **People could access the service when they needed it and received the right care promptly.**
- **It was easy for people to give feedback and raise concerns about care received.** The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- **For the most part, the service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- **The service engaged with patients and staff to plan and manage appropriate services.**
- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**

However:

- **Not all staff had received all of their mandatory training at the time of inspection.** There was an ongoing mandatory training improvement action plan in place to address this.
- **We found some issues with infection prevention control (IPC) in the theatre department and inpatient ward on the day of inspection.**
- **There continued to be higher levels of bacteria than normal in the water system.**
- **There were some minor issues found with resuscitation and difficult airway equipment on the day of inspection.**
- **Not all staff in recovery were aware of the steps to take in the event of recognised sepsis.**
- **Not all fluids or medication were stored satisfactorily in theatres on the day of inspection.**

Summary of findings

- **As the service had only opened in August 2018, evidence of effectiveness was limited in terms of patient outcomes, audit activity and continuing professional development opportunities for staff.**
- **Patient survey response rates were sometimes low.**
- **At the time of inspection, there was no formal guidance or policy in place relating to the opening of extra beds for day case surgeries.**
- **There was no formal mechanism to measure staff satisfaction or experience at the time of inspection.**
- **The service had high staff turnover rates and had not explored the reasons for this.**

We found areas of outstanding practice in surgery:

- Consultant intensivists covered the day-to-day care of patients on the ward and PACU. This differs from most other private providers, where this care is usually managed by middle-grade doctors. The consultant intensivists providing 24-hour support each had substantial years of experience in caring for deteriorating patients across a broad range of specialities, with enhanced skills in early diagnosis and management of complications and comorbidities. This meant a higher level of support for patients post-operatively.
- The service had purchased virtual reality (VR) headsets for patients undergoing procedures under local anaesthetic or spinal anaesthetics. They were designed to relax and reduce stress and anxiety for the patient, without the need for extra sedation or general anaesthetics. The headsets contained a range of movies, documentaries and environments appropriate to the age and preferences of the patient.

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

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Surgery

Good



Summary of each main service

Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated this service as good because it was safe, effective, caring, responsive and well-led.

Outpatients

Good



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

Summary of findings

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Good 

Schoen Clinic London

Services we looked at

Surgery; Outpatients.

Summary of this inspection

Background to Schoen Clinic London

Schoen Clinic London is operated by Schoen Clinic London Ltd. The hospital/service opened on 15 August 2018. It is a private hospital in central London. The hospital primarily serves patients requiring elective specialist orthopaedic surgery, on a private basis. No NHS patients are treated at the hospital. Referrals are taken from a wide geographic area, both nationally and abroad.

The hospital has had a registered manager in post since the service opened in August 2018.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, a CQC assistant

inspector and a specialist advisor with expertise in surgery and anaesthesia. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Information about Schoen Clinic London

The hospital has two wards and is registered to provide the following regulated activities:

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

During the inspection, we visited the 16-bedded surgical ward, which included four post anaesthetic care beds, the 14-bedded surgical ward (of which only six beds were in use on the day of inspection for day cases), two operating theatres, the recovery area, the outpatient department and the physiotherapy department. We spoke with 28 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with ten patients. During our inspection, we reviewed 12 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. This was the hospital's first inspection since registration with CQC.

Activity (August 2018 – February 2019):

- In the reporting period, there were 942 recorded visits to the operating theatre, as well as 303 inpatient attendances and 639 day cases. All of these were privately funded.
- There had been 4659 outpatient attendances in the same period; of these, 100% were privately funded.
- Nine employed consultants worked at the service, as well as 59 consultants working at the hospital under practising privileges. The hospital also employed 41 registered nurses, nine healthcare or theatre assistants, and seven other staff, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events
- Clinical incidents: 64 'no harm', 13 'low' harm, no 'moderate' harm, no 'severe' harm, no deaths
- No serious injuries
- No reported incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No reported incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No reported incidences of hospital acquired Clostridium difficile (C.Diff)
- No reported incidences of hospital acquired E-Coli

Summary of this inspection

- Between August 2018 and March 2019, there were 23 formal complaints

Services provided at the hospital under service level agreement:

- Diagnostic imaging
- Level 3 ITU (at another centre)
- Blood management
- Patient transport
- Housekeeping and soft facilities management
- Facilities management services and planned preventative management services
- Medical equipment maintenance
- Infection control
- Clinical coding

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?

This is the first time we have rated this service. We rated safe as

Good because:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- **Staff completed and updated risk assessments for each patient and removed or minimised risks.** Staff identified and quickly acted upon patients at risk of deterioration.
- **The service had enough medical and nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.** Managers regularly reviewed and adjusted staffing levels and skill mix.
- **Staff kept detailed records of patients' care and treatment.** Records were clear, up to date and easily available to all staff providing care.
- **The service used systems and processes to safely prescribe, administer, record and store medicines, on the whole.**
- **The service managed patient safety incidents well.** Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- **The service used safety monitoring results well.** Staff collected safety information and shared it. Managers used this to improve the service.

However:

- **Not all staff had received all of their mandatory training at the time of inspection.** There was an ongoing mandatory training improvement action plan in place to address this.
- **We found some issues with infection prevention control (IPC) in the surgery department on the day of inspection.**
- **There continued to be higher levels of bacteria than normal in the water system.**
- **There were some minor issues found with resuscitation and difficult airway equipment on the day of inspection.**

Good



Summary of this inspection

- **Not all staff in recovery were aware of the steps to take in the event of recognised sepsis.**
- **Not all fluids or medication were stored satisfactorily in theatres on the day of inspection.**

Are services effective?

This is the first time we have rated this service. We rated effective as **Good** for Surgery because:

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service made adjustments for patients' religious, cultural and other needs.
- **Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.**
- **Staff monitored the effectiveness of care and treatment.** They used the findings to make improvements and achieved good outcomes for patients. Data so far was limited as the service had only opened in August 2018.
- **The service made sure staff were competent for their roles.**
- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- **Staff supported patients to make informed decisions about their care and treatment.** They followed national guidance to gain patients' consent.

However:

- **As the service had only opened in August 2018, evidence of effectiveness was limited in terms of patient outcomes, audit activity and continuing professional development opportunities for staff.**

Good



Are services caring?

This is the first time we have rated this service. We rated caring as **Good** because:

- **Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- **Staff provided emotional support to patients to minimise their distress.**

Good



Summary of this inspection

- **Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

However:

- **Patient survey response rates were sometimes low.**

Are services responsive?

This is the first time we have rated this service. We rated responsive as **Good** because:

- **The service planned and provided services in a way that met the needs of the patients it provided services to.**
- **The service was inclusive and took account of patients' individual needs and preferences.**
- **People could access the service when they needed it and received the right care promptly.**
- **It was easy for people to give feedback and raise concerns about care received.** The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

However:

- **At the time of inspection, there was no formal guidance or policy in place relating to the opening of extra beds for day case surgeries.**

Good



Are services well-led?

This is the first time we have rated this service. We rated well-led as **Good** because:

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- **The service had a vision for what it wanted to achieve and workable plans to turn it into action.**
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- **For the most part, the service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**

Good



Summary of this inspection

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- **The service engaged with patients and staff to plan and manage appropriate services.**
- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**

However:

- **There was no formal mechanism to measure staff satisfaction or experience at the time of inspection.**
- **The service had high staff turnover rates and had not explored the reasons for this.**






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Surgery

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

Are surgery services safe?

Good 

This is the first time we rated safe for this service. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure the majority of staff completed it.

Mandatory training was provided to staff in the following subjects (tailored to their role): equality and diversity, health and safety in the workplace (including fire, first aid, display screen equipment, manual handling theory), infection prevention and control, information governance, safeguarding vulnerable adults and children, basic life support (BLS), manual handling practical skills, fire marshal, intermediate life support (ILS), medical gas safety for clinical staff, dementia awareness, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), blood transfusion, medicines management, complaints handling, Duty of Candour (DoC), advanced life support (ALS), acute kidney injury, sepsis and female genital mutilation (FGM).

Mandatory training was provided annually to all staff through a mix of both classroom and online sessions. Staff told us they were given time within their working day to complete this. The basic life support training, undertaken by healthcare assistants and physiotherapists, was a combination of e-learning and face-to-face training. Theory was delivered via e-learning and compression training and

assessment was delivered in-house in person by consultant intensivists. All other clinical staff were required to have intermediate life support or advanced life support training, dependent on their role.

At the time of inspection, the mandatory training figures for staff in the surgical division did not all meet the 95% target for completion, with only 65% of staff with immediate life support training, 50% of staff with safeguarding children level three training, 85% of staff with infection control training, 55% with medical gas safety training, and 66% with manual handling training. This gave the service an overall compliance rate of 83% for all mandatory training. The service did not admit those under 16 for treatment, with only some 16 or 17 year olds being seen dependent on prior review.

There was an ongoing mandatory training improvement action plan in place to address staff compliance with mandatory training. The provider told us that some new staff were awaiting sessions for face-to-face training such as ILS, infection control, medical gases and manual handling, and were booked into these sessions taking place in April and May 2019. The provider was also in the process of improving their system to record the expiry dates of staff members' existing ILS qualifications, as the figures above only show compliance with training provided by the hospital.

There were arrangements in place for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.

Safeguarding

Surgery

Staff understood how to protect patients from abuse and the service worked well with other agencies and used national guidance to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The hospital had clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect, that reflected relevant legislation and national requirements. Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to an up-to-date safeguarding policy and knew how to escalate concerns. Staff told us there was always ready access to a senior member of staff for a second opinion on any potential issues. The head of clinical services/chief nurse had completed safeguarding children training at level four, and the theatre manager was booked to attend level four training in May 2019. The hospital participated in Clinical Commissioning Group Private Hospital Network Safeguarding meetings to discuss and share any concerns that arose with other external parties, with access to specialist support from named designated professionals should the need arise. Staff in the hospital regularly talked about any potential safeguarding updates in weekly huddles.

The hospital had recently started to accept some patients aged 16 or 17 years, but told us that these patients were carefully assessed on an individual basis. The admission policy described the process by which any children identified as being subject to existing safeguarding protection plans would be signposted to another service provider.

At the time of inspection, 95% of staff in the surgical division had completed safeguarding vulnerable adults' level two training and safeguarding children level two training. Only 50% of staff had completed safeguarding children level three training.

The provider explained that the lower level of compliance with safeguarding children level three was due to this module only recently being introduced, as a result of the service beginning to see young adults. This module was still being completed by staff at the time of inspection. E-learning training was being used to provide a basic level of knowledge, to be followed up with group discussion and supervision. A pathway was in place to ensure that 16 to 18 year old patients were cared for by a member of staff who

had completed safeguarding children level three. Only one patient aged 16 to 18 years had been seen so far in the surgical department, as this patient group had only just started to be seen.

Cleanliness, infection control and hygiene

On the whole, the service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept most of the equipment and the premises visibly clean.

Since opening in August 2018, the hospital had not reported any cases of hospital-acquired MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. The hospital screened all elective surgical patients for MRSA prior to admission, in line with Department of Health guidelines. In the same period, there were also no cases of Clostridium difficile infection (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics), Meticillin Sensitive Staphylococcus Aureus (MSSA) infection or episodes of E coli.

When we visited the wards and theatres, we found them to be visibly clean. All rooms were cleaned between patients. We viewed cleaning logs for both the theatres and the ward. The external cleaning company cleaned each area every night, with a weekly environmental check taking place with senior staff. Daily checklists were also completed by the theatre team and the housekeeping team.

We found some environmental issues that could potentially present an infection risk, such as the placement of a shoe cleaning machine just outside of theatres. Following inspection, the hospital provided us with assurances from the manufacturer of the shoe cleaning machine that no fluid or chemical vapours were expelled into the environment, and that the heating system on the unit was filtered to eliminate any particulate emissions. Furthermore, staff told us shoe cleaning was only ever done at the end of the day after patients had been treated and transferred back to the ward.

We found some clean curtains being stored in the dirty sluice of the recovery area in theatres on the day of inspection. The provider assured us that all clean items were removed from the sluice area following inspection.

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As part of a rolling audit programme, an infection prevention and control (IPC) audit had been completed by an external company in March 2019, recording an overall compliance score of 93.3%. We found that some of the minor issues picked up by this audit had improved by the time of our inspection.

A labelling system was used to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean, apart from a blood gas machine, on which we noted there were some small spots of blood.

We saw there was access in all areas to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE), which included sterile gloves, gowns and aprons.

All staff in theatres and on the ward were bare below the elbows and used PPE where necessary. We saw staff washing and decontaminating their hands before and after patient contact, as well as both pre and post operatively, in line with the World Health Organisation (WHO) and Association for Perioperative Pathway (AfPP) guidance. Staff in theatres could tell us what precautions they would take to prevent the spread of infection. However, we noted that the theatre door was opened a number of times during surgical cases, which is not ideal in terms of IPC.

The hospital's admission policy excluded patients with notifiable diseases or infections which might pose a threat to the health of staff or other patients. However, hospital policy stated that in the case of surgery on an infected patient was due to be operated on, the patient should go last on the theatre list. The post anaesthetic care unit (PACU) pod in recovery would be used to recover the patient, to barrier isolate the patient as it had a negative pressure environment to minimise airborne transmission.

We saw monthly hand hygiene audits for January and February, with overall compliance scores of 96.1% and 98.4%, respectively.

Surgical site infection (SSI) information was collected for different types of surgeries. Information provided indicated there had been no SSIs since the service opened in August 2018.

The hospital had an up-to-date IPC policy. We saw that staff were provided with annual training in IPC. The clinical services manager acted as the IPC lead nurse, with a responsibility to increase awareness of infection control

issues and motivate staff to improve practice. She met monthly with the microbiologist to review infection rates and relevant audit results. There were quarterly meetings to discuss IPC, including any potential outbreaks of communicable diseases, changes to policy and procedure and relevant IPC audit results. Hand hygiene audit results were also discussed at the monthly departmental meetings.

We saw from the risk register that the provider had found higher levels of bacteria than normal in the water system, when random sampling had taken place at the end of March 2019. Appropriate mitigating actions had been taken after consultation with a microbiologist, such as bringing forward system chlorination, disinfecting and descaling theatres, use of surgical hand scrub following hand washing in theatres being introduced, and continuing to flush all unoccupied rooms on a weekly basis. Water quality results were presented in the IPC working group to enable close monitoring, with lower results noted at the end of April 2019. These were still higher than normal, so another system chlorination took place, with acceptable levels then found in well-used parts of the building, but in other parts of the building not used frequently, the levels remained elevated. Further works such as the UV treatment of incoming water and the installation of a chlorine dioxide dosing machine were planned to take place in May 2019. There were no associated infections or colonisations during this period.

We observed safe systems for managing and storing waste and clinical specimens during the course of inspection. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found some minor issues with resuscitation equipment on the day of inspection.

We saw that the ward and theatres were clean and clutter-free and corridors were kept clear to ensure patient beds could be manoeuvred easily. All patients had single

Surgery

rooms with ensuite bathroom facilities, which included a walk-in shower. Rooms were kept clean and tidy. In March 2019, the quarterly environmental audit scored 100% compliance against agreed standards.

Equipment decontamination and sterilisation was outsourced to an instrument decontamination company. We observed that the decontamination pathway in the theatres was clear and followed by all staff. Sterile equipment was stored appropriately in theatres, although the provider had identified that the lack of suitable storage space could pose a risk of service disruption. There had been some reported incidents relating to delays to theatre lists and surgical cases resulting from delayed delivery of surgical instruments and loan kit, which were not found to have any significant patient impact. As a result, some items were stored in the areas of the hospital not currently being used. Lists were planned in advance to ensure all equipment was available, with the provider working to identify a suitable longer term storage solution. On the day of inspection, we noted that some storage areas were cramped, but that this did not constitute a major risk.

We reviewed equipment logs and saw that equipment used was due to be serviced according to manufacturer's guidelines. All equipment in theatres was neatly stored and well-maintained. All portable clinical equipment we checked had been serviced and labelled to indicate the next review date. Disposable equipment was easily available, in date and appropriately stored. The theatres had a central preparation area which served all three theatres, with all of the consumables required for cases within easy reach. A central monitor displayed a preference card and photographs of how the operating surgeon liked their trolley laid out, to enable staff to prepare these quickly in advance.

The lifts contained suction pumps for use in the event of an emergency. However, the provider had recorded four incidents of delays in transporting patients between theatres and the ward, due to the bed lift being out of use. This had caused some delays in patient transport of patients from recovery back up to the ward, ranging from between 30 to 60 minutes. There were no occasions where the surgical list was delayed was a result of these delays. The provider had added this item to the hospital risk register, changed the lift maintenance provider and ensured that there was a fast call-out option (of under one hour) added to their maintenance contract as a result. The

onsite maintenance team had also been provided with further training on responding to and correcting faults. At the time of inspection, we found patients were transferred via lifts both pre and post-operatively in a timely and efficient way.

Resuscitation and difficult airway equipment was available, with evidence of daily and weekly checks to demonstrate that equipment was safe and fit for use. However, we noted some issues on the day of our inspection. In the surgical ward, we noted that one weekly check of the resuscitation trolley had been missed, with no explanation given as to why. In recovery, there were three resuscitation trolleys. Two of the trolleys were locked with a temporary tag. One of the trolleys was not. Staff informed us that this must have been an oversight after a check which had taken place earlier that day. The service undertook a monthly resuscitation audit to ensure that all necessary equipment was in place, with appropriate actions taken in cases where it was not.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

We saw the hospital admissions policy, which had clear exclusion and inclusion criteria. Patients currently receiving treatment for any psychiatric illness or substance abuse, those with notifiable diseases or infections, patients with heart problems or severe memory loss, and acute or severely unwell patients were all excluded from treatment at the hospital. In addition, pregnant patients beyond the first trimester, patients requiring dialysis, and patients requiring end of life care were also excluded from treatment.

The American Society of Anaesthesiologists (ASA) physical status classification system is a system for assessing the fitness of patients before surgery, with grade three indicating a patient with severe systemic disease, and grade four indicating a patient with severe systemic disease that is a constant threat to life. The treatment of patients of (ASA) grade three and above was not permitted at the hospital. Occasionally, the medical director told us that a grade three patient could be admitted, after thorough review and pre-assessment by a consultant intensivist. We saw evidence that these patients were assessed on a

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case-by-case basis. At the time of inspection, no major surgery had been undertaken on any ASA grade three patients, with all having been screened out by the consultant intensivist. ASA grade four patients were not suitable to be treated at the hospital under any circumstance.

The hospital had recently started to accept some patients aged 16 or 17 years, but told us that these patients were carefully assessed on an individual basis, with any complex cases being carefully screened and discussed prior to the referral being accepted. Only one patient aged 16 to 18 years had been seen so far in the surgical department. We saw evidence that this patient had been assessed to be fit to be treated in adult facilities at the hospital by the medical director and chief nurse, with close communication with their GP to ensure there were no safeguarding concerns. The admission policy specifically excluded any children under the age of 16 years, any young adults aged 16 to 18 years weighing less than 50kg and any young adults aged 16 to 18 years currently receiving treatment under 'children's services'. The admission policy stated that any requests to book a patient that was 16 or 17 years old must first be authorised by the senior nurse on duty, to ensure that appropriately qualified staff were on duty to care for the patient. However, this referred to level of safeguarding training staff possessed, and there were no paediatric nurses employed at the hospital. Some of the consultant body had paediatric experience. The hospital informed us that these consultants would be involved as necessary in the decision to treat or care planning of these patients.

The service had a pre-operative assessment team for all patients that provided advice and information to patients prior to their surgery. The service tested all patients for MRSA and offered patients the opportunity to clarify any details of their surgical journey. Patients who were not physically assessed would be assessed over the phone by a pre-assessment nurse prior to attending the hospital, with all information checked and consent taken again in person on the day of planned surgery.

The pre-anaesthetic checks involved a member of the surgical team going through patient consent and explaining the procedure to the patient again. The nil by mouth status and allergy status were also rechecked at this stage. This was checked again by the anaesthetist, who also checked the intended surgical site with the patient

(which was checked again pre-operatively by the surgeon). We saw on the day of inspection that a patient had been transferred from the ward to theatres without a red allergy band, but that this was picked up by way of these checks. The service reported this as an incident and found that this was due to human error on the part of the admitting nurse. It was discussed with the individual and the wider team. The incident report stated that if a similar incident reoccurred, they would consider implementing a double-checking process before taking patients to theatre and implementing a wider training programme.

The service used the World Health Organisation (WHO) surgical safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimize the most common and avoidable risks endangering the lives and well-being of surgical patients. This was in line with national recommendations.

We followed three patients through their procedures and saw the WHO checklist was completed. All members of the surgical team took part in the 'sign in', 'time out' and 'sign out'. A 'stop before you block' took place appropriately as per national guidance, which states that a stop should take place before inserting block needles. All patient records we examined also contained completed WHO checklists. The service audited compliance with the WHO checklist. In January and February 2019, the results were 91.7% and 93.3% respectively. Compliance fell to 83.3% in March 2019 due to the introduction of a new checklist system to standardise the approach across all theatres. Staff were still getting used to the new way of recording information and new documentation. The compliance for April 2019 was 91.5%. We saw printed vinyl stickers had been added inside all theatres to match the newly updated documentation, acting as prompts to remind staff to complete the checklist. Following the April audit, where 8.5% of cases did not have the 'sign in' section of the electronic WHO checklist completed, the provider had discussed this with the theatre team in safety huddles and the monthly departmental meeting.

There was an effective handover process between the ward and the theatres. The patient's named nurse would bring the patient down to the theatre floor and remain there until

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the first check was complete. The anaesthetist stayed with the patient post procedure for as long as necessary. The patient stayed in recovery for a short time before being taken back to their room.

Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital.' A scoring system based upon these observations known as a national early warning score (NEWS) was used to identify patients whose condition was at risk of deteriorating. The nurses documented each patients NEWS on the electronic system, which was then uploaded onto the central system. Nurses on the ward were able to explain the process of escalation if a patient presented with poor observations or a high NEWS score. In that case, the nurses would immediately contact the 24-hour intensivist, who supported the unit at all times.

After review, the intensivist would make the decision as to whether to escalate the patient to the post anaesthetic care unit (PACU). This was not a high dependency unit, with admission criteria clearly stating that only patients with an acute condition requiring level one or short term (less than 24 hour) level two care should be admitted. No patients requiring any length of level two care had been cared for at the hospital at the time of inspection. We saw evidence of clear escalation triggers for admission to the PACU. The PACU had a 23-hour maximum stay policy due to insurance restraints. However, patients could stay longer if clinically indicated, with those that might require admission to PACU post-surgery highlighted at the pre-assessment stage. The criteria for being stepped down to the surgical ward were that the patient was stable, with no central or arterial lines. Any patient being stepped down had to be seen by an intensivist.

The hospital did not provide high dependency or intensive care, with a service line agreement with another neighbouring hospital to provide any sustained high dependency care. There were emergency alarms available across the hospital, which we saw were operational. In the case of an emergency situation, the patient would be transferred to the most appropriate neighbouring NHS hospital, using the standard 999 system. A pathway was in place for the referral and transfer of patients to a neighbouring hospital, if a patient had consistently high NEWS for example, and required specialised care which the

hospital could not offer. The hospital was not yet operating at full capacity and was sometimes closed during less busy periods, such as Sunday nights. The service recognised that this meant that patients who had been discharged but who may experience emergency issues may therefore present at an NHS hospital, and had added this to their risk register. For non-emergency issues, patients were able to contact their named consultant.

Since opening in August 2018, there had been two unplanned transfers to other hospitals. Both of these transfers had been discussed and analysed at length, and in both cases, the patients required minimal levels of nursing intervention and were normally self-caring at the time of transfer. The provider informed us that neither of these transfers met the criteria of a serious incident, but that both had been thoroughly investigated nevertheless. One of these transfers was due to the PACU not being staffed with sufficient nurses to care for the patient, due to the patient requiring a higher level of care following revision spinal decompression surgery. This was because the PACU was not staffed with sufficient nurses to provide 24-hour care, as the patient required frequent observations, intravenous antibiotics, intravenous fluids, oxygen therapy and monitoring from a registered nurse. Following this incident, the provider recruited an additional four registered nurses to cover the PACU, including a lead nurse with critical care training.

During the daily bed meeting, team responsibilities during an emergency situation were agreed and allocated. This ensured staff were aware of their designated role to improve response rates if an emergency occurred.

Staff had attended training days on management of the deteriorating patients, which included sepsis recognition and management. The service used the 'sepsis 6' model for identifying and treating suspected sepsis. Most nurses that we spoke with knew the six steps for identifying and treating sepsis, but not all recovery staff were aware of the steps to take.

There was a major haemorrhage protocol, which laid out the roles and responsibilities of staff in the case of an emergency. Some emergency blood products were stored on site, in a temperature-controlled fridge. Other blood products were requested as required on a named basis, by a laboratory assistant or emergency courier. These were provided by a neighbouring hospital through a service line agreement.

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We saw evidence within the patient notes reviewed of risk assessments relevant to the patient's needs having been carried out. We saw that rate of patients assessed for the risk of venous thromboembolism (VTE) varied between 76.2% and 93.2% between August 2018 and February 2019. We saw that an action plan was in place to improve completion rates, which included the modification of documentation and communication to all staff.

Nursing and support staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

As of 1 February 2019, the hospital reported they had 18 filled whole-time equivalent (WTE) posts for inpatient nurses, against an establishment of 21 WTE nurses. There were two filled inpatient healthcare assistant (HCA) posts, against an establishment of three WTE posts. For theatre nurses, 19.41 WTE had been filled, against an establishment of 20.41, whereas all three WTE establishment theatre operating department practitioner (ODP) posts had been filled.

Between August 2018 and February 2019, use of bank and agency staff for inpatient nurses varied between 2.7% (December) and 14.2% (September), with an average of 8.1%. Inpatient healthcare assistant (HCA) figures provided varied between 2.4% (January) and 11.4% (November). The provider explained that the majority of these shifts were covered by permanent staff in the first instance, working on an overtime basis. Any agency nursing shifts in this period were covered by regular agency nurses, who were block booked. Between November 2018 and February 2019, this amounted to a total of 48 shifts in total, worked by a pool of 16 agency nurses.

For theatre staff, the provider told us that agency staff were not used to cover shifts. For theatre nurses, bank staff were used only in January (12.8%) and February 2019 (10.5%). Similarly, bank staff were used to cover theatre operating department practitioner (ODP) or HCA shifts only in January (27.2%) and February 2019 (29%).

Between August 2018 and February 2019, sickness rates for inpatient nurses varied between 0% and 2.4% (November), with an average of 0.8%. Sickness rates for inpatient HCAs varied between 0% and 5.7% (November), with an average

of 1.6%. Sickness for theatre nurses varied between 0% and 5% (February), with an average of 1.1%. Sickness for theatre ODPs/HCAs varied between 0% and 42.8% (February), with an average of 7%. The provider explained that the high rate of sickness for theatre ODPs/HCAs was due to the small number of these staff (three), with two staff taking sickness absence during this month.

There were no unfilled shifts in the surgical division between December 2018 and February 2019.

The hospital's turnover rates, since opening in August 2018, stood at 21.4% for inpatient nurses, 50% for inpatient HCAs, 50% for theatre nurses and 50% for theatre ODPs/HCAs. For other staff (including senior roles) this figure was 16.6%. We were provided with data that indicated that this equated to 14 staff in total across the surgical division. We asked the provider for data relating to exit interviews for these staff, but they informed us that no interviews had yet taken place (although six were scheduled). The provider informed us that they were currently exploring the use of an online exit interview survey tool, in order to allow for analysis of any feedback to detect and address any issues or trends from the exiting staff population.

Due to the size of the surgical ward, the hospital could allocate staff in advance, based on demand. The hospital used a modified version of the Safer Nursing Care Tool on the inpatient ward to determine the ratio of nurses to patients. Staffing was monitored and reviewed on a day-to-day basis, taking into account patient acuity, with a registered nurse to patient ratio of 1:4 or 1:5. The PACU was able to provide enhanced nursing care at ratio of 1:1 or 1:2. We saw evidence that these ratios were maintained. When there were no PACU patients, these nurses supported the nursing teams in recovery or the inpatient ward. The lead PACU nurse had an intensive care background.

Staffing levels in theatres complied with the Association for Perioperative Practice (AfPP) guidelines. All staff we spoke with in the theatre environment felt that there were adequate staffing levels to provide safe and effective care for patients.

We observed the nursing handover of patients between different stages of the patient journey and found it to be comprehensive and clear, covering all necessary aspects of patient care.

Medical staffing

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The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The hospital worked with consultants in two ways. The hospital had nine employed consultants at the time of inspection (either part time or full time), which helped to ensure consultant presence and availability in the event of a surgical complication. It also meant that the employed consultants were not required to care for patients on multiple sites at the same time, and that they were more engaged in the development of the service as a whole. The hospital also worked with consultants under a practising privileges framework. As of February 2019, this amounted to 59 consultants in total, of whom 32 undertook surgery, eight conducted outpatient clinics, 11 were consultant intensivists, and seven provided multidisciplinary support in areas such as cardiology and urology. Consultants were granted practising privileges after scrutiny by the medical advisory committee (MAC). The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work with an independent hospital. We reviewed consultant files which demonstrated all relevant documentation was up to date and reviewed annually. Evidence was provided to indicate that the process of granting and removing practising privileges worked in a satisfactory manner, and that reviews of consultant practice took place as and when necessary.

All patients were admitted under the care of a named consultant, who managed the care of these patients. We saw that all patients were reviewed twice daily by consultants in the medical notes. We observed a medical ward round, which was thorough and holistic, with good patient involvement.

Consultant intensivists covered the day-to-day care of patients on the ward and PACU. This differs from most other private providers, where this care is usually managed by middle-grade doctors. The consultant intensivists providing 24-hour support each had substantial years of experience in caring for deteriorating patients across a broad range of specialities, with enhanced skills in early diagnosis and management of complications and comorbidities. This meant a higher level of support for patients post-operatively, including access to an anaesthetist where required. Anaesthetists who had

undertaken an anaesthetic on a patient agreed as part of practising privileges arrangements to be available to return to the clinic for the first night following surgery. Emergency anaesthetic cover was also available via the consultant intensivist rota if required, with a second on-call rota in the event of the first intensivist being called upon to perform emergency anaesthesia or undertake a transfer.

We reviewed evidence that indicated that no individual undertook more than 24 hours of cover in one stretch. The provider assured us that it would be highly unusual for the consultants to be busy due to the acuity of patients cared for the hospital, meaning they would usually expect a period of at least eight hours rest overnight in this 24 hour period. Medical staff we spoke to were positive about this model of cover in terms of enhanced patient safety.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

Information governance training was part of the annual mandatory training requirement for all staff working at the hospital, and 95% of staff in surgical services had completed this within the last year.

The service used an electronic system to store medical records and observations. Formal consent was sought in regard to photographic images, with these stored electronically. Some records were kept on paper, for example consent forms. These paper records were all scanned onto the electronic system within 72 hours of admission and kept in locked cabinets on the ward. The service was in the process of further developing their electronic medical record to move towards a fully paperless medical record.

We reviewed nine sets of medical notes and found that these complied with General Medical Council (GMC) standards for documentation.

The hospital completed documentation audits on a quarterly basis. The first of these, completed in March 2019, showed a compliance score of 84%. The provider explained that requests to change the IT system to better suit the hospital processes had been made as a result. Completion of data registry forms by consultants was also monitored, with completion of spine department forms in February

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2019 at 80.3%, and at 92.6% for orthopaedic surgeons. In March 2019, these figures stood at 85.2% and 76.1% respectively. Issues were discussed with consultants and reminders were sent out to medical secretaries as a result.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, on the whole.

There was a service level agreement (SLA) in place with a local pharmacy for the supply of medicines. A pharmacist visited the clinic daily to check stock levels, remove any unwanted medication and review medicine charts. A pharmacy technician also visited three times a week. There was out of hours on-call provision where required.

Senior staff told us that they liaised with the pharmacist and conducted audits of any medicines in stock to ensure any unused items were returned and stock levels did not become too high. Staff were able to contact the pharmacist to order stock when needed. The service monitored the external pharmacy's performance against contractual key performance indicators (KPIs) on a regular basis.

On the ward, staff kept medicines and intravenous (IV) fluids in locked cupboards with restricted access to ensure security. All medicines that we checked were within date. Controlled drugs (CDs) were stored in locked cupboards, which a registered nurse held the keys for and which were checked twice a day. Two qualified nurses checked drug stock daily and a spot check of the register confirmed levels were correct.

In theatres, we found that the storage of IV fluids were not always in accordance with manufacturer recommendations. IV fluids were stored in two areas which were hot. We saw a temperature record for one of the areas, and noticed that the temperature had exceeded the recommended limit on a few occasions (standard range 15-25). This issue had been raised by the provider and advice sought from an external pharmacist. This had also been added to the hospital risk register. Actions implemented included the deactivation of an accessory heater and removal of the fluid warmer from the store. Following this, we saw evidence that the temperature readings had returned to normal.

Some ampoules of local anaesthetics were also kept in the fluid room at the time of inspection. Following inspection, the provider assured us that they had relocated these local anaesthetics to a more appropriate and secure location.

Staff in theatres were aware that it was unacceptable to prepare substances for injection in advance of their immediate use, or to administer medication drawn into a syringe by another practitioner when not in their presence. This was in line with hospital policy.

Medicine fridge temperatures were monitored daily. Appropriate actions were taken when these were out of normal range.

The service conducted a quarterly medicines management audit, which showed 95% compliance against agreed standards in March 2019. Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated. We saw incidents categorised as medication incidents, with lessons learned documented. We saw 21 medicine incidents had been reported within the four months prior to inspection. The themes of these incidents were as follows: incorrect dispensing of to take out (TTO) medication (eight), delay in receiving TTO medication (four), medication not signed for (four), equipment not available (two), dispensing error (one), documentation error (one), incorrect documentation in controlled drug (CD) register (one). All documentation errors had been discussed in ward meetings and in clinical supervision meetings with the individuals directly involved. The provider had recognised the high number of dispensing errors, all of which were identified by the ward nursing team and rectified by the pharmacy, before the TTO medication was given to the patient. This had been addressed directly with the pharmacy, and a process by which two registered nurses were required to check TTO medications was implemented, in order to mitigate against any immediate risk. The provider was also in the process of trialling an alternative supplier for TTO medication in response to the high rate of errors. We saw a detailed action plan that aimed to bring pharmacy service in-house by the end of the year.

Patients could self-administer using their own medication, but the medication was first assessed and checked by the pharmacist. This medication was kept in a locked trolley where appropriate.

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The National Institute of Health Care Excellence (NICE) guidance states 100% of patients should have an accurate drug history taken and medicines reconciled within 24 hours of admission. We saw a medicines audit which monitored whether patients received medicine reconciliation within 24 hours of admission as recommended by NICE guidelines. Audit results demonstrated that 92% of patients in March and April 2019 had met this standard.

We also noted that the provider had recognised a risk relating to delays in administering emergency medications, due to some historic delays in obtaining emergency medication from the pharmacy provider for stock medication. No incidents of administration delays had occurred, but the provider took proactive steps to develop a list of emergency medicines required and communicated these minimum stock levels to the pharmacy provider. Since then, no further delays had occurred.

The hospital had adult antimicrobial guideline for the use of antibiotics. This was in line with national guidance. We saw evidence in notes that patients prescribed an antimicrobial had microbiological samples taken before antibiotics were prescribed, where an infection was indicated. Microbiology advice was available 24 hours a day via phone, via a service level agreement.

Results of a March 2019 audit showed a number of inpatients had laxatives prescribed, but less than 10% of staff documented bowel activity. As a result, staff were reminded of the side effects of opioid pain relief and that bowel habits should be documented throughout the patient pathway.

We found that all medicines administration records we checked whilst on inspection were completed accurately and contained records of allergies if necessary.

Incidents

The service managed patient safety incidents well.

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available

at a national level, and should have been implemented by all providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events relating to surgery reported since the hospital opened in August 2018.

In accordance with the Serious Incident Framework, the hospital reported no serious incidents (SIs) in the surgical department since opening in August 2018.

The hospital had a policy in place to guide staff on how to report any incidents. Staff we spoke with were aware of how they would report incidents. Staff told us that when they reported an incident, they received feedback and told us how learning was shared across the service. We saw minutes of various departmental and executive meetings where incidents and relevant learning points were discussed.

Between August 2018 the time of inspection, a total of 69 incidents were reported, with the majority of these resulting in 'no harm' (56), and the rest 'low' harm (13). When the clinic first opened, the incident reporting system had been paper based, moving to an electronic reporting system at the end of February 2019. All incidents recorded on paper had been added to the system retrospectively to enable proper audit.

The duty of candour is a regulatory duty that related 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. Staff we spoke with were aware of the duty of candour. There had been no incidents in the surgical department when statutory duty of candour had to be used since the hospital had opened.

Safety Thermometer (or equivalent)

The service used safety monitoring results well. Staff collected safety information and shared it. Managers used this to improve the service.

The NHS safety thermometer is an improvement tool to measure patient harms and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections. The hospital was not required to

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use the safety thermometer as it was a private healthcare provider. However, the hospital collected this information as part of their quality dashboard, which was available to all staff.

Between August 2018 and February 2019, the hospital reported five patient falls, one pressure ulcer (grade two and above), and no cases of catheter associated urinary tract infections or venous thromboembolism (VTE). Senior staff told us that there was a low threshold for reporting falls and that all cases were investigated on an individual basis. Patients on the enhanced recovery programme often mobilised very quickly following surgery. This data was regularly reviewed at both the integrated governance and quality committee, and medical advisory committee.

Are surgery services effective?

Good



This is the first time we rated effective for this service. We rated it as **good**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Managers checked to make sure staff followed guidance.

Policies we sampled included appropriate references to national guidance, for instance Association of Anaesthetists of Great Britain & Ireland (AAGBI) guidelines.

The service used enhanced recovery pathways for spine and orthopaedic patients that incorporated National Institute for Health and Care Excellence (NICE) and British Association of Spine Surgeons (BASS) guidance. These focused on early mobilisation, helping hip replacement patients to mobilise just two hours following surgery, for instance. Pre-habilitation was included as part of the pathway, ensuring patients were in the best possible condition before surgery.

The spine enhanced recovery pathways were regularly reviewed and updated by one of the spine surgeons at the hospital, who was the secretary of BASS. We saw that there was a process for timely review and ratification of hospital policies. All staff were aware of where to find the policies and Standard Operating Procedures (SOPs) for all relevant procedures.

We saw a detailed audit programme for surgical services, although some of these had only just begun, as the hospital only opened in August 2018. The hospital contributed to relevant national audits including the National Joint Registry (NJR), British Spine Registry, Foot and Ankle Registry, National Ligament Registry, and Public Health England (PHE) surgical site infection surveillance. The hospital used the audit to benchmark their service against other similar services. For example, data from the NJR demonstrated that consultants employed by the clinic performed a high volume of specialist orthopaedic procedures, with the consultant head of department for orthopaedics (hip) performing over 600 hip replacements in a 12 month period (compared to an average of 50), and the consultant head of department for orthopaedics (knee) performing 430 operations in a year (compared to the average of 58). Both consultants had consistently lower revision rates than their peer group.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Dietitian services were provided via a service-level agreement (SLA) with a nearby hospital. Senior nurses were aware how to access this service if required for a patient if necessary or if they had any specific concerns.

We saw that all patients were assessed using a nutritional screening tool on admission. Patients had good access to a range of different food and drinks and could order food from a menu as and when they required. Patients we spoke with were complimentary about the food, although we noted the service had received complaints about catering. There was an improvement plan in place to increase the quality and choice of the food on offer to patients accordingly.

Staff followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) best practice guidance on fasting prior to surgery. There was a nil-by-mouth policy in place and patients we spoke with informed us that they had been provided guidance on fasting times pre-surgery. There was guidance in place regarding reorganisation of surgery if lists were delayed.

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Nausea and vomiting were managed effectively within the recovery department. We saw patients were prescribed anti-sickness medication if required and saw that nurses regularly checked that patients did not feel sick.

Patient records demonstrated that food and fluid intake was monitored after a patient's surgery. Minutes from the senior leadership team (SLT) meeting in March 2019 noted that there was not a great deal on offer for those patients who may require a liquid diet post-surgery. This was following a case where one patient required a texture modified diet. As a result, a new supplier of texture modified foods was sought out, with assistance from the dietitian from the neighbouring clinic.

We saw that food available catered for those with different nutritional requirements, including those with food allergies, halal, kosher, vegetarian and vegan requirements. The service had received some negative comments about the range and quality of food offered and an action plan to improve this was in place. Patients we spoke to during the course of inspection were positive about the range of food available to them.

Pain relief

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

Consistent pain assessment tools were in use across recovery and the wards. Nurses routinely asked patients about pain and all patients we spoke with told us that their pain had been managed appropriately during their stay. Support with managing pain was also provided by the consultant intensivists and anaesthetists. The notes we reviewed showed that patients had been given regular pain relief after their operations, as required. We witnessed patients being asked about their pain levels following procedures.

The service planned to audit pain management on a quarterly basis. The first audit in March 2019 found only 41% compliance with agreed standards. Analysis showed 100% compliance with documentation of pain post-operatively, but that no staff had documented pain pre-operatively to determine a baseline. As a result, the hospital had implemented pain teaching session and discussions with staff. Furthermore, 100% patients had analgesia prescribed both regularly and as required, but documentation of pain was highly inconsistent. A pain link

nurse had been nominated as a result, in order to champion comprehensive pain assessment utilising pain documentation on the electronic record. The pain link nurse was due to attend a pain management study day and share learning with staff, with a re-audit taking place to determine if there had been any improvement. A pain management module had also been added to the annual training schedule to improve staff competencies in managing pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Data so far was limited as the service had only opened in August 2018.

The hospital collected key performance data to assess patient outcomes and had invested in new technology to ensure quality of their data collection. A dedicated outcomes management team ensured data quality and collation, with some team members supporting patients with data collection. This included instances of unplanned return to theatres, readmissions within 28 days, surgical site infection information and mortality data. The hospital submitted this data to Private Healthcare Information Network (PHIN), who were due to publish this after a full year of data had been collected.

Between August 2018 (when the hospital opened) and February 2019, there had been 942 recorded visits to the operating theatre, of which 303 were inpatient attendances and 639 were day cases. In this time, there were two unplanned returns to theatre within the same admission and two unplanned patient readmissions (within 28 days of discharge).

The hospital reported information to the National Joint Registry (NJR), which collects information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor performance. The hospital had not yet been open long enough to be included in the NJR annual reports, or other national data sets, but data was being collected for submission. Other national data sets that the hospital gathered data for included: the British Spine Registry (BSR), the British Orthopaedic Foot & Ankle Society (BOFAS), the National Ligament Registry (NLR), the UK Knee Osteotomy Registry (UKKOR), the Non-arthroplasty Hip Registry (NAHR), the British Limb Reconstruction Society (BLRS) and the International Cartilage Regeneration & Joint

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Preservation Society (ICRS). We saw evidence that the hospital measured the volumes of procedures that each surgeon undertook and monitored and addressed complication rates proactively.

Patient reported outcomes measures (PROMs) assess the quality of care delivered from the patient's perspective. The hospital had started to collect PROMs data and were in the process of establishing ways they could improve levels of patient engagement in these surveys. Senior staff showed us the hospital outcomes dashboards, which included PROMs data relating to improvement in patients' functional ability and pain after surgery, although some data sets were not yet complete. This was because data was collected at baseline, six weeks, six months and one year after surgery to assess patient outcomes, and the hospital had only opened in August 2018. Data provided at the end of April 2019 indicated that results were in line with nationally reported data sets at six weeks post-operatively for spine pathway patients. There was not yet enough data collected to be statistically significant for other pathways, at six months or one year following surgery. The hospital produced these outcomes dashboards with data on each main pathway, targeted at different groups such as consultants and insurers, on a monthly basis, in order to locally monitor and discuss patient outcomes.

We saw that the hospital had rapid recovery patient pathways in place in order to improve patient outcomes insofar as possible, with a focus on mobilising patients as soon as possible after surgery and reduced analgesia to enable this, for instance.

We saw that improvements were suggested where appropriate to maximise patient outcomes and experience, such as education on taking urgent bloods and discussion of which analgesia approach produced lower rates of nausea, vomiting and urinary retention post-surgery. Any proposed changes to policy and procedure were discussed in the medical advisory committee (MAC).

At the time of inspection, the hospital told us that they had carried out a peer review of the theatre department with the Association for Perioperative Practice (AfPP) and were working towards achieving accreditation with them. Following our inspection, we were provided with evidence that AfPP accreditation had been awarded following a review which took place on 25 April 2019, which found standards required to receive accreditation had been fully met.

Competent staff

The service made sure staff were competent for their roles.

Continuing professional development (CPD) was identified as a key priority as the hospital developed, in order to promote morale and retain staff. The hospital was aware that career pathways were not fully developed as yet, having only opened in August 2018, and that inability to recruit and retain staff may hinder the future development of the service. This had been added to the hospital risk register, due to feedback from staff at end of probation meetings. The hospital was in the process of finalising their people strategy, which included details of formal learning and development opportunities for all staff. As an immediate result of this staff feedback, had introduced 'lunch and learn' sessions led by the employed consultants. We saw evidence that some teaching sessions had already taken place.

On the day of inspection, we observed that junior staff were being trained to take on more senior roles. For example, two of the scrub nurses in theatres were being shown how to complete tasks which were usually the responsibility of surgical assistants, as they were undertaking formal academic qualifications to take on these roles.

No formal staff appraisals had yet taken place because no staff had yet been employed by the service for 12 months. The appraisal cycle was due to begin in May 2019.

The Royal College of Surgeons (RCS) has recently decided to allow membership for non-medical surgical care and advanced care practitioners. The theatre manager and lead orthopaedic practitioner had been granted associate membership to the RCS, and as such had access to a range of courses, surgical resources and best practice documentation.

The hospital worked with consultants either under an employed model, or through practising privileges arrangements. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Consultants were invited to join the staff at the hospital following identification of suitability and discussion at the medical advisory committee. All consultants with practising privileges at the hospital had their GMC registration checked on an annual basis as part of the clinical governance process. Consultants were

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appraised through their NHS Trust and had to provide a copy of this to the hospital each year. Scope of practice was also reviewed and monitored, with an annual check as part of the practising privileges audit. Medical staff were required to be trained and signed off before using any specialised medical equipment before they were allowed to use these with patients.

There was a specialised physiotherapist service that actively reviewed and worked with all patients as appropriate.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff told us that they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between all grades of staff and all professional disciplines. Physiotherapists worked closely with nursing staff on the ward to offer early mobilisation and interventions to encourage enhanced rehabilitation.

Multidisciplinary team (MDT) meetings took place regularly on Thursdays, with individual discussions of patients as necessary. Consultants were able to bring outside patients for discussion at these MDTs with their permission, for the purposes of education. We observed a safety huddle on the day of inspection, which discussed any operational issues and conveyed key messages to different staff groups brought together for this purpose.

Senior staff told us that there had been some challenges in terms of working with external providers, such as the imaging service. As a result, the IT systems had been integrated so that the hospital could access reports directly. The manager of the imaging service attended the hospital's weekly operational meeting in order to proactively identify and discuss any potential issues. We spoke to the manager of the imaging service whilst on inspection, who was positive about their communication with senior staff and the working relationship with the hospital as a whole.

At the time of discharge, patients were provided with a pack which included an immediate admission summary

and details of any medication changes, including a copy to be given to the patient's GP by the patient. Consent was sought to share information directly with patients' GPs. All information sent to GPs was sent encrypted.

Seven-day services

Key services were usually available seven days a week to support timely patient care.

Patients were admitted under the care of named consultants, who were supported by consultant intensivists 24 hours a day, when the hospital was open (it sometimes closed on Sunday nights).

Diagnostic imaging services were available 24 hours a day, seven days a week via an arrangement with an external provider, co-located in the same building. This included access to x-ray, MRI and CT scans.

Dietitians were available via service-level agreement with another local hospital, 9am to 5pm, Monday to Friday. Nurses on the wards told us these arrangements were sufficient for the patients the hospital treated.

The physiotherapy team offered inpatient physiotherapy treatment, by appointment, between 8am to 8pm, Monday to Friday. Appointments could be made outside these times by arrangement, according to individual needs of patients. An on-call service was also provided to cover any periods when the hospital was closed.

Patients were able to contact staff at the hospital for support at any time, apart from some Sunday nights when it closed due to lack of demand. They were given a telephone number to call following their procedure, which went through to the inpatient ward, or to an on-call nurse when the hospital was closed.

Health promotion

Staff gave patients advice to lead healthier lives.

On admission, patients were provided with materials they could read that would outline their procedure. On discharge, patients were provided with further information on how to look after themselves post-surgery.

We saw various patient information leaflets were available across the hospital relating to health promotion and physiotherapy. There was also a range of information available on the provider's website.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

We saw evidence that systems were in place to obtain consent from patients before carrying out procedures and treatments. We observed staff gaining consent from patients before providing care such as routine observations.

We reviewed nine sets of notes with completed consent forms for surgical procedures. We saw that the majority of these consent forms (eight out of nine) were legibly completed by the consultant undertaking the procedure and outlined risks and benefits, which had been discussed with the patient. We saw that consent forms were signed again on the day of surgery, with patients given adequate time to consider their surgery between the consultation and the intended procedure date. Patients we spoke with told us they were given time to ask questions and felt fully informed about their procedures.

A consent audit, carried out in March 2019, showed 97.7% compliance with agreed documentation standards. The audit found that not all documentation was being filled out consistently, but that patient consent was being sought in 100% of cases. Staff were reminded of the importance of filling out documentation correctly as a result.

The hospital did not routinely accept patients for admission that were deemed to lack capacity regarding treatment decisions. Staff gave clear explanations about their responsibility in ensuring patients understood the treatment they had consented for, and described the process they would follow if they had concerns.

Since the hospital had opened in August 2018, the Care Quality Commission (CQC) received no notifications of Deprivation of Liberty applications.

Are surgery services caring?

Good 

This is the first time we rated caring for this service. We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed interactions between staff and three patients prior to, during and following a surgical procedure. Nurses and doctors introduced themselves to patients. Interactions between staff and patients were observed to be positive across the clinic. Staff had a caring, compassionate and sensitive manner. All patients we spoke with were consistently positive about the care they received, praising the staff as "fantastic".

Patient feedback, including compliments, was collected and shared with all staff during operational and staff meetings. We saw multiple examples of feedback praising the kind, considerate and respectful attitudes of various members of staff.

During inspection, we noted that there were clear glass panels in the doors on both sides of the anaesthetic room. We were concerned that this may impact on patient privacy. Following the inspection, the provider told us they would be installing blinds in these windows to offer additional assurance to patients regarding privacy.

We observed that call bells were answered promptly, in line with the feedback we received from patients. There was a nurse call system in all consultation and treatment rooms and toilets, linked to small screens in reception areas.

Patients were encouraged to give feedback via a patient satisfaction questionnaire. Between October 2018 and February 2019, patient response rates varied between 20% (December) and 70% (February), with an average of 47%. Of these patients, between 93% (December) and 100% (October) of patients said they would recommend the hospital as a place for treatment. Most recently, in March 2019, 68.1% of patients had completed this survey, with 97.1% of patients either 'likely' or 'very likely' to recommend the hospital as a place for treatment. Furthermore, 93.5% of these patients rated overall quality of care as 'excellent/outstanding', and 96.4% rated nursing care as the same.

Emotional support

Staff provided emotional support to patients to minimise their distress.

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Staff were aware of the importance of providing emotional support and advice. We observed positive interactions between patients and clinical staff and different members of staff supporting patients at different stages of their hospital stay. For example, we saw theatre staff reassuring patients and taking their time to explain procedures.

There was not the need for much formal psychological involvement due to the largely orthopaedic and elective nature of the current caseload. Patients requiring enhanced support, such as those currently receiving treatment for psychiatric illness, or those at the end of life, were not accepted for treatment at the hospital.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients told us that staff kept them informed about their treatment and care, and they felt fully involved in planning their care and treatment. All patients felt able to ask questions of those caring for them and felt listened to by their doctors and nurses. Patient information was explaining what to expect on the day of the procedure, and then upon discharge, and who they could contact if they had any concerns about their recovery.

The hospital provided information and support with the payment of fees. There was written information available on how to pay for treatment, and guide prices for self-pay patients available online.

Are surgery services responsive?

Good 

This is the first time we rated responsive for this service. We rated it as **good**.

Service delivery to meet the needs of patients

The service planned and provided services in a way that met the needs of the patients it provided services to.

The service had been adapted to meet the needs of their patient population. The hospital was newly opened and had been specifically designed with the needs of

orthopaedic patients in mind. For example, the main entrance provided step-free access, the inpatient rooms had high back chairs, and all rooms had suitable ensuite facilities.

As the hospital offered private care, all surgery undertaken was elective. This meant that admissions to the surgical inpatient ward was planned with the patient in mind.

As the service was not yet fully operational, there was capacity to accommodate surgery as and when patients were booked in. Consultants could book extra slots easily as capacity allowed this. Theatres generally operated between 8am and 8pm, Monday to Friday.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Although the service did not routinely treat patients with complex needs, we saw training slides delivered to staff on how they would care for these patients. The hospital told us that it could offer extended or double appointments if necessary, and any enhanced needs would be flagged at the time of booking to ensure suitable arrangements were in place. If these could not be accommodated, patients would be referred elsewhere. Staff told us that patients with enhanced needs could visit the ward or department ahead of their stay if they wished. Any carers who wished to stay with patients would be provided with accommodation and meals at no charge.

Although the hospital did not routinely admit patients suffering from memory loss, they recognised that this may affect some patients going forward. There was a dementia strategy action plan in place, which planned to provide training to all staff starting in May 2019. Senior staff informed us that there was a nominated team member in each department who was responsible for ensuring their environment was dementia friendly.

Translation services could be accessed if required. There was an onsite Arabic translator to cater for patients from the Middle East, and access to a translation service for other languages. The hospital employed an international patient liaison manager that organised admissions for overseas patients in advance. There was a multi-faith room available.

Chaperones were available for patients who requested one during their stay.

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Access and flow

People could access the service when they needed it and received the right care promptly.

Patients could contact the clinic via email or telephone to inquire about treatment. A new surgery booking form and process had been introduced to improve the experience of patients, as inconsistencies had previously been identified in the pre-assessment process. The pre-assessment service was nurse-led, with some patients being seen in person prior to surgery (in the case of major surgery or where patients had significant comorbidities) and the rest receiving a telephone call.

Prior to surgery, a pre-operative assessment took place with the anaesthetist. A pre-operative checklist was completed and consent was obtained for the procedure, first by the theatre nurse, and then by the anaesthetist.

There were no waiting times for patients at the hospital. The theatre department currently had capacity to enable consultants to book extra theatre time when necessary to meet the needs of patients. The hospital was newly opened and not yet operating at full capacity, with only two out of three operating theatres used at most times. Only one inpatient ward was in daily use at the time of inspection, with some beds in the other ward opened for day cases when required. At the time of inspection, there was no formal guidance or policy in place relating to the opening of these extra beds, although senior staff told us that volume was monitored on a weekly basis. Following inspection, we were shown some guidelines regarding staffing and capacity that had been introduced.

We saw daily bed management meetings took place, attended by senior staff to plan patient admission and discharges. We saw that staffing levels were reviewed to ensure the correct skill mix was available to meet the needs of patients.

Delays to the theatre list could occur, but staff told us that patients were always informed of any delays. No procedures had been cancelled for non-clinical reasons since the hospital opened in August 2018.

Nurses told us there were not usually delays in the discharge process due to most patients being self-caring and not requiring complex care arrangements.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Ward staff dealt with informal complaints in the first instance. In the case of a formal complaint, the hospital had a policy for handling complaints and concerns. The policy stated complaints would be acknowledged within two working days and a full response would be made within 20 working days of receipt. Where this timeframe was not possible, then a letter would be sent to the complainant to inform them of the revised schedule. At the time of inspection, the hospital was 100% compliant with providing a response within the 20 working day timeframe.

A complaints leaflet was available in all areas which described the process should a patient want to raise a concern. There was information about how to contact the Independent Sector Complaints Adjudication Service (ISCAS) if patient were unhappy about the outcome of their complaint. Patients we spoke with were aware of the complaints process and how to raise concerns.

Between August 2018 and March 2019, there were 23 formal complaints recorded across the hospital, of which 10 of these related to surgery. In surgical services, these most commonly related to catering or problems with food, and communication regarding delays, aftercare or appointments. The hospital demonstrated that they responded to patient feedback by making improvements to the service offered. This included changes to the telephone bookings system and improvements to food provision. In addition, the hospital responded to informal concerns such as air conditioning units being noisy. Work was being undertaken with the external imaging provider to equalise service levels across the two providers. Information from patient complaints was shared at hospital operational meetings.

Are surgery services well-led?

Good 

This is the first time we rated well-led for this service. We rated it as **good**.

Leadership

Surgery

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The hospital was led by the board of directors, which consisted of the managing director and hospital director, who also sat on the quality governance board (QGB). The board of directors were responsible for the corporate entity, strategic direction, financial management and organisation effectiveness of the hospital, as well as reporting to Schoen Clinic German management board (the shareholder of the provider company). The board of directors delegated responsibility for the day-to-day management of hospital to the QGB, who were responsible for providing assurance on all aspects of clinical safety and effectiveness, governance, regulatory compliance, audit, risk management and staff development and management. The QGB consisted of the two individuals already mentioned, as well as the medical director, head of clinical services/chief nurse and the non-executive director.

The medical advisory committee (MAC), chaired by the medical director, met on a monthly basis. Other members of the MAC included: the managing director, the hospital director, the head of clinical services/chief nurse, the chief operating officer of the company, the executive director of the company, the heads of the spine department (consultant spinal surgeons, one with paediatric experience), a consultant neurological spinal surgeon, the heads of the knee surgery department (consultant orthopaedic surgeons), and the head of the hip surgery department (a consultant orthopaedic surgeon).

There was a clear clinical management structure within surgical services, with a theatre manager and lead practitioners for each surgical speciality, and a clinical services manager and senior sister and leads for both the inpatient ward and the post anaesthetic care unit (PACU). They were overseen by the head of clinical services (also known as the chief nurse), who was the registered manager.

Staff in theatres told us they were well supported by the theatre manager, who was open to new ideas and suggestions. Staff on the wards were positive about the clinical services manager, who was supportive and involved in their clinical decision making. Medical staff told us senior clinicians and executives supported them well and they had access to senior staff when required. We saw evidence that staff were provided with opportunities to meet and

feedback with staff on the board of directors, with their regular presence at team meetings and 'tea with Erin' drop-in sessions held with the hospital director on a regular basis.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The hospital's vision was: 'To give every patient the prospect of a better quality of life by focusing on one medical speciality, strong collaboration with consultants, and relentless focus on quality outcomes to provide the very best evidence-based treatments and pathways of care for spinal and orthopaedic patients.' In tandem, with this their values were to be caring, accountable, collaborative, determined and courageous. This meant focusing on patient centred treatment, quality outcome measurement, multidisciplinary working, innovation and specialisation in the field of spinal and orthopaedic treatment. There was an annual operating plan for 2019, which included objectives relating to people, patient experience, quality and safety, finance and long-term positioning, with a number of key metrics used to measure progress in each of these areas. The service was not yet fully operational, and a key focus was on increasing the volume of referrals through a number of channels, and improving IT systems in order to accurately capture this data.

As the organisation was still new, with many staff still in their probation period, some were still in the process of developing their understanding of the service's vision, values and strategy. The service had included information on the hospital's strategy in the staff induction, as well regular discussion of the vision and values in the senior staff drop-in sessions and staff meetings. The values were also displayed on digital displays and noticeboards throughout the service. The hospital had also recently introduced 'values reward cards', for staff who had gone above and beyond their daily role in demonstrating the organisational values. All staff we spoke to were able to tell us about at least some of the values or strategy. Senior staff told us that new staff were now actively recruited against the values.

Culture

Surgery

Managers across the service promoted a positive culture that supported and valued staff, starting to create a sense of common purpose based on shared values

We observed good team working amongst staff of all levels. Staff we spoke with on the wards and in theatres told us they felt supported, respected and valued within the teams they worked in. Staff told us they were happy working at the hospital and felt they contributed to creating a positive work environment.

Staff told us that they felt confident to raise any concerns with their line managers. There was an up-to-date policy on raising concerns, which outlined how to escalate any issues. Senior staff told us that any errors were discussed openly and managed in a fair way, with an emphasis on learning, in order to better design systems that promoted safe behaviours. The service had introduced a 'speak up' guardian, whose role was to help staff to speak up about any issues in order to protect patient safety and improve the quality of care.

We saw a copy of the culture and organisational development strategy, which focused on leadership and instilling a learning culture within the organisation. We saw examples of how frontline staff had been encouraged to come up with their own solutions to issues they had found in the course of their work. More formal career development opportunities were still in the process of being introduced, in order to upskill and retain staff. The hospital recognised that it still needed to mechanisms to monitor how the leaders were influencing culture, through staff surveys and other feedback mechanisms.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

The hospital held a weekly operational meeting to review incidents and share learning. All senior staff were encouraged to attend these, or send a representative on their behalf, and then feed back any pertinent information or learning to their teams. The quality of these meetings appeared to have improved since the opening of the service judging by minutes viewed, with a wide range of topics now discussed in an appropriate level of detail, such as incidents, audits, patient satisfaction, complaints and

current risks. These weekly meetings fed into the monthly integrated governance and quality committee, where deeper discussions of emerging themes took place. The QGB met on a monthly basis so that senior staff could ensure oversight of these issues and ensure that issues were discussed and fed back to the parent company in Germany.

Staff in theatres and the ward had a good understanding of incidents, risk and local performance. We saw staff meeting minutes which demonstrated discussion of incidents and learning.

The medical advisory committee (MAC), chaired by the medical director, advised on matters such as the granting of practising privileges, scope of consultant practice, patient outcomes, clinical standards and implementing new and emerging professional guidance. The MAC ensured there was a process in place for overseeing and verifying doctor revalidation, continuing practice development and reviewing practicing privileges. All practising privileges documents we checked were in good order. We saw an example of a consultant's practice being reviewed where it was deemed necessary.

Managing risks, issues and performance

For the most part, the service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

We saw the hospital risk register, which was up to date and referenced ongoing risks. These were graded with level of risk and reviewed regularly, with appropriate actions taken to mitigate against them. Staff were able to tell us about current risks on the register, such as lack of appropriate storage for some equipment or items, and delays to treatment following imaging issues. The risk register was stored centrally on a shared drive. Hospital performance on key metrics, such as patient feedback and audit performance, was also available to all staff on performance dashboards.

An annual audit program ensured performance was monitored and managed consistently. Nursing staff participated in local audits, with the resulting information shared amongst staff to promote improvement. We saw appropriate actions were taken from internal audit results, although some quarterly audits had only just begun to be conducted. Other annual audits were yet to take place, but had been scheduled.

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Managers of the service were aware of the potential risk to staffing levels, as the turnover rates for staff had been high. However, no analysis or investigation of the reasons behind this high turnover had taken place, as no formal exit interviews had been conducted at the time of inspection.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Some aspects of patient records were electronic. The hospital was working towards making more aspects of records electronic, with a bi-monthly IT change management committee in place to review, authorise and prioritise IT change requests escalated by staff, in order to further develop the IT systems.

There was a shared drive available to all staff, which contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access this and the information contained within.

The service had recently introduced tablets to allow quick and easy access to patient records anywhere in the hospital using their Wi-Fi network.

All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

Engagement

The service engaged with patients and staff to plan and manage appropriate services. However, there was no formal mechanism to measure staff satisfaction at the time of inspection.

Patient views about care and treatment were captured using a patient feedback survey. The service had been exploring ways in which to improve levels of patients completing Patient Reported Outcome Measures (PROMS), which enabled the service to measure health gain in patients. The hospital gave examples of improvements that had been made based on feedback from patients.

Staff attended monthly departmental meetings, designed to foster staff engagement, share information and drive forward improvement. We viewed minutes of staff meetings where staff were able to raise issues and discuss suggestions for improvement as needed. We saw that some

improvements had been made to staff areas such as toilets and changing rooms as a result of staff suggestions. The provider showed us evidence that staff feedback was collated and acted upon.

Staff told us about staff benefits such as provision of personal health insurance, access to the gym, flexible working hours and a scheme where staff who had received good feedback got a voucher to spend locally in cafes. We saw examples of where positive feedback and comments made by patients were shared with staff.

There was a people strategy in development, which focused on how the organisation could improve the recruitment and retention of staff, through exploring possible internship and graduate schemes, staff rotation and training offers, as well as how to improve employee engagement. It was recognised that a staff survey needed to be introduced in order to measure staff satisfaction and experience, as there was not one in place at the time of inspection. The service was also considering how best collect data relating to equality, diversity and inclusion, in order to produce an annual workforce race equality standard (WRES) report, due for submission in October 2019.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

The hospital encouraged staff to make suggestions for improvements to the service. Staff had not yet been formally trained in quality improvement methodology, but we saw several examples of presentations that staff had created around improvement projects. These were presented in the weekly operational meetings, with project development supported by a member of senior leadership team.

The service had purchased virtual reality (VR) headsets for patients undergoing procedures under local anaesthetic or spinal anaesthetics. They were designed to relax and reduce stress and anxiety for the patient, without the need for extra sedation or general anaesthetics. The headsets contained a range of movies, documentaries and environments appropriate to the age and preferences of the patient.

Outpatients

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

Are outpatients services safe?

Good 

This is the first time we rated safe for this service. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff, but not all staff had completed all of it.

Staff received mandatory training on a rolling annual programme which was provided through a mix of classroom based sessions and e-learning. Topics for outpatient staff included: basic and intermediate life support, manual handling (clinical staff), infection control, information governance, medical gas safety, health and safety, medicines management, and equality and diversity. Data provided showed mandatory training completion rates for outpatient staff were 100% for all training modules except for manual handling (75%) and medical gas safety (17%). There was a mandatory training improvement action plan and staff were booked in for upcoming training courses to improve compliance.

The lead nurse had oversight over the mandatory training of all outpatient staff and sent reminders if necessary. Mandatory training completion was reviewed on a regular basis and we were told this would happen during appraisals once they took place (the clinic had only been open since August 2018). Staff told us they were given enough time to complete training modules during working hours.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies and used national guidance to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding policies and procedures were in place. These were available for staff to refer to on the hospital's intranet. Staff were aware of their roles and responsibilities to safeguard people and knew how to raise matters of concern appropriately. There was a named safeguarding lead and staff were aware of them. The hospital participated in Clinical Commissioning Group Private Hospital Network Safeguarding meetings to discuss and share any concerns that arose with other external parties.

Patients from 16 years old were treated in the outpatient department. Data provided showed all outpatient staff had 100% compliance with safeguarding training of vulnerable adults and children level two. The compliance rate of safeguarding training children level three was 50%. Remaining staff were signed up for upcoming training sessions. There was a pathway to ensure that 16 to 18 year old patients were looked after by a member of staff who had completed safeguarding children level three training. The head of clinical services/chief nurse had completed safeguarding children level four training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All clinical and waiting areas we visited were visibly clean and tidy. We saw completed cleaning checklists dating

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back three months for all outpatient areas and bright 'I am clean' stickers on equipment with information about when it was last cleaned. Disposable curtains in consultation and treatment rooms were dated when they were put up and were changed every six months. Personal protective equipment, such as gloves and aprons, were available to staff.

There were enough hand wash basins and hand sanitisers available in all areas of the outpatient department. Posters with illustrated hand wash instructions were placed near each basin. We saw staff adhering to 'bare below the elbow' guidelines and being compliant with recommended hand hygiene practices. Monthly hand hygiene audit results showed 100% compliance rates for the outpatient department in January and February 2019.

We saw completed cleaning logs for outpatient areas for the previous three months. Monthly cleaning audits showed overall compliance rates between 98% and 100% for January to March 2019.

Waste was segregated in different colour coded waste bags or appropriate containers. All clinical areas contained domestic waste and clinical waste bins. Clinical waste was contained in orange bins and the lids were closed when not in use. We saw that sharps bins in use were signed and dated and not overfilled. Waste emptied was stored in locked dirty utility rooms and collection was arranged through cleaning staff. Waste awaiting collection was stored securely in a way that prevented unauthorised staff, patients and members of the public from accessing it. There was a waste management and handling policy available for staff.

There was a service level agreement with an external company to provide an infection prevention and control programme for the service. It included named infection control doctor and infection control nurse. The programme included clinical microbiology support 24 hours and seven days a week, meetings with clinical staff for discussion and advice, education and training, infection risk assessments and outbreak management.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff

were trained to use them. Staff managed clinical waste well. However, an emergency resuscitation bag on the ground floor was not sealed and there were minor issues with checks of emergency equipment.

All outpatient areas we visited were well-lit and free from clutter. Consultation rooms were spacious, each with a separate clinical area with an examination bed. The treatment room was locked and equipped with an electric reclining chair. Storage cupboards looked organised and sufficiently stocked.

There was a nurse call system in all consultation and treatment rooms and toilets, linked to small screens in reception areas. Consultants used the system to call for assistance or chaperoning service, for example.

The gym was spacious and contained various gym equipment. All therapies areas were visibly clean and tidy, and we saw cleaning equipment, such as antibacterial wipes. There were changing rooms for patients using the gym, which contained lockers for secure storage. There was a shower facility and clean towels were provided upon request.

We saw equipment was labelled with information about last the safety testing date and next due date. The hospital kept a register of all equipment and when it was last serviced. Consultants were only allowed to use their own equipment in clinics after registering it with the hospital and having it safety tested. Physiotherapy equipment and devices were serviced annually by an external company. Portable oxygen cylinders were provided and serviced by a medical gases company. Oxygen levels and expiry dates were checked weekly as part of the resuscitation equipment checks.

Emergency resuscitation equipment, including automatic external defibrillators, were stored behind both reception desks on the ground and first floor within the outpatient department. We saw evidence of weekly checks of the emergency grab bags on each floor. We did not see evidence of defibrillator checks, except for visual checks of the battery status. The outpatient department was equipped with additional wall mounted and portable oxygen cylinders in corridors and within the gym. A portable suction machine was stored on the first floor. The emergency resuscitation case on the first floor was sealed and tagged. However, the security tag number was not always recorded. The emergency resuscitation bag on

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the ground floor was not sealed, so staff could not be assured the bag had not been tampered with. Monthly resuscitation audit results showed compliance rates of 80% in January and 97% in February. Lower compliance for the January resuscitation audit was due to missing certain contents, and these had since been ordered.

Hazardous substances were stored appropriately according to a chemical handling, use and management policy, in compliance with control of substances hazardous to health (COSHH) regulations.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The hospital staff were aware of patients' needs and what to do in case someone deteriorated. If a patient checked in at the reception desk and looked unwell, the front of house team would alert a staff nurse to deal with the situation. If a patient was identified as deteriorating, staff nurses would inform the patient's consultant and escalate to the crash team if appropriate. A crash team is a medical team with special equipment able to be mobilised quickly to treat rapidly deteriorating patients. An in-house consultant intensivist was available for advice and support at all times.

All clinical rooms were equipped with a cardiac arrest call system which alerted a member of staff to attend immediately and dial the hospital crash call number if required. The call system was tested every morning by the lead nurse. Staff were able to describe the procedure of what to do if a patient was suspected of suffering from a cardiac arrest or anaphylaxis. All staff we spoke with knew the crash call process.

Staff told us about emergency scenario training sessions they had attended within outpatient and physiotherapy areas. We saw training protocols, which contained observations and identified areas of learning. Staff felt these sessions helped them to be better prepared for a real emergency.

Basic life support training was part of mandatory training for outpatient health care assistants and physiotherapy staff. Intermediate life support was mandatory for registered nurses. Data showed 100% compliance.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service was staffed with three whole time equivalent registered nurses, four health care assistants (HCAs) and seven support staff. There were no vacancies at the time of inspection. Due to set clinic times and room allocations for pre-assessment clinics and consultant clinics, the lead nurse was able to anticipate staffing demands in advance. Pre-assessment clinics were run by one of the registered nurses, including the lead nurse. Consultant clinics were supported by a registered nurse or HCA.

There had been no unfilled shifts from December 2018 to February 2019.

Staff turnover rate from March 2018 to February 2019 was 50% for registered nurses, 25% for HCAs and 16.6% for other staff. We asked the provider for data relating to exit interviews for these staff that had left, but they informed us that no interviews had yet taken place. The provider informed us that they were currently exploring the use of an online exit interview survey tool, in order to allow for analysis of any feedback to detect and address any issues or trends from the exiting staff population.

The average rate of use of nurse bank staff was 14.7% (from November 2018 to February 2019). The average rate of use of HCA bank staff was 8.6% for the same period. The service did not use agency staff.

The average sickness rates (August 2018 to February 2019) for outpatient nurses was 2.7%. This was 1.9% for HCAs.

The physiotherapy team was fully staffed with three whole time equivalent therapists, one therapy manager, one outpatient lead physiotherapist and one chartered physiotherapist.

Medical staffing

Outpatients

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Consultants worked as employees of the clinic or under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Most consultants with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts.

A resident consultant intensivist provided 24-hour resident medical cover for all patients and was available for outpatient staff to contact and review patients if required.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

Medical information was kept on an electronic patient record system that all staff had access to. Consultants dictated clinic letters after each patient appointment, or filled in a medical documentation sheet provided by the hospital. The clinic letter contained information about patient interaction, assessments, medication prescribed, recommendations and treatment provided by the consultant. Those documents were then scanned into the electronic patient record system within 24 hours. Each consultant's secretary was responsible for the production of the letter. Patients always received a copy of the letter for their records and could share it with their GP. We reviewed five electronic patient records and they contained a complete summary of the consultation.

The electronic medical record was integrated with the laboratory, and imaging reports and test results were accessible. The electronic record was integrated between outpatients and inpatients, including surgery. This enabled staff to access information relevant for outpatient appointments. Formal consent was sought in regard to photographic images, with these stored electronically.

There was a downtime procedure in place, in the event that IT systems went down, so that staff could access clinic lists and patients test results (both imaging and

laboratory). Consultants had access to electronic medical records off site, using their Schoen Clinic laptop computers only. The laptop computers were password protected and encrypted, and each consultant had an individual login to the electronic medical record. There were lockable medical records bags in the event that a patient needed to be transferred. All information sent to GPs, referring clinicians or the patients themselves, was sent encrypted. Data protection training for staff was part of the mandatory training programme.

No patients had been seen without relevant medical records being available in the previous three months.

Throughout the areas we visited, we found no patient identifiable documentation or information openly displayed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

For our detailed findings on medicines please see the relevant section in the Surgery report.

All medicines in the outpatient department were stored securely in locked cupboards in a locked room, enabling only authorised personnel to enter. There were no controlled drugs stored in the outpatient department. Controlled drugs were prescribed and acquired from the pharmacy if required.

The drug fridges and drug room temperatures were monitored electronically. Senior staff would be alerted via email in case temperatures were out of range. We saw drug rooms and fridge temperatures were within recommended range during inspection.

Consultants used pharmacy specific prescription pads to write prescriptions, which patients could use in the pharmacy close to the clinic. The prescriptions could only be filled at the specified pharmacy. Prescriptions required the General Medical Council (GMC) number of the doctor to be filled out, and the pharmacy held a list of doctors and their GMC numbers. Copies of prescriptions were retained by the clinic, the pharmacy and the patient. Prescription pads were stored securely in a locked cupboard in a locked room. They were handed out to consultants at the beginning of their clinics and collected afterwards.

Outpatients

Incidents

The service managed patient safety incidents well.

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There were no never events reported in the period August 2018 to March 2019 specific to the outpatient department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

No serious incidents were reported for outpatient services in the same period. A serious incident requires investigation and can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.

There were eight clinical incidents reported for outpatient services in the period August 2018 to March 2019, none resulting in any harm. Themes identified related to administration, documentation, communication, medical devices, equipment and supplies or service disruptions.

Incidents were reported using an electronic reporting system. Staff could tell us how to report incidents and felt encouraged to do so. We saw documentation of investigations and actions after reported incidents.

Incidents were discussed at various regular hospital governance meetings. Learning from incidents was shared through departmental team meetings, and we saw evidence of this in meeting minutes. Outpatient staff we spoke with could provide examples of recent incidents and learning arising from these.

The duty of candour is a regulatory duty that related 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. Staff we spoke with were aware of the duty of candour. There had been no recent incidents in the outpatient department when statutory duty of candour had to be used.

Are outpatients services effective?

We do not rate effective for this core service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Policies and procedure guidelines relevant for outpatient services were accessible for staff on computers in a shared document folder. The policies we sampled were aligned to national guidance and were in date. There were pathways for pre- or peri-operative management relevant for the outpatient department, for example management of patients on anticoagulant or antiplatelet therapy.

Consultants of different orthopaedic subspecialties had agreed on pathways they shared for various conditions for optimised pre- and post-operative care and to minimise risk. Physiotherapy staff used standardised protocols for post-operative care of different orthopaedic procedures.

The outpatient department undertook monthly cleaning, hand hygiene and resuscitation equipment audits as part of the regular audit programme.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients had access to hot and cold beverages at all times in waiting areas. Biscuits or sandwiches could be obtained for patients if required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Consultants assessed patients in their clinics and prescribed pain medication accordingly. The department did not store analgesia, but prescriptions could be filled in a nearby pharmacy.

Pain assessment and management was integral part of physiotherapy rehabilitation programme and the team documented progress of pain and mobility during each session. Physiotherapists assessed and documented pain using the Visual Analogue Scores (VAS pain scores) and

Outpatients

the Patient Specific Functional Scale (PSFS), which assessed the functional impairment of the patient. Both were incorporated into the physiotherapy assessment document.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Data so far was limited as the service had only opened in August 2018.

Due to lack of published data from similar organisations, the service used NHS data as benchmark for friends and family test results, number of cancelled clinics, did not attend rates, face to face follow-up rate and average new to follow-up ratio. The service had achieved similar or better outcomes against data from 2018.

The hospital submitted data to the National Joint Registry (NJR), which collects information on all hip, knee, ankle, elbow and shoulder replacement operations to monitor performance. However, the hospital had not yet been open long enough to be included in the NJR annual reports.

Patient reported outcomes measures (PROMs) assess the quality of care delivered from the patient's perspective. The hospital had started to collect PROMS data and were in the process of establishing ways they could improve levels of patient engagement in these.

Competent staff

The service made sure staff were competent for their roles.

All new staff attended an induction at a local level, before they were allowed to begin working.

Continuing professional development was identified as a key priority by senior management, in order to promote morale and retain staff. The hospital was aware that career pathways were not fully developed as yet, having only opened in August 2018, and that inability to recruit and retain staff may hinder the future development of the service. This had been added to the hospital risk register, due to feedback from staff at end of probation meetings. The hospital was in the process of finalising their people strategy, which included details of formal learning and development opportunities for all staff. As an immediate result of this staff feedback, the hospital was considering introducing 'lunch and learn' sessions led by the

employed consultants. We saw evidence that some teaching sessions had already taken place. Staff could also attend study mornings and evenings where consultants held education sessions about sports related topics, for example spine, knee or hip injuries.

Nursing staff and health care assistants we spoke with confirmed they felt encouraged to undertake continual professional development and were given opportunity to develop their skills and knowledge through training relevant to their roles. For example, venous cannulation. The lead nurse supported staff in their training and would appraise staff's work performance. There had been no appraisals due as yet because staff had not reached the 12 month cycle, as the hospital only opened in August 2018.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There were regular multidisciplinary team (MDT) meetings for different orthopaedic specialties to review patient cases, both prospectively and retrospectively. Spine MDTs took place twice weekly and separate orthopaedic subspecialty MDTs were held once weekly. We saw minutes of various MDT meetings, which were well attended by orthopaedic surgeons, neurosurgeons, pain specialists, radiologists, physiotherapists, nursing and theatre staff. Each case was documented on a standardised MDT form, which included patient history, radiology findings, details of discussion and recommendations.

There were good working relationships between consultants, nurses and allied health professionals. Consultants of different specialties worked together to achieve optimal results for patients.

Seven-day services

Key services were available five days a week to support timely patient care.

The service provided clinics Monday to Friday 8am until 8pm.

Health promotion

Staff gave patients advice to lead healthier lives.

Outpatients

The physiotherapy service offered treatment for outpatients in the gym. Individual or group sessions helped patients improve strength, mobility and independence.

Most patient information leaflets were held by consultants' secretaries and were sent to patients prior to appointments. Hospital staff had access to various patient information leaflets on the intranet and could print them off to hand out a copy if required. These included leaflets on healthy living and topics such as smoking cessation.

The hospital offered fresh fruit for staff which promoted healthy eating.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Policies on deprivation of liberty safeguards and mental capacity were available on the hospital's intranet. Staff we spoke with were aware of the Mental Capacity Act 2005 and its implications for their practice, although they told us they rarely saw patients with mental capacity issues in their service.

The hospital had a consent policy in place and staff were aware of it and knew how to access it. Consent was obtained prior to the delivery of care and treatment and before sharing any kind of information with a third party. We observed staff obtaining consent for submitting data to the national joint registry (NJR), for instance.

Are outpatients services caring?

Good 

This is the first time we rated caring for this service. We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed staff addressing patients and visitors in a polite and friendly manner and actively offering their assistance.

Patients we spoke with praised the friendly and competent staff. One patient told us there was not anything she could think that would have improved her experience.

The outpatient department collected local patient feedback using a patient satisfaction questionnaire specific to their service. We saw these leaflets throughout the department for patients to pick up. Part of the questionnaire was to ask patients how likely they would recommend the hospital to friends and family. In December 2018 to January 2019, 97% of participants (33) were extremely likely or likely to recommend outpatients services to friends and family. In March 2019, the FFT result showed 100% of participants (12) would recommend the service. However, the participation rates were low with just 2% of patients responding in December 2018 to January 2019, and 1.1% in March 2019. The service had recognised this as an issue and developed an action plan to improve participation rates.

Patient satisfaction results for the outpatient service in December 2018 to January 2019 showed that 97% of participants (33) rated consultants as 'excellent' and 96% rated outpatient nurses as 'excellent'. During the same period, 91% rated overall quality of care as 'outstanding'. However, the participation rate was only 2%.

Patients' privacy was respected, and we observed closed doors when having consultations or treatment. Staff respectfully knocked on doors before entering consulting rooms. This enabled an atmosphere for patients to feel safe and allowed confidential conversations.

There were chaperone signs throughout the outpatient department advising how to access a chaperone should patients wish to do so. Health care assistants undertook chaperoning if requested and had completed chaperone training.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Outpatients

Nursing staff provided emotional support to patients in the outpatient department. Staff explained how they gave patients time in a quiet environment when needed. We saw separate quiet areas were available throughout the department for confidential conversations.

Staff told us how they would support each other as a team, including consultants, in stressful situations.

There was a quiet room accessible in the outpatient department that could also be used as a prayer room.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients we spoke with felt informed about their condition and treatment. They had been given opportunity to ask questions and felt involved in their treatment. Consultants had discussed different treatment options and patients felt encouraged to be part of the decision-making process.

We observed a pre-assessment appointment with the patient's consent. The nurse explained what tests would be done that day and when results could be expected. The patient was encouraged to ask questions and was kept informed about each step of the assessment process.

Patients were informed about fees before visits when making clinic appointments.

Are outpatients services responsive?

Good 

This is the first time we rated responsive for this service. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of the patients it provided services to.

The service specialised in orthopaedic surgery, with approximately 50% of patients seen by spine specialists,

30% by hip and knee specialists, 10% by upper and lower limb specialists, 9% by musculoskeletal physiotherapy team and 1% by pain specialists/neurophysiology or rheumatology specialists.

The waiting areas were furnished to a high standard and provided sufficient comfortable seating. There was a range of free hot and cold beverages available, as well as newspapers and magazines to read.

The service employed porters who would accompany patients with reduced mobility from the main entrance desk to the appropriate outpatient area. Wheelchairs were available if required.

There were nine consulting rooms in the outpatient department. All were spacious and appropriately furnished with a separate clinical area and hand washing facilities.

There was adequate signposting and good lift access in all outpatient areas.

There service level agreements with external providers for blood tests, cleaning, medical equipment and servicing. Cardiac reviews and deteriorating patients were referred to a local independent hospital.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Secretaries and staff would enquire if patients had special needs or required additional support when booking appointments. This allowed them to make arrangements ahead of visits.

Staff told us they would come in earlier or stay late if a patient requested this, to accommodate their work or travel schedule, for example.

The outpatient department offered hearing loops for patients with hearing impairment. Deaf awareness and visual awareness training were offered to staff.

Staff underwent 'caring for patients with learning disabilities/autism/enhanced needs' training sessions. The service offered extended or double appointments for patients where this would assist to support effective communication. Patients were offered a choice of appointment time. For example, the first or last appointments were offered to anxious patients or those

Outpatients

who found sitting in busy waiting areas difficult. Pictures or diagrams were available to enhance patients' understanding of information given to them. Patients requiring extra support were highlighted in the electronic patient record.

There was a dementia strategy action plan in place, which planned to provide training to all staff starting in May 2019. Senior staff informed us that there was a nominated team member in each department who was responsible for ensuring their environment was dementia friendly.

The physiotherapy team told us they would try to accommodate to female patients' preference to be treated by a female physiotherapist. However, this was not always possible. This was identified as an issue particularly with international patients. The team had commenced a quality improvement plan, which included recruitment of female physiotherapists for the outpatient team.

Interpreting services were available through an external organisation and staff knew how to access them.

There was wheelchair access to outpatient areas and disabled toilets were available.

Access and flow

People could access the service when they needed it and received the right care promptly.

There had been 4659 outpatient attendances between October 2018 and February 2019.

Patients could book appointments over the phone through consultants' secretaries, with a confirmation email sent afterwards to confirm. The secretaries provided a list of booked patients to the outpatient reception team 24 hours before clinics took place.

Nursing and reception staff told us that patient waiting times to be seen after arriving in the clinic were usually short and aimed to be less than 15 minutes. This was not audited. However, staff told us most patients were seen straight away, or within few minutes. During inspection, we did not observe patients sitting for a long time in waiting areas of the outpatient department. Patients we spoke with confirmed there were short waiting times. The

service had developed an audit tool to measure patient satisfaction of waiting times in outpatient clinics and planned to implement this audit in April 2019, as outpatient volumes were increasing.

The pre-assessment appointments included a physiotherapy assessment, which was done immediately after the nurse assessment in the same clinic room. This allowed for the patient to have all procedures completed in the same room.

Data provided for August 2018 to March 2019 showed that 9% of booked outpatient appointments had been cancelled, due to consultants' illness. All patients had been offered an appointment within 10 days. The percentage of patients who did not attend (DNA) was 0.2%.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Complaints were dealt with by staff in the outpatient department in an attempt to resolve issues locally and informally. If this was unsuccessful, staff would escalate concerns to the lead nurse. We saw leaflets with information how to make a complaint in the department.

The departmental lead was responsible for investigating complaints. Investigations were documented electronically, and the head of clinical services/chief nurse had overall responsibility for signing off complaints. A written acknowledgement to the complainant was sent within three working days of receipt of the complaint, unless a full investigation outcome could be provided within five working days. If they were unable to provide a full response within five working days, they would respond within 20 working days. If a response could not be provided within 20 working days, the complainant would be informed in writing for each 20-day period until a written response was provided. The hospital subscribed to the Independent Sector Complaints Adjudication Service (ISCAS) to resolve complaints independently, should the complainant feel their complaint had not been resolved at local level.

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There had been 13 formal complaints in the outpatient department since August 2018. Most complaints were about delays or scheduling of clinic appointments. All had been formally responded to within the time scale set by the hospital.

Details of complaints were discussed in weekly operational management meetings and departmental team meetings. We were shown evidence of this.

Are outpatients services well-led?

Good 

This is the first time we rated well-led for this service. We rated it as **good**.

Leadership

Managers in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The lead nurse was in charge of the outpatient department and reported to the clinical services lead for nursing. At the time of inspection, the clinical services manager had been in post for three months and demonstrated a sound knowledge of performance in their area of responsibility, and was aware of challenges to the service.

Staff felt valued and supported by local leaders and found them to be approachable and visible. The lead nurse was hands on and saw patients for pre-assessment and would cover a clinic if needed.

Staff were aware of the executive team and found them visible and approachable. Staff told us senior managers had daily walk rounds in the hospital, including the outpatient department.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The hospital's vision was to give every patient the prospect of a better quality of life by focusing on one

medical specialty, strong collaboration with consultants, and relentless focus on quality outcomes, to provide the very best evidence based treatments and pathways of care for spinal and orthopaedic patients.

The mission statement for the hospital was to provide superb quality orthopaedic and spine care and leadership into a new model of healthcare in the London market, centring around specialisation, transparent outcome measurement, and unique consultant relationships.

The service's vision and strategy were aligned to the hospital's vision and strategy. The strategy was centred around recruitment and retainment of an engaged workforce, positive patient experience, quality and patient safety, finance and long-term positioning.

Information on the hospital's strategy was part of staff induction and staff we spoke with were familiar with the concepts of the hospital's vision and values. The values were also displayed on digital displays and noticeboards throughout the service.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The lead nurse and staff we spoke with had a strong commitment to their role and were proud of the team working and quality of care, focusing on having a positive impact to both patient care and experience.

Staff expressed high job satisfaction and it was clear from talking to staff that there was a good working relationship between staff of all different levels. There was a good sense of teamwork and people helped each other out.

Outpatient nurses said they enjoyed their work. Staff attended monthly team meetings and data showed meetings were well attended.

Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which managers encouraged. Staff told us they felt valued and supported by colleagues and managers.

Governance

Outpatients

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

For our detailed findings on hospital governance please see the relevant section in the Surgery report.

Governance issues related to outpatient department were presented in monthly head of department meetings. There were weekly hospital wide operational meetings where complaints, compliments, learning, and complex cases or workflows were discussed.

Departmental team meetings for all outpatient staff were scheduled monthly and were chaired by the lead nurse. We saw meeting minutes with a structured agenda and action points arising from discussion. Staff discussed current issues and shared relevant information. Meeting minutes were emailed to staff and were available to read in a shared folder.

The lead nurse of the outpatient department used daily staff meetings in the morning to share information and updates.

Managing risks, issues and performance

For the most part, the service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

For our detailed findings on managing risks, issues and performance please see the relevant section in the Surgery report.

The service had clear processes and systems in place for identifying and mitigating risks. The lead nurse reviewed the risk register for the outpatient department monthly.

We saw the departmental risk register, which contained description of risks, risk score, level of risk, controls in place, progress notes and dates for re-assessment. An example from the risk register was the risk of falling in the outpatient shower or therapies room. We saw risk assessments were undertaken and covered all aspects of the service, staff, environment and equipment. Risks were discussed at departmental team meetings and hospital wide governance meetings. High level risks were escalated to the hospital risk register.

The outpatient department undertook monthly cleaning, hand hygiene and resuscitation equipment audits as part of the regular audit programme.

Regular hospital wide mortality and morbidity meetings took place every four to six weeks and were chaired by the medical director.

Managers of the service were aware of the potential risk to staffing levels, as the turnover rates for staff had been high. However, no analysis or investigation of the reasons behind this high turnover had taken place, as no formal exit interviews had been conducted at the time of inspection.

We saw fire evacuation plans throughout the department and staff were aware of them. Department specific evacuation procedures and department specific business continuity plans were available. Staff knew where to access these. Emergency evacuation chairs were installed within the building and 40% of outpatient staff had completed training for this. However, training was not mandatory as staff would use a dedicated passenger lift in the event of evacuation of the first floor outpatient department. This was an evacuation lift, conforming to Evacuation Lift Specification: EN 81 -76. The lifts contained emergency lights and suction pumps in the event of an emergency. However, the provider had recorded incidents of delays in transporting patients between theatres and the ward, due to the bed lift being out of use. The provider had added this item to the hospital risk register and ensured that there was a fast call-out option added to their maintenance contract as a result.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff used the hospital's computer systems to access hospital policies and resource material. Each member of staff had their personal login information to access the systems. During inspection, we saw staff logging off before leaving computers and we did not see unlocked computer screens. This prevented unauthorised access to data.

Outpatients

Staff had access to electronic patient records on the hospital's computer systems. Paper documents were scanned into the electronic system and then destroyed.

Information governance training for staff was part of the mandatory training programme and data provided showed 100% compliance of outpatient staff.

Engagement

The service engaged with patients and staff to plan and manage appropriate services.

For our detailed findings on engagement please see the relevant section in the Surgery report.

Patient views were actively sought within the outpatient department with local patient satisfaction questionnaires. We saw forms available for patients and visitors throughout the department. However, participation rates were low from December 2018 to March 2019. The service had developed an action to plan to improve patient satisfaction return rates, for example to hand out feedback forms to each patient attending clinics.

The hospital had introduced a staff suggestion and feedback scheme where staff were encouraged to complete feedback cards on themes such as 'tell us about a good idea', 'tell us how we can improve', and 'say thank you'. From January to March 2019, outpatient staff had completed four cards, all containing suggestions how

to improve patient and staff experience. The service had taken each suggestion into consideration and, for example, started to offer fresh fruit for staff as a result of a suggestion. However, the service did not undertake any anonymised staff surveys to measure staff satisfaction.

There were six-monthly staff forums where all staff were invited to meet the hospital director in an informal setting. Staff would be informed about updates and could ask questions. At the last session earlier this year, 100% of outpatient nursing staff attended.

Staff told us they benefitted from private healthcare insurance, discounted gym membership and discounts at local restaurants and pharmacy.

The hospital participated in social media where members of the public could post comments or ask for information.

Learning, continuous improvement and innovation

The service improved services by learning from when things went well or wrong, promoting training, research and innovation.

The service organised emergency scenario training sessions for staff within outpatient or physiotherapy areas. The teams simulated different emergency situations of deteriorating patients during outpatient appointments. This exercise helped staff identify areas of learning. Staff told us the sessions helped them feel better prepared for a real emergency.

Outstanding practice and areas for improvement

Outstanding practice

- Consultant intensivists covered the day-to-day care of patients on the ward and PACU. This differs from most other private providers, where this care is usually managed by middle-grade doctors. The consultant intensivists providing 24-hour support each had substantial years of experience in caring for deteriorating patients across a broad range of specialities, with enhanced skills in early diagnosis and management of complications and comorbidities. This meant a higher level of support for patients post-operatively.
- The service had purchased virtual reality (VR) headsets for patients undergoing procedures under local anaesthetic or spinal anaesthetics. They were designed to relax and reduce stress and anxiety for the patient, without the need for extra sedation or general anaesthetics. The headsets contained a range of movies, documentaries and environments appropriate to the age and preferences of the patient.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure all staff receive their mandatory training.
- The provider should consider how to improve infection prevention control (IPC) in the surgery department.
- The provider should continue to monitor the elevated levels of bacteria in the water system and ensure all mitigating actions are taken.
- The provider should ensure issues found with resuscitation and difficult airway equipment are resolved.
- The provider should ensure all staff in recovery are aware of the steps to take in the event of recognised sepsis.
- The provider should ensure all fluids and medication continue to be stored satisfactorily in theatres.
- The provider should consider exploring the reasons for the high turnover rates in the service.
- The provider should consider how to improve response rates to patient surveys.
- The provider should consider how to formally measure staff satisfaction and experience.